State of Delaware

Summary of Non-Medicare Prescription Plan Benefits

Plan Year July 1, 2025 through June 30, 2026

State of Delaware Non-Medicare Prescription Plan

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, 2025**.

This is a summary of the most important provisions of the Plan. While this summary should answer most of your questions, it does not provide all the details of the Plan. These can be found in Plan documents maintained by 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 de.gov/statewidebenefits.

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About Your Participation

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

Who Is Eligible?

This Prescription Health Plan is automatically available through the State of Delaware to individuals who enrolled in a State of Delaware non-Medicare health plan, administered by Highmark Delaware or Aetna.

Note: The Spousal Coordination of Benefits (SCOB) Policy applies to prescription drug coverage, and is used to determine your spouse's eligibility to receive primary coverage under the GHIP.

The complete SCOB Policy can be found at de.gov/statewidebenefits. Contact the Statewide Benefits Office at 1-800-489-8933 for more information.

Enrollment Date

Your enrollment date is the effective date of your enrollment in the State of Delaware non-Medicare health plan, administered by Highmark Delaware or Aetna.

How to Enroll

When you select a State of Delaware non-Medicare health plan, administered by Highmark Delaware or Aetna, you will be automatically enrolled in the Plan. Please note that you cannot enroll in prescription drug coverage only; it must be in combination with a non-Medicare health plan.

Coverage Levels

The coverage level you choose under your State of Delaware non-Medicare 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 do not wish to enroll when you are first eligible.

Paying for Prescription Benefit Coverage

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

Making Changes during the Year

You may make a benefit or dependent change outside of the Annual Benefits Open Enrollment if you experience an eligible Qualifying Event. Qualifying events include, but may not be limited to:

- Marriage or civil union
- Divorce
- Birth or adoption of a child
- Involuntary loss of spouse coverage

Benefit election changes must be made **within 30 days** of the date of the eligible qualifying event.

Additional information regarding Qualifying Events is located online at de.gov/statewidebenefits.

When Prescription Drug Coverage Ends

Your entitlement to benefits automatically ends on the date that your State of Delaware health plan 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.

Death

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

Loss of Benefits

Your coverage (and your dependents coverage) will end under the Plan if your employment with an employer that participates in the State of Delaware Group Health Insurance plan ends, you are no longer eligible for coverage, you do not make the required contributions or you become covered under another plan offered by the State of Delaware.

State Drops Coverage

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

Divorce

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

Other Events Ending Your Coverage

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

Note: 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 Your Plan Coverage

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

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

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

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

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

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

Terms You Should Know

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.

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

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

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

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

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

CVS Caremark Prescription Drug Benefits

The drug benefit described in this document is provided by the State of Delaware and administered by CVS Caremark. Please visit the CVS Caremark website at www.caremark.com or call CVS Caremark Customer Care at 1-833-458-0835 for more information.

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 three ways:

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

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

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

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

Member Drug Costs

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

- A generic, preferred or non-preferred brand, or specialty drug,
- On the CVS Caremark Formulary (a list of drugs covered under the plan), and
- Filled at the appropriate participating pharmacy.

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

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

Up to a 30-Day Supply (Available at a **participating** retail pharmacy)		
Non-Specialty Drugs	**In-Network Pharmacy**	**Out-of-Network Pharmacy**
Generic Drugs	$10 Copay	Not Covered
Preferred Brand Name (Formulary)	$32 Copay	Not Covered
Non-Preferred Brand Name (Non-Formulary)	$60 Copay	Not Covered

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

Preventive Drugs	**In-Network Pharmacy**	**Out-of-Network Pharmacy**
Drugs classified as preventive under the Affordable Care Act may be covered at 100%.	$0 Copay (no member cost)	Not Covered

Up to a 30-Day Supply (Available **ONLY** at CVS Specialty® pharmacy through Home Delivery)		
Specialty Drugs	Enrolled in PrudentRx	Not Enrolled in PrudentRx
The PrudentRx program applies to all specialty medications on the CVS Caremark Specialty Drug List.*	$0 Copay (no member cost)	30% Coinsurance

Fertility Drugs	**In-Network Pharmacy**	**Out-of-Network Pharmacy**
There is a $15,000 lifetime maximum for all prescriptions for Fertility under the State of Delaware prescription plan.	25% Coinsurance	Not Covered

Annual Out-of-Pocket Maximums	**In-Network Pharmacy**	**Out-of-Network Pharmacy**
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

Formulary Drug 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 or a covered brand-name drug that appears on the Formulary (Preferred). In most cases, your share of the cost will be highest if your physician prescribes a covered brand-name drug that does not appear on the Formulary (Non-Preferred).

You can find the Formulary online at www.caremark.com or call CVS Caremark Customer Care at 1-833-458-0835. Information is also available at 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 $32 for a 30-day supply; $64 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 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.

Specialty Medications

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

Specialty medications are limited to a 30-day supply, and are required to be filled at a participating CVS Specialty® pharmacy. Specialty medications may not be filled at participating retail pharmacies, or the member will be responsible for paying the entire cost.

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

PrudentRx Solution for Specialty Medications

In order to provide a comprehensive and cost-effective prescription drug program for you and your family, the State of Delaware has contracted to offer the PrudentRx Solution for certain specialty medications. The PrudentRx Solution assists members by helping them enroll in manufacturer copay assistance programs. Medications on the PrudentRx Program Drug List are included in the program and will be subject to a 30% co-insurance. However, if a member is participating in the PrudentRx Solution, which includes enrollment in an available manufacturer copay assistance program for their specialty medication, the member will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Solution.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications - in particular, specialty medications. The PrudentRx Solution will assist members in obtaining copay assistance from drug manufacturers to reduce a member's cost share for eligible medications thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs, but please be assured that this is done in compliance with HIPAA.

If you currently take one or more specialty medications included in the PrudentRx Program Drug List, you will receive a welcome letter from PrudentRx that provides information about the PrudentRx Solution as it pertains to your medication. All eligible members must call PrudentRx at 1-800-578-4403 to register for any manufacturer copay assistance program available for your specialty medication as some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications. If you do not call PrudentRx, PrudentRx will make outreach to you to assist with questions and enrollment.

If you choose to opt out of the PrudentRx Solution, you must call 1-800-578-4403. Eligible members who fail to enroll in an available manufacturer copay assistance program or who opt out of the PrudentRx Solution will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx Solution.

If you or a covered family member are not currently taking, but will start a new medication covered under the PrudentRx Solution, you can reach out to PrudentRx, or they will proactively contact you so that you can take full advantage of the PrudentRx Solution. PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Solution.

The PrudentRx Program Drug List may be updated periodically.

Payments made on your behalf, including amounts paid by a manufacturer's copay assistance program, for medications covered under the PrudentRx Solution will not count toward your plan deductible or out-of-pocket maximum (if any), unless otherwise required by law. Also, payments made by you for a medication that does not qualify as an "essential health benefit" under the Affordable Care Act (ACA), will not count toward your deductible or ACA out-of-pocket maximum (if any), unless otherwise required by law. A list of specialty medications that are not considered to be "essential health benefits" under the Affordable Care Act is available. An exception process is available for determining whether a medication that is not an "essential health benefit" under the Affordable Care Act is medically necessary for a particular individual.

PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Solution.

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.

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.

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.

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 Plan's 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. Under certain conditions, the appeal process could take 24-72 hours to process. You or your prescriber may ask for an urgent appeal(expedited) 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 to 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.
- The dosage of the medication being prescribed exceeds the FDA (and formulary) limits.

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 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.

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.

Fertility Services

Members receiving any fertility 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 fertility services. There is a $15,000 lifetime maximum benefit for all prescriptions for fertility 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.

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.

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 the Health Plan Diabetes Care Management Program
- Mifeprex
- Cosmetic and hypopigmentation drugs
- 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 (drugs designated to be covered under the health plan)

Standard Control Formulary drug exclusions (varies by year). For a list of the most recent formulary exclusions, visit 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.

Member Cost Saving Programs

Maintenance Medication Program

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

The Maintenance Medication Program provides prescription cost savings by allowing members to fill 90-day prescriptions at reduced copays, when eligible. When members receive maintenance medications every thirty days, they pay three 30-day copays in order to receive a 90-day supply of medication. Under the maintenance medication program, one 90-day prescription costs the same as two 30-day fills.

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.

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		
Non-Specialty Drugs	**In-Network Pharmacy**	**Out-of-Network Pharmacy**
Generic Drugs	$20 Copay	Not Covered
Preferred Brand Name (Formulary)	$64 Copay	Not Covered
Non-Preferred Brand Name (Non-Formulary)	$120 Copay	Not Covered

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 Pharmacy

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

Diabetic Medications & Supplies

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

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

diabetic medications on the same day and submit the lowest cost generic medication first.

When multiple diabetic medications are filled and purchased on the same day, you will pay one copay, but if the doctor in the same month, prescribes another diabetic medication that is filled on a different day, another copay will be assessed. It is the member's responsibility to work with their physician and pharmacist to coordinate the prescriptions to be processed on the same day. **The Plan will not provide adjustments for prescriptions not originally processed on the same day**.

For more information on Diabetic Resources, visit de.gov/statewidebenefits.

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).

- 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 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.

For additional information, please reference the **Preventive Medications & Services** document available online at de.gov/statewidebenefits.

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 Pharmacy. 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 Pharmacy, generic drugs are used to fill prescriptions whenever possible, unless your doctor specifies otherwise. The pharmacist may contact your doctor to suggest that a preferred brand name drug be substituted with a comparable drug from the 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.”

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.

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.

The CVS Caremark® Mail Service Pharmacy

To receive your covered drugs through home delivery, you may sign up online by logging into your www.caremark.com account and select “Start Rx Delivery by Mail” OR ask your doctor to send in a new prescription electronically for delivery from the CVS Caremark® Mail Service Pharmacy. (Only your doctor can electronically send prescriptions to CVS Caremark.) Only 90-day supplies of maintenance medications can be obtained through the CVS Caremark® Mail Service Pharmacy. Refills may be ordered online at www.caremark.com.

For more information, visit www.caremark.com/MailService or call CVS Caremark Customer Care at 1-833-458-0835.

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.

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

In situations where you have other primary prescription 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 Plan will reimburse up to the approved contract amount (minus the state copay) for a claim submission amount that was not covered under the primary insurance.

Secondary claims will not be reimbursed for more than the amount that would be paid for a primary claim. All Utilization Management (UM) Requirements (i.e.: Formulary Specifications, Prior Authorizations, Step Therapy) must be met under the Plan.

When a member's dependent has other prescription coverage through an employer or former employer, the dependent must first use the primary coverage at the pharmacy to fill all prescriptions. Secondary prescription claims are not electronically adjudicated, which means coordination does not happen at point of sale. The member must submit a CVS Caremark Prescription Reimbursement Claim Form for consideration. **In addition, claims submitted as secondary cannot be filled through the CVS Caremark® Mail Service Pharmacy under the Plan.**

CLAIMS MUST BE FILED WITHIN 90 DAYS OF THE PRESCRIPTION FILL DATE.

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 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
Department of Human Resources, Statewide Benefits Office
841 Silver Lake Blvd
Rodney Building
Dover, DE 19901

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: 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
841 Silver Lake Blvd
Rodney Building, Suite 100
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

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.

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 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 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.

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 de.gov/statewidebenefits.

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

Under certain circumstances, Plan benefits may be denied or reduced from those described in this summary. 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.

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 841 Silver Lake Blvd Rodney Building Dover, DE 19901
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.

Last Updated 2/28/2025 for the Plan Year July 1, 2025 through June 30, 2026