State of Delaware

Your Summary of Prescription Drug Plan Benefits for Post-65 Medicare Eligible Pensioners

For Calendar Year 2019

State of Delaware

This booklet summarizes and describes the main provisions of the prescription drug plan (Plan) called the Express Scripts Medicare® (PDP) for the State of Delaware (State) made available to eligible Post-65 Medicare Eligible Pensioners and their eligible dependents enrolled in the State of Delaware Group Health Insurance Program (GHIP). This Plan supplements Medicare Part D prescription drug coverage. The effective date of this summary is January 1, 2019.

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

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 benefits, please contact the Office of Pensions at 1-800-722-7300 or Express Scripts Medicare, the prescription drug benefit manager, directly at 1-877-680-4883.

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

Table of Contents

About Your Participation

This section includes important information about your participation in the 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 Drug Coverage

This Plan is made available through the State of Delaware who elected to provide Medicare supplementary coverage for:

- Retired employees age 65 and older and their eligible spouses age 65 or older
- Disabled employees, on long term disability of the Disability Pension Plan, spouses and dependent children who are Medicare eligible
- Employees, spouses and dependent children who have End-Stage Renal Disease (ESRD) or Amyotrophic lateral sclerosis (ALS)

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

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.

Pensioner

Eligible Pensioners include retired employees who are permitted to participate in the GHIP. An eligible Pensioner shall also include former employees who are receiving or are eligible to receive retirement benefits in accordance with the following provisions:

- The State Employees’ Pension Plan under Chapters 53 and 55 of Title 29 of the Delaware Code,
- The State Police Pension Plan under subchapter II and the subchapter III of Chapter 83 of Title 11 of the Delaware Code,

- The Pension Plan for the Members of the State Judiciary under Chapter 56 of Title 29 of the Delaware Code,

- The County & Municipal Police/Firefighter Pension Plan or other county & municipal pension plans under Chapter 88 of Title 11 of the Delaware Code and 55A of Title 29 of the Delaware Code, and

- The Teachers' Retirement and Disability plan of Chapter 39 of Title 14 of the Delaware Code.

Eligible Pensioners shall also include the following classes of individuals:

- Those individuals who were employed by the county prothonotary offices immediately prior to October 1, 1987, and who chose to remain in their respective county pension plans and who would otherwise be eligible to receive retirement benefits in accordance with the State Employees' Pension Plan under Chapters 53 and 55 of Title 29 of the Delaware Code, and

- Those employees who are receiving disability benefits pursuant to § 5253(c) of Title 29 of the Delaware Code.

This subsection shall not apply to members of boards or commissions.

Spouse

Your eligible spouse can also participate in the Plan if you elect medical coverage for them. An eligible spouse is a spouse that is receiving Medicare Part A and Part B and 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 www.ben.omb.delaware.gov/cusgm.

Note: If your Medicare eligible spouse is covered under this Plan, you may need to complete the Spousal Coordination of Benefits Form if your spouse's employment or health status changed since July 2012, or the first time completed after July 2012. The Spousal Coordination of Benefits form is available at http://ben.omb.delaware.gov/documents/cob/spousal.shtml. Contact the Statewide Benefits Office at 1-800-489-8933 for more information.

If your spouse is under age 65, your spouse may be eligible to participate in the pre-65 prescription drug program. Please see spouse eligibility requirements in the Summary of

Prescription Drug Plan Benefits for Active State Employees and Non-Medicare Eligible Pensioners.

Child(ren)

Your eligible child(ren) that are receiving Medicare Part A and Part B 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:
  - a natural 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 the Pension Office at McArdle Building, 860 Silver Lake Blvd., Suite #1, Dover, DE 19904-2402.
- If your dependent is under age 26, your dependent may be eligible to participate in the pre-65 prescription drug program. Please see the dependent eligibility requirements in the Summary of Prescription Drug Plan Benefits for Active State Employees and Non-Medicare Eligible Pensioners.

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 the Pension 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 http://ben.omb.delaware.gov/medical/. Please print the form, complete it, and provide to the Pension Office.

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

Eligibility and Enrollment

Medicare Eligibility and Enrollment

You, and your spouse and your dependents, are eligible to enroll in Medicare Parts A and B based on being at least 65 years of age, or sooner if you are disabled. In accordance with 29 Delaware Code § 5203(b) and the State of Delaware's GHIP's Eligibility and Enrollment Rule 4.08 you, your spouse and your dependents 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 under this Plan for you, your spouse and dependents.

If you are an eligible Pensioner, or a spouse of an eligible Pensioner, about three months before turning 65:

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

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

- If you are under 65 and have a disability, you are automatically enrolled in Part A and Part B after you get Social Security or Railroad Retirement benefits for 24 months
- When you receive your Medicare Parts A and B card, provide the State's Office of Pensions with a copy of your identification card. The Office of Pensions will enroll you in a Medicare supplement plan to cover costs not covered by Medicare Parts A and B.

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 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. 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 Aetna or Highmark Delaware plan with the State's Group Health Insurance Plan.

Enrollment in the Prescription Drug Plan

Enrollment Date

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

How to Enroll

When you receive your Medicare card, you will need to provide a signed copy of the card to the Office of Pensions as soon as possible so your enrollment in the Medicare supplement plan and prescription drug coverage under this Plan can be entered into the Pension system.

A completed health application is required and can be obtained from the Office of Pensions. When you select a Medicare supplement plan with prescription drug coverage, you will be automatically enrolled in Plan. If you do not elect this coverage combination, you would need to wait until the next annual Medicare supplement Open Enrollment in October for coverage beginning the following January. Please note that you cannot enroll in prescription drug coverage only; it must be in combination with a Medicare supplement plan.

You should then receive information and welcome kits before your Medicare eligibility date, and you would use the new ID card beginning on the effective date of your coverage. Please contact the Office of Pensions at 1-800-722-7300 for assistance if you are unable to obtain your Medicare enrollment far enough in advance of your effective date. (Late enrollment may cause penalties and/or coverage problems.)

If you want to cover your spouse, you'll need to complete the Spousal Coordination of Benefits Form. See the Pension Office to get the enrollment information. The Spousal Coordination of Benefits form is available at http://ben.omb.delaware.gov/documents/cob/spousal.shtml.

Coverage Levels

The coverage level you choose under your State of Delaware medical plan will be the same coverage level you have under the Prescription drug plan. This Prescription drug 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 medical plan.

How to Decline Coverage

You may decline medical and prescription drug coverage if you don't want to enroll when you are first eligible. You will need to complete the enrollment process with the Pension Office indicating that you are waiving coverage.

Paying for Prescription Drug Benefit Coverage

The cost of the Plan is included in the cost of the State of Delaware medical plan you choose. You and State of Delaware share in the cost of your coverage. Expected costs and contributions are group rates — that is, they are determined by the total cost of providing coverage to all Plan participants. Your premium will be deducted from your pension check each month.

Your actual premium will be determined by the portion of the State of Delaware contribution for which you are eligible, according to your years of service and retirement date. If your adjusted gross income exceeds a certain amount, you may be required to pay an amount in addition to your monthly premium. This extra amount is paid directly to Medicare, and not to the Plan.

A late enrollment penalty is an amount added to your Medicare Part D monthly premium if, for any continuous period of 63 days or more after your Initial Enrollment Period is over, you go without one of the following:

- A Medicare Prescription Drug Plan (Part D)
- A Medicare Advantage Plan (Part C) (like an HMO or PPO)
- Another Medicare health plan that offers Medicare prescription drug coverage
- Creditable prescription drug coverage

When Prescription Drug Benefit Coverage Begins

When your coverage begins is determined by:

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

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

- Timely Enrollee; or
- Special Enrollee.

Timely Enrollees

You are a Timely Enrollee if you enroll when you are first eligible to be covered by Medicare.

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, adoption, or placement in the home for adoption, or court ordered support.

If you do not request enrollment within the 30-day enrollment period, you will be required to wait until the next open enrollment period to enroll.

Loss of Other Coverage

To qualify as a Special Enrollee because of loss of coverage, you (the Pensioner 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 (Pensioner or dependent) are a Special Enrollee if the Pensioner gets a new eligible 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 the Pension Office was notified of a loss of coverage or new dependent within 30 days and your application and premium is subsequently submitted:

- Pensioners: the first day of the month after the loss of coverage.
- Eligible Spouses: either the date of the marriage or civil union or the first day of the month after the marriage or civil union or the date your spouse turns 65.
- Eligible 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 do not request enrollment within the 30-day enrollment period, you will be required to wait until the next open enrollment period to enroll.

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 http://ben.omb.delaware.gov/documents/cob/spousal.shtml, and provide a copy of your Marriage/Civil Union Certificate to the Pension Office. The Spousal Coordination of Benefits Form must be completed upon enrollment and subsequently when your spouse has a change of job status or health insurance status.

Making Changes during the Year

Marriage or Civil Union

You may add your eligible 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, you must pay when you request enrollment.

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 required to wait until the next open enrollment period to enroll.

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 http://ben.omb.delaware.gov/documents/cob/spousal.shtml and provide a copy of your marriage or civil union certificate to the Pension Office. The Spousal Coordination of Benefits Form must be completed initially upon enrollment and subsequently when your spouse has a change of job status or health insurance status. 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 the Pension 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 for the former spouse ends on the last day of the month in which the divorce becomes final. Failure to provide notice of your divorce to the Pension 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

If your newborn child is eligible for enrollment in the Plan, you may add your newborn child. A birth certificate or legal documentation needs to be supplied to the Pension Office upon enrollment. 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, you must pay it when you enroll.

If your newborn is not eligible for coverage under the Plan, your newborn may be eligible to participate in the pre-65 prescription drug program. Please see the dependent eligibility requirements in the Summary of Prescription Drug Plan Benefits for Active State Employees and Non-Medicare Eligible Pensioners.

Adopted Children

You may add an eligible child because of adoption or placement in your home for adoption. A birth certificate or legal documentation needs to be supplied to the Pension 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.

Other Children

You may also cover an eligible child who is not your or your spouse's natural 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 the Pension 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 http://ben.omb.delaware.gov/medical/bcbs/forms.shtml .Please print the form, complete it, and provide to the Pension 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 http://ben.omb.delaware.gov/medical/bcbs/forms.shtml. Please print the form, complete it, and provide to the Pension 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. 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 required to wait until the next open enrollment period to enroll.

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 July 31, 2018. Contact your State for more information on eligibility.

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – 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	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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: http://www.indianamedicaid.com Phone 1-800-403-0864

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov/ Phone: 1-800-635-2570	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
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075

MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 1-402-473-7000 Omaha: 1-402-595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2018, 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.

OMB Control Number 1210-0137 (expires 12/31/2019)

When Prescription Drug 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:

- The Plan is discontinued;
- You voluntarily stop your coverage;
- You are no longer eligible for coverage;
- You do not retain coverage under both Part A and Part B of Medicare;
- Express Scripts Medicare receives written notice from State of Delaware to end your coverage;
- You are enrolled in another Medicare Part D prescription drug plan, which includes a Medicare Advantage Plan;
- 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;
- Your dependent does not retain coverage under both Part A and Part B of Medicare;
- Express Scripts Medicare receives written notice from State of Delaware to end their coverage;
- Your dependent becomes eligible for comparable benefits under this or any other group plan offered by your employer;
- Your dependent no longer qualifies as a dependent under this Plan; or
- The Plan is canceled.

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

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 notify the Pension 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 the Pension 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 spouses and his or her children.

Other Events Ending Your Coverage

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

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

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.

For an explanation of your plan's rules, please refer to the 2019 Express Scripts Member Communications. The 2019 Evidence of Coverage (EOC) lists other instances where membership may end. You can review the *Evidence of Coverage* (EOC) by visiting our website at express-scripts.com/drugs or may request a copy by contacting Express Scripts Medicare Customer Service at 1-877-680-4883.

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 retardation or a physician 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.

Benefits after Your Coverage Ends

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

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

Continuing Coverage under COBRA

If you lose your State of Delaware medical 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 medical plan coverage through COBRA, your coverage under the Prescription drug plan is also extended. See the “Continuation of Coverage Rights under COBRA” section later in this summary of Plan benefits for more information.

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

Terms You Should Know

Claims Administrator: Express Scripts Medicare, who 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 prescription drug plan. Plans may have their own formularies.

Express Scripts Medicare Prescription Drug Benefits

Express Scripts Medicare® (PDP) for the State of Delaware

Your Prescription Drug Plan Benefit

The drug benefit described in this document is your final benefit after combining the standard Medicare Part D benefit with additional drug coverage being provided by the State of Delaware. The following table provides a summary of what you will pay for covered prescription drugs across the different stages of your Medicare Part D benefit. You can fill your covered prescriptions at any participating retail network pharmacy or by mail through the Express Scripts PharmacySM. Some network retail pharmacies in your plan will only dispense a one-month supply, while Walgreens as well as select local retail pharmacies (including some grocery store chains) will provide up to a 90-day supply. Please visit our website at express-scripts.com or call Express Scripts Medicare Customer Service for more information.

<table>
<tr><td>Plan Premium</td><td colspan="4">Your actual premium will be determined by the portion of the State contribution for which you are eligible, according to your years of service and retirement date.</td></tr>
<tr><td rowspan="5">Initial Coverage stage</td><td colspan="4">You will pay the following copayments:</td></tr>
<tr><td>Tier</td><td>Retail One-Month (31-day) Supply</td><td>Retail Three-Month (90-day) Supply</td><td>Home Delivery Three-Month (90-day) Supply</td></tr>
<tr><td>Tier 1: Generic Drugs</td><td>$8 copayment</td><td>$16 copayment*</td><td>$16 copayment</td></tr>
<tr><td>Tier 2: Preferred Brand Drugs</td><td>$28 copayment</td><td>$56 copayment*</td><td>$56 copayment</td></tr>
<tr><td>Tier 3: Non-Preferred Brand/Generic Drugs</td><td>$50 copayment</td><td>$100 copayment*</td><td>$100 copayment</td></tr>
<tr><td></td><td colspan="4">*Some retail pharmacies in your plan only provide a one-month supply of your covered prescriptions at the one-month supply cost-share.

You may fill 90-day maintenance prescriptions (medications taken on a long-term basis) at a participating retail pharmacy. You may also receive up to a 90-day supply of certain maintenance drugs by mail through the Express Scripts Pharmacy. There is no charge for standard shipping. Not all drugs are available at a 90-day supply.</td></tr>
<tr><td>Catastrophic Coverage stage</td><td colspan="4">After your yearly out-of-pocket drug costs (what you and others pay on your behalf, including manufacturer discounts but excluding payments made by your Medicare prescription drug plan) reach $5,100 you will pay the greater of 5% coinsurance <u>or</u>:
▪ a $3.40 copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard copayment during the Initial Coverage stage
▪ a $8.50 copayment for all other covered drugs, with a maximum not to exceed the standard copayment during the Initial Coverage stage.</td></tr>
</table>

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 Express Scripts Medicare Formulary (a list of preferred drugs).

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/generic drugs, as well as other Medicare-approved drugs that are not on the Formulary.

Formulary Drug List

The list of drugs covered by the plan is also known as the "formulary." It contains a list of highly utilized Medicare Part D drugs selected by Express Scripts Medicare in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. The formulary also includes information on requirements or limits for some covered drugs that are part of the Express Scripts Medicare standard formulary drug rules.

You can reduce how much you have to pay for a covered prescription drug 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 or generic drug that does not appear on the Formulary (tier three – non-preferred).

For more information on your plan's specific drug coverage, please review your other plan materials, visit us on the Web at express-scripts.com or contact Express Scripts Medicare Customer Service at 1-877-680-4883.

Member Cost Saving Programs

Maintenance Medication Program

Under this program, you can fill 90-day prescriptions for maintenance medications for reduced copays. When you receive maintenance medications every 30 days, you will pay three 30-day copays in order to receive a 90-day supply of medication. A 90-day prescription costs the same as two 30-day fills. Some network retail pharmacies in your plan will only dispense a one-month supply, while Walgreens as well as select local retail pharmacies (including some grocery store chains) will provide up to a 90-day supply. Please visit our website at express-scripts.com or call Express Scripts Medicare Customer Service for more information.

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. Non-maintenance medications are those medications used to treat short term conditions, such as bronchitis, bacterial infections or pain following minor surgery.

Medicare Part B

Some medications as well as diabetic medications and supplies described under the Diabetic Program are covered through Medicare Part B. Prescriptions for these medications and supplies will be processed first through Medicare Part B and second through Express Scripts Medicare at the time of purchase.

Questions about specific medications and supplies covered through Medicare Part B may be answered by calling Express Scripts Member Services at 1-800-939-2142 (active employees), or Express Scripts Medicare Customer Service at 1-877-680-4883 (retirees).

Diabetic Program

Diabetic supplies (lancets, test strips, syringes/needles) are provided at no costs ($0 copay) when the prescription is filled at a retail participating pharmacy or through the Express Scripts Pharmacy (home delivery). 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 retail pharmacy that participates in the Express Scripts Network or through the Express Scripts Pharmacy (home delivery). For more information on the Diabetic Program, visit https://ben.omb.delaware.gov/script/retiree-medicare/costs.shtml

Additional Coverage

The State of Delaware provides additional coverage on certain Tier 3 Non-Preferred Brand drugs. You can find a list of these drugs on the State of Delaware Benefits website. You will only be charged the applicable Tier 2 Preferred Brand Drugs copayment when you fill your prescription at a network pharmacy.

If you have any questions regarding your prescription drug coverage, please contact Express Scripts Medicare Customer Service at 1-877-680-4883 (TTY users only: 1-800-716-3231). Customer Service is available 24 hours a day, 7 days a week.

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.
- The ingredients that (1) are not approved by the FDA for use in compounds, or (2) have experienced significant unjustified cost increases, are not covered under your plan. For more information contact Express Scripts Medicare Customer Service at; 1-877-680-4883.
    - 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.
    - Express Scripts Pharmacy (mail order pharmacy) does not fill prescriptions for compound medications.

If you use a non-network compounding pharmacy, you must pay out of pocket for your prescription and submit a direct claim to Express Scripts Medicare for partial reimbursement, based on the maximum allowable cost for the total ingredients.

Drug Coverage Provided by your State of Delaware Medical Plan

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

If you qualify for Extra Help

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

Long-Term Care (LTC) Pharmacy

If you reside in an LTC facility, you pay the same as at a network retail pharmacy. LTC pharmacies must dispense brand-name drugs in amounts of 14 days or less at a time. They may also dispense less than a one month's supply of generic drugs at a time. Contact Express Scripts Medicare Customer Service at; 1-877-680-4883, if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.

Out-of-Network Coverage

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

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.
- Other instances where certain restrictions or limitations apply.

If you are taking any drugs that are subject to coverage review, Express Scripts Medicare will need to review additional information from your doctor before a decision can be made if the prescription can be covered under the prescription drug plan. Check the Statewide Benefits website at http://ben.omb.delaware.gov/script/retiree_medicare.shtml for more information.

Prior Authorization

You or your doctor may be required to get prior authorization for certain drugs. This means that you will need to get approval from the plan before you fill your prescriptions. If you don't get approval, the drugs may not be covered.

Some drugs may be covered under Part B or under Part D, depending on your medical condition. Your doctor will need to get a prior authorization for these drugs as well, so your pharmacy can process your prescription correctly.

Step Therapy

Certain medications may not be covered unless you have first tried another medication or therapy. To obtain the preferred alternative medication, contact Express Scripts Medicare Customer Service at; 1-877-680-4883. If the preferred alternative medication does not show in your prescription history with Express Scripts Medicare, 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 Express Scripts Medicare Customer Service at; 1-877-680-4883.

Your ID Card

When you first enroll in your State of Delaware medical plan, you will receive an identification card from Express Scripts Medicare. If you need additional cards you can request a card by calling Express Script Medicare Customer Service at; 1-877-680-4883. In an emergency, you are able to print a temporary identification card from Express Scripts website, express-scripts.com. It is important to remember to use your Prescription drug plan ID card at the pharmacy rather than your medical plan's insurance card.

When You Need to Fill a Prescription

When you need to fill a prescription, you can choose to go to your local participating retail pharmacy or, for mail order, use the Express Scripts Pharmacy (Home Delivery). If your prescription is for a 30-day supply of a medication or less, one of the retail options is best. If you are filling a maintenance medication that you are expecting to take for a longer period of time, the Express Scripts Pharmacy for Home Delivery is your best choice.

Regardless of whether you choose a participating pharmacy or the Express Scripts Pharmacy for Home Delivery, 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 Express Scripts Medicare formulary. You and your doctor decide whether or not to switch to the formulary medication.

If you choose to fill your prescription at a non-participating pharmacy, or, in other words, at an out-of-network pharmacy, no benefits are payable from the Plan and you are responsible for the full cost, except in certain circumstances.

Retail Pharmacies

Express Scripts Medicare has contracted with retail pharmacies, including most major drug stores and local pharmacy locations. These retail pharmacies in the Express Scripts Medicare network are referred to as "participating pharmacies." To verify coverage at a particular pharmacy, check the Express Scripts Medicare Website or call Express Scripts Medicare Customer Service at 1-877-680-4883. 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 Express Scripts Medicare network.

The Express Scripts Pharmacy℠ (Home Delivery)

You may mail the prescription, a completed mail-order form, and payment to Express Scripts Medicare Pharmacy, OR ask your doctor to send in a new prescription electronically for delivery from the Express Scripts Pharmacy or fax the prescription to the Express Scripts Pharmacy at 1-800-837-0959. (Only your doctor can fax or electronically send prescriptions to Express Scripts Medicare.) Refills may be ordered online at express-scripts.com.

For more information, call Express Scripts Medicare Customer Service at 1-877-680-4883.

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 Express Scripts Medicare 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 Express Scripts Medicare for reimbursement of the covered expenses. **Claims must be filed within 90 days of the prescription fill date**.

To obtain a claim form, call Express Scripts Medicare Customer Service toll-free at 1-877-680-4883 or visit http://ben.omb.delaware.gov/script/retiree-medicare/resources.shtml to view and print an Express Scripts Medicare Part D Prescription drug claim form. You should submit your claim form to:

Express Scripts Medicare
Attention: Medicare Part D
P.O. Box 14718
Lexington, KY 40512-4718

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 Express Script's Medicare network. To find out if your pharmacy is affiliated with Express Scripts Medicare, for instructions on filing claims, for refills and for status of an order call Express Scripts Medicare Customer Service toll-free at 1-877-680-4883.

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 Express Scripts Medicare. Express Scripts Medicare, acting on behalf of State of Delaware, will provide the following claims and appeals review services:

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

Definitions

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

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.

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

Prior Authorization – Express Scripts Medicare' prior authorization review of a member's initial request for a particular medication. Express Scripts Medicare will apply a set of pre-defined clinical criteria to determine whether there is need for the requested medication.

Prior 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. Prior authorization claims include member requests for prior authorization.

Express Scripts Medicare Claims and Appeals Process

Prior Authorization Review

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

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

Initial Coverage Determination

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

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

Appeals of Adverse Benefit Determinations

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

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

Level 1 Appeal

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

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

- Name of the person the appeal is being filed for
- Medicare and Express Scripts Medicare Identification Number
- Date of birth

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

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

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

If you need help right away:
Call: 1-844-374-7377 (1-844-ESI-PDPS)
TTY Users Call: 1-800-716-3231
Fax: 1-877- 852-4070
Hours of Operation: Monday through Friday: 8:00 a.m. to 8:00 p.m. Central Time

Physicians may submit urgent appeal requests by calling the physician-only toll-free number 1-800-946-3979.

Members will receive an appeal notice with the determination of their claim. A standard appeal will result in a response within 7 days and an expedited appeal will have a response as quickly as your health condition requires, but no later than 72 hours.

Level 2 Appeal

If you disagree with the determination in Level 1, you can request a standard or expedited reconsideration by a government contracted Independent Review Entity (IRE) within 60 days from the date of the Level 1 Appeal determination notice.

If the Level 1 Appeal issues an unfavorable determination, you will receive a "Request for Reconsideration" form. To request a Level 2 Appeal, you should complete and return this form to the IRE via the fax or address listed in the Level 1 determination notice.

Members will receive an appeal notice with the determination of their claim. A standard appeal will result in a response within 7 days and an expedited appeal will have a response as quickly as your health condition requires, but no later than 72 hours.

Level 3 Appeal

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

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

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

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

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

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

A hearing will generally be held by video-teleconference (VTC). However, an in-person hearing may be held if the ALJ or attorney adjudicator determines the circumstances of the appeal warrant an in-person hearing. Telephone hearings may also be arranged in certain

circumstances for the convenience of the parties. Your hearing may take longer to schedule if the ALJ or attorney adjudicator needs to schedule a medical or non-medical expert to testify.

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

Level 4 Appeal

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

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

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

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

Department of Health and Human Services
Departmental Appeals Board, MS 6127
Medicare Operations Division – Cohen Building

330 Independence Avenue, SW, Room G-644
Washington DC 20201

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

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

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

Level 5 Appeal

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

For more information on the appeals process:

- Visit the State of Delaware Statewide Benefits Office at de.gov.statewidebenefits
- Visit https://www.medicare.gov/claims-and-appeals/file-an-appeal/appeals.html
- Call 1-800-MEDICARE (1-800-633-4227)
- Visit https://www.medicare.gov/forms-help-and-resources/forms/medicare-forms.html
- Call your State Health Insurance Assistance Program (SHIP_ for free, personalized health insurance counseling, including help with appeals. Please visit https://www.medicare.gov/contacts/ or call 1-800-MEDICARE for the SHIP phone number in your state.

Filing a Grievance or Complaint

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

If your complaint involves the quality of care you received, you can file a grievance with Express Scripts Medicare by calling 1-877-680-4883 (TTY users only: 1-800-716-3231) or your Beneficiary and Family Centered Quality Improvement Organization (BFCC-QIO). Visit https://www.medicare.gov/contacts/, or call 1-800-MEDICARE for the phone number of your local BFCC-QIO.

If you want to file a complaint:

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

  Express Scripts Medicare
  Attn: Grievance Resolution Team
  P.O. Box 3610
  Dublin, OH 43016-0307

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

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

For More Information on filing a complaint

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

Additional Rules that Apply to this Prescription Drug Plan

Women's Health and Cancer Rights Act of 1998

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

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

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

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

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

Qualified Medical Child Support Order (QMCSO)

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

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

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

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO. When an order is received, each affected participant and each child

(or the child's representative) covered by the order will be given notice of the receipt of the order and a copy of the Plan's procedure for determining if the order is valid. Coverage under the Plan pursuant to a medical child support order will not become effective until the Plan Administrator determines that the order is a QMCSO. If you have any questions or if you would like to receive a copy of the written procedure for determining whether a QMCSO is valid, please contact the Pension Office.

Subrogation and Right of Reimbursement

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

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

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

The coordination of benefits rules described in your State of Delaware medical plan summary of benefits will also apply to the Plan. Please refer to that document or contact the Pension 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 of Plan benefits. Cancellation or discontinuance of coverage is permitted if it has only a prospective effect on coverage, or is effective retroactively due to failure to pay required premiums or contributions.

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 medical plan coverage. Medical plan coverage may be continued under certain circumstances under the federal Consolidated Omnibus Reconciliation Act of 1985 (COBRA).

Continuing Coverage through COBRA

If you lose your Plan coverage, you have the right to extend it under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) if you elect to continue your State of Delaware medical plan coverage under COBRA. COBRA continuation coverage can become available to you when you would otherwise lose coverage under the Plan. It can also become available to your spouse and your dependent children who are covered under the Plan when they would otherwise lose such coverage.

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This continuation is available to you if you elect to continue your State of Delaware medical plan coverage only. **This notice generally explains COBRA continuation coverage, when it may become available to you and your covered spouse and dependent children, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose coverage under the Plan. It can also become available to your spouse and dependent children who are covered under the Plan when they would otherwise lose such coverage.

What Is COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when you would otherwise lose such coverage because of a life event known as a “qualifying event.” Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if covered under the Plan at the time of a qualifying event, and such coverage is lost because of the qualifying event. Additionally, a child who is born to or adopted or placed for adoption with you (the covered individual) during the COBRA continuation coverage period is also considered a qualified beneficiary, provided that you elected COBRA continuation coverage for yourself. Under the Plan, qualified beneficiaries must pay for the COBRA continuation coverage they elect, as described in the “Paying for COBRA Continuation Coverage” section.

COBRA Qualifying Events

If you are the **spouse of a Pensioner**, 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."

Certain Pensioners, and their spouses and dependents, may also be eligible for COBRA coverage if the Company commences a bankruptcy proceeding and those individuals lose coverage.

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.

Giving Notice that a COBRA Qualifying Event (or Second Qualifying Event) Has Occurred

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been timely notified that a qualifying event has occurred. When the qualifying

event is the death of the Pensioner or commencement of a bankruptcy proceeding, the employer must notify the Plan Administrator of the qualifying events. For the other qualifying events, you are responsible for notifying the Plan Administrator.

Important Note: For the other qualifying events (divorce or legal separation of the Pensioner and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator in writing within 60 days after the later of: 1) the date of qualifying event (or second qualifying event) or 2) the date the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event (or second qualifying event). You must provide this notice through the Pension Office.

How Is COBRA Continuation Coverage Provided

Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered (through a "COBRA Continuation Coverage Election Notice") to each of the qualified beneficiaries. This notice will come from CONEXIS, State of Delaware's COBRA administrator. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Pensioners may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For questions about your COBRA notice, you may call CONEXIS at 1-866-864-9546 and through the web at http://www.cobrabenefits.wageworks.com/.

If coverage under the Plan is changed for Pensioners, the same changes will apply to individuals receiving COBRA continuation coverage. Qualified beneficiaries also may change their coverage elections during the annual enrollment period, or at other times under the Plan to the same extent that Pensioners may do so.

Duration of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of health coverage. When the qualifying event is the death of the Pensioner, or your divorce or legal separation, COBRA continuation coverage for the Pensioner's spouse and/or dependent children (but not the Pensioner) lasts for up to a total of **36 months** from the date of the qualifying event. Also, the Pensioner's dependent children are entitled to COBRA continuation coverage for up to **36 months** after losing eligibility as a dependent child under the terms of the Plan.

The table below provides a summary of the COBRA provisions outlined in this section.

	Maximum Continuation Period		
Qualifying Events That Result in Loss of Coverage	*Pensioner*	*Spouse*	*Child*
Pensioner dies	N/A	36 months	36 months
Pensioner and spouse legally separate or divorce	N/A	36 months	36 months
Child no longer qualifies as a dependent child under the terms of the Plan	N/A	N/A	36 months

Electing COBRA Continuation Coverage

You and/or your covered spouse and dependent children must choose to continue coverage within 60 days after the later of the following dates:

- The date you and/or your covered spouse and dependent children would lose coverage under the Plan as a result of the qualifying event, or
- The date State of Delaware notifies you and/or your covered spouse and dependent children (through a "COBRA Continuation Coverage Election Notice") of your right to choose to continue coverage as a result of the qualifying event.

Paying for COBRA Continuation Coverage

Cost: Generally, each qualified beneficiary is required to pay the entire cost of COBRA continuation coverage. The cost of COBRA continuation coverage is 102% of the cost to the group health plan (including both employer and Pensioner contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage. The Trade Act of 2002, as reinstated by the Trade Adjustment Preferences Act of 2015, created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance, including continuation coverage under COBRA.

Premium Due Dates: If you elect COBRA continuation coverage, you must make your initial payment for continuation coverage (including all premiums due but not paid) no later than 45 days after the date of your election. (This is the date the COBRA Election Notice is post-marked, if mailed.) If you do not make your initial payment for COBRA continuation coverage within 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the Plan. **Payment is considered made on the date it is sent to the third party COBRA Administrator.**

After you make your initial payment for COBRA continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The premium due date and exact amount due each coverage period for each qualified beneficiary will be shown in the COBRA Election Notice you receive.

Although periodic payments are due on the dates shown in the COBRA Election Notice, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

If you elect COBRA continuation coverage but then fail to make an initial or periodic payment before the end of the 45- or 30-day grace period, respectively, for that coverage period, you will lose all rights to COBRA continuation coverage under the plan, and such coverage will be terminated retroactively to the last day for which timely payment was made (if any).

When COBRA Continuation Coverage Ends

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

- The applicable 36-month COBRA continuation coverage period ends
- Any required premium is not paid on time
- After the date COBRA continuation coverage is elected, a qualified beneficiary first becomes covered (as an employee or otherwise) under another group health plan (not offered by State of Delaware)
- State of Delaware ceases to provide any group health plan for its employees and Pensioners.

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

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, 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. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your rights as well as the rights of your spouse and dependent children, you should keep the COBRA administrator informed of any address changes for your spouse and/or dependent children. You should also keep a copy for your records of any notices you send to the COBRA administrator.

COBRA Contact Information

COBRA Administrator
CONEXIS (a division of Wageworks)
P.O. Box 226101
Dallas, TX 75222

1-877-864-9546
https://cobrabenefits.wageworks.com/

Plan Administration

DETAILS ABOUT PLAN ADMINISTRATION	
Plan Sponsor/Plan Administrator	State of Delaware
Official Plan Name	Prescription Drug Plan Benefits for Post-65 Medicare Eligible Pensioners, a component plan of the State of Delaware Health and Welfare Benefits Plan
Plan Year	January 1 – December 31
Type of Plan	Group health plan providing prescription drug benefits
Agent for Service of Legal Process	State of Delaware 97 Commerce Way, Suite 201 Dover, DE 19904
Carrier/Vendor/Claims Administrator	Express Scripts Medicare P.O. Box 66587 St. Louis, MO 63166-6587 1-800-939-2142 express-scripts.com

DETAILS ABOUT PLAN ADMINISTRATION	
Plan Funding	The Plan is self-funded as part of the State of Delaware Health and Welfare Benefits Plan. Benefits from this Plan are paid from Pensioner contributions, as applicable, and from the general assets of State of Delaware, as needed. State of Delaware has contracted with third-party administrators to administer this Plan.

Plan Administrator's Discretionary Authority to Interpret the Plan

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

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

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

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

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

Limitation on Assignment

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

Legal Action

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

Type of Coverage

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

Right of Recovery

If the amount of the payments made by Express Scripts Medicare 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.