This Is Your Prescription Drug Plan Addendum to your Evidence of Coverage for the 2026 Plan Year
(herein called the "EOC Addendum")

Provided By
SilverScript® Insurance Company

The coverage described in this Evidence of Coverage Addendum (EOC Addendum) is based upon the conditions set forth in the Group Agreement between SilverScript Insurance Company and to the Contract Holder (your former employer/union), and relates to certain non-Medicare supplemental benefits provided to Contract Holder's Members described in the group Medicare Evidence of Coverage. This EOC Addendum summarizes information found in the Group Agreement, group application and the Medicare Evidence of Coverage, which collectively make up the contract under which benefits are provided for covered prescription drugs (Covered Drugs). As such, the description of the benefits included in this EOC Addendum is meant to be read together with and summarize, rather than supersede, the information provided with respect to the Covered Drugs in the Group Agreement, group application and Medicare Evidence of Coverage.

This EOC Addendum refers to non-Medicare benefits that supplement those paid under the Group Medicare Part D Plan which is part of the group retiree benefits offered by the Group pursuant to the Group Agreement. The Group Medicare Part D Plan is a standalone drug plan (Part D only plan). Coverage provided under the Group Medicare Part D Plan is explained in the Medicare Evidence of Coverage.



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Section One – What is Covered Under This EOC Addendum

A. Your Coverage under this EOC Addendum and the Group Medicare Part D Plan

The Group Medicare Part D Plan is the primary payer plan for all covered Medicare Part D eligible drugs. This EOC Addendum supplements benefits under that plan by providing reduced cost sharing on covered Medicare Part D eligible drugs. If the Group Medicare Part D plan covers a Medicare Part D eligible drug, then this EOC Addendum will supplement benefits paid by your Group Medicare Part D Plan up to, but not including, the deductible, coinsurance or copay amounts shown in this EOC Addendum's benefit chart.

All outpatient drugs covered under the "Enhanced Drug Coverage" benefit, as outlined in the benefit chart, are covered only under this EOC Addendum and not the Group Medicare Part D Plan. The "Enhanced Drug Coverage" benefit includes outpatient prescription drug coverage required under New York State Law.

When the Group Medicare Part D Plan is the primary payer plan, it will determine whether the Member's drug will be covered or whether coverage will be subject to any Quantity Limit or Prior Authorization restrictions. When this EOC Addendum provides benefits for "Enhanced Drug Coverage," it will determine whether the Member's drug is covered or whether coverage will be subject to any Quantity Limit or Prior Authorization restrictions. Information on whether a particular drug has any restrictions can be found on the Group Medicare Part D Plan *Drug List* (also called Formulary).

You will receive benefits under the terms and conditions of this EOC Addendum only when the drug is:

- Medically Necessary;
- Listed as a Covered Drug;
- Received while this EOC Addendum and the Group Medicare Part D Plan is in force.

B. How to Obtain Prescription Drug Benefits

Show your Aetna Medicare Rx offered by SilverScript Plan ID card to your pharmacist to obtain covered benefits under both the base Group Part D Plan and this EOC Addendum. We will process your claim for Covered Drugs under the base Group Part D Plan or this EOC Addendum automatically when you use a network pharmacy. As long as the drug is covered and you pay your cost share, there is nothing more you need to do.

C. What You Pay Per Covered Drug

You will pay either a coinsurance or copayment amount for each Covered Drug. The amount you pay is listed in the Schedule of Benefits in the next section of this document. You will pay this amount directly to the network pharmacy. When you have a copayment, you will pay either the defined copayment or the cost of the drug, whichever is less.

Section Two – Schedule of Benefits

Except where stated otherwise, after you have satisfied the deductible, if applicable, you must pay the cost sharing in the Schedule of Benefits section of your Medicare Evidence of Coverage or this EOC Addendum for covered drugs.

Benefit Chart
This Benefit Chart (sometimes called Schedule of Benefits) provides a summary of the costs you must pay after benefits provided under this EOC Addendum and the Group Medicare Part D Plan are combined. For a more detailed explanation of benefits provided, please refer to the appropriate sections of the Medicare Evidence of Coverage.

Benefit Period	**January 1, 2026 – December 31, 2026**
Formulary	**Closed/Core Plus**
Deductible per calendar year	**$0**

Part D Covered Drugs
After benefits have been paid by the Group Medicare Part D plan and this EOC Addendum for covered drugs, you will be responsible for the amounts shown below during the period when you are in the Group Medicare Part D Plan's Initial Coverage phase. In addition, there is a separate chart below which outlines the amounts that you will pay during the Catastrophic Coverage phase.

INITIAL COVERAGE PHASE

Covered Services	**You Pay**
Retail Pharmacy	Per 30-day supply
• Preferred Generic	$10 copay at a standard retail pharmacy $5 copay at a preferred retail pharmacy
• Generic	$10 copay at a standard retail pharmacy $10 copay at a preferred retail pharmacy
• Preferred Brand	$20 copay at a standard retail pharmacy $20 copay at a preferred retail pharmacy
• Non-Preferred Brand	$45.50 copay at a standard retail pharmacy $45.50 copay at a preferred retail pharmacy
• Specialty	$45.50 copay at a standard retail pharmacy $45.50 copay at a preferred retail pharmacy (Drugs on the Specialty tier limited to a 30-day supply)
Retail pharmacies typically dispense a 30-day supply of medication. Most of our retail pharmacies can also dispense up to a 90-day supply of medication.	

Covered Services	You Pay
Mail Order Pharmacy	Per 90-day supply (Drugs on the Specialty tier limited to a 30-day supply)
• Preferred Generic	$10 copay
• Generic	$20 copay
• Preferred Brand	$40 copay
• Non-Preferred Brand	$91 copay
• Specialty	(Drugs on the Specialty tier limited to a 30-day supply)

CATASTROPHIC COVERAGE PHASE
Once you reach the Catastrophic Coverage Phase of your Part D benefit, your cost share for Part D covered drugs will be $0 for the remainder of the plan year.

In the Catastrophic Coverage Phase, enhanced non-Medicare supplemental drugs (if included under the plan) are covered at the same copayment as during the Initial Coverage Phase.

Enhanced Drug Coverage – New York Mandates	
These prescription drugs are often excluded from coverage under Medicare Part D Plans, but, as required by law, are covered under plans issued in New York. Therefore, as provided in this EOC Addendum, these drugs are covered by the Group Medicare Part D Plan. Any payments for these drugs will not count towards your total out-of-pocket limit.	
• Contraceptive drugs, devices and other products, including over-the-counter contraceptive drugs, devices and other products, approved by the FDA and as prescribed or otherwise authorized under State or Federal law. "Over-the-counter contraceptive products" means those products provided for in comprehensive guidelines supported by HRSA. Coverage also includes emergency contraception when provided pursuant to a prescription or order or when lawfully provided over-the-counter. You may request coverage for an alternative version of a contraceptive drug, device and other product if the covered contraceptive drug, device and other product is not available or is deemed medically inadvisable, as determined by your attending Health Care Provider.	$0 copay
• **Enteral Formulas:** Prescription or non-prescription enteral formulas for home use, whether administered orally or via tube feeding, for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen. Specific diseases and disorders include but are not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies. Multiple food allergies include but are not limited to: immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.	$10 copay for generic drugs; $20 copay for brand drugs at a standard retail pharmacy $5 copay for generic drugs; $20 copay for brand drugs at a preferred retail pharmacy Per 30-day supply

Additional information regarding your coverage

- **Off-label cancer drugs:** We cover off-label cancer drugs as long as the prescription drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or is recommended by review article or editorial comment in a major peer reviewed professional journal. We reserve the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, you are entitled to an Appeal as described in the Coverage Determination, Appeal, and External Appeal sections of this Addendum.
- **Eye Drops:** For prescription eye drop medication, we allow for the limited refilling of the prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early refill of renewals. To the extent practicable, the quantity of eye drops in the early refill will be limited to the amount remaining on the dosage that was initially dispensed. Your cost-sharing for the limited refill is the amount that applies to each prescription or refill as set forth in the Schedule of Benefits section of this EOC Addendum.
- **Mail Order Drugs:** This Group Medicare Part D Plan does not require you to use a mail-order pharmacy; this is an option that is available to you. You will have the same cost share as at mail order if you use a network retail pharmacy. Notwithstanding the foregoing, Group Medicare Part D plans offered under a collectively bargained agreement may not have the same cost share for the 90-day retail and 90-day mail order, and may have a lower cost share at mail order than if you use a network retail pharmacy to fill or refill that covered prescription.
- Initial Limited Supply of Prescription Opioid Drugs. If You receive an initial limited prescription for a seven (7) day supply or less of any schedule II, III, or IV opioid prescribed for acute pain, and you have a copayment, your copayment will be prorated. If you receive an additional supply of an opioid Prescription Drug within the 30-day period in which you received the seven (7) day supply, your Copayment for the remainder of the 30-day supply will also be prorated. In no event will the prorated Copayment(s) total more than your Copayment for a 30-day supply.
- The Group Medicare Part D Plan has a large nationwide retail pharmacy network, plus mail order pharmacies for convenient home delivery. When you use a retail pharmacy, you may pay less by using one of the network's preferred retail pharmacies. Our preferred retail pharmacies can be found in our pharmacy network directory. You can call Customer Service at the number on the back of your membership card if you have any questions about this benefit.

Section Three - Who is eligible for coverage (Eligibility)

This EOC Addendum is provided pursuant to the terms of the Group Agreement between us and the Group contract holder (your former employer/union/trust). Eligibility for the coverage included in this EOC Addendum is determined by the eligibility rules established by the Group Part D Plan. Refer to the Medicare Evidence of Coverage for the eligibility requirements.

Section Four - What is Not Covered (Exclusions and Limitations)

This EOC Addendum supplements the benefits paid by the Medicare Group Part D Plan you have through your former employer/union/trust. Your covered benefits under your combined plan (your Group Part D Plan and this EOC Addendum) do not include the following:

1. Drugs not covered by your Group Part D Plan formulary, except costs for drugs covered under this EOC Addendum.
2. Drugs covered under Medicare Part A or Part B, unless listed in Schedule of Benefits in this EOC Addendum.
3. Costs you pay towards meeting your deductible, if applicable.
4. Drugs purchased outside: (a) the United States; (b) its possessions; or (c) the countries of Canada or Mexico provided that (c) is limited to drugs covered under the Schedule of Benefits included with this EOC Addendum.
5. Non-prescription drugs (also called over-the-counter drugs).
6. Drugs when used to promote fertility.
7. Drugs when used for cosmetic purposes.
8. War. We do not cover an illness, treatment or medical condition due to war, declared or undeclared.

Section Five - Coordination of Benefits (COB)

This section applies when you also have group health coverage with another plan. When you receive a Covered Drug under this EOC Addendum, we will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This coordination prevents duplicate payments and overpayments.

A. Definitions Used in Section Five.

1. **"Allowable expense"** is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

2. **"Plan"** is other group health coverage with which we will coordinate benefits. The term "plan" includes:
    - Group health benefits and group blanket or group remittance health benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
    - Medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
    - Hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private insurance coverage.

3. **"Primary plan"** is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: 1) the plan has no order of benefits rules or its rules differ from those required by regulation; or 2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

4. **"Secondary plan"** is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

B. Rules to Determine Order of Payment.

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. If the other plan does not have a provision similar to this one, then the other plan will be primary.

2. If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this EOC Addendum will be primary.

3. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year will be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

4. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:

    - The plan of the parent who has custody will be primary;
    - If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third; and
    - If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

5. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

6. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

C. Effects of Coordination.

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed our maximum available benefit for each covered service. Also, the amount we pay will not be more than the amount we would pay if we were primary. As each claim is submitted, we will determine our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

D. Right to Receive and Release Necessary Information.

We may release or receive information that we need to coordinate benefits. We do not need to tell anyone or receive consent to do this. We are not responsible to anyone for releasing or obtaining this information. You must give us any needed information for coordination purposes, in the time frame requested.

E. Our Right to Recover Overpayment.
If we made a payment as a primary plan, you agree to pay us any amount by which we should have reduced our payment. Also, we may recover any overpayment from the primary plan or the provider receiving payment and you agree to sign all documents necessary to help us recover any overpayment.

F. Coordination with "Always Excess," "Always Secondary," or "Non-Complying" Plans.
Except as described below, we will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

1. If this EOC Addendum is primary, as defined in this section, we will pay benefits first.
2. If this EOC Addendum is secondary, as defined in this section, we will pay only the amount we would pay as the secondary insurer.
3. If we request information from a non-complying plan and do not receive it within 30 days, we will calculate the amount we should pay on the assumption that the non-complying plan and this EOC Addendum provide identical benefits. When the information is received, we will make any necessary adjustments.

If a blanket accident insurance policy issued in accordance with Section 1015.11 of the General Business Law contains a provision that its benefits are excess or always secondary, then this EOC Addendum is primary.

Section Six – Coverage Decisions and Appeals

The following *coverage decision and appeals processes apply* ***only to*** *prescription drugs that are* ***not*** *covered by Medicare.*

I. Utilization Review.

Your coverage under this EOC Addendum or the Group Medicare Part D Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing provider may be asked to give more details before we can decide if the prescription drug is medically necessary.

- **Prior Authorization**. Prior authorization may be needed for certain prescription drugs to make sure proper use and guidelines for prescription drug coverage are followed. When appropriate, we will contact your provider to determine if preauthorization should be given.
    - Prior Authorization is not required for Covered antiretroviral Prescription Drugs for the treatment or prevention of HIV or AIDS and medications to treat substance use disorder, including opioid overdose reversal medications prescribed or dispensed to you.
- **Quantity Limits**. We may limit quantities, day supply, early refill access and/or duration of therapy for certain medications based on medical necessity including acceptable medical standards and/or FDA recommended guidelines.

For a list of prescription drugs that need prior authorization, or for details about your formulary or rules or restrictions that apply to that plan, refer to your Medicare Group Part D Plan Evidence of Coverage, or call customer service. This plan will only make payments for drugs that are determined to be covered benefits under your Group Part D Plan. This means that if your Group Part D Plan determines that a particular drug is not a covered benefit, we will not make payment for that drug under this EOC Addendum either, unless it is listed in the Schedule of Benefits included with this EOC Addendum. See the "Coverage Decisions and Appeals" content below for additional details on how to request or appeal a determination.

II. Formulary Exception Process.

For the outpatient drugs covered under this "Enhanced Drug Coverage" benefit, as outlined in this EOC Addendum, if a Prescription Drug is not on our Formulary, you, your designee or your prescribing Health Care Professional may request a Formulary exception for a clinically-appropriate Prescription Drug in writing, electronically or telephonically. The request should include a statement from your prescribing Health Care Professional that all Formulary drugs will be or have been ineffective, would not be as effective as the non-Formulary drug, or would have adverse effects. If coverage is denied under our standard or expedited Formulary exception process, you are entitled to an external appeal as outlined in the External Appeal section of this EOC Addendum. Call the number on Your ID card to find out more about this process.

- **Standard Review of a Formulary Exception.** We will make a decision and notify you or your designee and the prescribing Health Care Professional by telephone no later than 72 hours after our receipt of your request. We will notify You in writing within three (3) business days of receipt of your request. If we approve the request, we will cover the Prescription Drug while you are

taking the Prescription Drug, including any refills.

- **Expedited Review of a Formulary Exception.** If you are suffering from a health condition that may seriously jeopardize your health, life or ability to regain maximum function or if you are undergoing a current course of treatment using a non-Formulary Prescription Drug, you may request an expedited review of a Formulary exception. The request should include a statement from your prescribing Health Care Professional that harm could reasonably come to you if the requested drug is not provided within the timeframes for our standard Formulary exception process. We will make a decision and notify you or your designee and the prescribing Health Care Professional by telephone no later than 24 hours after our receipt of your request. We will notify you in writing within three (3) business days of receipt of your request. If we approve the request, we will cover the Prescription Drug while you suffer from the health condition that may seriously jeopardize your health, life or ability to regain maximum function or for the duration of your current course of treatment using the non-Formulary Prescription Drug.

III. Coverage Decisions and Appeals.

A. Coverage Decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs. We are making a coverage decision for you whenever we decide what is covered for you and how much we pay.

Here are examples of coverage decisions you ask us to make about your drugs:

- You ask us to make an exception, including:
    - Asking us to cover a drug that is not on the plan's *List of Covered Drugs (Formulary)*.
    - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get).
    - Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier.

- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan's *List of Covered Drugs (Formulary)* but we require you to get approval from us before we will cover it for you.)
    - *Please note:* If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.

- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

What is an exception?

If a drug is not covered in the way you would like it to be covered, you, your designee or your prescribing Health Care Professional may request can ask us to make an "exception" for a clinically-appropriate prescription drug in writing, electronically or telephonically. An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision, including an external appeal as outlined in the External Appeal section of this Addendum.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. Covering a drug for you that is not on our List of Covered Drugs (Formulary). (We call it the "Drug List" for short.)

    - If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in the non-preferred drug/non-preferred brand tier. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

2. Removing a restriction on our coverage for a covered drug. There are extra rules or restrictions that apply to certain drugs on our List of Covered Drugs (Formulary).

    - The extra rules and restrictions on coverage for certain drugs include:
        - Being required to use the generic version of a drug instead of the brand name drug.
        - Getting plan approval in advance before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
        - Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.

    - If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. Changing coverage of a drug to a lower cost-sharing tier. Every drug on our Drug List is in one of up to 5 cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

    - You cannot ask us to change the cost-sharing tier for any drug in the Specialty tier, for a drug that is not on the formulary, or for a drug that is covered solely through an Enhanced Drug Coverage benefit.

Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally not approve your request for an exception. If you ask us for a tiering exception, we will generally not approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you.

We can say yes or no to your request

If you meet our plan coverage requirements, the approval length is based upon the plan coverage criteria for the drug.

If we approve your request for an exception to our coverage requirements, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.

If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. The **Level 1 Appeals** section below tells you how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Step-by-step: How to ask for a coverage decision, including an exception

Step 1: You ask us to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a "fast coverage decision." You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. (Your representative can either be appointed by you, or authorized under State or other applicable law to act on your behalf.) You can also access the coverage decision process through our website. For the details, call us at the phone number on your Group Part D Plan ID card. Or if you are asking us to pay you back for a drug, see "*If you want to ask us to pay you back for a drug*" section below.

- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Call us at the phone number on your Group Part D Plan ID card for information on how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.

- **If you want to ask us to pay you back for a drug,** send us your request for payment, along with your receipt documenting any payment you have made. It's a good idea to make a copy of your receipts for your records. Mail your request for payment together with the receipts to us at this address:

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

  You must submit your claim to us within 36 months of the date you received the service or item.

Some situations in which you may need to ask for reimbursement include: when you use an out-of-network pharmacy to get a prescription filled (this includes all pharmacies in Canada and Mexico), when you pay the full cost for a prescription because you don't have your plan membership card with you, or if you are retroactively enrolled in the plan.

- **If you are requesting an exception, provide the "supporting statement.**" Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "supporting statement.") Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

- **We must accept any written request,** including our plan's form, which is available on our website.

If your health requires it, ask us to give you a "fast coverage decision"

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines.
    - Standard review of an exception: We will make a decision and notify you or your designee by telephone and in writing, and the prescribing health care professional in writing, no later than 72 hours after our receipt of your request. If we approve the request, we will cover the prescription drug while you are taking the prescription drug, including any refills.
    - Expedited review of an exception: If you are suffering from a health condition that may seriously jeopardize your health, life or ability to regain maximum function or if you are undergoing a current course of treatment, you may request an expedited review of an exception. We will make a decision and notify you or your designee by telephone no later than 24 hours after receipt of your request and in writing within three (3) business days of receipt of your request. We will notify your prescribing health care professional in writing within three (3) business days of receipt of your request. If we approve the request, we will cover the prescription drug while you suffer from the health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of your current course of treatment.

- To get a fast coverage decision, you must meet two requirements:
    - You can get a fast coverage decision only if you are asking for a drug you have not yet received. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
    - You can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.

- If you or your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.

Step 2: We consider your request and we give you our answer.

Deadlines for a "fast" coverage decision

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.

    - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
    - **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
    - **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a "standard" coverage decision about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer **within 72 hours.**

    - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.

- **If our answer is yes to part or all of what you requested –**

    - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a "standard" coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Step 3: If we say no to your coverage request, you decide if you want to make an appeal.

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

B. Level 1 Appeals

<u>Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)</u>

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Your appeal is handled by different reviewers than those who made the original unfavorable decision.

Step 1: You contact us and make your Level 1 Appeal. If your health requires a quick response, you may ask for a **"fast appeal."**

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
    - For details on how to reach us by phone, fax, or mail, or on our website, for any purpose related to your appeal, call us at the number on your Group Part D Plan ID card.
- **If you are asking for a standard appeal, make your appeal by: submitting a written request by mail or through the website; calling us at the number on your Group Part D Plan ID card; or asking your doctor to fax the request.**
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown on your Group Part D Plan ID card.**
- **We must accept any written request**
- **Our electronic appeal request form** may be accessed on the following website https://www.caremark.com.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- For the Enhanced Drug Coverage of non-Part D drugs described on page 6 of this EOC Addendum, you can make your appeal request within 180 calendar days from the date on the written notice we sent to tell you our answer to your request for a coverage decision.
- **You can ask for a copy of the information in your appeal and add more information.**
    - You have the right to ask us for a copy of the information regarding your appeal.
    - While your appeal is pending decision, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal"

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in **(Section II.A above)**.

Step 2: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a "fast" appeal

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a "standard" appeal

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for "fast" appeal.
- **If our answer is yes to part or all of what you requested –**
    - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
    - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

Step 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

C. Level 2 Appeal (External Appeal)

1. Your Right to an External Appeal.

In some cases, you have a right to an external appeal of a denial of coverage. If we have denied coverage on the basis that a drug is not medically necessary (including appropriateness or effectiveness of a covered benefit) or is an experimental or investigational treatment, you or your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for you to be eligible for an external appeal you must meet the following two (2) requirements:

- The drug must otherwise be a covered benefit under this Addendum; and
- In general, you must have received a final adverse determination through our internal appeal process. But, you can file an external appeal even though you have not received a final adverse determination through our internal appeal process if:
    - We agree in writing to waive the internal appeal. We are not required to agree to your request to waive the internal appeal; or
    - You file an external appeal at the same time as you apply for an expedited internal appeal; or
    - We fail to adhere to claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and we demonstrate that the violation was for good cause or due to matters beyond our control and the violation occurred during an ongoing, good faith exchange of information between you and us).

2. Your Right to Appeal a Determination that a Drug is Not Medically Necessary.
If we have denied coverage on the basis that the drug is not medically necessary, you may appeal to an External Appeal Agent if you meet the requirements for an external appeal in paragraph "1" above.

3. Your Right to Appeal a Determination that a Service is Experimental or Investigational.
If we have denied coverage on the basis that the drug is an experimental or investigational treatment, you must satisfy the two (2) requirements for an external appeal in paragraph "1" above and your attending physician must certify that your condition or disease is one for which:

1. Standard drugs are ineffective or medically inappropriate; or
2. There does not exist a more beneficial standard drug covered by us; or
3. There exists a clinical trial or rare disease treatment (as defined by law).

In addition, your attending physician must have recommended one (1) of the following:

1. A drug that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered drug (only certain documents will be considered in support of this recommendation – your attending physician should contact the State for current information as to what documents will be considered or acceptable); or
2. A clinical trial for which you are eligible (only certain clinical trials can be considered); or

3. A rare disease drug treatment for which your attending physician certifies that there is no standard drug treatment that is likely to be more clinically beneficial to you than the requested drug, the requested drug is likely to benefit you in the treatment of your rare disease, and such benefit outweighs the risk of the drug. In addition, your attending physician must certify that your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, your attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat your condition or disease. In addition, for a rare disease drug treatment, the attending physician may not be your treating physician.

4. Your Right to Appeal a Formulary Exception Denial.
If we have denied your request for coverage of a non-formulary prescription drug through our formulary exception process, you, your designee or the prescribing health care professional may appeal the formulary exception denial to an External Appeal Agent. See the Prescription Drug Coverage section of this EOC Addendum for more information on the formulary exception process.

5. The External Appeal Process.
You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal appeal process to file a written request for an external appeal. If you are filing an external appeal based on our failure to adhere to claim processing requirements, you have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through our internal appeal process or our written waiver of an internal appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If you meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with your external appeal request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which we based our denial, the External Appeal Agent will share this information with us in order for us to exercise our right to reconsider our decision. If we choose to exercise this right, we will have three (3) business days to amend or confirm our decision. Please note that in the case of an expedited external appeal (described below), we do not have a right to reconsider our decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of your completed application. The External Appeal Agent may request additional information from you, your physician, or us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify you in writing of its decision within two (2) business days.

If your attending physician certifies that a delay in providing the drug that has been denied poses an imminent or serious threat to your health or if your attending physician certifies that the standard external appeal time frame would seriously jeopardize your life, health or ability to regain maximum function, you may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of your completed application. Immediately after reaching a decision, the External Appeal Agent must notify you and us by telephone or facsimile of that decision. The External Appeal Agent must also notify you in writing of its decision.

If your internal formulary exception request received a standard review through our formulary exception process, the External Appeal Agent must make a decision on your external appeal and notify you or your designee and the prescribing health care professional by telephone within 72 hours of receipt of your completed application. The External Appeal Agent will notify you or your designee and the prescribing health care professional in writing within two (2) business days of making a determination. If the External Appeal Agent overturns our denial, we will cover the Prescription Drug while you are taking the Prescription Drug, including any refills.

If your internal formulary exception request received an expedited review through our formulary exception process, the External Appeal Agent must make a decision on your external appeal and notify you or your designee and the prescribing health care professional by telephone within 24 hours of receipt of your completed application. The External Appeal Agent will notify you or your designee and the prescribing health care professional in writing within 72 hours of receipt of your completed application. If the External Appeal Agent overturns our denial, we will cover the Prescription Drug while you suffer from the health condition that may seriously jeopardize your health, life or ability to regain maximum function or for the duration of your current course of treatment using the non-formulary Prescription Drug.

If the External Appeal Agent overturns our decision that a drug is not Medically Necessary or approves coverage of an experimental or investigational drug, we will provide coverage subject to the other terms and conditions of this EOC Addendum. Please note that if the External Appeal Agent approves coverage of an experimental or investigational drug that is part of a clinical trial, we will only cover the cost of the drug to you according to the design of the trial. We will not be responsible for the costs of health care services, the costs of managing the research, or costs that would not be covered under this EOC Addendum for non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both you and us. The External Appeal Agent's decision is admissible in any court proceeding.

6. Your Responsibilities.

It is your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist you with your application; however, the Department of Financial Services may contact you and request that you confirm in writing that you have appointed the representative.

Under New York State law, your completed request for external appeal must be filed within four (4) months of either the date upon which you receive a final adverse determination, or the date upon which you receive a written waiver of any internal appeal, or our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

Section Seven – Termination of Your Coverage

This EOC Addendum is provided under the terms of the Group Agreement between us and the Group contract holder (your former employer/union/trust). Your coverage under this EOC Addendum will terminate in accordance with the termination rules established by the Group Part D Plan. Refer to the Medicare Evidence of Coverage for those termination rules.

Section Eight - General Provisions

1. Assignment.
You cannot assign any benefits under this EOC Addendum to any person, corporation or other organization and any such assignment will be void and unenforceable.

Assignment means the transfer to another person, corporation or other organization of your right to the services provided under this EOC Addendum. Nothing in this paragraph shall affect your right to appoint a designee or representative as otherwise permitted by applicable law.

2. Changes in this EOC Addendum.
We may unilaterally change this EOC Addendum upon renewal, if we give the Group 60 days' prior written notice.

3. Choice of Law.
This EOC Addendum shall be governed by the laws of the State of New York.

4. Clerical Error.
Clerical error, whether by the Group or us, with respect to this EOC Addendum, or any other documentation issued by us in connection with this EOC Addendum, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

5. Conformity with Law.
Any term of this EOC Addendum which is in conflict with New York State law or with any applicable federal law that imposes additional requirements from what is required under New York State law will be amended to conform with the minimum requirements of such law.

6. Enrollment ERISA.
The Group may have additional responsibilities as the "plan administrator" as defined by the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. The "plan administrator" is the Group, or a third party appointed by the Group. We are not the ERISA plan administrator.

7. Entire Agreement.
This EOC Addendum, including any endorsements, riders and the attached applications, if any, constitutes the entire EOC Addendum.

8. Furnishing Information and Audit.
The Group and all persons covered under this EOC Addendum will promptly furnish us with all information and records that we may require from time to time to perform our obligations under this EOC Addendum. You must provide us with information over the telephone for reasons such as the following: to allow us to determine the level of care you need; or so that we may certify care authorized by your physician. The Group will, upon reasonable notice, make available to us, and we may audit and make copies of, any and all records relating to Group enrollment at the Group's New York office.

9. Identification Cards.

Identification ("ID") cards are issued by us for identification purposes only. Possession of any ID card confers no right to services or benefits under this EOC Addendum. To be entitled to such services or benefits, your premiums must be paid in full at the time the services are sought to be received.

10. Incontestability.
No statement made by you will be the basis for avoiding or reducing coverage unless it is in writing and signed by you. All statements contained in any such written instrument shall be deemed representations and not warranties.

11. Independent Contractors.
Network pharmacies are independent contractors. They are not our agents or employees. We and our employees are not the agent or employee of any network pharmacy. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by you while receiving care from any network pharmacy.

12. Material Accessibility.
We will give you ID cards, EOC Addendums, and other necessary materials.

13. More Information about Your Prescription Drug Plan.
You can request additional information about your coverage under this EOC Addendum. Upon your request, we will provide the following information:

- A list of the names, business addresses and official positions of our board of directors, officers and members; and our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
- The information that we provide the State regarding our consumer complaints.
- A copy of our procedures for maintaining confidentiality of member information.
- A copy of our drug formulary. You may also inquire if a specific drug is covered under this EOC Addendum.
- A written description of our quality assurance program.
- A copy of our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- A copy of our clinical review criteria (e.g., Medical Necessity criteria), and where appropriate, other clinical information we may consider regarding a specific disease, course of treatment or Utilization Review guidelines.
- Written application procedures and minimum qualification requirements for pharmacies.

14. Notice.
Any notice that we give you under this EOC Addendum will be mailed to your address as it appears in our records or to the address of the Group. You agree to provide us with notice of any change of your address. If you have to give us any notice, it should be sent by U.S. mail, first class, postage prepaid to: the address on your Group Part D Plan ID card.

15. Premium Refund.
We will give any refund of premiums, if due, to the Group.

16. Recovery of Overpayments.

On occasion, a payment will be made to you when you are not covered, for a service that is not covered, or which is more than is proper. When this happens, we will explain the problem to you and you must return the amount of the overpayment to us within 60 days after receiving notification from us. However, we shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless we have a reasonable belief of fraud or other intentional misconduct.

17. Right to Develop Guidelines and Administrative Rules.
We may develop or adopt standards that describe in more detail when we will or will not make payments under this EOC Addendum. Those standards will not be contrary to the descriptions in this EOC Addendum. If you have a question about the standards that apply to a particular benefit, you may contact us and we will explain the standards or send you a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable us to carry out our duties in connection with the administration of this EOC Addendum.

18. Right to Offset.
If we make a claim payment to you or on your behalf in error or you owe us any money, you must repay the amount you owe us. Except as otherwise required by law, if we owe you a payment for other claims received, we have the right to subtract any amount you owe us from any payment we owe you.

19. Severability.
The unenforceability or invalidity of any provision of this EOC Addendum shall not affect the validity and enforceability of the remainder of this EOC Addendum.

20. Significant Change in Circumstances.
If we are unable to arrange for Covered Drugs as provided under this EOC Addendum as the result of events outside of our control, we will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of participating providers' personnel, or similar causes. We will make reasonable attempts to arrange for Covered Drugs. We and our network pharmacies will not be liable for delay, or failure to provide or arrange for covered services if such failure or delay is caused by such an event.

21. Subrogation and Reimbursement.
These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for your injury, illness or other condition and we have provided benefits related to that injury, illness or condition. As permitted by applicable state law, unless preempted by federal law, we may be subrogated to all rights of recovery against any such party (including your own insurance carrier) for the benefits we have provided to you under this EOC Addendum. Subrogation means that we have the right, independently of you, to proceed directly against the other party to recover the benefits that we have provided.

Subject to applicable state law, unless preempted by federal law, we may have a right of reimbursement if you or anyone on your behalf receives payment from any responsible party (including your own insurance carrier) from any settlement, verdict or insurance proceeds, in connection with an injury, illness, or condition for which we provided benefits. Under Section 5-335 of the New York General Obligations Law, our right of recovery does not apply when a settlement is reached between a plaintiff and defendant, unless a statutory right of reimbursement exists. The law also provides that, when

entering into a settlement, it shall be deemed that you did not take any action against our rights or violate any contract between you and us. The law conclusively presumes that the settlement between you and the responsible party does not include any compensation for the cost of health care services for which we provided benefits.

We request that you notify us within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by you for which we have provided benefits. You must provide all information requested by us or our representatives including, but not limited to, completing and submitting any applications or other forms or statements as we may reasonably request.

22. Third Party Beneficiaries.
No third party beneficiaries are intended to be created by this EOC Addendum and nothing in this EOC Addendum shall confer upon any person or entity other than you or us any right, benefit, or remedy of any nature whatsoever under or by reason of this EOC Addendum. No other party can enforce this EOC Addendum's provisions or seek any remedy arising out of either our or your performance or failure to perform any portion of this EOC Addendum, or to bring an action or pursuit for the breach of any terms of this EOC Addendum.

23. Time to Sue.
No action at law or in equity may be maintained against us prior to the expiration of 60 days after written submission of a claim has been furnished to us as required in this EOC Addendum. You must start any lawsuit against us under this EOC Addendum within two (2) years from the date the claim was required to be filed.

24. Translation Services.
Translation services are available under this EOC Addendum for non-English speaking members. Please contact us at the number on your ID card to access these services.

25. Venue for Legal Action.
If a dispute arises under this EOC Addendum, it must be resolved in a court located in the State of New York. You agree not to start a lawsuit against us in a court anywhere else. You also consent to New York State courts having personal jurisdiction over you. That means that, when the proper procedures for starting a lawsuit in these courts have been followed, the courts can order you to defend any action we bring against you.

26. Waiver.
The waiver by any party of any breach of any provision of this EOC Addendum will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

27. Who May Change this EOC Addendum.
This EOC Addendum may not be modified, amended, or changed, except in writing and signed by one of our corporate officers. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this EOC Addendum in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by one of our corporate officers.

28. Who Receives Payment under this EOC Addendum.
Payments under this EOC Addendum for Covered Drugs provided by a network pharmacy will be made directly by us to the pharmacy. If you receive services from a non-network pharmacy, we reserve the right to pay either you or the pharmacy.

29. Workers' Compensation Not Affected.
The coverage provided under this EOC Addendum is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

30. Your Medical Records and Reports.
In order to provide your coverage under this EOC Addendum, it may be necessary for us to obtain your medical records and information from providers who treated you. Our actions to provide that coverage include processing your claims, reviewing appeals or complaints involving your care, and quality assurance reviews of your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this EOC Addendum, except as prohibited by state or federal law, you automatically give us or our designee permission to obtain and use your medical records for those purposes and you authorize each and every provider who renders services to you to:

- Disclose all facts pertaining to your care, treatment, and physical condition to us or to a medical, dental, or mental health professional that we may engage to assist us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- Render reports pertaining to your care, treatment, and physical condition to us, or to a medical, dental, or mental health professional that we may engage to assist us in reviewing a treatment or claim; and
- Permit copying of your medical records by us.

We agree to maintain your medical information in accordance with state and federal confidentiality requirements. However, to the extent permitted under state or federal law, you automatically give us permission to share your information with the New York State Department of Health, quality oversight organizations, and third parties with which we contract to assist us in administering this EOC Addendum, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

Section Nine – Glossary of Terms

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of prescription drugs or payment for drugs you already received. For example, you may ask for an appeal if we don't pay for a drug you think you should be able to receive.

Brand-name prescription drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Group Medicare Prescription Drug Plan where you pay a $0 cost share for your formulary-covered Part D drugs after you or other qualified parties on your behalf have spent $2,100 in Covered Drugs during the covered year. In the Catastrophic Coverage Stage, enhanced non-Medicare supplemental drugs (if included under the plan) are covered at the same copayment as during the Initial Coverage Stage, and any payments for these non-Medicare supplemental drugs will not count towards your total out-of-pocket limit.

Coinsurance – An amount you may be required to pay as your share of the cost for prescription drugs after you pay any deductibles (if applicable). Coinsurance is usually a percentage (for example, 20%).

Copay, copayments – An amount you may be required to pay as your share of the cost for a prescription drug. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a prescription drug.

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when services or drugs are received. Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a drug, that a plan requires when a specific drug is received. A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment.

Cost-Sharing Tier – Every drug on the list of Covered Drugs is in one of a number of cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Deductible – The amount (if applicable) you must pay for prescriptions before our plan begins to pay.

Formulary (or "drug list") – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both Brand-name and Generic prescription drugs.

Generic prescription drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a "generic" drug works the same as a brand name drug and usually costs less.

Group – The employer/former employer or union that has entered into a Group Agreement with SilverScript Insurance Company to provide this coverage to the Group's Medicare-eligible retirees.

Group Medicare Prescription Drug Plan (Group Part D Plan) – A plan that gives Medicare prescription drug coverage to employees and former employees or members of a union/trust. These plans are offered to people through their or a spouse's current or former employer or employee organization.

Initial Coverage Stage – This is the stage before your total drug costs, including amounts you have paid and what your plan has paid on your behalf, for the year have reached $2,100**.**

Mail order pharmacy – A **pharmacy** where **prescription drugs** are legally dispensed by mail or other carrier.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a Medicare Cost Plan (where available), a PACE plan (where available), or a Medicare Advantage Plan.

Network pharmacy – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network retail pharmacy – A **retail pharmacy** that is contracted with our plan to fill prescriptions for our members. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Non-preferred drug – A **prescription drug** or device that may have a higher out-of-pocket cost than a **preferred drug**.

Out-of-network pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide Covered Drugs to members of our plan. As explained in this EOC Addendum, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-pocket limit – The amounts you pay for covered Part D drugs that count towards your Medicare Part D prescription drug plan's annual out-of-pocket threshold. Your yearly deductible, if applicable, and coinsurance or copayments, all count towards this out-of-pocket limit. In addition, payments for your drugs made by a friend or relative, by most charities and assistance programs are all included in the calculation of the CMS out-of-pocket limit.

Pharmacy – An establishment where **prescription** drugs are legally dispensed. This includes a **retail pharmacy**, **mail order pharmacy** and **specialty pharmacy**.

Preferred drug – A **prescription drug** or device that may have a lower out-of-pocket cost than a **non-preferred drug**.

Preferred network pharmacy – A **network retail pharmacy** that **is** identified as a **preferred network pharmacy** on this plan**.**

Prescription drug – An FDA approved drug or biological which can only be dispensed by **prescription.**

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

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Retail pharmacy – A community **pharmacy** that dispenses outpatient **prescription drugs** at retail prices.

Specialty prescription drugs – These are **prescription drugs** that include typically high-cost drugs that require special handling, special storage or monitoring and may include things such as oral, topical, inhaled and injected routes of administration.

Specialty pharmacy – This is a **pharmacy** designated as a **network pharmacy** by this plan to fill **prescriptions** for **specialty prescription drugs**.