Open Enrollment

2012

Health • Prescription • Dental • Vision

State of Delaware

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Introduction & What's New!

Open Enrollment • May 7 - May 23, 2012

The State Employee Benefits Committee is pleased to present your 2012 Open Enrollment information. The comprehensive benefits package offered to all benefit eligible State of Delaware employees and pensioners, as well as their dependents, covers all your health, dental, vision and prescription needs. Your benefit plan options for health (including prescription), dental and vision will remain the same as of July 1, 2012. New additions were made to the DelaWELL program including Weight Watchers, tobacco cessation prescription medication copay waiver and an option to earn incentive dollars as early as December 2012.

Make sure your coverage is right for you and your family by reviewing your options during Open Enrollment. Open Enrollment - May 7th to 23rd - is your once-a-year opportunity to enroll, make changes or terminate coverage in your health, dental and vision plans unless you have a qualifying event during the year (for example, birth or adoption, marriage/civil union or divorce). If you have questions please contact the Statewide Benefits Office at 1-800-489-8933 or Office of Pensions at 1-800-722-7300, or visit ***www.ben.omb.delaware.gov/oe****.*

Statewide Benefits Office Mission Statement

Our mission is to support the health of employees and pensioners by providing progressive comprehensive benefits, quality customer service, ongoing employee education and efficient management to ensure the best interests of program participants.

New for July 1, 2012

Health Plan Rates

- *House Bill 81, signed into law on May 2, 2011, established a cost share of the total rate for health care between the State and employees for each health plan as follows:*
  - ***First State Basic Plan** – State share 96%, Employee share 4%*
  - ***Consumer Directed Health Plans** – State share 95%, Employee share 5%*
  - ***HMO Plans** – State share 93.5%, Employee share 6.5%*
  - ***Comprehensive PPO Plan** – State share 86.75%, Employee share 13.25%*
  - ***Special Medicfill** (for Medicare eligible pensioners – State share may be impacted by years of service)*
    - *For those retired on or before July 1, 2012 – State share 100%, Pensioner share 0%*
    - *For those retired after July 1, 2012 - State share 95%, Pensioner share 5%*

A chart containing rates and new employee contribution levels for the health plans based on the cost share listed above is on page 13.

- *In addition, House Bill 81 eliminated Double State Share for any newly eligible employees or pensioners as of January 1, 2012, and established an employee cost of $25 per contract per month for each existing Double State Share contract as of July 1, 2012.*

More information on House Bill 81 and Double State Share changes can be found at www.ben.omb.delaware.gov/hb81.

2012

If there is an conflict in interpretation between the contents of this booklet and the contract provisions and existing law pertaining to any of the enclosed benefit programs, contract provisions and existing law govern.

What's New!

Prescription Plan Changes

- *As part of the 2012 DelaWELL Tobacco Cessation Program, copays for prescription tobacco cessation medications will be waived beginning July 1, 2012 at participating retail pharmacies and the Medco Pharmacy (mail order). The covered medications include Nicotrol NS, Nicotrol Inhaler, bupropion HCl (generic for Zyban*) and Chantix.*

  *Note: The brand medication Zyban is subject to the State of Delaware plan requirement to use generic medications when available. If there is a medical reason that the generic cannot be taken, your doctor should appeal through Medco for an authorization.

- *The following medications will be subject to new coverage management rules beginning July 1, 2012: Incivek, Victrelis (Hepatitis C medications) and Simponi, Cimza (Rheumatoid Arthritis medications).*

Additional information is available at www.ben.omb.delaware.gov/script.

The benefits you elect during the Open Enrollment period will take effect July 1, 2012.

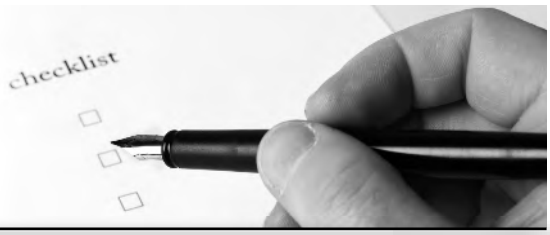
Remember:

*If you cover your spouse in one of the State of Delaware Group Health Insurance medical plans, you **MUST** complete a new Spousal Coordination of Benefits form each year during Open Enrollment and anytime your spouse's employment or insurance status changes.*
Failure to complete this form will result in a reduction of spousal benefits.

*You **MUST** complete the form online at*
www.ben.omb.delaware.gov/documents/cob
no later than May 23, 2012. If you do not have access to a computer, contact your Human Resources or Benefits Office.

Go to page 27 for complete details.

2012 Enrollment Action Checklist



OPEN ENROLLMENT is May 7 - May 23, 2012

- ❑ Read all Open Enrollment information contained in this booklet.
- ❑ Mark your calendar to attend one of the Statewide Benefit Health Fairs (see page 48 for dates, times and locations).
- ❑ Review Open Enrollment Frequently Asked Questions (FAQ) located on the Statewide Benefits website at **www.ben.omb.delaware.gov/oe**.
- ❑ **If you cover your spouse in one of the State of Delaware Group Health Insurance medical plans,** go to page 27 for complete details on the Spousal Coordination of Benefits policy and required form.
- ❑ **If you wish to enroll an adult dependent to age 26** in a health, dental or vision plan, go to Page 28 for complete details on the Administration of Adult Dependent to Age 26 Policy and the required Adult Dependent Coordination of Benefits form. Completion of the Adult Dependent COB form does not enroll the Adult Dependent in benefits. See action steps below for the process to add the dependent during Open Enrollment by midnight May 23, 2012.
- ❑ **If you are not making any changes and do not cover a spouse or adult dependent** under your State of Delaware Group Health Insurance medical plan, no action is required.

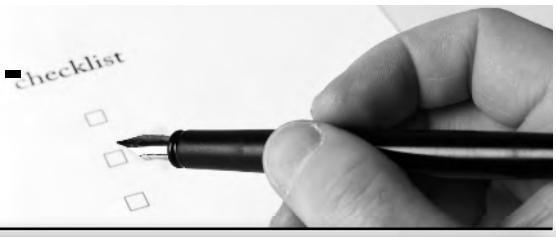
If you are enrolling in any plan or enrolling a spouse or dependent for the first time:

- ❑ If enrolling in an HMO (health or dental) plan for the FIRST TIME, make sure that **before you enroll** your health or dental provider participates in the plan you select and enter their provider information when you enroll.
  REMEMBER: You cannot change plans during the plan year if your provider decides to no longer participate in the plan.
- ❑ If enrolling a spouse for the FIRST TIME: You **MUST** supply a copy of your marriage/civil union certificate to your organization's Human Resources or Benefits Office, or to the Office of Pensions, as applicable.
- ❑ If enrolling a dependent for the FIRST TIME: You **MUST** submit a copy of the birth certificate or other legal document to your organization's Human Resources or Benefits Office, or to the Office of Pensions, as applicable.
- ❑ If enrolling a spouse or children as a result of a civil union for the FIRST TIME: You **MUST** also submit the completed Certification of Tax Dependent Status form to your organization's Human Resources/Benefits Office, or to the Office of Pensions, as applicable. The form can be found at **www.ben.omb.delaware.gov/cu**.

Active Employees - Action Steps:

- ❑ Review Open Enrollment Checklist above.
- ❑ To enroll or make changes to your health, dental, vision or blood bank coverage, go online to eBenefits at **https://eapps.erp.delaware.gov/** by May 23, 2012.
  - ❑ Refer to the eBenefits Quick Reference Guide (online at **www.ben.omb.delaware.gov/oe**) for complete log in and enrollment instructions.
  - ❑ **If you have general online enrollment or benefits questions**, call the Open Enrollment Help Desk at 1-800-489-8933 from 8 a.m. to 4:30 p.m. Monday through Friday during the Open Enrollment period.
  - ❑ **If you do not have access to a computer**, or have questions about your benefits or eligible dependents, contact your organization's Human Resources or Benefits Office.
  - ❑ **If you need your password reset** - go to **www.omb.delaware.gov/epay**, click on **USER ACCOUNT ASSISTANCE** (located on the left hand side), click on "Submit an online request" and complete and submit the form to have your password reset. For additional information, refer to the last page of the eBenefits Quick Reference Guide at **www.ben.omb.delaware.gov/oe**.
- ❑ Complete your Spousal Coordination of Benefits Form online by May 23, 2012, if you cover your spouse on your health plan (see page 27 for details).

2012 Enrollment Action Checklist - Action Steps!



Active Employees - Action Steps (cont):

- ❑ Submit your Adult Dependent Coordination of Benefits Form to your Human Resources/Benefits Office by May 23, 2012 if you are covering a dependent who turned 21 prior to the end of 2011 (see page 28 for details).Completion of the Adult Dependent COB form does not enroll the Adult Dependent in benefits. The eBenefits online enrollment process to add the dependent must be completed during Open Enrollment by midnight May 23, 2012.
- ❑ **Following Open Enrollment**, view your benefits elections by accessing the Benefits Summary section under Employee Self Service in (PHRST). Please refer to the eBenefits Quick Reference Guide (**www.ben.omb.delaware.gov/oe**), for more detailed instructions. If an error has been made, you **MUST** contact your organization's HR/Benefits Office to correct the error by June 8, 2012. **No corrections will be made after June 8, 2012.**

Pensioners - Action Steps:

- ❑ Review Open Enrollment Checklist on page 3.
- ❑ **To enroll or make changes to your health, dental, vision or blood bank coverage:**
  You must complete the necessary forms available on the Office of Pensions Website at **www.delawarepensions.com** or complete the applications included in the packet mailed to your home. You must submit your completed enrollment forms to the Office of Pensions by May 23, 2012.
  Pensioner Enrollment Forms should be sent to: **State of Delaware, Office of Pensions**
  McArdle Building, 860 Silver Lake Boulevard, Suite 1
  Dover, DE 19904-2402

  Forms may be faxed to 1-302-739-6129
- ❑ Contact the Office of Pensions at 302-739-4207 or (toll-free) 1-800-722-7300 for the forms to cancel medical, dental, vision or blood bank coverage.
- ❑ Contact the Office of Pensions if you, your spouse or your dependents are Medicare eligible and not enrolled in the Special Medicfill Medicare Supplement health plan.
- ❑ Submit the Spousal Coordination of Benefits Form to the Office of Pensions by May 23, 2012, if you cover your spouse in one of the State of Delaware Group Health Insurance medical plans. Go to page 27 for complete details on the Spousal Coordination of Benefits policy and required form.
- ❑ If you cover your spouse under the BCBSD Special Medicfill Medicare supplement plan, you must still complete a Spousal Coordination of Benefits form online for the health care carrier's records. **PLEASE NOTE: THIS IS A CHANGE FROM PRIOR OPEN ENROLLMENT PERIODS**.
- ❑ Submit your Adult Dependent Coordination of Benefits Form to the Office of Pensions by May 23, 2012 if you are covering a dependent who turned 21 prior to the end of 2011 (see page 28 for details).Completion of the Adult Dependent COB form does not enroll the Adult Dependent in benefits. You must submit a completed enrollment form to the Office of Pensions if enrolling the Adult Dependent for the first time.
- ❑ If you have questions about your health benefits, please call the Office of Pensions at 302-739-4208 or 1-800-722-7300 from 8 a.m. to 4:30 p.m. Monday through Friday during the Open Enrollment period or attend a health fair. The health fair schedule can be found on page 48.

Non-State Participating Groups - Action Steps:

- ❑ Review Open Enrollment Checklist on page 3.
- ❑ Contact your Human Resources Office within your organization for forms to enroll, make changes or cancel current health or dental coverage.
- ❑ Complete your Spousal Coordination of Benefits Form online by May 23, 2012, if you cover your spouse on your health plan (see page 27 for details).
- ❑ Submit your Adult Dependent Coordination of Benefits Form to your Human Resources/Benefits Office by May 23, 2012 if you are covering a dependent who turned 21 prior to the end of 2011 (see page 28 for details).Completion of the Adult Dependent COB form does not enroll the Adult Dependent in benefits. You must contact your Human Resources/Benefits Office to obtain an enrollment form to enroll the Adult Dependent in benefits.

Health Care Coverage for Active Employees and Non-Medicare Eligible Retirees

Consumer-Directed Health Plans

The State now offers two Consumer-Directed Health Plans (CDH Gold) through Aetna and Blue Cross Blue Shield of Delaware (BCBSD). The CDH Gold Plans provide access to quality, comprehensive health care coverage and give you more control over your health and how your healthcare dollars are spent. Below is additional information on how a Consumer-Directed Health Plan works and why it may be a good fit for you and your family.

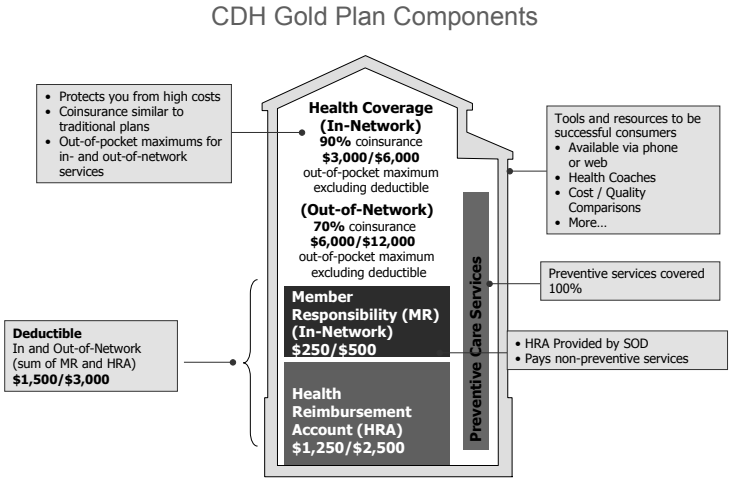
How Does the Consumer-Directed Health Plan Work?

A Consumer-Directed Health (CDH) Plan is similar to any other type of health plan that provides in- and out-of-network benefits. You and your family will receive higher benefits if you see providers within the Aetna and BCBSD networks. The plans include an annual deductible you must meet before the plan pays in full. These plans include a fund, called a Health Reimbursement Account (HRA), for you to pay eligible medical expenses and meet the required deductible. The State provides the funding for the HRA. Generally, out of pocket expenses for the eligible health care services will be paid from the HRA fund, as long as there is money available. If you are no longer enrolled in a CDH Gold Plan through the State of Delaware Group Health Insurance Program, you forfeit the funds within the HRA.

Preventive Care and well visits are covered at 100 percent with no deductible when you see an in-network provider. Prescription drug coverage is the same as all other health plans and co-pays do not apply to your deductible.

How the HRA Fund Works

- The HRA fund is 100 percent funded each year by the State of Delaware Group Health Insurance fund and helps you pay eligible out-of-pocket expenses.
- After you use up the funds in the HRA, you must satisfy an annual deductible.
- After you satisfy the deductible, you and the State of Delaware share the cost of the medical expenses through co-insurance. Under the CDH Gold Plan, the State of Delaware pays 90 percent and you pay 10 percent (in-network).
- The CDH Gold Plan pays 100 percent for the rest of the year after you reach your annual out-of-pocket maximum.
- Unused HRA funds rollover to the next plan year as long as you remain enrolled in a State of Delaware CDH Gold Plan.
- HRA funding is forfeited upon termination from state employment or upon becoming a Medicare eligible retiree.



Added Financial Protection and Peace of Mind

The CDH Gold Plan also provides extra financial protection through an annual out-of-pocket maximum. This means there is a limit on the amount you pay out of your pocket after you meet the deductible during the plan year. Once you meet your out-of-pocket limit within a calendar year, the plan generally takes over and covers all of your eligible expenses for the rest of the same calendar year.

Be Responsible for Making Informed Decisions

Accepting responsibility for your plan choice is the first step in investing in your health and your future! The following pages highlight each of the plans offered through the State of Delaware Group Health Insurance Program and provide more information on how the CDH Gold Plan offered by Aetna and BCBSD compares to the other plans available. More details on each health plan option can be found at **www.ben.omb.delaware.gov/oe** .

Health Care Coverage for Active Employees and Non-Medicare Eligible Retirees

Health Plan Descriptions

Aetna

Two Plans to choose from:
Aetna HMO Plan

- Local and National Network Access - It's simple to access care from Aetna's large network of providers in DE, PA, SNJ, MD and across the country.
- Primary Care Physician Selection is required – Your PCP will assist in managing your care with your other Health Care providers.
- Referrals are required for certain services and are obtained through your primary care physician.

Aetna CDH Gold Plan (Open Choice PPO) with an HRA

- You can see any doctor you want, without a referral.
- Most Preventive Care is covered at 100% when rendered in-network.
- Your employer provides you with a fund to help cover eligible health expenses.

Here's how your fund would work with the Aetna CDH Gold Plan, there are three parts – the fund, the deductible and the health plan. Here's how they work:

1. **The Fund:**
   Each year, your employer funds a health reimbursement account – the fund- for you. You can use fund dollars to pay eligible out-of-pocket health care costs. Fund dollars can even pay partial amounts of these costs. If you don't use the whole fund in one year, no worries, unused amounts can roll over to the next year. However, if you change employers or leave the health plan, you can't take the fund with you.
2. **Your Deductible:**
   This is an amount you must pay for eligible expenses. Once you pay the full deductible, your health plan begins to pay benefits. As you use the fund, the payments count toward your deductible. That means you have less to pay out of your own pocket!
3. **Your Health Plan:**
   Once you meet your deductible, your health plan pays its share for eligible expenses. You pay a smaller share of these costs from your own pocket.

No matter which Aetna plan you choose, you can **SAVE** with **AETNA DISCOUNT PROGRAMS!** Aetna offers discounts such as: Vision Discounts, Gym and Gym Equipment Discounts, Vitamin Discounts, Hearing Aid Discounts, Massage Therapy Services and many more. Join Aetna and Begin Saving!

Call customer service at 1-877-542-3862 to learn more about how the **Aetna HMO Plan and Aetna CDH Gold Plan** has everything you need to help you be your healthiest. Additional information can be viewed at **www.ben.omb.delaware.gov/medical/Aetna**.

Tip: Considering an HMO?

Go to the Statewide Benefits Office, OMB website at www.ben.omb.delaware.gov, under Group Health Plans, select carrier (Blue Cross or Aetna). Select "Find a Health Care Provider" for BCBSD OR select "Locate Participating Providers - Doc Find" for Aetna to check on which health care professionals are on their approved provider lists.

Health Care Coverage for Active Employees and Non-Medicare Eligible Retirees

Health Plan Descriptions

Blue Cross Blue Shield of Delaware: First State Basic Plan

In-network services will have a deductible of $500 per individual and $1,000 per family. The plan will then pay at 90% of the BCBSD allowable charge. The out-of-pocket maximum is $2,000 per individual and $4,000 per family (including the deductible) per plan year. The out-of-pocket maximum applies to medical services only. Copays for prescription medications are not applied to the out-of-pocket maximum. Preventive services are covered in network at 100% of the allowable charge and are not subject to a deductible or coinsurance.

Out-of-network services will be subject to a deductible of $1,000 per individual and $2,000 per family and then the plan will pay at 70% of the allowable charge. The out-of-pocket maximum is $4,000 per individual and $8,000 per family per plan year.

Blue Cross Blue Shield of Delaware: Comprehensive Preferred Provider Organization (PPO) Plan

Using in-network services you will pay a small copay/coinsurance with no deductible. If you use out-of-network providers, you must meet a $300 per person/$600 per family plan year deductible unless otherwise noted. The out-of-pocket maximum is $1,800 per person/$3,600 per family (including the deductible) per plan year. The out-of-pocket maximum applies to medical services only. Copays for prescription medications are not applied to the out-of-pocket maximum.

Blue Cross Blue Shield of Delaware: Blue Care® HMO

Blue Care® is BCBSD's HMO-Managed Care plan in which each member must select a primary care physician (PCP) to manage his/her health care needs. Referrals are required for certain services and are obtained through your primary care physician.

Blue Cross Blue Shield of Delaware: CDH Gold

BCBSD's CDH Gold Plan offers many of the features of a Preferred Provider Organization (PPO) plan with the added advantage of a State-funded Health Reimbursement Account (HRA).

The plan includes a $1,500 deductible for employee only (Individual) coverage and $3,000 for Family coverage. The HRA pays the first $1,250 in deductible expenses for Individuals and $2,500 for Families. The member is financially responsible for the remaining in-network deductible ($250 for Individuals and $500 for Families). When the deductible is satisfied, in-network health care services are paid at 90 percent, with an in-network coinsurance maximum of $3,000 for Individuals and $6,000 for Families. When the deductible is satisfied, out-of-network health care services are paid at 70 percent, with an out-of-network coinsurance maximum of $6,000 for Individuals and $12,000 for Families.

Benefits are subject to a single plan year deductible, combining in- and out-of-network deductible amounts. In- and out-of-network coinsurance amounts accumulate together toward the coinsurance maximums.

In addition, preventive care services are covered at 100 percent and are not subject to a deductible or coinsurance. Prescriptions are provided through the prescription benefits manager, Medco, and prescription copays are not applicable to the medical deductible or out-of-pocket maximum.

NOTE: BCBSD's allowable charges are based on the price BCBSD determines is reasonable for care or services provided.

***Complete information on all Blue Cross Blue Shield of Delaware plans, including a summary plan description, can be found at www.ben.omb.delaware.gov/medical/bcbs**

Summary of Benefits

First State Basic Plan

This Summary of Benefits highlights the health plans available. Summary Plan Booklets are available at www.ben.omb.delaware.gov/medical.

Description of Benefit	In-Network Benefits Deductible: $500/$1,000* Out–of-Pocket Max: $2,000/$4,000** including deductible	Out-of-Network Benefits Deductible: $1,000/$2,000* Out-of-Pocket Max: $4,000/$8,000** including deductible
Inpatient Room & Board	90% after deductible	70% after deductible
Inpatient Physicians' and Surgeons' Services	90% after deductible	70% after deductible
Outpatient Services	90% after deductible	70% after deductible
Prenatal and Postnatal Care	90% after deductible	70% after deductible
Delivery Fee	90% after deductible	70% after deductible
Hospice	90% after deductible for up to 365 days	70% after deductible for up to 365 days
Home Care Services	90% after deductible for up to 240 days per plan year	70% after deductible for up to 240 days per plan year
Urgent Care	100% after $25 copay	100% after $25 copay
Emergency Services	90% after deductible	90% after deductible
MENTAL HEALTH CARE/SUBSTANCE ABUSE CARE		
Inpatient Acute/Partial Hospitalization	90% after deductible (subject to authorization)	70% after deductible (subject to authorization)
Outpatient	90% after deductible	70% after deductible
OTHER SERVICES		
Durable Medical Equipment	90% after deductible	70% after deductible
Skilled Nursing Facility	90% for up to 120 days per confinement	70% for up to 120 days per confinement
Emergency Ambulance	90% after deductible	70% after deductible
Physician Home/Office Visits (sick)	90% after deductible	70% after deductible
Specialist Care	90% after deductible	70% after deductible
Chiropractic Care	90% after deductible for up to 30 visits per plan year	75% after deductible for up to 30 visits per plan year
Allergy Testing/Allergy Treatment	90% after deductible	70% after deductible
X-Ray, MRI's , CT Scans, PET Scans, Lab & Other Diagnostic Services* **	90% after deductible	70% after deductible
Short-Term Therapies: Physical, Speech, Occupational	90% after deductible	70% after deductible
Annual Gyn Exam/Pap Smear	100% covered, no deductible	70% covered, no deductible
Periodic Physical Exams, Immunizations, Diabetes Education	100% covered, no deductible	70% covered, no deductible
Vision Care	Not covered	Not covered
Hearing Tests	100% covered, no deductible	70% covered, no deductible
Hearing Aids	90% after deductible, under age 24	70% after deductible, under age 24
ALL INFERTILITY SERVICES		
	75% after deductible; $10,000 lifetime maximum for medical services 75% after deductible; $15,000 lifetime maximum for prescription services	55% after deductible; $10,000 lifetime maximum for medical services 55% after deductible; $15,000 lifetime maximum for prescription services
BARIATRIC SURGERY		
	90% after deductible if "Blue Distinction Center for Bariatric Surgery" is used; 75% after deductible if an authorized hospital/surgical center is used	55% after deductible

**Two individuals must meet the deductible each plan year in order for the family deductible to be met.*
*** Out-of-pocket maximums apply to each plan year and include your deductible but do not include your prescription costs.*
****MRI, MRA, CT and PET scans require a prior authorization.*

Summary of Benefits

HMO Plans

This Summary of Benefits highlights the health plans available. Summary Plan Booklets are available at www.ben.omb.delaware.gov/medical.

Description of Benefit	Aetna	Blue Care
Inpatient Room & Board	$100 copay/day with max of $200/admission	$100 copay/day with max of $200/admission
Inpatient Physicians' and Surgeons' Services	100%	100%
Outpatient Surgery–Ambulatory Center	$30 copay	$30 copay
Outpatient Surgery–Doctor's Office Visit	$20 copay	$20 copay
Outpatient Surgery–Hospital	$75 copay	$75 copay
Prenatal and Postnatal Care	100% after $20 initial copay (inpatient room and board copays do apply to hospital deliveries/birthing centers)	100% after $20 initial copay (inpatient room and board copays do apply to hospital deliveries/birthing centers)
Delivery Fee	100%	100%
Hospice	100%	100% up to 365 days
Home Care Services	100% for up to 240 visits per plan year	100% for up to 240 visits per plan year
Urgent Care	$20 copay	$20 copay
Emergency Services	$135 copay (waived if admitted)	$135 copay (waived if admitted)
MENTAL HEALTH CARE/SUBSTANCE ABUSE CARE		
Inpatient Acute/Partial Hospitalization	$100 copay/day with max. of $200/hospitalization (subject to authorization)	$100 copay/day with max. of $200/hospitalization (subject to authorization)
Outpatient	$20 copay per visit	$10 copay per visit
OTHER SERVICES		
Durable Medical Equipment	80%, limited to $5,000 per member per plan year	80%
Skilled Nursing Facility	100%	100%
Emergency Ambulance	$50 copay	$50 copay
Physician Home/Office Visits (sick)	$10 copay per office visit $25 copay per home or after hours visit	$10 copay per office visit $25 copay per home or after hours visit
Specialist Care	$20 copay per visit	$20 copay per visit
Chiropractic Care	80% of the allowable charges	80% of the allowable charges for up to 60 consecutive days per condition
Allergy Testing/Allergy Treatment	$20 copay per visit (allergy testing)/ $5 copay per visit (allergy treatment)	$20 copay per visit (allergy testing)/ $5 copay per visit (allergy treatment)
X-Ray, Lab & Other Diagnostic Services	Lab: $5 copay per visit/X-Ray: $15 copay per visit	Lab: $5 copay per visit/X-Ray: $15 copay per visit
MRI's , CT Scans, & PET Scans* **	$25 copay per visit	$25 copay per visit
Short-Term Therapies: Physical, Speech, Occupational	80%, 45 visits per condition for physical and occupational therapy combined/ 80%, 45 visits per condition for speech therapy	80%, 60 consecutive days/except for physical therapy. Physical therapy/45 visits per condition
Annual Gyn Exam Pap Smear	Exam: $10 copay Pap Smear: $5 copay	Exam: $10 copay Pap Smear: $5 copay
Periodic Physical Exams, Immunizations, Diabetes Education	$10 copay per visit/100% Diabetes education	$10 copay per visit/100% Diabetes education
Vision Care	100% after office visit copay (one exam every 24 months)	100% after office visit copay (one exam every 24 months)
Hearing Tests	100% after office visit copay	100% after office visit copay
ALL INFERTILITY SERVICES		
	75% covered; $10,000 lifetime maximum for medical services 75% covered; $15,000 lifetime maximum for prescription services	75% covered; $10,000 lifetime maximum for medical services 75% covered; $15,000 lifetime maximum for prescription services
BARIATRIC SURGERY		
	100% if "Institute of Excellence for Bariatric Surgery" is used; 75% if an authorized hospital/surgical center is used	100% if "Blue Distinction Center for Bariatric Surgery" is used; 75% if an authorized hospital/surgical center is used

****MRI, MRA, CT and PET scans require a prior authorization.*

Summary of Benefits

Aetna CDH Gold Plan

This Summary of Benefits highlights the health plans available. Summary Plan Description Booklets are available at www.ben.omb.delaware.gov/medical

	AETNA	AETNA
Description of Benefit	**In-Network Benefits Deductible: $1500/$3,000* Out–of-Pocket Max: $3,000/$6,000****	**Out-of-Network Benefits Deductible: $1,500/$3,000* Out-of-Pocket Max: $6,000/$12,000****
Health Reimbursement Account	**$1,250 Employee/$2,500 Family**	**$1,250 Employee/$2,500 Family**
	In-Network	**Out-of-Network**
Inpatient Room & Board	90% after deductible	70% after deductible
Inpatient Physicians' and Surgeons' Services	90% after deductible	70% after deductible
Outpatient Services	90% after deductible	70% after deductible
Prenatal and Postnatal Care	90% after deductible	70% after deductible
Delivery Fee	90% after deductible	70% after deductible
Hospice	90% after deductible	70% after deductible
Home Care Services	90% after deductible for up to 240 days per plan year	70% after deductible for up to 240 days per plan year
Urgent Care	90% after deductible	70% after deductible
Emergency Services	90% after deductible	90% after deductible
MENTAL HEALTH CARE/SUBSTANCE ABUSE CARE	**In-Network**	**Out-of-Network**
Inpatient Acute/Partial Hospitalization	90% after deductible	70% after deductible
Outpatient	90% after deductible	70% after deductible
OTHER SERVICES	**In-Network**	**Out-of-Network**
Durable Medical Equipment	90% after deductible	70% after deductible
Skilled Nursing Facility	90% after deductible for up to 120 days per confinement	70% after deductible for up to 120 days per confinement
Emergency Ambulance	90% after deductible	70% after deductible
Physician Home/Office Visits (non-routine)	90% after deductible	70% after deductible
Specialist Care	90% after deductible	70% after deductible
Chiropractic Care	90% after deductible for up to 30 visits per plan year	75% after deductible for up to 30 visits per plan year
Allergy Testing/Allergy Treatment	90% after deductible	70% after deductible
X-Ray, MRI's , CT Scans, PET Scans, Lab & Other Diagnostic Services***	90% after deductible	70% after deductible
Short-Term Therapies: Physical, Speech, Occupational	90% after deductible	70% after deductible
Annual Gyn Exam/Pap Smear	100%, no deductible	70% covered, after deductible
Routine Physical Exam & Immunizations	100%, no deductible	70% after deductible
Vision Care	Not covered	Not covered
Hearing Tests – 1 exam every 12 months	100% covered, no deductible	70% covered, no deductible
Hearing Aids – Children to age 24	90% after deductible, under age 24	70% after deductible, under age 24
ALL INFERTILITY SERVICES	**In-Network**	**Out-of-Network**
	75% covered; $10,000 lifetime maximum for medical services 75% covered; $15,000 lifetime maximum for prescription service	55% covered; $10,000 lifetime maximum for medical services 55% covered; $15,000 lifetime maximum for prescription service
BARIATRIC SURGERY	**In-Network**	**Out-of-Network**
	90% after deductible if "Institute of Excellence for Bariatric Surgery" is used;; 75% after deductible if an authorized hospital/surgical center is used.	55% after deductible

**Once the Family Deductible Limit is met, all family members will be considered as having met their deductible.*
***Out-of-pocket maximums apply to each benefit year and DO NOT include your deductible.*
****MRI, MRA, CT and PET scans require a prior authorization.*

Summary of Benefits

Blue Cross Blue Shield of Delaware CDH Gold Plan

This Summary of Benefits highlights the health plans available. Summary Plan Description Booklets are available at www.ben.omb.delaware.gov/medical

	BCBSD	BCBSD
Description of Benefit	**In-Network Benefits Deductible: $1500/$3,000* Out–of-Pocket Max: $3,000/$6,000****	**Out-of-Network Benefits Deductible: $1,500/$3,000* Out-of-Pocket Max: $6,000/$12,000****
Health Reimbursement Account	**$1,250 Employee/$2,500 Family**	**$1,250 Employee/$2,500 Family**
	In-Network	**Out-of-Network**
Inpatient Room & Board	90% after deductible	70% after deductible
Inpatient Physicians' and Surgeons' Services	90% after deductible	70% after deductible
Outpatient Services	90% after deductible	70% after deductible
Prenatal and Postnatal Care	90% after deductible	70% after deductible
Delivery Fee	90% after deductible	70% after deductible
Hospice	90% after deductible	70% after deductible
Home Care Services	90% after deductible for up to 240 days per plan year	70% after deductible for up to 240 days per plan year
Urgent Care	90% after deductible	70% after deductible
Emergency Services	90% after deductible	90% after deductible
MENTAL HEALTH CARE/SUBSTANCE ABUSE CARE	**In-Network**	**Out-of-Network**
Inpatient Acute/Partial Hospitalization	90% after deductible	70% after deductible
Outpatient	90% after deductible	70% after deductible
OTHER SERVICES	**In-Network**	**Out-of-Network**
Durable Medical Equipment	90% after deductible	70% after deductible
Skilled Nursing Facility	90% after deductible for up to 120 days per confinement	70% after deductible for up to 120 days per confinement
Emergency Ambulance	90% after deductible	70% after deductible
Physician Home/Office Visits (non-routine)	90% after deductible	70% after deductible
Specialist Care	90% after deductible	70% after deductible
Chiropractic Care	90% after deductible for up to 30 visits per plan year	75% after deductible for up to 30 visits per plan year
Allergy Testing/Allergy Treatment	90% after deductible	70% after deductible
X-Ray, MRI's , CT Scans, PET Scans, Lab & Other Diagnostic Services***	90% after deductible	70% after deductible
Short-Term Therapies: Physical, Speech, Occupational	90% after deductible	70% after deductible
Annual Gyn Exam/Pap Smear	100%, no deductible	70% covered, after deductible
Routine Physical Exam & Immunizations	100%, no deductible	70% after deductible
Vision Care	Not covered	Not covered
Hearing Tests – 1 exam every 12 months	100% covered, no deductible	70% after deductible
Hearing Aids – Children to age 24	90% after deductible	70% after deductible
ALL INFERTILITY SERVICES	**In-Network**	**Out-of-Network**
	75% covered; $10,000 lifetime maximum for medical services 75% covered; $15,000 lifetime maximum for prescription service	55% covered; $10,000 lifetime maximum for medical services 55% covered; $15,000 lifetime maximum for prescription service
BARIATRIC SURGERY	**In-Network**	**Out-of-Network**
	90% after deductible if "Blue Distinction Center for Bariatric Surgery" is used; 75% after deductible if an authorized hospital/surgical center is used	55% after deductible.

**Once the Family Deductible Limit is met, all family members will be considered as having met their deductible.*
***Out-of-pocket maximums apply to each benefit year and DO NOT include your deductible.*
****MRI, MRA, CT and PET scans require a prior authorization.*
***Please note**: Existing contracts and law supersede any discrepancies in this brief benefits overview.*

Summary of Benefits

Comprehensive Preferred Provider Organization

This Summary of Benefits highlights the health plans available. Summary Plan Booklets are available at www.ben.omb.delaware.gov/medical.

Description of Benefit	In-Network Benefits	Out-of-Network Benefits Deductible: $300/$600* Out-Of-Pocket Max: $1,800/$3,600 Including Deductible**
Inpatient Room & Board	$100 copay/day with max. of $200/admission	80% after deductible
Inpatient Physicians' and Surgeons' Services	100%	80% after deductible
Outpatient Services	100%	80% after deductible
Prenatal and Postnatal Care	100% (inpatient room and board copays do apply to hospital deliveries/birthing centers)	80% after deductible
Delivery Fee	100%	80% after deductible
Hospice	100% up to 365 days	80% after deductible up to 365 days
Home Care Services	100%	80% after deductible for up to 240 visits per plan year
Urgent Care	$25 copay	80% after deductible
Emergency Services	$125 copay (waived if admitted)/Physician: 100%	$125 copay (waived if admitted)/Physician: 100% after deductible
MENTAL HEALTH CARE/SUBSTANCE ABUSE CARE		
Inpatient Acute/Partial Hospitalization	$100 copay/day with max of $200/adm. (subject to authorization)	80% after deductible (subject to authorization)
Outpatient	100% after $15 copay	80% after deductible
OTHER SERVICES		
Durable Medical Equipment	100%	80% after deductible
Skilled Nursing Facility	100% up to 120 days per confinement	80% after deductible up to 120 days per confinement
Emergency Ambulance	100%	100% no deductible
Physician Home/Office Visits (sick)	$15 copay	80% after deductible
Specialist Care	$25 copay	80% after deductible
Chiropractic Care	85% covered; 30 visits per plan year	80% after deductible; 30 visits per plan year
Allergy Testing/Allergy Treatment	Testing: $25 copay/ Treatment: $5 copay	80% after deductible
X-Ray, MRI's , CT Scans, PET Scans, Lab & Other Diagnostic Services* **	Lab: $5 copay per visit/X-ray: $15 copay per visit	80% after deductible
Short-Term Therapies: Physical, Speech, Occupational	85%	80% after deductible
Annual Gyn Exam/Pap Smear	Exam: $15 copay Pap Smear: $5 copay	80% after deductible
Periodic Physical Exams, Immunizations, Diabetes Education	100% after $15 copay	80% after deductible
Vision Care	Not covered	Not covered
Hearing Tests	100% after office visit copay	80% after deductible
Hearing Aids	100%, under age 24	80% after deductible, under age 24
ALL INFERTILITY SERVICES		
	75% covered; $10,000 lifetime maximum for medical services 75% covered; $15,000 lifetime maximum for prescription services	55% after deductible; $10,000 lifetime maximum for medical services 55% after deductible; $15,000 lifetime maximum for prescription services
BARIATRIC SURGERY		
	100% covered if "Blue Distinction Center for Bariatric Surgery" is used; 75% covered if an authorized hospital/surgical center is used	55% after deductible

**Two individuals must meet the deductible each plan year in order for the family deductible to be met.*
*** Out-of-pocket maximums apply to each plan year and include your deductible but do not include your prescription costs.*
****MRI, MRA, CT and PET scans require a prior authorization.*

2012 Health Plan Rates

	Total Monthly Rate	State Pays	Employee/Pensioner Pays
First State Basic Plan *(includes prescription drug coverage at the same level as all other plans)* *Administered by Blue Cross Blue Shield of Delaware*			
Employee	$514.56	$493.98	$20.58
Employee & Spouse	$1,064.66	$1,022.08	$42.58
Employee & Child(ren)	$782.20	$750.92	$31.28
Family	$1,330.86	$1,277.64	$53.22
Aetna CDH Gold *Administered by Aetna*			
Employee	$532.56	$505.94	$26.62
Employee & Spouse	$1,104.26	$1,049.06	$55.20
Employee & Child(ren)	$813.70	$773.02	$40.68
Family	$1,402.86	$1,332.72	$70.14
BCBSD CDH Gold *Administered by Blue Cross Blue Shield of Delaware*			
Employee	$532.56	$505.94	$26.62
Employee & Spouse	$1,104.26	$1,049.06	$55.20
Employee & Child(ren)	$813.70	$773.02	$40.68
Family	$1,402.86	$1,332.72	$70.14
Aetna HMO *Administered by Aetna*			
Employee	$537.22	$502.30	$34.92
Employee & Spouse	$1,132.64	$1,059.02	$73.62
Employee & Child(ren)	$821.80	$768.38	$53.42
Family	$1,413.30	$1,321.44	$91.86
BlueCARE® HMO *Administered by Blue Cross Blue Shield of Delaware*			
Employee	$537.66	$502.72	$34.94
Employee & Spouse	$1,136.22	$1,062.38	$73.84
Employee & Child(ren)	$822.62	$769.16	$53.46
Family	$1,417.62	$1,325.48	$92.14
Comprehensive PPO Plan *Administered by Blue Cross Blue Shield of Delaware*			
Employee	$587.46	$509.62	$77.84
Employee & Spouse	$1,219.04	$1,057.52	$161.52
Employee & Child(ren)	$905.38	$785.42	$119.96
Family	$1,523.98	$1,322.06	$201.92

When you enroll in a health care plan, you will automatically be enrolled in prescription drug coverage managed by Medco.

*** Rates listed above are per month.**

NOTE: House Bill 81 eliminated Double State Share for any newly eligible employees or pensioners as of January 1, 2012, and established an employee cost of $25 per month for each Double State Share plan as of July 1, 2012.

Health Care Coverage for Medicare Eligible Retirees

IMPORTANT NOTICE FOR PENSIONERS – MEDICARE ELIGIBILITY & ENROLLMENT

Delaware Law and the State of Delaware's Group Health Insurance Program's Eligibility and Enrollment Rules mandate that you, your spouse, and your dependents enroll in Medicare Parts A & B upon eligibility (due to age or disability). Even if you are under 65, you must enroll in Medicare Parts A & B as a pensioner when eligible.

To obtain Medicare eligibility information, please call the Social Security Administration at 1-800-722-1213 or visit **www.ssa.gov**.

You MUST contact the Office of Pensions upon receipt of your Medicare card. Failure to enroll and maintain enrollment when eligible, due to age or disability, shall result in the termination of coverage through the State of Delaware Group Health Insurance Program. Claims for health care and prescription coverage will be denied and become your personal financial responsibility.
See **www.ben.omb.delaware.gov/medicare** or **www.medicare.gov** for more information.

Information about Medicare: Parts A, B, and D

Part A Hospital Insurance

Most people don't pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working. Medicare Part A (Hospital Insurance) helps cover inpatient care in hospitals, including critical access hospitals and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. Beneficiaries must meet certain conditions to get these benefits.

Part B Medical Insurance

Most people pay a monthly premium for Part B as determined by the Social Security Administration. Medicare Part B (Medical Insurance) helps cover doctor's services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary. As a State of Delaware pensioner, spouse, or dependent, you are required to enroll in Medicare Part B, when eligible, based on age or disability.

Part D Prescription Drug Coverage

If you are in the State's pension health plan, you already have prescription drug coverage that is at least as generous as the Medicare Part D private insurer plans that are offered. **You do not need to enroll in Medicare Part D**. In fact, if you do enroll in Medicare Part D, your prescription coverage through the State will be terminated. You may maintain your health coverage. **NOTE:** Review the **NOTICE OF CREDITABLE COVERAGE** regarding Medicare Part D prescription coverage included with your Open Enrollment packet or at **www.ben.omb.delaware.gov/script** or by contacting the Office of Pensions.

Special Medicare Supplement Plan and Benefits

More About Medicare

See page 16 and 17 for the Summary of Benefits for the BCBSD Special Medicfill Medicare Supplement plan available to you. For a complete description of your health benefits under Medicare and any limitations on those benefits, consult Medicare Publications or the Centers for Medicare and Medicaid (CMS). More information can be found on the Internet at **www.medicare.gov**.

Health Care Coverage for Medicare Eligible Retirees

2012 Medicare Supplement Health Plan Rates

	Total Monthly Rate	State Pays	Pensioner Pays
BCBSD Medicare Supplement for Pensioners Retired On or Before July 1, 2012			
Special Medicfill With Prescription	$414.26	$414.26	$0
Special Medicfill WITHOUT Prescription*	$191.76	$191.76	$0
BCBSD Medicare Supplement for Pensioners Retired After July 1, 2012			
Special Medicfill With Prescription	$414.26	$393.56	$20.70
Special Medicfill WITHOUT Prescription*	$191.76	$182.18	$9.58

** Medicare Supplement plans without prescriptions are provided for Medicare Beneficiaries enrolled in Medicare Part D.*

Eligible Pensioners hired by the state on or after July 1, 1991

(Except those receiving a disability pension or receiving an LTD benefit from The Hartford)
Including spousal/children coverage if elected.

Years of Service	Percentage of State Share Paid by the State
Less than 10 years	0%
10 years but less than 15 years	50%
15 years but less than 20 years	75%
20 years or more	100%

Eligible Pensioners hired by the state on or after January 1, 2007

(Except those receiving a disability pension or receiving an LTD benefit from The Hartford)
Including spousal/children coverage if elected.

Years of Service	Percentage of State Share Paid by the State
Less than 15 years	0%
15 years but less than 17.5 years	50%
17.5 years but less than 20 years	75%
20 years or more	100%

Health Care Coverage for Medicare Eligible Retirees

Summary of Benefits Medicare Supplement Plan (Part B)—Special Medicfill

(Administered by Blue Cross Blue Shield of Delaware)

This plan supplements Medicare. Unless otherwise indicated on the Benefit Highlights pages included in this booklet, benefits will be paid as noted only after Medicare pays its full amount.

The following chart provides a Summary of Benefits for the BCBSD Special Medicfill Medicare Supplement plan offered through the State of Delaware Group Health Insurance Program for Medicare participants.

This Summary of Benefits is intended as a **highlight** of the Special Medicfill Medicare Supplement plan available. A Summary Plan Booklet is available to view online at www.delawarepensions.com.

Description of Benefit	Medicare	Special Medicfill
Inpatient Hospital		
Days 1-60	Pays all but the Part A deductible	Covers the Part A deductible
Days 61-90	Pays all but a specified dollar amount of coinsurance per day	Covers the specified dollar amount of the coinsurance
Days 91-150	Pays nothing*	Covers care in a general hospital (except mental & nervous). These days may be used before Medicare's 60 lifetime reserve days. Covers coinsurance amount
Days 151-365	Pays nothing*	Covers care in a general hospital (except mental & nervous). These days may be used before Medicare's 60 lifetime reserve days. Covers coinsurance amount
Hospice	Pays part of the cost for inpatient respite care, and you must receive care from a Medicare certified hospice	Balances paid up to the Medicare reasonable charge**
Emergency Services	80% of the reasonable charges** after the Medicare Part B deductible	Covers Part B deductible and 20% of the reasonable charges**
Prosthetics & Durable Medical Equipment	80% of the reasonable charges** after the Medicare Part B deductible	Covers Part B deductible and 20% of the reasonable charges**
Physician Home & Office Visits	80% of the reasonable charges** after the Medicare Part B deductible	Covers Part B deductible and 20% of the reasonable charges**

Health Care Coverage for Medicare Eligible Retirees

Description of Benefit	Medicare	Special Medicfill
Specialist Care/Chiropractic Care	80% of the reasonable charges** after the Medicare Part B deductible	Covers Part B deductible and 20% of the reasonable charges**
Emergency Ambulance	80% of the reasonable charges** after the Medicare Part B deductible	Covers Part B deductible and 20% of the reasonable charges**
X-ray, Lab & other Diagnostic Services, Radiation Therapy	80% of the reasonable charges** after the Medicare Part B deductible	Covers Part B deductible and 20% of the reasonable charges**
Outpatient Rehabilitation Services, Occupational Therapy, Physical Therapy, Speech Therapy	80% of the reasonable charges** after the Medicare Part B deductible	Covers Part B deductible and 20% of the reasonable charges**
Routine GYN exam, Pap Smear, Mammogram	Covers 80% of the reasonable charges,** for routine GYN exam and mammogram. You pay $0 for Pap smear once every 24 months, annually if high risk. Mammograms covered once every12 months age 40 and older	Covers 20% of the reasonable charges.** One routine exam and Pap Smear is covered in a 12-month period.
Prostate Cancer Screening Exams (age 50 & over)	Covers 100% for approved lab services. Covers 80% of the reasonable charges** for other related services after the Part B deductible	Covers Part B deductible and 20% of the reasonable charges**
Periodic Physical Exams	Covers one exam every 12 months at 100% of reasonable charges**, if doctor accepts the assignment	Coverage at 100% of Blue Cross allowable, based on age guidelines published by American Medical Association after Medicare pays
Flu & Pneumococcal Pneumonia Vaccines	Covers 100% of reasonable charges.** **Pneumonia**–check with physician for frequency. **Flu**–once per year	**Pneumonia**–once at age 65 and up **Flu**–once per calendar year for age 65 and over
Routine Vision Care	Not covered	Not covered

**Medicare's 60 Lifetime Reserve Days may be used only once; they are not renewable.*

***Reasonable Charge means the amount approved by the Medicare carrier as the allowable charge for reimbursement under the Medicare Program.*

Prescription Coverage

Medco

When you enroll in a health care plan, you will automatically be enrolled in the prescription drug plan managed by Medco Health Solutions, Inc. (Medco). The Coordination of Benefits (COB) policy also applies to prescription coverage. If your spouse or dependents have other health coverage that is primary (pays first), the prescription coverage provided through the State's plan for the spouse or dependents will become secondary.

The State of Delaware, in partnership with Medco, has designed and implemented a comprehensive prescription drug program to provide you with the medications required in a cost-effective and efficient manner. Your copays remain unchanged for the coming plan year.

2012 Prescription Copay Rates

STATE OF DELAWARE PRESCRIPTION COVERAGE	TIER 1 GENERIC	TIER 2 PREFERRED	TIER 3 NON-PREFERRED
30-DAY SUPPLY	$8.50	$20.00	$45.00
90-DAY SUPPLY	$17.00	$40.00	$90.00

Maintenance Medication Program

Maintenance Medications are those used to treat chronic conditions and long-term conditions. Examples include blood pressure medications, cholesterol-lowering medications, and asthma medications. For more information, see **www.ben.omb.delaware.gov/script**.

Since July 1, 2009, the State of Delaware Prescription Plan has required that maintenance medications be filled for 90 days and a penalty applies when a 30-day prescription is filled for the 4th time. The penalty is that the member receives a 30-day supply of medication and is charged the 90-day copay, as shown on the chart below.

STATE OF DELAWARE MAINTENANCE MEDICATION PROGRAM	TIER 1 GENERIC	TIER 2 PREFERRED	TIER 3 NON-PREFERRED
Penalty: On the 4th fill of a 30-day supply of a Maintenance Medication member receives 30 days of medication and pays the 90-day copay	$17.00	$40.00	$90.00

Members can avoid paying a penalty by asking their doctor to write maintenance medication(s) prescriptions for a 90-day supply. Members can then fill 90-day prescriptions:

1. At **retail pharmacies participating in the 90-day network**: Visit the Statewide Benefits website at **www.ben.omb.delaware.gov/script** to view a list of retail pharmacies participating in the 90-day network or call Medco at **1-800-939-2142** to ask about a particular pharmacy.

2. **Through the Medco Pharmacy (mail order)**: To get started call **1-800-939-2142** to speak with one of Medco's Member Services representatives.

Diabetic Program

- Diabetic supplies (lancets, test strips, syringes/needles) are provided at no cost ($0 copay) when the prescription is filled at a retail participating pharmacy, a 90-day participating pharmacy or the Medco Pharmacy (mail order). Supplies do not need to be ordered at the same time as medications to take advantage of the $0 copay.

- Multiple diabetic medications may be obtained for just one copay when the prescriptions are filled at the same time at a 90-day participating pharmacy or the Medco Pharmacy (mail order).

For more information on the Diabetic Program, visit **www.ben.omb.delaware.gov/script**.

Prescription Coverage

Prescription Plan Changes As Of July 1, 2012

As part of the 2012 DelaWELL Tobacco Cessation Program, copays for prescription tobacco cessation medications will be waived beginning July 1, 2012 at participating retail pharmacies and the Medco Pharmacy (mail order). The covered medications include Nicotrol NS, Nicotrol Inhaler, bupropion HCl (generic for Zyban) and Chantix.*

** Note: The brand medication Zyban is subject to the State of Delaware plan requirement to use generic medications when available. If there is a medical reason that the generic cannot be taken, your doctor should appeal through Medco for an authorization.*

The following medications will be subject to new coverage management rules beginning July 1, 2012: Incivek, Victrelis (Hepatitis C medications) and Simponi, Cimza (Rheumatoid Arthritis medications).

Additional information is available at **www.ben.omb.delaware.gov/script**.

The Coverage Review Process

The Coverage Review Process was designed to ensure that plan participants receive prescription medication that results in appropriate, cost-effective care. If you are taking any of the medications referenced in the programs below, Medco will review the prescription with your doctor before the prescription is filled if additional information is required. The Coverage Review Process uses plan rules based on FDA approved prescribing and safety information, clinical guidelines and usage that is considered reasonable, safe and effective. You, your doctor or your pharmacy may begin the Coverage Review Process by calling 1-800-753-2851 from 8:00 a.m. to 9:00 p.m., Monday through Friday. The Coverage Review Process usually takes two business days to complete upon receipt of necessary information. You and your doctor will receive written confirmation of approval or denial. The following programs fall under the Coverage Review Process:

Traditional Prior Authorization requires that you obtain pre-approval through a coverage review for certain medications. The review will determine whether your plan covers your prescribed medication. Examples of common medications that may require prior authorization are Solodyn used to treat teenage acne, Botox and Myobloc, Regranex, Synagis and Respigam, Xolair, medications that may have cosmetic uses, Erythroid Stimulants used for certain anemias, Growth Hormones used to stimulate skeletal growth and Psoriasis medications.

Step Therapy is an automated process used to determine whether you qualify for coverage using facts Medco has on file, such as medical history, drug history, age and gender. If your history does not qualify you for coverage, a prior authorization is required to permit coverage. Certain medications may not be covered unless you have first tried another medication or therapy. These medications are part of this process: Lyrica used to treat partial onset seizures in adults and to manage fibromyalgia related pain and neuropathic pain, Forteo, Revatio, COX-II Inhibitors such as Celebrex, injectable rheumatoid arthritis medications, select high blood pressure (ARB's) medications such as Benicar, Proton Pump Inhibitors such as Aciphex or Prevacid and select antidepressants such as Lexapro, and Migraine Headache medications such as Imitrex and Maxalt.

Quantity Duration Rules are in place for some medications which require a Coverage Review Process to request additional quantities. These include medications used to help you sleep such as Ambien and Lunesta, Xifaxan used to treat traveler's diarrhea in patients 12 years old and older or hepatic encephalopathy, selected antifungal medications such as Sporanox and Lamisil, selected migraine medications such as Imitrex and Maxalt, selected nausea medication such as Anzemet and Zofram and erectile dysfunction medications such as Cialis and Viagra.

The Choice Program…Generic vs. Brand Drugs allows you to receive a brand name medication when a generic drug is available; however, you will be responsible for the generic copay plus the cost difference between the generic and the brand drug. If there is a medical reason why you cannot take the generic equivalent, you, your doctor or your pharmacist may initiate the copay appeal process to allow you to obtain the brand drug at the non-preferred copay.

Certain medications are not covered by the prescription drug plan including drugs for weight loss, allergy shots, reusable syringes, immunizations and injectable medication administered in the doctor's office.

NOTE: *All drugs and categories listed above are subject to change.*

Questions About Your Prescription Coverage

If you have specific questions about medication or pharmacy participation, contact Medco's Member Services at 1-800-939-2142, 24 hours a day, 7 days a week. Pharmacists are available around the clock for medication consultations. Medco's website, **www.medco.com** offers extensive online resources, including health and benefit information and online pharmacy services.

Dela*WELL* Health Management Program

Wellness Benefits with Dela*WELL*

The State of Delaware, in partnership with Alere, has designed a comprehensive health management program to support you in developing healthy habits for a lifetime. Whether you want to learn how to better care for yourself or a loved one, have more energy or increase your physical activity, the tools you need are available at your fingertips.

Dela*WELL* is pleased to provide you and your eligible spouse and dependents with activities, tools and resources to help you take charge of your health and wellness. Through the Dela*WELL* Health Management Program, members will have FREE access to many health program options.

When you enroll in a health plan, you will automatically be enrolled in the Dela*WELL* Program managed by Alere.

Follow These Simple Steps to Participate Starting July 1, 2012

- **Register and Set Up Your Personal Profile** – Visit the Dela*WELL* Health Portal at **https://delawell.alerehealth.com** and follow the steps to register on the log in page.

- **Attend a Dela*WELL* Health Screening** – Visit the Dela*WELL* Health Portal and sign up for a FREE Health Screening Appointment provided at various State of Delaware locations during the 2012 - 2013 plan year.

- **Complete Your Confidential Online Wellness Assessment** – After you attend your health screening appointment, your next step is to complete your confidential online Wellness Assessment. To receive the most comprehensive report and recommendations, include your recent health screening values. You can enter these directly from the sheet provided at your Dela*WELL* Health Screening OR wait about two weeks after your screening for your values to be automatically included in your assessment for you. If you want your values loaded for you, do not click "Finish" on your assessment until after your values are included.

- **Participate in a recommended Alere Health Coaching Program, Condition Care Program or Weight Watchers** – Based on your answers to the Wellness Assessment, you may be invited to participate in a condition care, health coaching program or other Dela*WELL* activity. The Dela*WELL* Program has many options, including healthy living programs, onsite health seminars, Weight Watchers discount programs, wellness challenges, online seminars and much more.

$100 - $200 Incentive Program

Benefit eligible state agency, school district, charter school and higher education employees, as well as state non-Medicare eligible pensioners, who are currently enrolled in a State of Delaware Group Health Plan, can earn up to $200 for participating in program activities from July 1, 2012 through May 31, 2013.

- **Silver Level:** Complete an annual Wellness Assessment AND Health Screening to earn a **$100 Incentive**.
  *** NEW: Participants who complete the Silver Level activities by October 15, 2012 will receive an "Early Bird" payment of $100 in a December 2012 paycheck.**

- **Gold Level:** Complete a Wellness Assessment, Health Screening AND actively participate in a Health Coaching Program, Condition Care Program or Weight Watchers to earn a **$200 incentive**.

If you have questions about Dela*WELL* visit **www.delawell.delaware.gov** or contact the Alere Nurse24 line at 1-866-674-9103, 24 hours a day, 7 days a week. Nurses are available for questions.

Employee Assistance Program (EAP)

Balancing the needs of work, family and personal responsibilities can be challenging. To make the balancing act a little easier, Human Management Services, Inc. (HMS) offers a place to turn for confidential assistance. The EAP offers face-to-face assessment and confidential counseling services to employees, pensioners and their dependents enrolled in a non-Medicare health insurance plan and offers confidential assistance in the following areas:

- Marital Relationships
- Family Issues
- Alcohol and Drug Abuse
- Child Care
- Parenting Issues
- Elder Care
- Productivity Problems
- Adolescent Issues
- Balancing Work and Family
- Financial Issues
- Stress Management
- Legal Issues
- Difficult Emotional Problems
- Grief and Loss

To receive an assessment and/or up to five short-term counseling sessions free of charge, call HMS at 1-800-343-2186 or visit HMS online at **www.hmsincorp.com** to access EAP or Work/Life services. If your HMS professional refers you to another provider for continued assistance you will incur out-of-pocket expenses. Additional information may be viewed at **www.ben.omb.delaware.gov/eap**

• Log into the HMS website using the following:

Username: **Delaware**
Password: **statehms04**

Blood Bank of Delmarva

FIRST FACT!
"One pint of blood can save 3 lives.
Blood Bank of Delmarva

What Is The Blood Bank?

Blood Bank of Delmarva is a non-profit organization, which provides over 100,000 units of blood and blood products each year to hospitals in Delaware and Maryland's Eastern Shore. Members receive blood replacement coverage in exchange for their support.

Why Should You Join?

By joining the Blood Bank, you will help ensure the continued availability of blood for our community and its citizens. Each year in our area over 20,000 patients need blood transfusions. Blood is needed every day for emergencies such as auto accidents, surgeries and for people undergoing treatment for cancer and other diseases. 350 donors are needed every day on Delmarva.

What Are The Benefits Of Being A Blood Bank Member?

Membership in the Blood Bank covers you, your spouse and dependents for unlimited blood replacement coverage at any hospital in the United States. While health insurance plans cover testing and processing fees, the cost of the blood itself is often not covered. Non-members are billed for any blood they use or may replace it pint for pint.

What Are Blood Bank Members Asked To Do?

Members agree to take a turn in providing blood approximately once every 12 months. You can provide blood by either:

- Giving blood yourself or
- Having someone else give for you or
- Paying $30 (the current cost of replacing one pint of blood in our area)

Most healthy people can give blood. Anyone can join, even if you can't give blood yourself.

The State of Delaware provides Blood Bank of Delmarva membership to full-time, permanent State employees and Pensioners as a paid benefit. Part-time employees pay an annual fee of $5, which is deducted on the first pay of the calendar year or the first pay after enrolling in the Blood Bank.

Active State employees enrolling in the Blood Bank **for the first time** must go online to eBenefits at **https://eapps.erp.delaware.gov** by May 23, 2012.

Pensioners can continue their membership even if they no longer live in the Delmarva area. Pensioners enrolling in the Blood Bank **for the first time** must complete the blood bank application available on the Office of Pensions Website at **www.delawarepensions.com** or the blood bank application included in the packet of information mailed to their home. The completed application must be returned to the Office of Pensions by May 23, 2012.

PLEASE NOTE: If your membership in the Blood Bank has been terminated due to non-fulfillment of your Blood Bank obligation, please contact the Blood Bank directly to discuss reinstatement. If you have any questions about the Blood Bank, please call toll-free at (888) 825-6638, or in New Castle County, (302) 737-8400.

About Your Dental Plans

Delta Dental and Dominion Dental Services administer the State's dental programs

Remember:

Enrollment in any of these dental plans is a Binding Election until next year's open enrollment. If you are enrolling in the Dominion Dental HMO – before you enroll make sure your dentist participates in this plan. You cannot change plans or drop coverage during the plan year if your dentist decides to no longer participate in the plan. You will be given the opportunity to choose another participating dentist. Call before enrolling to be sure the dentist is accepting new patients.

Delta Dental PPO℠ Plus Premier Plan

This program allows you to visit any dentist you choose and receive applicable benefits. You'll likely save the most if you visit a dentist who participates with Delta Dental. You do not have to pick a primary care dentist; you are free to choose any dentist for any covered service at any time.

Delta Dental has the largest network of participating dentists in Delaware and the United States. Your Delta Dental program gives you access to two Delta Dental dentist networks at once that offer different degrees of savings. You can choose a dentist from the larger Delta Dental Premier® network or one from the smaller Delta Dental PPO network, which features lower allowances and lower out-of-pocket costs, or a dentist who does not participate with Delta Dental. Your choice of dentists can determine the cost savings you receive.

Delta Dental payments vary by service, based on Delta Dental's schedule of allowed amounts for its networks. Reimbursement maximums and deductibles apply. Your annual reimbursement maximum is $1,500 per plan year per participant. Delta Dental dentists cannot balance bill above the applicable allowed amount for covered services. Non-participating dentists can bill you for the difference between their full charge and Delta Dental's payment.

Here is an example of how you can save by using a Delta Dental dentist:

Example	Delta Dental Participating Providers		Non-Participating Dentists
	Delta Dental PPO Dentists	Delta Dental Premier Dentists	
Dentist's Charge for a Crown	$1,200	$1,200	$1,200
Plan Allowance	$900	$1,000	$1,100
Coinsurance Amount	50%	50%	50%
Plan Payment	$450	$500	$550
PATIENT PAYMENT	$450 ($900 - $450 =)	$500 ($1,000 - $500 =)	$650 ($1,200 - $550 =)

Additional information can be viewed at **www.ben.omb.delaware.gov/dental/delta** including a dentist directory or by contacting Delta's Customer Service at 1-800-873-4165.

About Your Dental Plans

Dominion Dental HMO Plan (same as a DHMO)

Dental Plan 605xs

Dominion Dental's Select Plan provides great value, fixed fees, limited costs and lower premiums. Simply choose any general dentist from the list of participating Select Plan dentists to receive care.

Plan Features	Select Plan 605xs
Office Visit Copayment	$10
Deductibles	None
Maximum Annual Limit	No Limit
Maximum Lifetime Ortho	No Limit
Claim Forms	None
Benefits	Scheduled (Fixed Fees)
Pre-existing Condition	None
Waiting Periods	None

No Charge[1] For

- Oral Exams
- Semi-annual cleanings
- Bitewing X-rays
- Topical fluoride for children

These procedures account for over 65% of dental services most frequently performed for adults and almost 90% of the most frequently performed services for children[2].

- Dominion's preventive incentive program will pay subscribers $20 for each family member who gets two cleanings during the plan year (between 7/1/12 and 8/1/13).
- Simply complete a brief member satisfaction survey (more information coming soon) and Dominion will send you a check upon confirmation of your cleanings.
- Dominion's Select Plan covers an extra cleaning for diabetics and expectant mothers.

Fillings, crowns, dentures, root canals, periodontal care, oral surgery, orthodontics, etc., are covered at fees up to 70% lower than usual and customary charges[3]. Specialty care is provided at the listed copayment, whether performed by a participating general dentist or a participating specialist.

State of DE Employees Enrolled With Dominion…

- Received $1.32 in value for every $1.00 spent on dental premium[2]
- 97% of survey respondents rated the treatment by their dentist "Satisfactory to Excellent[4]"

[1] There is a $10 office visit fee.
[2] Dominion Dental Services, Inc. – based on annual review of utilization data.
[3] Based on the Captiva context fee schedule's 80th percentile fee information.
[4] Dominion Dental Services, Inc. – State of Delaware Member Satisfaction Survey, 2009

Additional information can be viewed at **www.ben.omb.delaware.gov/dental/dom** or by calling Dominion's Customer Service at 888-518-5338.

Dental Plan Rates

	Total Monthly Rate	State Pays	Employee/Pensioner Pays
Dominion Dental HMO *Administered by Dominion Dental*			
Employee	$22.68	$0.00	$22.68
Employee & Spouse	$42.14	$0.00	$42.14
Employee & Child(ren)	$45.42	$0.00	$45.42
Family	$61.66	$0.00	$61.66
Delta Dental PPO Plus Premier *Administered by Delta Dental*			
Employee	$31.62	$0.00	$31.62
Employee & Spouse	$64.54	$0.00	$64.54
Employee & Child(ren)	$63.34	$0.00	$63.34
Family	$105.70	$0.00	$105.70

About Your Vision Coverage

EyeMed VISION CARE®

Enroll Today in a Vision Wellness Plan That's Convenient and Affordable

As a current employee or pensioner of the State of Delaware, you are eligible for valuable savings on vision care. Take care of your vision and health today by enrolling in the State Vision Plan* offered by EyeMed Vision Care:

- **Eye Health Equals Better Health:** Eye exams are important for your health. A comprehensive eye exam may help you preserve your sight by detecting eye conditions early. Other diseases, such as diabetes and high blood pressure, may also be detected during an eye exam.
- **Great Savings of Approximately 40%:** Save on eye care and eyewear, including many lens options that meet your needs.
- **Convenience and Choice:** The State of Delaware Access Network offers you the choice of leading private practitioners and optical retailers.

See the Savings!
With only a $10 copay on eye exams and a $160 allowance for frames, you can save a significant amount on vision care. Below is an example of what you can save:

Purchase a Complete Pair of Eyeglasses		
Transaction Details	**Retail**	**Cost with the State Vision Plan**
Eye Exam	$88	$10
Frame	$160	$0
Premium Progressive Lenses	$230	$117
Premium Anti-Reflective	$97	$57
Total Cost	$575	$184
Yearly Subscriber Premiums	$73.44	
Your Total Expense	$257.44	
Total Savings Compared to Retail	**55%**	

Enroll in EyeMed Vision Care Today!

About Your Vision Coverage

Total Monthly Rates for EyeMed Vision Plan:

Plan	Rate
Subscriber	$6.12
Subscriber + Spouse	$9.64
Subscriber + Children	$9.84
Subscriber + Family	$15.88

To view your vision benefits and see great savings At-a-Glance, please visit
www.ben.omb.delaware.gov/vision/documents/benefits_at_a_glance_2012.pdf

For more EyeMed Vision Plan information, please visit
www.ben.omb.delaware.gov/vision

Want to learn more?

- For a complete list of providers near you, use our Provider Locator on ww.eyemedvisioncare.com and choose the ACCESS network or call 1-855-259-0490.
- For Lasik providers, call 1-877-5LASER6.

Additional Discounts and Features:

- 40% off additional eyewear purchases.
- 20% off non-prescription sunglasses.
- 20% off remaining balance beyond plan coverage.
- Laser vision correction—15% off the retail price or 5% off the promotional price for Lasik or PRK procedures.

How To Enroll

Active State Employees: Refer to the eBenefits Quick Reference Guide (online at **www.ben.omb.delaware.gov/oe**) for complete login and enrollment instructions.

Pensioners: You must complete the EyeMed vision care enrollment form provided in the packet of information you received in the mail and also available on the Office of Pensions Website at www.delawarepensions.com. Completed enrollment form must be submitted to the Office of Pensions by May 23, 2012.

*State vision plan does not apply to participating non-state groups.

State of Delaware Deferred Compensation Plan

State of Delaware 457(b) Deferred Compensation Plan and 403(b) TSA Plan Administered by the Delaware State Treasury

A great way to save for retirement and reduce your current taxes is by participating in the 457(b) and/or 403(b) retirement savings plans, administered by the Delaware State Treasury. Contributions are made through pre-tax payroll deductions and grow tax-deferred. Whether you are starting your career, or nearing retirement, the State of Delaware Deferred Compensation Plans can help you build a secure financial future.

Enrollment in Deferred Compensation is open year-round. However, we encourage you to enroll now while you are evaluating your other benefits. Are you already participating? Open Enrollment is a great time to consider increasing your contributions, bringing you another step closer to your retirement savings goals. The benefits of each plan are highlighted below. You can learn more about each plan by visiting our website at **www.DelawareSaves.com**.

State of Delaware 457(b) and 403(b) Plan Comparison

Feature	457(b) Deferred Compensation	403(b) TSA Plan
Eligible Participants	State employees who are pension eligible (Casual-Seasonal employees are not eligible)	All employees working in a public school, charter school, DTCC, DSU and the Dept of Education regardless of pension eligibility
Basic Contribution Limits	$17,000 in 2012 (IRS may increase or decrease limit each year)	$17,000 in 2012 (IRS may increase or decrease limit each year)
Age 50 and over Catch-up Limits	$5,500 in 2012 (IRS may increase or decrease limit each year)	$5,500 in 2012 (IRS may increase or decrease limit each year)
Other Catch-up Limits	Recapture option. Allows employees who are at least 3 years from obtaining normal retirement age the option to increase the amount deferred, up to twice the yearly maximum	No
Match Plan	$10 per pay after 6 months of participation (Currently Suspended)	No
Distribution of Funds	Age 70 1/2, Upon separation from employment, Unforeseeable Emergency Withdrawal, QDRO, Death	Age 59 1/2, Upon separation from employment, Becomes disabled, Hardship, QDRO, Death
Rollover	Can roll previous employer's pre-tax plans such as 401k, 403b, IRA or 457(b) into the State's 457(b)	Can roll previous employer's pre-tax plans such as 401k, 403b, IRA or 457(b) into the State's 457(b)
Trustee-to-Trustee Transfer (To buy State service)	Yes	Yes
Enroll or Make Changes	**www.fidelity.com/atwork**	**www.myretirementmanager.com/?delaware**

Policies

State of Delaware – Spousal Coordination Of Benefits Policy

The State of Delaware Spousal Coordination of Benefits Policy was instituted in 1993 and updated in 2011 to include spouses who retire from an employer other than the State of Delaware.

In General, the policy states that **if**:

- the state employee/pensioners's spouse is employed full-time or retired from another employer, **and**
- that employer/former employer offers group health coverage, **and**
- the employer/former employer pays at least 50% of the premium for the lowest employee/pensioner only plan, **then**,
- the spouse must obtain coverage as primary through his/her employer/former employer.

The complete Spousal Coordination of Benefits Policy can also be found at **www.ben.omb.delaware.gov/documents/cob**.

The Spousal Coordination of Benefits Policy Form must be completed if you cover your spouse in one of the State of Delaware Group Health Insurance medical plans. The completed form is used to determine a spouse's eligibility to receive primary coverage through the State of Delaware medical plans. ***Failure to complete this form will result in a reduction of spousal benefits.***

- **If you are an active employee covering your spouse in one of the State of Delaware Group Health Insurance medical plans, you MUST complete a new Spousal Coordination of Benefits form each year during Open Enrollment and anytime your spouse's employment or insurance status changes. Active employees MUST complete the form online at www.ben.omb.delaware.gov/documents/cob no later than May 23, 2012.**
- **If you are a pensioner covering a spouse in one of the State of Delaware Group Health Insurance medical plans which is not a Medicare supplement plan, you MUST complete a new Spousal Coordination of Benefits form each year during Open Enrollment and anytime your spouse's employment or insurance status changes.**
- **IMPORTANT: If you are a pensioner covering a spouse in the BCBSD Special Medicfill Medicare supplement plan, you must complete a Spousal Coordination of Benefits Form during this 2012 Open Enrollment. PLEASE NOTE: THIS IS A CHANGE FROM PRIOR OPEN ENROLLMENT PERIODS.**

  If you are a pensioner and have access to the internet, complete the form online at www.ben.omb.delaware.gov/documents/cob by May 23, 2012. If you do not have access to the internet, please complete the paper form included in your packet and return it to the Office of Pensions by May 23, 2012.
- If you and your spouse are both benefit-eligible State of Delaware employees or pensioners, you must still complete a Spousal Coordination of Benefits form for the health care carrier's records. A checkbox is located on the Spousal Coordination of Benefits form to confirm your spouse is a benefit eligible State of Delaware employee or pensioner.
- If you are a Participating Group employee, married to a State of Delaware employee who is enrolled in the Group Health Insurance Program, you MUST elect coverage for yourself through your organization rather than be covered under your spouse. For additional information, visit **www.ben.omb.delaware.gov/nonpayroll**.

REMINDER! After completing the form online, click on "Printable Summary" to print a copy for your records.

If your spouse's employer offers a High Deductible Health Plan with a Health Savings Account (HSA) , you and your spouse should take careful note of important information regarding these plans on our website at **www.ben.omb.delaware.gov/documents/cob**.

Adult Dependent Coverage to Age 26 Policy

In accordance with the Patient Protection and Affordable Care Act (PPACA), also known as Health Care Reform, effective July 1, 2011, the State Group Health Insurance Program (GHIP) provides coverage for adult dependent children to age 26. Under PPACA, "grandfathered health plans" may exclude full coverage for adult children to age 26 if the child has access to health coverage through his or her own employer under certain circumstances. As all of the State's health plans are considered to be "grandfathered health plans" with the exception of the Consumer-Directed Health Gold Plans, the State Employee Benefits Committee (SEBC) adopted the Administration of Dependent Coverage to Age 26 Policy to effectively manage enrollment and coordination of benefits. This policy is located at **www. ben.omb.delaware.gov/documents/cob.**

State employees, pensioners, and employees of those groups designated through Delaware Code to participate in the GHIP may enroll their adult dependent children to age 26 in their State health care plan, dental plan and/or vision plan from May 7 through May 23, 2012. Adult dependent children may be enrolled with no restriction on marital, employment, student, resident or tax status. For purposes of extension to age 26, an employee's children are defined by federal law as sons, daughters, stepchildren and adopted children. During Open Enrollment from May 7, 2012 to May 23, 2012, active State employees should enroll their dependents online through eBenefits. State pensioners should complete the necessary applications to enroll their adult dependent and forward to the Pension Office no later than May 23, 2012. Participating group members should submit the appropriate applications to their Human Resource Office no later than May 23, 2012. COBRA participants should submit the appropriate applications to the Statewide Benefits Office no later than May 23, 2012.

Members are responsible for enrolling their adult dependent children and completing the Adult Dependent Coordination of Benefits Form, (AD-COB form – which follows this policy in the booklet), when enrolling each adult dependent child who turned 21 prior to the end of the preceding calendar year. The form is also required within 30 days of any change to the adult dependent's employment which impacts benefit eligibility, at the end of the calendar year in which an enrolled adult dependent turns 21 and during subsequent open enrollment periods. A hard copy of the AD-COB form must be completed and submitted to the member's Human Resources/Benefits Office no later than May 23, 2012. Members who do not complete and submit the required AD-COB form will have claims for the adult dependent processed at 20% of allowable charges from July 1, 2012 until the AD-COB form is received and processed by the appropriate health care provider.

An adult dependent does not need to be enrolled in his/her employer sponsored health care plan if any of the following reasons apply:

- The adult dependent is less than 21 or turned/turning 21 in the current calendar year (2012), or
- The adult dependent is less than 24 and is a full-time student; or
- The adult dependent does not work full-time; or
- The adult dependent is not eligible to participate under his/her employer's health care plan because he/she has not satisfied his/her employer's requirement as to the number of hours worked; or
- The adult dependent's employer requires an employee contribution of more than 50% of the premium for the lowest health care plan available; or
- The adult dependent's employer does not provide health care coverage.

Policies

If an adult dependent has coverage through his/her employer, the member may also cover the adult dependent. The adult dependent's coverage will process first and then the member's coverage will process second. Payment from both plans combined will not exceed 100% of the covered charges.

If an adult dependent is not eligible to participate in his/her employer's health care plan and is, therefore, not enrolled, the member's selected plan will process claims in accordance with the selected plan provided the AD-COB form is completed.

To determine the 50% contribution of an employer to an adult dependent's health care, all flexible benefit dollars and or credits available to the dependent are counted as contributions provided by the employer. If the employer contributes less than 50% of the premium for the lowest benefit plan, it is not necessary for the adult dependent to enroll in his/her employer's health care plan.

If the adult dependent's employer's health care plan has an eligibility waiting period (a time when the adult dependent is not eligible to enroll for health care coverage) or a contribution waiting period (a time when the dependent is responsible for more than 50% of the cost of the health care plan), the adult dependent may participate under the member's health care plan until the waiting period has been satisfied. Upon satisfying the waiting period, claims for the adult dependent will be processed with the adult dependent's coverage first and then the member's coverage will process second. If the adult dependent fails to enroll in his/her employer's coverage when eligible, then the member's coverage will process claims for the adult dependent at 20% of the allowable charge.

If the adult dependent's employer provides only a Health Maintenance Organization (HMO) plan and the adult dependent lives outside of the HMO service area, it is not necessary for the adult dependent to enroll in his/her employer's health care plan, however, the State will evaluate the adult dependent's enrollment under the member's health care plan on an annual basis beginning July 1, 2012. If, in the judgment of the State, the adult dependent's employer offers only an HMO plan to avoid covering adult dependents of State members, then the State reserves the right to process claims for the adult dependent at 20% of the allowable charge.

Adult Dependent Coordination of Benefits Form

State of Delaware

PLEASE PRINT ALL INFORMATION REQUESTED **Check Carrier: ☐ Blue Cross ☐ Aetna**

EMPLOYEE FULL NAME - Last, First, Middle Initial			YOUR HOME PHONE - Include area code
EMPLOYEE SOCIAL SECURITY NUMBER			Check one: This is the first form for my adult dependent ☐ This is an updated form for my adult dependent ☐
ADULT DEPENDENT'S FULL NAME - Last, First, Middle Initial	ADULT DEPENDENT'S SOCIAL SECURITY NUMBER	☐ Male ☐ Female	DEPENDENT'S BIRTH DATE / /

EMPLOYER INFORMATION

MY ADULT DEPENDENT IS: ☐ Not Employed ☐ Employed Full-time ☐ Employed Part-time ☐ Self-employed

NAME AND ADDRESS OF EMPLOYER		EMPLOYER PHONE NUMBER Include Area Code
Does this employer offer health care insurance to employees? ☐ Yes ☐ No	Is your adult dependent enrolled in health care insurance through this employer? ☐ Yes ☐ No Is this a High Deductible Plan with a Health Savings Account (HSA)? ☐ Yes ☐ No	If not enrolled, what percentage of the premium of the lowest benefit employee only plan would your adult dependent be required to pay?* **Flexible benefits and credits apply toward employer's contribution*
What is the name of your adult dependent's health care insurance carrier'?	What is the plan policy number? Effective Date:	Annual plan renewal date for this employer: Month: Day:
Does this employer's medical plan cover prescription drugs? ☐ Yes ☐ No	Your additional comments:	
If you are completing this form due to your adult dependent's loss of coverage please indicate the termination date of that coverage.	Date:	

AUTHORIZATION

I understand that the following policy applies to adult dependents age 21 to 26 who are eligible for health care coverage through their own employers:

- This information will be shared with the State of Delaware's plan administrator(s).
- If adult dependents over age 21 take advantage of their own employer's health care coverage, these plans pay their benefits first. Then the State of Delaware will pay additional covered expenses, if any, up to the maximum allowed under our employee's family benefit plan, not exceeding a limit of 100% coverage from both plans combined.
- If adult dependents over age 21 do not take advantage of their own employer's health care coverage, the State will pay 20% of covered services provided by the employee's State of Delaware benefit plan.

I understand this form must also be completed every year during Open Enrollment or any time my adult dependent's employment or coverage situation changes in order to cover my adult dependent under the State of Delaware Group Health Insurance plan. The form is used to determine eligibility to receive primary State of Delaware health benefits. Generally, the following adult dependents over age 21 are not required to enroll in their employers' plans:

- Adult dependents who are not working full time, or
- Adult dependents whose employer does not offer health care coverage, or
- Adult dependents whose employers require a contribution of more than 50% of the premium for the lowest benefit employee only plan available.

If any of this information changes, I must complete a new form within 30 days and submit to my agency benefits representative.

Notice to all parties completing this form: To insure benefits are coordinated properly between employers, the State of Delaware will verify the accuracy of information by conducting audits, contacting you, and contacting your adult dependent's employer. It is fraudulent to fill out this form with any information which is false or incorrect or to omit important facts. Providing false or incorrect information may result in disciplinary action and sanctioned payment (reduced to 20%) of claims for your adult dependent. Any claims paid based on false or incorrect information will be reversed and payment will be the responsibility of the employee.

Please return completed form to your organization's Human Resources or Benefits Representative.

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT Member's Signature	Date: / /

A complete copy of the State of Delaware's Policy can be found online at **www.ben.omb.delaware.gov/documents/cob**

4/1/2011

Policies

Double State Share

House Bill 81 signed into law on May 2, 2011 made several changes to the State of Delaware Group Health Insurance Plan. One of the changes impacts the policy of Double State Share. Double State Share was eliminated for new employees hired after January 1, 2012, as well as employees/pensioners if they became benefit eligible or married another benefit eligible state employee/pensioner after January 1, 2012.

Effective July 1, 2012, employees/pensioners who are enrolled in a Double State Share (DSS) plan will pay a premium of $25 per month for each health plan chosen. If enrolled in DSS Employee and Spouse or Family plans, one $25 per month charge will apply. If enrolled in separate plans (for example - two DSS Employee Only plans or one DSS Employee Only plan and one DSS Employee and Children plan,) a $25 per month charge will apply to each plan. If enrolled in First State Basic employee only coverage you will be charged the employee share of the monthly premium, as the premium is less than $25.

If you and your spouse have chosen to be enrolled in separate DSS contracts, you will both be charged $25 per month, or the applicable employee only premium (if enrolled in First State Basic employee only coverage). To avoid two monthly charges, you and your spouse may change your enrollment to a DSS Employee and Spouse, or Family contract, during open enrollment and only one $25 per month charge will apply. The spouse whose birthday falls first in the calendar year should carry the coverage.

Active employees eligible for Double State Share must make changes to their enrollment by logging onto eBenefits at **https://eapps.erp.delaware.gov** from May 7 to May 23, 2012 and making the appropriate changes. If you do not remember your password, click on Self-Service User Account Assistance on the left and submit an online request to reset your password.

Pensioners eligible for Double State Share and enrolled through the Office of Pensions will be charged as follows:

- If you and your spouse are not Medicare eligible and have chosen to be enrolled in separate DSS non-Medicare contracts, you will both be charged $25 per month (or the applicable employee only premium if enrolled in the First State Basic Plan with employee only coverage as the premium is less than $25 per month). To avoid two monthly charges, you and your spouse may change your enrollment to an Employee and Spouse, or Family contract, during open enrollment and only one $25 per month charge will apply.
- If you and your spouse are enrolled in separate contracts as one of you is not Medicare eligible and enrolled in a non-Medicare health plan, and one of you is Medicare eligible and enrolled in the Special Medicfill Medicare Supplement plan, you will only be charged $25 per month on the non-Medicare health plan.
- If you and your spouse are enrolled in separate contracts and are both Medicare eligible and enrolled in the Special Medicfill Medicare Supplement plan, you will not be charged if one retired on or before July 1, 2012.
- If you and your spouse are enrolled in separate contracts and are both Medicare eligible and enrolled in the Special Medicfill Medicare Supplement plan, the spouse whose birthday is first in the calendar year will be charged 5% of the cost of one Special Medicfill Medicare Supplement contract if both retired after July 1, 2012.
- Pensioners eligible for Double State Share plans who wish to make changes to their health care plan during open enrollment should complete the appropriate application forms and return them to the Office of Pensions no later than May 23, 2012.

More information about House Bill 81 and this change to Double State Share can be found at **www.ben.omb.delaware.gov/hb81**.

Policies

Qualifying Events

You may not make changes at any other time during the year unless you experience a qualifying event. Therefore, if you want to make any changes in your coverage, now is the time to do it.

Qualifying events include, but may not be limited to:

- Birth or adoption of a child
- Marriage/Civil Union
- Divorce
- Employment of spouse
- Involuntary loss of spouse coverage
- Spouse's employment termination
- Child now eligible for coverage
- Death of a spouse or dependent
- Spouse becomes a State of Delaware employee

If you want to make a benefit or dependent change as a result of a qualifying event during the year, you must contact your organization's Human Resources or Benefits Office within 30 days of the qualifying event and request the change.

You can find a complete copy of the State's Group Health Insurance Program Eligibility and Enrollment Rules at **www.ben.omb.delaware.gov/documents**

Health Care Coverage Notices and Other Important Information

- These Notices relate to the State of Delaware Group Health Insurance Program.
- These Notices are effective March 1, 2012, and were revised as of March 1, 2012.
- Questions regarding these notices can be addressed to the Statewide Benefits Office at 1-800-489-8933 or at **www.ben.omb.delaware.gov**, or questions may be directed to additional contacts identified in the various notices.

If you and/your dependents have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the enclosed "Notice of Creditable Coverage" for more details.

Notice of Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. To request special enrollment or obtain more information, contact the Statewide Benefits Office at 1-800-489-8933 or at **www.ben.omb.delaware.gov**.

***Requests for special enrollment rights must be made within 30 days of the date of the qualifying event. Qualifying events are the loss of eligibility for other coverage (or if the employer stops contributing to the other coverage), or gaining a new dependent through marriage, birth, adoption or placement for adoption.**

Special Enrollment Rights for Individuals Eligible for the Delaware Healthy Children Program (CHIP)

If you or a dependent are eligible for but not enrolled in coverage under one of the State of Delaware Group Health Insurance Program plans, you may enroll in coverage if you or your dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility for that coverage, or you or your dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (not currently offered in Delaware). You must request enrollment in the plan within 60 days of the date you or your dependent lost Medicaid or CHIP coverage or within 60 days of the date your eligibility for premium assistance is determined under Medicaid or CHIP.

Notices

Women's Health and Cancer Rights Act (WHCRA) of 1998

Do you know that the State of Delaware Group Health Insurance Program, as required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Contact the Statewide Benefits Office at 1-800-489-8933 or at **www.ben.omb.delaware.gov** for more information.

Grandfathered Health Plan

The State of Delaware Group Health Insurance Program believes the Aetna HMO, Blue Cross Blue Shield of Delaware First State Basic, Blue Cross Blue Shield Comprehensive PPO, Blue Cross Blue Shield Point of Service and Blue Cross Blue Shield of Delaware Blue Care® HMO Plans are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the above plans may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the appropriate plan administrator, Aetna at 1-877-542-3862 or **www.aetna.com** or Blue Cross Blue Shield of Delaware at 1-800-633-2563 or **www.bcbsde.com**, or to the Statewide Benefits Office at 1-800-489-8933 or at **www.ben.omb.delaware.gov**. You may also contact the U.S. Department of Health and Human Services at **www.healthreform.gov**.

Notices

This Notice Applies To All Plan Participants, Including Family Members. Please Provide This Notice To Your Family Members Who At Anytime Are Participants In This Plan.

Notice About The Early Retiree Reinsurance Program

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

If you have received this notice, you are responsible for providing a copy of this notice to your family members who are participants in this plan.

IMPORTANT NOTICE

COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

This Notice Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To This Information. Please Review It Carefully.

This Notice is provided to you on behalf of:

The State of Delaware Employee Health Care Plan
The State of Delaware Employee Dental Care Plan
The State of Delaware Employee Assistance Program
The State of Delaware Employee Flexible Benefits Plan
The State of Delaware Employee Pharmacy Care Plan
The State of Delaware Employee Vision Care Plan

These plans comprise what is called an "Affiliated Covered Entity," and are treated as a single plan for purposes of this Notice and the privacy rules that require it. For purposes of this Notice, we'll refer to these plans as a single "Plan."

The Plan's Duty to Safeguard Your Protected Health Information.

Individually identifiable information about your past, present, or future physical or mental health or condition, including genetic information, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required by law to extend certain protections to your PHI, and to give you this Notice about its privacy practices that explains how, when and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required by law to follow the privacy practices described in this Notice currently in effect, though it reserves the right to change those practices and the terms of this Notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other manner. This Notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan's Privacy Official, described below), and will be posted on the website maintained by State of Delaware that describes benefits available to employees and dependents.

Notices

You may also receive one or more other privacy notices, from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI, and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information.

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative, e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations. Do Not Require Your Authorization

Treatment: Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.

Payment: Another important function of the Plan is that it pays for all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans, in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan, and your spouse's plan, or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.

Health care operations: The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received, or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverage.

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Other Uses and Disclosures of Your PHI That Do Not Require Your Authorization.

The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:

To the Plan Sponsor: The Plan may disclose PHI to the employers (such as State of Delaware) who sponsor or maintain for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. For example, PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage and other disputes related to the Plan's provision of benefits; The State Insurance Department for the purpose of reviewing the state's insured plans.

Required by law: The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in the course of judicial or administrative proceedings. Your PHI may be disclosed for law enforcement purposes under some conditions. It must also disclose PHI to authorities who monitor compliance with these privacy requirements.

National Priority Uses and Disclosures: When permitted by law, the Plan may use or disclose medical information for various activities that are recognized as "national priorities." In other words, the Federal government has determined that under certain circumstances (described below) it is so important to disclose medical information that it is acceptable to disclose it without the individual's authorization. We will only disclose medical information about you in the following circumstances when we are permitted to do so by law:

> ***For public health activities:*** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
>
> ***For health oversight activities:*** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
>
> ***Relating to decedents:*** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.

For research purposes: In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research. Research means a systematic investigation designed to develop or contribute to generalized knowledge.

To avert threat to health or safety: In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

For specific government functions: The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.

Uses and Disclosures Requiring Written Authorization

For uses and disclosures beyond treatment, payment and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. Your authorizations can be revoked in writing at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.

Uses and Disclosures Requiring You to have an Opportunity to Object

The Plan may share PHI with your family, close personal friend or any other person you identify if that person is involved in your care and the information is relevant to your care. If the patient is a minor, we may disclose PHI about the minor to a parent, guardian or other person responsible for the minor except in limited circumstances. We may also provide PHI about your location, general condition, or death to assist in the notification of a family member, or personal representative or other person responsible for your care. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and/or disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Uses and Disclosures of genetic information for underwriting purposes

The Plan is prohibited from using or disclosing PHI that is genetic information about you or your dependents for underwriting purposes. Genetic information for purposes of this prohibition means information about (i) your genetic tests; (ii) genetic tests of your family members; (iii) family medical history.

Breach of Unsecured PHI
You must be notified in the event of a breach of unsecured PHI. A "breach" is the acquisition, access, use, or disclosure of PHI in a manner that compromises the security or privacy of the PHI. PHI is considered compromised when the breach poses a significant risk of financial harm, damage to your reputation, or other harm to you. This does not include good faith or inadvertent disclosures or when there is no reasonable way to retain the information. You must receive a notice of the breach as soon as possible and no later than 60 days after the discovery of the breach.

Your Rights Regarding Your Protected Health Information.
You have the following rights relating to your protected health information. To exercise these rights, please submit a written request to the Privacy Official identified below:

To request a copy of this Notice: You have a right to request a copy of this Comprehensive Notice of Privacy Policy and Procedures at any time. In addition, a copy of this Notice is available on the State of Delaware website at **http://ben.omb.delaware.gov**.

To request restrictions on uses and disclosures: You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law. In addition, you have the right to restrict disclosure of PHI to the Plan for payment or healthcare operations (but not for carrying out treatment) in situations where you have paid the healthcare provider out-of-pocket in full. In this case, the Plan is required to implement the restrictions that you request.

To choose how the Plan contacts you: You have the right to ask that the Plan send you information at an alternative address or by an alternative means. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.

To inspect and copy your PHI: Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but it may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.

To request amendment of your PHI: If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors, you may request, in writing, that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not part of the Plan's records that you may inspect and copy. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

To find out what disclosures have been made: You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your personal representative. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain about the Plan's Privacy Practices.

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. You will not be retaliated against by the Plan, its vendors or the State if you make such complaints.

Contact Person for Information, or to Submit a Complaint.

If you have questions about this Notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see next page). If you have any complaints about the Plan's privacy practices or handling of your PHI, please contact the Plan's Privacy Official (see next page).

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Privacy Official.
The Plan's Privacy Official, the person responsible for ensuring compliance with this Notice, is:

Director, Benefits Administration, Office of Management and Budget (OMB)
500 W. Loockerman St., Suite 320, Dover, DE 19904
Telephone Number: (302) 739-8331

The Plan's Deputy Privacy Official(s) is/are:

Human Resources Specialists, Statewide Benefits Unit, OMB
500 W. Loockerman St., Suite 320, Dover, DE 19904, (302) 739-8331

Information Systems Manager, PHRST
802 Silver Lake Blvd, Suite 200, Dover, DE 19904, (302) 739-2260

Human Resources Manager, PHRST Benefits
802 Silver Lake Blvd, Suite 200, Dover, DE 19904, (302) 739-2260

Organized Health Care Arrangement Designation.
The Plan participates in what the federal privacy rules call an "Organized Health Care Arrangement." The purpose of that participation is that it allows PHI to be shared between the members of the Arrangement, without authorization by the persons whose PHI is shared, for health care operations. Primarily, the designation is useful to the Plan because it allows the insurers who participate in the Arrangement to share PHI with the Plan for purposes such as shopping for other insurance bids.

The members of the Organized Health Care Arrangement are:

The State of Delaware Employee Health Care Plan
The State of Delaware Employee Dental Care Plan
Dominion Dental Services, Inc.
Delta Dental
The State of Delaware Employee Assistance Program
The State of Delaware Employee Flexible Benefits Plan
The State of Delaware Employee Pharmacy Care Plan
The State of Delaware Employee Vision Care Plan

NOTICE OF CREDITABLE COVERAGE

Important Notice from State of Delaware Group Health Insurance Program About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the State of Delaware Group Health Insurance Program currently administered by Medco and your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The State of Delaware has determined the prescription drug coverage offered by the State of Delaware Group Health Insurance Program currently administered by Medco is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year after from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you are a Medicare-eligible retiree, you cannot have a Medicare prescription drug plan and retain your coverage with the State of Delaware. If you enroll in a Medicare prescription drug plan, prescription drug coverage through the State of Delaware for you and your eligible dependents will terminate. You will not be able to re-enroll in the State of Delaware's Prescription Drug Program until the state's open enrollment period (usually May in each year).

If you are a Medicare-eligible active employee, you can keep your prescription drug plan with the State of Delaware and enroll in a Medicare prescription drug plan. In this case, the State of Delaware plan will pay primary and Medicare will pay secondary.

It is important that you compare your current plan, including which drugs are covered, with the coverage and costs of Medicare Part D plans in your area before making these decisions. If you consider enrolling in a Medicare prescription drug plan, check with the State of Delaware Statewide Benefits Office or State Pension Office before you enroll.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know if you drop or lose your current coverage with the State of Delaware prescription drug plan and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1 percent of the Medicare base beneficiary premium per month for every month you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19 percent higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

Notices

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the office listed below for further information.

NOTE: You'll receive this notice each year and if this coverage through the State of Delaware Group Health Insurance Program changes. You also may request a copy of this notice at any time.

Statewide Benefits Office
State of Delaware
500 W. Loockerman St., Suite 320,
Dover, DE 19904
302 739-8331 or 1-800-489-8933

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Statewide Benefits Health Fairs

Mark Your Calendar to Attend a Health Fair!

To learn more about the programs and benefits available and to receive personalized assistance in helping you choose the best benefit plans for you and your family, plan to attend a benefit health fair scheduled at various site locations in each county. Health Fair dates and location information are listed below.

Date	Time	Location	Address
New Castle County			
Wednesday, May 9, 2012	10 a.m. - 2 p.m.	Carvel State Building ***2nd Floor Mezzanine (Elevator is accessible)***	820 N. French Street Wilmington, DE 19801 ***Directions:*** www.delawarepersonnel.com/admin/office/locations.shtml
Friday, May 18, 2012	4 p.m. - 7 p.m.	William Penn High School ***Main Lobby & Cafeteria 1***	713 E. Basin Road New Castle, DE 19720 ***Directions:*** http://www.wpcolonials.com/
Kent County			
Friday, May 11, 2012	10 a.m. - 2 p.m.	Delaware State University ***MLK Student Center, Multi-Purpose Room Parlor C – 2nd floor***	1200 N. DuPont Highway Dover, DE 19901 ***Directions:*** http://www.desu.edu/directions
Monday, May 14, 2012	4 p.m. - 7 p.m.	Lake Forest Central Elementary ***Gym/Cafeteria***	5424 Killens Pond Road Felton, DE 19943 ***Directions:*** http://www.lf.k12.de.us/central/
Sussex County			
Monday, May 7, 2012	10 a.m. - 2 p.m.	Delaware Technical and Community College, Owens Campus ***Carter Partnership Center- Rooms 540 A-H***	RT 18, Georgetown, DE 19947 ***Directions:*** www.dtcc.edu/owens/directions
Wednesday, May 16, 2012	4 p.m. - 7 p.m.	Sussex Tech High School ***School Lobby***	17099 County Seat Highway Georgetown, DE 19947 ***Directions:*** http://www.sussexvt.k12.de.us/hs/index.php/home/contacting-us

Phone Numbers and Websites

Company Name	Phone Number	Website
Aetna	1-877-542-3862	***www.aetna.com***
Blue Cross Blue Shield of Delaware (BCBSD)	302-429-0260 or 1-800-633-2563	***www.bcbsde.com***
DelaWELL	1-800-556-6106	***www.delawell.delaware.gov***
Human Management Services, Inc. (HMS) **(Employee Assistance and Work/Life Program)**	1-800-343-2186	***www.hmsincorp.com*** USERNAME: Delaware PASSWORD: statehms04
Medco	1-800-939-2142	***www.medco.com***
EyeMed Vision Care	1-855-259-0490	***www.eyemedvisioncare.com***
Delta Dental	1-800-873-4165	***www.deltadentalins.com/*** ***stateofdelaware***
Dominion Dental Services	1-888-518-5338	***www.dominiondental.com***
Blood Bank of Delmarva	302-737-8400 or 1-888-825-6638	***www.delmarvablood.org***
Ceridian, COBRA Administration	1-800-877-7994	***www.ceridian-benefits.com***
Office of Pensions, Office of Management and Budget	302-739-4208 or 1-800-722-7300	***www.delawarepensions.com***
Elder Information Hotline	1-800-336-9500	
Statewide Benefits Office, Office of Management and Budget	302-739-8331 or 1-800-489-8933	***www.ben.omb.delaware.gov***

State of Delaware

2012