



BENEFIT ENROLLMENT FOR NEW HIRES FY2016

PLAN YEAR: JULY 1, 2015 - JUNE 30, 2016

HEALTH - PRESCRIPTION - LIFE - DENTAL - VISION - SUPPLEMENTAL BENEFITS

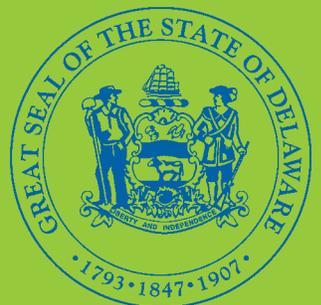


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HOW TO NAVIGATE THROUGH THIS BOOKLET



GROUP KEY

UNDERSTANDING THE GROUP KEY

We have made it easy for you to locate information that applies to you and find the programs you are eligible for. Here's how it works...

- Each page has a group key located in the top right corner.
- Locate your group icon to find information that applies to you.



What do these symbols mean?

AS The letter code "**AS**" applies to **A**ctive **S**tate Employees.

NO The letter code "**NO**" applies to State **N**on-Medicare Pensioners.

SM The letter code "**SM**" applies to **S**tate **M**edicare Pensioners.

PG The letter code "**PG**" applies to **P**articipating **G**roup Employees.

CB The letter code "**CB**" applies to **C**OBRA Participants.



WHAT'S NEW FOR THE FY2016 PLAN YEAR (JULY 1, 2015 - JUNE 30, 2016)

New rates for health, dental and life. Vision rates remain unchanged.
(See page 14 for more details)

Supplemental Benefits
(See pages 34-51 for more details)

The State of Delaware is offering employees the opportunity to enroll in the following insurance upon hire:

- Group Critical Illness
- Group Accident

Preventive care (as defined by the Affordable Care Act (ACA)) will be covered at no charge through your health and prescription coverage.

Preventive care is one of the most important ways to keep you and your family healthy -

- Annual Physical Exam
- OB/GYN Exam
- Cancer screening, including mammograms and colonoscopies
- Flu, pneumonia and other shots (age parameters may apply)
- Preventive medications such as aspirin to prevent cardiovascular events and folic acid for women through age 50

Most preventive care will be covered at 100 percent if you see a network doctor. Check your plan for details and prior authorizations.

DelaWELL Health Management Program - All programs and services will be provided through Highmark Delaware and Aetna (See pages 22-26 for more details)

All of your health, medical and wellness programs, services and information will now come from one source – your trusted health carrier! Enrolling in a State of Delaware Group Health Plan provided by Highmark Delaware or Aetna gives you automatic, confidential access to their online resources, health coaching, online health assessments and disease management programs.

Minnesota Life Group Universal Life (GUL) Insurance - Enrollment Opportunity
(See page 33 for more details)

Eligible employees are allowed to enroll in life insurance coverage upon hire with certain restrictions. Enroll or make changes to coverage by accessing Minnesota Life's website through Employee Self-Service at

www.employeeselfservice.omb.delaware.gov.

- Lower GUL rates effective July 1, 2015
- Visit "Ellie", your Interactive Benefits Guide, to learn more about the program
- New Travel Assistance Services benefit is provided

Added protection of Out of Pocket Limits on all health plans and prescription coverage



FY2016 ENROLLMENT CHECKLIST!

- **READ** your Enrollment information in this booklet.
- **REVIEW** Enrollment Frequently Asked Questions (FAQs) at www.ben.omb.delaware.gov/oe.
- **READ** the Spousal Coordination of Benefits policy (page 55) if you cover your spouse in one of the medical plans.

Reminders:

- If enrolling in an HMO plan for the **FIRST TIME**, make sure your health or dental provider participates in the plan **before you enroll**. 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 is located at www.ben.omb.delaware.gov/cusgm.

Call To Action



AS Active State Employees

- To enroll in supplemental benefits by Aflac, go online to www.delaware.hrintouch.com.
- To verify, enroll or make changes to your health, dental, life, vision or blood bank coverage, contact your organizational Human Resources/Benefits Office.
- Complete your Spousal Coordination of Benefits Form online in Employee Self Service, if you cover your spouse on your health plan (see page 55 for details).
- **For assistance with Employee Self Service (such as password reset requests) including Spousal Coordination of Benefits form completion and Minnesota Life GUL online access**, go to www.employeeelfservice.omb.delaware.gov and have your Employee ID number available or contact the Employee Self Service Call Center toll-free at 1-866-751-7833, between the hours of 8:00 a.m. to 4:30 p.m. Monday through Friday.
- **If you have general benefits or enrollment questions**, call the Statewide Benefits Office at 1-800-489-8933 from 8:00 a.m. to 4:30 p.m. Monday through Friday.
- **Following Enrollment**, view your benefit elections by accessing the Benefits Summary section in Employee Self Service. Please refer to **How to Access the Benefits Summary** at www.ben.omb.delaware.gov/oe for instructions. If an error has been made, you **MUST** contact your organization's Human Resources/Benefits Office to correct the error. AFLAC and Minnesota Life elections are not reflected on the Benefits Summary. Employees must contact AFLAC and/or Minnesota Life directly with questions or concerns regarding enrollment.



NO Pensioners

SM

- 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. You must submit your completed enrollment forms to the Office of Pensions. **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**

- To cancel medical, dental, vision or blood bank coverage, contact the Office of Pensions at 302-739-4208 or (toll-free) 1-800-722-7300 for the forms.
- If you cover your spouse on a non-Medicare health plan, complete the Spousal Coordination of Benefits – Electronic Form online at www.ben.omb.delaware.gov/documents/cob (see page 55 for details).
 - If you cover a spouse under the Highmark BCBSD Special Medicfill Medicare Supplement plan, you do not need to complete a Spousal Coordination of Benefits form, **unless your spouse’s employment or health insurance status has changed since July 2012.**
- If you have questions about your health benefits, please call the Office of Pensions at 302-739-4208 or 1-800-722-7300 from 8:00 a.m. to 4:30 p.m. Monday through Friday.

PG Non-State Participating Group Employees

- Contact your Human Resources Office within your organization for health and/or dental rates and for forms to enroll, make changes or cancel current health or dental coverage.
- Complete your Spousal Coordination of Benefits – Electronic Form online at www.ben.omb.delaware.gov/documents/cob, if you cover your spouse on your health plan (see page 55 for details).

CB COBRA Participants

- Review the detailed instructions for COBRA Participants available online at www.ben.omb.delaware.gov/cobra.
- Complete your Spousal Coordination of Benefits – Electronic Form online at www.ben.omb.delaware.gov/documents/cob, if you cover your spouse on your health plan (see page 55 for details).
- If you have general benefits or enrollment questions, call the Statewide Benefits Office at 1-800-489-8933 from 8 a.m. to 4:30 p.m. Monday through Friday.

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HEALTH CARE COVERAGE FOR ACTIVE EMPLOYEES AND NON-MEDICARE ELIGIBLE RETIREES



CONSUMER-DIRECTED HEALTH GOLD PLANS

The State offers two Consumer-Directed Health Gold Plans (CDH Gold) through Aetna and Highmark Delaware. 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 Gold Plan works and why it may be a good fit for you and your family.

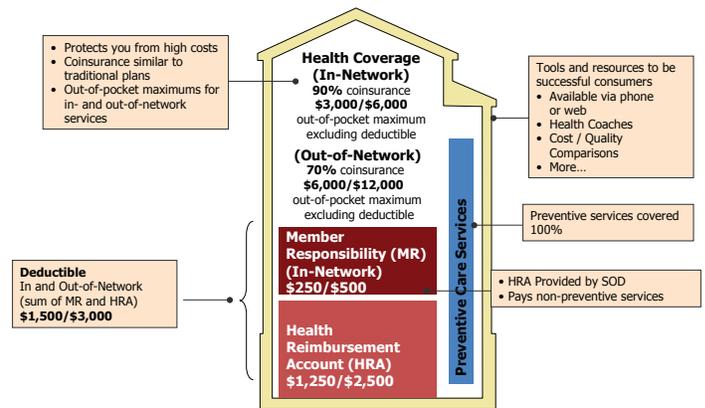
How Does the Consumer-Directed Health Gold Plan Work?

A Consumer-Directed Health Gold (CDH) Plan is similar to any other type of health plan that provides in-network and out-of-network benefits. You and your family will receive higher benefits if you see providers within the Aetna and Highmark Delaware 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. As long as you remain enrolled in a State of Delaware CDH Gold Plan, unused HRA funds will rollover to the next plan year. 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% 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% 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 coinsurance. Under the CDH Gold Plan, the State of Delaware pays 90% and you pay 10% (in-network).
- The CDH Gold Plan pays 100% 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 enrollment in any other State of Delaware health plan, upon termination from coverage through the State of Delaware or upon becoming a Medicare eligible retiree.



Added Financial Protection and Peace of Mind

The CDH Gold Plan also provides extra financial protection through annual medical and prescription out-of-pocket maximums. This means there is a limit on the amount you pay out of your pocket for in-network expenses and after you meet the deductible during the plan year. Once you meet your out-of-pocket limits within a plan year, the plan generally takes over and covers all of your eligible expenses for the rest of the same plan 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 Highmark Delaware compares to the other plans available. More details on each health plan option including an online video 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, Southern NJ, 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.
- Most Preventive Care is covered at 100%.

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.

When you become an Aetna member you can sign up for Aetna's members-only website. You get tools and resources to help you manage your health and your benefits. All of your plan information and cost-savings tools are in one place - your Aetna Navigator member website.

Call Aetna's Member Services at 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 Benefit Programs select "Health", then select carrier (Highmark or Aetna) and choose "Find a Health Provider" to locate which health care professionals are on their approved provider lists.

HEALTH CARE COVERAGE FOR ACTIVE EMPLOYEES AND NON-MEDICARE ELIGIBLE RETIREES



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HEALTH PLAN DESCRIPTIONS - HIGHMARK

Highmark Delaware: First State Basic Plan

In-network services will have a deductible of \$500 per individual and \$1,000 per family then the plan will generally pay at 90% of the Highmark Delaware allowable charge. The medical out-of-pocket maximum is \$2,000 per individual and \$4,000 per family (including the deductible) per plan year. The prescription drug out-of-pocket maximum is \$2,100 per individual and \$4,200 per family. 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 generally pay at 70% of the allowable charge. The medical out-of-pocket maximum is \$4,000 per individual and \$8,000 per family per plan year. There is no out-of-network out-of-pocket maximum for prescription drugs.

Highmark Delaware: Comprehensive Preferred Provider Organization (PPO) Plan

By 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 medical in-network out-of-pocket maximum is \$4,500 per individual and \$9,000 per family. Preventive services are covered in network at 100% of the allowable charge and are not subject to a copay. The out-of-network out-of-pocket maximum is \$7,500 per individual and \$15,000 per family (including the deductible) per plan year. The prescription drug in-network out-of-pocket maximum is \$2,100 per individual and \$4,200 per family. There is no out-of-network out-of-pocket maximum for prescription drugs.

Highmark Delaware: IPA/HMO Plan

Highmark Delaware's IPA/HMO managed care plan requires each member to select a primary care physician (PCP) to coordinate his/her health care needs. Members can seek care from any IPA/HMO specialists in the Highmark Delaware IPA/HMO network. Authorizations are required for certain services and are obtained by your PCP or IPA/HMO network specialist. The medical out-of-pocket maximum is \$4,500 per individual and \$9,000 per family. The prescription drug in-network out-of-pocket maximum is \$2,100 per individual and \$4,200 per family. Preventive services are covered in network at 100% of the allowable charge and are not subject to a copay.

Highmark Delaware: CDH Gold Plan

Highmark Delaware'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%, with an in-network out-of-pocket maximum of \$4,500 for individuals and \$9,000 for families. When the deductible is satisfied, out-of-network health care services are paid at 70%, with an out-of-network out-of-pocket maximum of \$7,500 for individuals and \$15,000 for families.

In addition, preventive care services are covered at 100% and are not subject to a deductible or coinsurance. Prescriptions are provided through a prescription benefits manager, Express Scripts, and prescription copays are not applicable to the medical deductible. The prescription drug in-network out-of-pocket maximum is \$2,100 per individual and \$4,200 per family. There is no prescription drug out-of-network out-of-pocket maximum.

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

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

SUMMARY OF BENEFITS



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HIGHMARK DELAWARE 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-Network Benefits Deductible: \$1,000/\$2,000*
	Out-of-Pocket Max: \$2,000/\$4,000** including deductible	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 - Children to age 24	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. There are separate out-of-pocket maximums for prescription drugs.

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

SUMMARY OF BENEFITS



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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 Out-of-Pocket Max: \$4,500/\$9,000*	Highmark Delaware IPA/HMO Out-of-Pocket Max: \$4,500/\$9,000*
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	\$50 copay	\$50 copay
Outpatient Surgery - Doctor's Office Visit	\$20 copay	\$20 copay
Outpatient Surgery - Hospital	\$100 copay	\$100 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% for up to 365 days	100% for 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	\$150 copay (waived if admitted)	\$150 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%	80%
Skilled Nursing Facility	100%	100%
Emergency Ambulance	\$50 copay	\$50 copay
Physician Home/Office Visits (sick)	\$15 copay per office visit \$25 copay per home or after hours visit	\$15 copay per office visit \$25 copay per home or after hours visit
Specialist Care	\$25 copay per visit	\$25 copay per visit
Chiropractic Care	Lesser of either \$10 copay or 20% of the allowable charges	20% 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: \$10 copay per visit/X-Ray: \$20 copay per visit	Lab: \$10 copay per visit/X-Ray: \$20 copay per visit
MRI's , CT Scans, PET Scans***	\$35 copay per visit	\$35 copay per visit
Short-Term Therapies: Physical, Speech, Occupational	80% for up to 45 visits per condition for physical and occupational therapy combined/ 80% for up to 45 visits per condition for speech therapy	80% for up to 60 consecutive days/except for Physical therapy/45 visits per condition
Annual Gyn Exam/Pap Smear	100%	100%
Periodic Physical Exams, Immunizations, Diabetes Education	100%	100%
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
Hearing Aids - Children to age 24	80%, under age 24	80%, under age 24
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

*Out-of-pocket maximums apply to each plan year. There are separate out-of-pocket maximums for prescription drugs.
***MRI, MRA, CT and PET scans require a prior authorization.

SUMMARY OF BENEFITS



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AETNA CDH GOLD 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: \$1,500/\$3,000* Out-of-Pocket Max: \$4,500/\$9,000** including deductible	Out-of-Network Benefits Deductible: \$1,500/\$3,000* Out-of-Pocket Max: \$7,500/\$15,000** including deductible
	Health Reimbursement Account	\$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	100% after \$25 copay
Emergency Services	90% after deductible	90% after deductible
MENTAL HEALTH CARE/SUBSTANCE ABUSE CARE	In-Network	In-Network
Inpatient Acute/Partial Hospitalization	90% after deductible	70% after deductible
Outpatient	90% after deductible	70% after deductible
OTHER SERVICES	In-Network	In-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% covered, no deductible	70% covered, after deductible
Routine Physical Exam & Immunizations	100% covered, no deductible	70% covered 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% covered after deductible, under age 24	70% covered after deductible, under age 24
ALL INFERTILITY SERVICES	In-Network	In-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	In-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 plan year and include your deductible. There are separate out-of-pocket maximums for prescription drugs.
***MRI, MRA, CT and PET scans require a prior authorization.

SUMMARY OF BENEFITS



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HIGHMARK DELAWARE CDH GOLD 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: \$1,500/\$3,000* Out-of-Pocket Max: \$4,500/\$9,000** including deductible	Out-of-Network Benefits Deductible: \$1,500/\$3,000* Out-of-Pocket Max: \$7,500/\$15,000** including deductible
	Health Reimbursement Account	\$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	100% after \$25 copay
Emergency Services	90% after deductible	90% after deductible
MENTAL HEALTH CARE/SUBSTANCE ABUSE CARE	In-Network	In-Network
Inpatient Acute/Partial Hospitalization	90% after deductible	70% after deductible
Outpatient	90% after deductible	70% after deductible
OTHER SERVICES	In-Network	In-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% covered, no deductible	70% covered, after deductible
Routine Physical Exam & Immunizations	100% covered, no deductible	70% covered after deductible
Vision Care	Not covered	Not covered
Hearing Tests - 1 exam every 12 months	100% covered, no deductible	70% covered after deductible
Hearing Aids - Children to age 24	90% covered after deductible	70% covered after deductible
ALL INFERTILITY SERVICES	In-Network	In-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	In-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 plan year and include your deductible. There are separate out-of-pocket maximums for prescription drugs.

***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



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HIGHMARK DELAWARE 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:
	Out-of-Pocket Max: \$4,500/\$9,000	\$300/\$600* Out-Of-Pocket Max: \$7,500/\$15,000 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 Surgery	\$50 Ambulatory Ctr/\$100 Hospital	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 for 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	\$150 copay (waived if admitted)/Physician: 100%	\$150 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/hospitalization (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% for up to 120 days per confinement	80% after deductible for up to 120 days per confinement
Emergency Ambulance	100%	100% no deductible
Physician Home/Office Visits (sick)	\$20 copay	80% after deductible
Specialist Care	\$30 copay	80% after deductible
Chiropractic Care	85% covered for up to 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: \$10 copay per visit X-ray: \$20 copay MRI's, CT Scans & Pet Scans: \$35 copay	80% after deductible
Short-Term Therapies: Physical, Speech, Occupational	85%	80% after deductible
Annual Gyn Exam/Pap Smear	100%	80% after deductible
Periodic Physical Exams, Immunizations, Diabetes Education	100%	80% after deductible
Vision Care	Not covered	Not covered
Hearing Tests	100% after office visit copay	80% after deductible
Hearing Aids - Children to age 24	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. There are separate out-of-pocket maximums for prescription drugs.

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

HEALTH PLAN RATES EFFECTIVE SEPTEMBER 1, 2015



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	Total Monthly Rate	State Pays	Employee/Pensioner Contributions
Highmark First State Basic Plan <i>(includes prescription drug coverage at the same level as all other plans)</i> <i>Administered by Highmark Delaware</i>			
Employee/Pensioner	\$645.74	\$619.88	\$25.86
Employee/Pensioner & Spouse	\$1,336.02	\$1,282.60	\$53.42
Employee/Pensioner & Child(ren)	\$981.60	\$942.34	\$39.26
Family	\$1,670.08	\$1,603.30	\$66.78
Aetna CDH Gold <i>Administered by Aetna</i>			
Employee/Pensioner	\$668.32	\$634.92	\$33.40
Employee/Pensioner & Spouse	\$1,385.74	\$1,316.48	\$69.26
Employee/Pensioner & Child(ren)	\$1,021.10	\$970.06	\$51.04
Family	\$1,760.46	\$1,672.44	\$88.02
Highmark CDH Gold <i>Administered by Highmark Delaware</i>			
Employee/Pensioner	\$668.32	\$634.92	\$33.40
Employee/Pensioner & Spouse	\$1,385.74	\$1,316.48	\$69.26
Employee/Pensioner & Child(ren)	\$1,021.10	\$970.06	\$51.04
Family	\$1,760.46	\$1,672.44	\$88.02
Aetna HMO <i>Administered by Aetna</i>			
Employee/Pensioner	\$674.14	\$630.34	\$43.80
Employee/Pensioner & Spouse	\$1,421.36	\$1,328.96	\$92.40
Employee/Pensioner & Child(ren)	\$1,031.28	\$964.24	\$67.04
Family	\$1,773.54	\$1,658.28	\$115.26
Highmark Delaware IPA/HMO <i>Administered by Highmark Delaware</i>			
Employee/Pensioner	\$674.68	\$630.86	\$43.82
Employee/Pensioner & Spouse	\$1,425.86	\$1,333.18	\$92.68
Employee/Pensioner & Child(ren)	\$1,032.32	\$965.22	\$67.10
Family	\$1,778.98	\$1,663.34	\$115.64
Highmark Delaware Comprehensive PPO Plan <i>Administered by Highmark Delaware</i>			
Employee/Pensioner	\$737.22	\$639.54	\$97.68
Employee/Pensioner & Spouse	\$1,529.78	\$1,327.10	\$202.68
Employee/Pensioner & Child(ren)	\$1,136.16	\$985.64	\$150.52
Family	\$1,912.44	\$1,659.06	\$253.38

When you enroll in a health care plan, you will automatically be enrolled in prescription drug coverage managed by Express Scripts. Note: State share and pensioner contributions depend on years of service and date of hire/retirement.

*Rates listed above are per month.



IMPORTANT INFORMATION FOR ACTIVE EMPLOYEES AND PENSIONERS REACHING AGE 65 - MEDICARE ELIGIBILITY & ENROLLMENT

Delaware Law and the State of Delaware's Group Health Insurance Program's (GHIP) Eligibility and Enrollment Rules require members covered under a State of Delaware health plan to follow certain obligations with regards to Medicare enrollment in order to be eligible for health coverage through the State of Delaware based on employment status, age and/or disability. Below are several situations:

SITUATION A: Active employee or active employee's spouse enrolled in a State of Delaware GHIP plan turns age 65.

- Enrollment in Medicare Part A is required;
- Enrollment in Medicare Part B is not required until active employee retires or no longer has active employer health coverage.

NOTE: Special enrollment rules apply to active employees/spouses who are diagnosed with End-Stage Renal Disease (ESRD-kidney disease) or Amyotrophic Lateral Sclerosis (ALS), also known as Lou Gehrig's disease.

SITUATION B: Pensioner or pensioner's spouse enrolled in a State of Delaware GHIP plan AND covered under another active employer's health plan (under pensioner or spouse) turns age 65 or becomes disabled.

- Enrollment in Medicare Part A is required;
- Enrollment in Medicare Part B can be deferred until no longer covered under active employer's health plan;
- Eligible to remain enrolled in a State of Delaware GHIP non-Medicare plan until no longer covered under active employer's health plan. Active employer's health plan will provide primary coverage.

SITUATION C: Pensioner or pensioner's spouse enrolled in a State of Delaware GHIP plan, not covered by another active employer's health plan, turns age 65 or becomes disabled.

- Enrollment in Medicare Part A is required;
- Enrollment in Medicare Part B is required;
- Eligible to enroll in Medicare Supplement plan (Highmark Delaware's Special Medicfill plan) with or without prescription coverage (Express Scripts Medicare PDP plan).

Additional information on Medicare can be obtained from your local Social Security Administration Office at 1-800-722-1213 or www.ssa.gov or on Medicare's website at www.medicare.gov.

The employee and spouse are responsible for providing a copy of their Medicare Identification Cards to the HR/Benefits Office, if an active employee, or to the Office of Pensions, if a pensioner. Pensioners enrolled in Medicare Part A and Part B must provide a copy of their Medicare Identification Card to the Office of Pensions to be enrolled in the GHIP's Special Medicfill plan. Failure to enroll and maintain enrollment in Medicare Part A and Part B upon eligibility may result in being held financially responsible for the cost of claims incurred, including prescription costs.

MEDICARE ELIGIBILITY - ENROLLMENT OBLIGATIONS



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

Medicare-eligible retirees and Medicare-eligible dependents of retirees who wish to receive prescription drug benefits through the GHIP will be offered the opportunity to participate in the only prescription drug plan available through the GHIP for Medicare-eligible retirees – the employer-sponsored **enhanced** Medicare Part D Prescription Drug Plan called the **Express Scripts Medicare (PDP) for the State of Delaware**. Coverage through another Medicare Part D prescription drug plan is not allowed if you wish to retain your coverage through the Express Scripts Medicare PDP for the State of Delaware. If you enroll in a Medicare prescription drug plan, other than the Express Scripts Medicare PDP for the State of Delaware, prescription drug coverage through the State of Delaware for you and your eligible dependents will terminate.

HEALTH CARE COVERAGE FOR MEDICARE ELIGIBLE RETIREES



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State of Delaware Pensioners, spouses and dependents enrolled in Medicare Part A and Part B for primary medical coverage and also eligible for or enrolled in the Highmark Delaware Special Medicfill Medicare Supplement plan, **DO NOT make changes in Special Medicfill coverage until a separate Enrollment period available each October for the following January.**

Current rates below are for the 2016 plan year (January 1, 2016 – December 31, 2016) and remain in effect through December 31, 2016.

2016 MEDICARE SUPPLEMENT HEALTH PLAN RATES

	Total Monthly Rate	State Pays***	Pensioner Pays
Highmark Delaware Medicare Supplement for Pensioners Retired Prior to July 2, 2012			
Special Medicfill With Prescription*	\$426.60	Up to \$426.60	\$0.00
Special Medicfill WITHOUT Prescription**	\$241.86	Up to \$241.86	\$0.00
Highmark Delaware Medicare Supplement for Pensioners Retired After July 2, 2012			
Special Medicfill With Prescription*	\$426.60	\$405.28	\$21.32
Special Medicfill WITHOUT Prescription**	\$241.86	\$229.78	\$12.08

* Includes an enhanced Medicare Part D plan - Express Scripts Medicare (PDP) for the State of Delaware.

** Medicare Supplement plans WITHOUT prescription are provided for Medicare Beneficiaries enrolled in Medicare Part D.

*** State share and pensioner contributions depend on years of service and date of hire/retirement.

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 HIGHMARK DELAWARE)

State of Delaware Pensioners, spouses and dependents enrolled in Medicare Part A and Part B for primary medical coverage and also eligible for or enrolled in the Highmark Delaware Special Medicfill Medicare Supplement plan, **DO NOT make changes in Special Medicfill coverage until a separate Enrollment period available in October 2015 for calendar year 2016.**

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 Highmark Delaware 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	Highmark Delaware Special Medicfill
Inpatient Hospital		
Days 1-60	Pays all but the Part A deductible for each benefit period	Covers the Part A deductible
Days 61-90	Pays all but a specified dollar amount of coinsurance per day for each benefit period	Covers the specified dollar amount of the coinsurance
Days 91-120	Pays nothing*	Covers care in a general hospital (except mental & nervous). These days may be used before Medicare's 60 lifetime reserve days. If the lifetime reserve days are used, the plan covers the coinsurance amount
Days 121-365	Pays nothing*	Covers care in a general hospital (except mental & nervous). These days may be used before Medicare's 60 lifetime reserve days. If the lifetime reserve days are used, the plan covers the coinsurance amount
Hospice	Pays all for hospice care. Pays 95% of the Medicare-approved amount for up to 5 days of inpatient respite care. You must receive care from a Medicare certified hospice	Covers 5% coinsurance for up to 5 days of inpatient respite care
Emergency Services	Pays all but a specified copayment for the hospital emergency room visit. Pays 80% of the Medicare-approved amount for the doctor's services, and the Part B deductible applies. Costs may be different if admitted to the hospital	Covers specified copayment for emergency room visit. Covers Part B deductible and 20% of the Medicare-approved amount for doctor's services
Prosthetics & Durable Medical Equipment	Pays 80% of the Medicare-approved amount after the Medicare Part B deductible	Covers Part B deductible and 20% of the Medicare-approved amount
Physician Home & Office Visits	Pays 80% of the Medicare-approved amount after the Medicare Part B deductible	Covers Part B deductible and 20% of the Medicare-approved amount

HEALTH CARE COVERAGE FOR MEDICARE ELIGIBLE RETIREES



Description of Benefit	Medicare	Highmark Delaware Special Medicfill
Specialist Care/Chiropractic Care	Pays 80% of the Medicare-approved amount after the Medicare Part B deductible for specialist care and chiropractic manipulations. Pays nothing for any other services or tests ordered by a chiropractor	Covers Part B deductible and 20% of the Medicare-approved amount for specialist care and chiropractic manipulations. Covers nothing for any other services or tests ordered by a chiropractor
Emergency Ambulance	Pays 80% of the Medicare-approved amount after the Medicare Part B deductible	Covers Part B deductible and 20% of the Medicare-approved amount
X-ray, Lab & other Diagnostic Services, Radiation Therapy	Generally pays 80% of the Medicare-approved amount after the Medicare Part B deductible. Pays all for certain blood tests, urinalysis and some screening tests	Covers Part B deductible and 20% of the Medicare-approved amount. Covers nothing for services for which Medicare pays all
Outpatient Rehabilitation Services, Occupational Therapy, Physical Therapy, Speech Therapy	Pays 80% of the Medicare-approved amount after the Medicare Part B deductible	Covers Part B deductible and 20% of the Medicare-approved amount
Routine GYN exam, Pap Smear, Mammogram	Pays all for the lab Pap test, Pap test specimen collection, pelvic exam or the mammogram if the provider accepts assignment. Pap tests and pelvic exams generally covered once every 24 months. Screening mammograms covered once every 12 months for women age 40 and older, plus one baseline mammogram covered for women between 35–39	When covered by Medicare, this Plan covers nothing. When Pap smear is not covered by Medicare, covers 100% of the Medicare-approved amount for a Pap smear every 12 months
Prostate Cancer Screening Exams (age 50 & over)	Pays all for the PSA test. For the digital rectal exam, pays 80% of the Medicare-approved amount after the Part B deductible. PSA and digital rectal exam covered once every 12 months	Covers nothing for PSA test. For digital rectal exam, covers Part B deductible and 20% of the Medicare-approved amount.
Periodic Physical Exams	Pays all for the “Welcome to Medicare” preventive visit or the “Yearly Wellness Visit,” if the provider accepts assignment. Yearly Wellness Visit covered once every 12 months	Covers nothing for “Welcome to Medicare” preventive visit or “Yearly Wellness Visit”
Flu & Pneumococcal Pneumonia Vaccines	Pays all if the provider accepts assignment Pneumonia - generally covered once per lifetime Flu - covered once per flu season	Covers nothing for flu and pneumonia vaccines
Routine Vision Care	Not covered	Not covered; however, discounts are available through your eyewear discount program administered by Davis Vision

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



EXPRESS SCRIPTS

When you enroll in a health plan, you are automatically enrolled in the prescription drug plan managed by Express Scripts. The Spousal Coordination of Benefits (SCOB) policy also applies to prescription coverage.

PREVENTIVE MEDICATIONS:

Prescriptions are provided through the prescription benefits manager, Express Scripts. Preventive medications are covered at **no cost** to the member for all non-Medicare health plans and are not subject to a deductible or coinsurance. The prescription copays are not applicable to the medical deductible or medical out-of-pocket maximum. The prescription drug in-network out-of-pocket maximum is \$2,100 per individual and \$4,200 per family. There is no prescription drug out-of-network out-of-pocket maximum.

The preventive medications covered under your prescription drug plan include:

- Aspirin (to prevent cardiovascular events)
- Oral Fluoride
- Folic Acid
- Iron Supplements
- Immunizations / Vaccines
- Smoking Cessation
- Vitamin D
- Bowel Preps
- Women's Contraceptives
- Breast Cancer Prevention

For a complete listing of preventive medications visit <http://ben.omb.delaware.gov/script/programs.shtml>, under Member Cost Saving Programs to see Preventive Medications & Services.

NONCOVERED MEDICATIONS:

Effective September 1, 2015, erectile dysfunction medications will not be covered unless medically necessary for a condition other than erectile dysfunction.* Coverage of erectile dysfunction medications for medical necessity requires coverage review. Additional information on the coverage review process can be found on the following page and complete details are available at www.ben.omb.delaware.gov/script/programs.shtml. Erectile Dysfunction medications can be obtained at the pharmacy with a prescription for a discounted price.

PRESCRIPTION COPAY RATES EFFECTIVE SEPTEMBER 1, 2015*

STATE OF DELAWARE PRESCRIPTION COVERAGE	TIER 1 GENERIC	TIER 2 PREFERRED	TIER 3 NON-PREFERRED
30-DAY SUPPLY	\$8.00	\$28.00	\$50.00
90-DAY SUPPLY	\$16.00	\$56.00	\$100.00

*Prescription copay rates reflected above and non coverage of erectile dysfunction medications effective January 1, 2016 for Medicare pensioners enrolled in the Highmark Delaware Special Medical Medicare Supplement plan.

COST SAVING PRESCRIPTION PROGRAMS

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 Express Scripts 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 Express Scripts Pharmacy (mail order).

For more information on the Diabetic Program, visit <http://ben.omb.delaware.gov/script/diabetic.shtml>.



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.

The State of Delaware Prescription Plan requires 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	\$16.00	\$56.00	\$100.00

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 Express Scripts at 1-800-939-2142 to ask about a particular pharmacy.
2. Through the Express Scripts Pharmacy (mail order):
To get started call 1-800-939-2142 to speak with an Express Scripts Member Services representative.

THE COVERAGE REVIEW PROCESS

The Coverage Review Program is designed to keep up with changes in the prescription marketplace and ensures that plan participants are receiving prescription medications that result in appropriate, cost-effective care. The coverage review process may be necessary when:

- the medication is not on the formulary or covered under the plan; or,
- the medication is used to treat multiple conditions.

If you are taking any drugs that are subject to coverage review, Express Scripts will need to review additional information from your doctor before a decision can be made if prescription can be covered under the prescription drug plan. Please check the Statewide Benefits website at www.ben.omb.delaware.gov/script/programs.shtml for a list of affected medications and the type of coverage review required. Members are encouraged to check the list of medications whenever a new medication is prescribed. The Coverage Review Program is designed to keep up with changes in the prescription marketplace.

QUESTIONS ABOUT YOUR PRESCRIPTION COVERAGE

If you have specific questions about medication or pharmacy participation, contact;

- Express Scripts Member Services (for non-Medicare members) at 1-800-939-2142, 24 hours a day, 7 days a week.
- Express Scripts Medicare Member Services (Medicare eligible members) at 1-877-680-4883, 24 hours a day, 7 days a week.

Pharmacists are available around the clock for medication consultations. Express Scripts' website, www.express-scripts.com offers extensive online resources, including health and benefit information and online pharmacy services.



DelaWELL HEALTH MANAGEMENT PROGRAM OVERVIEW

Beginning July 1, 2015, all of your health, medical and wellness programs, services and information will now come from one source – your trusted health carrier! Enrolling in a State of Delaware Group Health Plan provided by Highmark Delaware or Aetna gives you automatic, confidential access to their online resources, health coaching, online health assessments and disease management programs. Beginning July 1st, a licensed professional Health Coach may call if you have a health condition to offer you services to better manage your health. You are encouraged to take the call as what you learn could make a real difference in improving your health.

The greatest wealth is having your health! There are **no** cash incentives in the 2015-2016 DelaWELL Program Year; however, the State of Delaware encourages you to focus on the things that really matter like leading a happy and healthy life. In addition, participation in the DelaWELL Health Management Program is an effective way to help control health care costs for the State of Delaware and its members.

We heard you! Recent survey research revealed that many State of Delaware employees would prefer to work with their own doctor and take the online health assessment when participating in DelaWELL, so we have changed our strategy to focus on these two areas.

Call To Action

↳ **The State of Delaware is encouraging employees who are enrolled in either a Highmark Delaware or Aetna plan to complete these two simple steps:**

1. Schedule and attend your Annual Physical Exam

Most preventive care will be covered 100% starting July 1st. Your doctor (Internal Medicine, General Practitioners, Family Practice and GYNs) can provide annual physicals, as well as treat small problems before they become serious. During a routine physical, your doctor can measure things like your height, weight and blood pressure, review your health history and make sure you are up to date with your age-appropriate screenings. A regular exam is a great way to help strengthen your doctor-patient relationship. *Please note: Onsite biometric health screenings will not be offered during this upcoming program year.*

2. Complete your online Health Assessment (Wellness Profile)

It is a simple online survey, located on the Highmark Delaware and Aetna websites, which helps you understand where you stand with your health and provides an action plan and recommendations that can help you to maintain or improve your well-being. When completing your online Health Assessment, be sure to have your latest biometric numbers handy from your annual physical exam, as it will ask for this information.

The services and programs offered through Highmark Delaware and Aetna are outlined on the next few pages of this booklet.

For complete details on the DelaWELL Health Management Program, visit www.ben.omb.delaware.gov/delawell.

Here you will find information on gym and wellness discounts, healthy resources, frequently asked questions, an annual physical exam checklist, tracking sheet and doctor memo and the wellness and disease management benefits provided through the health carriers.





WELLNESS AND DISEASE MANAGEMENT BENEFITS PROVIDED BY HIGHMARK DELAWARE



REGISTER OR LOG-IN

To take advantage of Highmark's helpful health tools and resources, visit www.highmarkbcbsde.com and log in, or register if it's your first visit.

The State of Delaware and Highmark Blue Cross Blue Shield Delaware encourage you to focus on your health by completing two easy steps beginning July 1, 2015:

- 1. ANNUAL PHYSICAL EXAM:** Most preventive care will be covered 100% starting July 1st. Your doctor (Internal Medicine, General Practitioners, Family Practice and GYNs) can provide annual physicals, as well as treat small problems before they become serious. During a routine physical, your doctor can measure things like your height, weight and blood pressure, review your health history and make sure you are up to date with your age-appropriate screenings. A regular exam is a great way to help strengthen your doctor-patient relationship. **Please visit the Highmark Delaware website after you have your annual physical exam or OB/GYN exam and certify online that you completed it.**
- 2. WELLNESS PROFILE:** The Wellness Profile is an online series of questions about topics ranging from blood pressure to exercise habits. It is designed to identify your current and future health risks. When you complete the Wellness Profile, you will receive a detailed health summary, personalized action plan and recommendations for health and wellness programs that can help improve your health.

ADDITIONAL SERVICES:

Maintaining your health isn't a solo act—you need the right support and resources. As a Highmark Delaware member, you have access to our Blues On CallSM Health Coaches 24 hours a day/ 7 days a week, along with your member website www.highmarkbcbsde.com.

BLUES ON CALL HEALTH COACHES HAVE THE ANSWERS

Imagine these situations:

- You've tried to lose weight, quit tobacco or manage stress - and failed. How can you succeed this time?
- You've been newly diagnosed with diabetes, heart disease or asthma. What do you need to know and do to manage your condition properly?
- Your doctor told you that your cholesterol numbers aren't healthy. What exactly do the numbers really mean? What can you do to make them healthy?
- You've been having back pain for a long time. Do you really need an operation?
- Your family has a history of heart disease. What can you do to protect yourself?
- Your soccer player injured her ankle, and it's really painful. Should she go to the emergency room?
- Your health is good. How can you keep it that way?

Our licensed professional Health Coaches can help you answer your health questions and guide you to solutions for your health problems. A Health Coach provides information and support – at no cost to you. Health Coaches are specially trained to answer your questions and support you in making informed health decisions.





A Health Coach May Call You

If you have a health condition, a Health Coach may call to offer you resources that can help you manage it better. We encourage you to talk about these with your Health Coach.



It's Confidential and Voluntary

All information shared during your phone conversations with a Health Coach will remain confidential and will not be shared with your employer, your manager or other employees. There is no obligation to participate in the programs offered. If you do not want to participate in coaching conversations, simply tell the Health Coach and no further attempt will be made to contact you.

Make the Call

Get the answers you need anytime day or night. Call a Health Coach at 1-888-BLUE-428 (1-888-258-3428) for assistance.

HEALTHY RESOURCES ARE JUST A CLICK AWAY

Online Resources for Living Healthier

Whether you want to improve your health, manage a health condition or maintain your health, support is as close as your desktop or mobile device. Check out these helpful tools and resources:

My Health Assistants: Get help to eat healthier, manage stress, quit tobacco or start an exercise program as close as your computer or mobile device.

Health Trackers: Track your progress in health measures like blood pressure, blood sugar, cholesterol, weight and physical activity.

Health Information: Research health topics and stay informed on the latest health news with news articles, a health library, e-newsletters, videos and more.

Symptom Checker: Find out what could be causing that ache, pain, itch, rash or weird feeling, what can you do to make it feel better and if you should see your doctor.

Blue 365 Discount Program

Whether you are looking for discounted gym memberships, weight loss programs or a discount on massage therapy, it can all be found on the member website. Take advantage of the great discounts on health care products and services, along with health and wellness information you can use throughout the year.

ARE YOU EXPECTING?

Get off to a healthy start. Our Baby Blue Prints® program encourages you to take a more proactive role in your health by providing clear, in-depth educational information and ongoing personalized support throughout your pregnancy and after the delivery.

Enrolling in a Baby Blueprint is Easy.

Just call toll-free at 1-866-918-5267. You can enroll anytime during your pregnancy, but the earlier the better to take advantage of all the program's offerings.





WELLNESS AND DISEASE MANAGEMENT BENEFITS PROVIDED BY AETNA



REGISTER OR LOG-IN

To take advantage of Aetna's helpful health tools and resources, visit www.aetna.com and log in, or register if it's your first visit.

The State of Delaware and Aetna encourage you to focus on your health by completing two easy steps beginning July 1, 2015:

- 1. ANNUAL PHYSICAL EXAM** (Well-Adult Exam or Well-Woman Exam): Most preventive care will be covered 100% starting July 1st. Your doctor (Internal Medicine, General Practitioners, Family Practice and GYNs) can provide annual physicals, as well as treat small problems before they become serious. During a routine physical, your doctor can measure things like your height, weight and blood pressure, review your health history and make sure you are up to date with your age-appropriate screenings. A regular exam is a great way to help strengthen your doctor-patient relationship.
- 2. ONLINE HEALTH ASSESSMENT:** Make a difference in your health in just a few minutes by completing a simple health assessment online. It asks questions about your health history and habits. The health assessment can help you learn more about your health risks, so you can take steps to lower them. Plus, it will give you personalized health results you can share with your doctor.

ADDITIONAL SERVICES:

AETNA HEALTH CONNECTIONS – DISEASE MANAGEMENT PROGRAM

Ready to be your healthiest you?

You can get solid support managing your condition with the disease management program. And, it's included with your Aetna health benefits and insurance plan, so you can start living healthier.

You'll learn how to:

- Manage your condition
- Lower your risks for new conditions
- Work better with your doctor
- Take your medicine safely
- Find helpful resources

Support for more than 35 conditions

This includes diabetes, heart disease, cancer, low back pain and digestive conditions. Your condition is likely covered, too.

How to start the program:

If you need help, there are a few ways we'll be able to find you:

- Your doctor's referral
- Your medical or prescription claims
- Our Patient Management staff

If you have a condition or think you're at risk, put in a request through your secure member website at www.aetna.com or call us at 1-866-269-4500.





HEALTHY LIFESTYLE COACHING – CONNECTING WITH MEMBERS WHERE AND HOW THEY LIVE



- Phone coaching sessions
- Email
- Group coaching
- Online lifestyle communities

Help for living your healthiest

With Healthy Lifestyle Coaching, you can work one-on-one with a highly trained wellness coach to help improve the way you feel, every day. It's a powerful step. On your schedule. And at no extra cost.

When you sign up, we pair you with one person who'll stick with you throughout the program. Your wellness coach is your ally who will help you make the changes you want to make and celebrate your successes with you.

Your personal goals and your privacy

It's confidential. No one will receive personal information about you, or your coaching sessions.

You're in charge

You choose what health goals you want to work on — whether it's one or many. Your wellness coach will help you in ways that work for you:

- Losing weight
- Quitting smoking or tobacco
- Increasing physical activity
- Eating better
- Sleeping better
- Managing stress
- Preventing disease and more

ONLINE WELLNESS PROGRAMS

Focuses on topics like weight management and physical activity, nutrition and diet, stress management, smoking cessation and sleep improvement.

AETNA DISCOUNT PROGRAM

Save on gym memberships, eyeglasses and contacts, weight-loss programs, chiropractic and more.

Start saving today:

Aetna members can log into their secure member website at www.aetna.com.

1. Choose "Health Programs," then "See the discounts."
2. Follow the steps for each discount you want to use.

INFORMED HEALTH LINE

Gives you 24/7 toll-free access to registered nurses for health information. Call **1-800-556-1555** to speak to one of our nurses - 24 hours a day, 365 days a year.

BEGINNING RIGHT MATERNITY PROGRAM

Learn more about having a healthy pregnancy and baby. If you are thinking about becoming or are already pregnant, contact Aetna's Beginning Right® maternity program at **1-800-CRADLE-1 (1-800-272-3531)** to enroll.



EMPLOYEE ASSISTANCE PROGRAM (EAP) + WORK/LIFE PROGRAM



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Your EAP+Work/Life Program is a valuable benefit provided to you by the State of Delaware. Through Human Management Services (HMS), a Health Advocate Company, you have access to Licensed Professional Counselors for short-term, confidential help with a wide variety of personal issues. If needed, your counselor can refer you for more in-depth support. You also have access to Work/Life Specialists, who can refer you to services in your area for help balancing your work and life responsibilities. Or, visit the EAP+Work/Life website to access a host of online resources, including educational materials, newsletters, webinars, provider databases and other online tools.

Licensed Professional Counselors can help with:

- Depression, stress and anxiety
- Family/parenting issues; work conflicts
- Anger, substance abuse, grief and loss

Work/Life Specialists can assist with:

- Legal and financial problems
- Childcare, eldercare and parenting concerns
- Time management and relocation support

Easy to reach and available 24/7 to assist you!

1-800-343-2186

<http://hms.HealthAdvocate.com/>

(Website Log-In: Enter "State of Delaware" as the name of your organization)

WHO IS ELIGIBLE TO USE THE PROGRAM?

The EAP+Work/Life program is available to benefit eligible employees and non-Medicare pensioners and their dependents who are currently enrolled in a State of Delaware Group Health Plan. **NEW** - Beginning July 1, 2015, parents and parents-in-law are now also eligible for EAP+Work/Life services.

IS MY PRIVACY PROTECTED?

Yes. HMS (Health Advocate) staff follows careful protocols and complies with all government privacy standards. Your medical and personal health information is kept strictly confidential.

Additional information may be viewed at www.ben.omb.delaware.gov/eap.



WHAT IS THE BLOOD BANK?

Blood Bank of Delmarva is a non-profit community service program that provides blood and blood products for hospitals in the Delmarva region. Each year, Blood Bank of Delmarva supplies over 100,000 blood products in our area to over 20,000 patients needing blood transfusions.

WHY BE A PART OF MEMBERS FOR LIFE?

By joining *Members for Life*, you are showing your support for this valuable community service and helping to ensure a stable blood supply for everyone in our community. Blood is needed every day for emergencies such as auto accidents, surgeries and for people undergoing treatment for cancer and other diseases. You can help ensure that enough blood is always available by joining and supporting the Blood Bank of Delmarva.

WHAT ARE MEMBERS FOR LIFE ASKED TO DO?

Blood Bank of Delmarva asks everyone to join its **NEW Members for Life** plan and take a turn providing blood at least once a year and allow the Blood Bank to contact them if there is ever a need for their blood type. Most healthy people between 17 and 79 can give blood. Those age 80+ require medical approval.

WHAT ARE THE BENEFITS OF THE MEMBERS FOR LIFE PLAN?

- The NEW *Members for Life* program is FREE and available to all State employees.
- Personalized *Members for Life* card featuring your blood type.
- Wellness Checks before every donation including blood pressure, temperature, hemoglobin level and pulse.
- Glucose Screening.
- By donating blood or platelets, you will have the opportunity to earn reward points. You can redeem these points for merchandise in the online Rewards Store at www.DelmarvaBlood.org.

FIRST FACT!
350 donors are needed every day on Delmarva.
Blood Bank of Delmarva

HOW DO YOU JOIN MEMBERS FOR LIFE?

Active State employees enrolling in the Blood Bank for the first time must go online to eBenefits at www.employeeselfservice.omb.delaware.gov.

Pensioners enrolling for the first time must complete the Blood Bank enrollment form available on the Office of Pensions Website at www.delawarepensions.com or complete and submit the enrollment form included in the packet of information mailed to your home. You must submit the enrollment form to the Office of Pensions.

Following your enrollment, you will be called by the Blood Bank for your first blood donation. Your *Members for Life* benefits begin when you begin giving blood.

Note: Existing Blood Bank of Delmarva Members DO NOT need to take action during Open Enrollment to continue membership in the Blood Bank. Current Blood Bank Members will automatically convert to the new *Members for Life* program. Participation in *Members for Life* and access to health and wellness benefits are contingent upon blood donations.

For more information or to schedule an appointment, visit www.DelmarvaBlood.org or please call toll-free at (888) 825-6638 or in New Castle County, (302) 737-8405.

ABOUT YOUR DENTAL PLANS



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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



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DOMINION DENTAL HMO PLAN (SAME AS A DHMO)

Dental Plan 605xsd

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 605xsd	No Charge ¹ For	
Office Visit Copayment	\$10	<ul style="list-style-type: none"> Oral Exams Semi-annual cleanings Bitewing X-rays Topical fluoride for children 	<ul style="list-style-type: none"> Dominion's Prevention Rewards program will pay subscribers \$20 for each family member who gets two cleanings during the plan year between (7/1/15 and 6/30/16). 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.
Deductibles	None	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	
Maximum Annual Limit	No Limit		
Maximum Lifetime Ortho	No Limit		
Claim Forms	None		
Benefits	Scheduled (Fixed Fees)		
Pre-existing Condition	None		
Waiting Periods	None		

Fillings, crowns, dentures, root canals, periodontal care, oral surgery, orthodontics, etc., are covered at fees up to 70% lower than usual and customary charges³. 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 an average of \$1.32 in value for every \$1.00 spent on dental premium²
- 98% of survey respondents rated the treatment by their dentist "Satisfactory to Excellent"⁴

¹There is a \$10 office visit fee.

²Dominion Dental Services, Inc. - based on annual review of utilization data.

³Based on the Captiva context fee schedule's 80th %ile fee information.

⁴Dominion Dental Services, Inc. Member Satisfaction Survey, 2014

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 <i>Administered by Dominion Dental</i>			
Employee/Pensioner	\$24.74	\$0.00	\$24.74
Employee/Pensioner & Spouse	\$46.00	\$0.00	\$46.00
Employee/Pensioner & Child(ren)	\$49.58	\$0.00	\$49.58
Family	\$67.32	\$0.00	\$67.32
Delta Dental PPO Plus Premier <i>Administered by Delta Dental</i>			
Employee/Pensioner	\$35.34	\$0.00	\$35.34
Employee/Pensioner & Spouse	\$72.14	\$0.00	\$72.14
Employee/Pensioner & Child(ren)	\$70.82	\$0.00	\$70.82
Family	\$118.18	\$0.00	\$118.18

ABOUT YOUR VISION COVERAGE



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EYEMED VISION CARE

Improving your health. Saving more money. What could be better? As a current employee or pensioner in the State of Delaware, you're eligible to enroll in the State Vision Plan* offered by EyeMed Vision Care.

So, Why Enroll?

- **BETTER OVERALL HEALTH:** Annual eye exams help to monitor your health and detect any changes from year to year. They can even catch early signs of serious health conditions sooner.
- **AMAZING SAVINGS:** You'll love spending less on eye care and eyewear – including many lens options.
- **CHOICE AND CONVENIENCE:** EyeMed offers the biggest network available, with independent providers and many of the most preferred national retail chains.

Explanation Of Savings:

A \$10 co-pay on eye exams will give you a \$160 frame allowance. 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*	\$75.60
Your total expense	\$259.60
Total savings compared to retail	45%

*Premium based on employee-only rate

The Largest Network And The Most Choice:

For a complete list of providers near you, visit the Provider Locator at www.eyemedvisioncare.com and choose the ACCESS network, or call 1.855.259.0490. For LASIK providers, call 1.877.552.7376.

ABOUT YOUR VISION COVERAGE



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TOTAL MONTHLY RATES FOR EYEMED VISION PLAN:

Plan	Rate
Employee/Pensioner	\$6.30
Employee/Pensioner + Spouse	\$9.94
Employee/Pensioner + Children	\$10.14
Family	\$16.36

EVEN MORE GREAT SAVINGS:

- 40% off additional complete set of prescription glasses
- 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 and PRK procedures

Vision elections are “binding elections”.

Once enrolled, you may not drop coverage during the plan year.

Remember – Open Enrollment is your only time each year to change your benefit choices, unless you have a qualifying event during the plan year (i.e. birth/adoption, marriage or divorce, loss of other coverage).

To learn more about your vision benefits, please visit www.eyemedvisioncare.com

And click the **Members** tab.

Get a quick look at your vision benefits and savings at www.ben.omb.delaware.gov/vision



GROUP UNIVERSAL LIFE (GUL) INSURANCE PROGRAM UNDERWRITTEN BY MINNESOTA LIFE

During your initial 90-day eligibility period, you may elect guaranteed coverage for you and your dependents without providing proof of good health. Outside of this period, proof of good health may be required.

- **For you:** Elect one to three times your base annual salary - up to \$200,000 - without providing proof of good health. Or, you may elect four to six times your base salary up to \$350,000 with proof of good health to Minnesota Life.
- **For your dependents:** Elect one of the following Group Term Life options for your eligible spouse and/or dependent children: \$10,000 or \$20,000 spouse only and/or \$10,000 child only.

What's new in the GUL program?

- Visit "**Ellie**", your Interactive Benefits Guide, to learn more about the program. By answering a few simple questions, you can determine how the GUL program meets your needs and get a quote to see how the cost fits your budget. Visit **Ellie** at www.ben.omb.delaware.gov/life.
- Lower GUL Rates effective July 1, 2015!¹

Age	Rate/\$1,000	Age	Rate/\$1,000
< 30	\$0.050	87	\$5.113
30-34	\$0.059	88	\$5.483
35-39	\$0.077	89	\$5.889
40-44	\$0.096	90	\$6.323
45-49	\$0.142	91	\$6.830
50-54	\$0.244	92	\$7.393
55-59	\$0.382	93	\$8.067
60-64	\$0.594	94	\$8.852
65-69	\$1.037	95	\$10.088
70-74	\$1.837	96	\$12.119
75-79	\$2.843	97	\$15.608
80-84	\$4.357	98	\$21.543
85	\$4.449	99	\$23.140
86	\$4.763		

Dependent Term Life Rates²

Option	Monthly Cost
\$10,000 Spouse Only	\$3.08
\$20,000 Spouse Only	\$7.05
\$10,000 Spouse/\$10,000 Child(ren)	\$4.24
\$20,000 Spouse/\$10,000 Child(ren)	\$8.21
\$10,000 Child(ren)	\$1.16

1. GUL rates increase with age and include Accidental Death & Dismemberment (AD&D) coverage until age 70.
2. Dependent Term Life for children – one rate covers all eligible child(ren) in your family.

- **New Travel Assistance Services** benefit is provided by Redpoint WTP LLC to active enrolled employees, spouses and child(ren). Emergency and transport assistance available 24/7/365 when traveling 100 or more miles away from home.

Complete information on the GUL program can be found at www.ben.omb.delaware.gov/life.

How do I enroll or make changes?

Active State employees enrolling (or making changes to their enrollment) in the GUL program must access Minnesota Life's website through Employee Self-Service.

Access Employee Self Service at www.employeeselfservice.omb.delaware.gov

- Once logged in, follow the navigation: **Main Menu > Self Service > Benefits > Minnesota Life GUL**



AFLAC GROUP ACCIDENT ADVANTAGE PLUS INSURANCE

GROUP ACCIDENTAL INJURY INSURANCE – 24-HOUR WITH WELLNESS PLAN
Policy Series CAI7800

AC^G

Introducing added protection for life's unexpected moments.

According to the National Safety Council, 43% of all medically consulted injuries occur at home. In fact, 1 in every 14 people in the United States experience an unintentional injury at home serious enough to consult with a medical professional.¹ If you're like most people, you don't budget for life's unexpected moments.

But at some point, you may make an unexpected trip to your local emergency room. And that could add a set of unexpected bills into the mix.

That's the benefit of the Aflac group Accident Advantage Plus plan.

In the event of a covered accident, the plan pays cash benefits fast to help with the costs associated with out-of-pocket expenses and bills—expenses major medical may not take care of, including:

- Ambulance rides.
- Wheelchairs, crutches, and other medical appliances.
- Emergency room visits.
- Surgery and anesthesia.
- Bandages, stitches, and casts.



Understanding the facts can help you decide if the Aflac group Accident Advantage Plus plan makes sense for you.

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PEOPLE, ABOUT 1 OUT OF 8 – SOUGHT MEDICAL ATTENTION FOR AN INJURY IN 2012.*

¹Injury Facts, 2014 Edition, National Safety Council.

Underwritten by Continental American Insurance Company (CAIC)
A proud member of the Aflac family of insurers

AFLAC SUPPLEMENTAL BENEFITS



Here's why the Aflac group Accident Advantage Plus plan may be right for you.

For almost 60 years, Aflac has been dedicated to helping provide individuals and families peace of mind and financial security when they've needed it most. Our group Accident Advantage Plus plan is just another innovative way to help make sure you're well protected under our wing.

But it doesn't stop there. The group Accident Advantage Plus plan from Aflac means that your family has access to added financial resources to help with the cost of follow-up care as well.

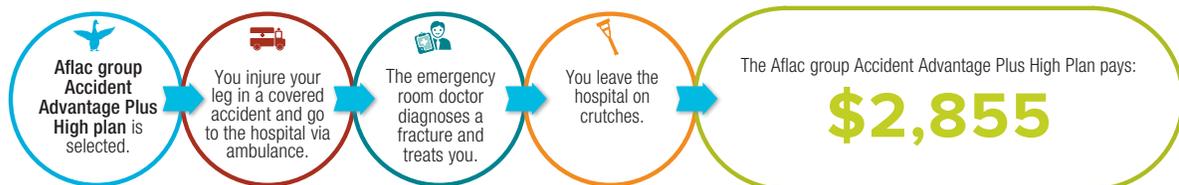
The Aflac group Accident Advantage Plus plan benefits:

- A Wellness Benefit for covered preventive screenings
- Transportation and Lodging benefits
- An Emergency Room Treatment Benefit
- A Rehabilitation Unit Benefit
- Coverage for certain serious conditions, such as coma and paralysis
- An Accidental-Death Benefit
- A Dismemberment Benefit

Features:

- Coverage is guaranteed-issue (which means you may qualify for coverage without having to answer health questions).
- Benefits are paid directly to you unless you choose otherwise.
- Coverage is available for you, your spouse, and dependent children.
- Coverage is portable (with certain stipulations). That means you can take it with you if you change jobs or retire.
- Fast claims payment. Most claims are processed in about four business days.

How it works



Amount payable was generated based on benefit amounts for: Closed-Reduction Leg Fracture (\$2,400), Emergency Room Treatment (\$125), one Follow-Up Treatment (\$30), Ambulance (\$200) and Appliance (\$100)

The plan has limitations and exclusions that may affect benefits payable. This brochure is for illustrative purposes only. Refer to your certificate for complete details, definitions, limitations, and exclusions.

For more information call 1.800.433.3036, or visit aflacgroupinsurance.com.

AFLAC SUPPLEMENTAL BENEFITS



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Benefits Overview

HOSPITAL BENEFITS EMPLOYEE / SPOUSE / CHILD	HIGH OPTION	LOW OPTION
<p>HOSPITAL ADMISSION</p> <p>We will pay the amount shown, when because of a covered accident, you are injured, require hospital confinement, and are confined to a hospital for at least 24 hours within 6 months after the accident date. We will pay this benefit once per calendar year. We will not pay this benefit for confinement to an observation unit. We will not pay this benefit for emergency room treatment or outpatient surgery or treatment.</p>	\$1,000	\$500
<p>HOSPITAL CONFINEMENT (per day)</p> <p>We will pay the amount shown when, because of a covered accident, you are injured and those injuries cause confinement to a hospital for at least 24 hours within 90 days after the accident date.</p> <p>The maximum period for which you can collect the Hospital Confinement Benefit for the same injury is 365 days. This benefit is payable once per hospital confinement even if the confinement is caused by more than one accidental injury.</p> <p>We will not pay this benefit for confinement to an observation unit. We will not pay this benefit for emergency room treatment or outpatient surgery or treatment.</p>	\$200	\$100
<p>HOSPITAL INTENSIVE CARE (per day)</p> <p>We will pay the amount shown when, because of a covered accident, you are injured, and those injuries cause confinement to a hospital intensive care unit.</p> <p>This benefit is paid up to 30 days per covered accident. Benefits are paid in addition to the Hospital Confinement Benefit.</p>	\$400	\$200
<p>MEDICAL FEES (for each accident)</p> <p>We will pay up to the amount shown for X-rays and doctor services when, because of a covered accident, you are injured and those injuries cause you to receive initial treatment from a doctor within 72 hours after the accident.</p> <p>If you do not exhaust the maximum benefit paid during the initial treatment, we will pay the remainder of this benefit for treatment received due to injuries from a covered accident and for each covered accident up to one year after the accident date.</p>	<p>\$125 Employee/Spouse</p> <p>\$75 Child</p>	<p>\$62.50 Employee/Spouse</p> <p>\$37.50 Child</p>
<p>PARALYSIS (lasting 90 days or more and diagnosed by a physician within 90 days)</p> <p>Quadriplegia</p> <p>Paraplegia</p> <p><i>Paralysis</i> means the permanent loss of movement of two or more limbs. We will pay the appropriate amount shown if, because of a covered accident, you are injured, the injury causes paralysis which lasts more than 90 days, and the paralysis is diagnosed by a doctor within 90 days after the accident.</p> <p>The amount paid will be based on the number of limbs paralyzed. If this benefit is paid and you later die as a result of the same covered accident, we will pay the appropriate Death Benefit, less any amounts paid under the Paralysis Benefit.</p>	<p>\$10,000</p> <p>\$5,000</p>	<p>\$5,000</p> <p>\$2,500</p>

The plan has limitations and exclusions that may affect benefits payable. This brochure is for illustrative purposes only. Refer to your certificate for complete details, definitions, limitations, and exclusions.

AFLAC SUPPLEMENTAL BENEFITS



GROUP KEY

AS

ACCIDENTAL-DEATH AND -DISMEMBERMENT (within 90 days)	EMPLOYEE HIGH/LOW	SPOUSE HIGH/LOW	CHILD HIGH/LOW
ACCIDENTAL-DEATH	\$50,000/\$25,000	\$25,000/\$12,500	\$5,000/\$2,500
ACCIDENTAL COMMON-CARRIER DEATH (plane, train, boat, or ship)	\$100,000/\$50,000	\$50,000/\$25,000	\$15,000/\$7,500
SINGLE DISMEMBERMENT	\$12,500/\$6,250	\$5,000/\$2,500	\$2,500/\$1,250
DOUBLE DISMEMBERMENT	\$25,000/\$12,500	\$10,000/\$5,000	\$5,000/\$2,500
LOSS OF ONE OR MORE FINGERS OR TOES	\$1,250/\$625	\$500/\$250	\$250/\$125
PARTIAL AMPUTATION OF FINGERS OR TOES (including at least one joint)	\$100/\$50	\$100/\$50	\$100/\$50

If the Accidental Common-Carrier Death Benefit is paid, we will pay the Accidental-Death Benefit.

Accidental-Death Benefit

We will pay the amount shown if, because of a covered accident, you are injured, and the injury causes you to die within 90 days after the accident.

Accidental Common-Carrier Death Benefit

We will pay the amount shown if you are a fare-paying passenger on a common carrier, as defined below, are injured in a covered accident, and die within 90 days after the covered accident.

We will pay the Accidental-Death Benefit in addition to the Accidental Common-Carrier Death Benefit.

Dismemberment Benefit

We will pay the appropriate amount shown if, because of a covered accident, you are injured and lose a hand, a foot, or sight within 90 days after the accident as a result of the injury. If you lose one hand, one foot, or the sight of one eye in a covered accident, we will pay the single dismemberment benefit shown. If you lose both hands, both feet, the sight of both eyes, or a combination of any two, we will pay the double dismemberment benefit shown. If you lose one or more fingers or toes in a covered accident, we will pay the finger/toe benefit shown.

If the Dismemberment Benefit is paid and you later die as a result of the same covered accident, we will pay the appropriate death benefit, less any amounts paid under this benefit.

MAJOR INJURIES EMPLOYEE / SPOUSE / CHILD (diagnosis and treatment within 90 days)	HIGH	LOW
FRACTURES (closed reduction)		
Hip/Thigh	\$4,000	\$2,000
Vertebrae (except processes)	\$3,600	\$1,800
Pelvis	\$3,200	\$1,600
Skull (depressed)	\$3,000	\$1,500
Leg	\$2,400	\$1,200
Forearm/Hand/Wrist	\$2,000	\$1,000
Foot/Ankle/Kneecap	\$2,000	\$1,000
Shoulder Blade/Collar Bone	\$1,600	\$800
Lower Jaw (mandible)	\$1,600	\$800
Skull (simple)	\$1,400	\$700
Upper Arm/Upper Jaw	\$1,400	\$700
Facial Bones (except teeth)	\$1,200	\$600
Vertebral Processes	\$800	\$400
Coccyx/Rib/Finger/Toe	\$320	\$160

Fracture is a break in the bone that can be seen by X-ray. If a bone is fractured in a covered accident, we will pay the appropriate benefit shown.

Multiple fractures means having more than one fracture requiring open or closed reduction. If these fractures occur in any one covered accident, we will pay the appropriate benefits shown for each fracture, but no more than double the amount for the bone fractured that has the highest benefit amount.

Chip fracture means a piece of bone that is completely broken off near a joint. If a doctor diagnoses a chip fracture, we will pay 25% of the appropriate benefit shown.

Dislocation* means a completely separated joint. If a doctor diagnoses and treats the dislocation within 90 days after the covered accident,

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AFLAC SUPPLEMENTAL BENEFITS



GROUP KEY

AS

Benefits Overview

MAJOR INJURIES EMPLOYEE / SPOUSE / CHILD	HIGH	LOW	
DISLOCATIONS (closed reduction)			<p>Dislocation means a completely separated joint. If a doctor diagnoses and treats the dislocation within 90 days after the covered accident, we will pay the amount shown. If the dislocation requires open reduction, we will pay 200% of the appropriate amount shown.</p> <p>Multiple Dislocations means having more than one dislocation requiring either open or closed reduction. For each dislocation, we will pay the amounts shown. We will not pay more than 200% of the benefit amount for the dislocated joint that has the highest benefit amount.</p> <p>Partial dislocation means the joint is not completely separated. If a doctor diagnoses and treats the partial dislocation, we will pay 25% of the amount shown for the affected joint.</p>
Hip	\$3,000	\$1,500	
Knee (not kneecap)	\$1,950	\$975	
Shoulder	\$1,500	\$750	
Foot/Ankle	\$1,200	\$600	
Hand	\$1,050	\$525	
Lower Jaw	\$900	\$450	
Wrist	\$750	\$375	
Elbow	\$600	\$300	
Finger/Toe	\$240	\$120	

SPECIFIC INJURIES EMPLOYEE / SPOUSE / CHILD	HIGH	LOW
RUPTURED DISC (treatment within 60 days; surgical repair within one year)		
Injury occurring during first certificate year	\$100	\$50
Injury occurring after first certificate year	\$400	\$200
TENDONS/LIGAMENTS (treatment within 60 days; surgical repair within 90 days)		
If you tear, sever, or rupture a tendon or ligament in a covered accident, we will pay one benefit. We will pay the largest of the scheduled benefit amounts for tendons and ligaments repaired.	\$600 (Multiple) \$400 (Single)	\$300 (Multiple) \$200 (Single)
TORN KNEE CARTILAGE (treatment within 60 days; surgical repair within one year)		
Injury occurring during first certificate year	\$100	\$50
Injury occurring after first certificate year	\$400	\$200
EYE INJURIES		
Treatment and surgical repair within 90 days	\$250	\$125
Removal of foreign body nonsurgically, with or without anesthesia	\$50	\$25

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AFLAC SUPPLEMENTAL BENEFITS



GROUP KEY

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SPECIFIC INJURIES EMPLOYEE / SPOUSE / CHILD	HIGH	LOW
<p>CONCUSSION A <i>concussion or mild traumatic brain injury (MTBI)</i> is defined as a disruption of brain function resulting from a traumatic blow to the head.</p>	\$200	\$100
<p>COMA <i>Coma</i> means a state of profound unconsciousness caused by a covered accident. If you are in a coma lasting 30 days or more as the result of a covered accident, we will pay the benefit shown.</p>	\$10,000	\$5,000
<p>EMERGENCY DENTAL WORK (per accident; injury to sound, natural teeth)</p>		
Repaired with crown	\$150	\$75
Resulting in extraction	\$50	\$25
<p>BURNS (treatment within 72 hours and based on percentage of body surface burned)</p>		
<p>Second-Degree Burns</p>		
Less than 10%	\$100	\$50
At least 10%, but less than 25%	\$200	\$100
At least 25%, but less than 35%	\$500	\$250
35% or more	\$1,000	\$500
<p>Third-Degree Burns</p>		
Less than 10%	\$1,000	\$500
At least 10%, but less than 25%	\$5,000	\$2,500
At least 25%, but less than 35%	\$10,000	\$5,000
35% or more	\$20,000	\$10,000
First-degree burns are not covered.		
<p>LACERATIONS (treatment and repair within 72 hours)</p>		
Under 2" long	\$50	\$25
2" to 6" long	\$200	\$100
Over 6" long	\$400	\$200
Lacerations not requiring stitches	\$25	\$12.50
<p>Multiple Lacerations: We will pay for the largest single laceration requiring stitches.</p>		

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AFLAC SUPPLEMENTAL BENEFITS



GROUP KEY

AS

Benefits Overview

ADDITIONAL BENEFITS EMPLOYEE / SPOUSE / CHILD	HIGH	LOW
<p>EMERGENCY ROOM TREATMENT</p> <p>We will pay the amount shown for injuries received in a covered accident if you receive treatment in a hospital emergency room and receive initial treatment within 72 hours after the covered accident. This benefit is payable only once per 24-hour period and only once per covered accident.</p> <p>We will not pay the Emergency Room Treatment Benefit and the Medical Fees Benefit for the same covered accident. We will pay the highest eligible benefit amount.</p>	\$125	\$62.50
<p>EMERGENCY ROOM OBSERVATION</p> <p>We will pay the amount shown for injuries received in a covered accident if you receive treatment in a hospital emergency room, are held in a hospital for observation for at least 24 hours, and receive initial treatment within 72 hours after the accident.</p> <p>This benefit is payable only once per 24-hour period and only once per covered accident. This benefit is payable in addition to Emergency Room Treatment Benefit.</p>	\$100	\$50
<p>MAJOR DIAGNOSTIC TESTING</p> <p>We will pay the amount shown if, because of injuries sustained in a covered accident, you require one of the following exams, and a charge is incurred: computerized tomography (CT scan); computerized axial tomography (CAT); magnetic resonance imaging (MRI); electroencephalography (EEG).</p> <p>These exams must be performed in a hospital or a doctor's office. This benefit is limited to one payment per covered accident.</p>	\$200	\$100
<p>POST TRAUMATIC STRESS DISORDER DIAGNOSIS</p> <p><i>Post-traumatic Stress Disorder (PTSD)</i> is a mental health condition triggered by a covered accident.</p> <p>We will pay the amount shown if you are diagnosed with post-traumatic stress disorder. You must meet the diagnostic criteria for PTSD, stipulated in the Diagnostic and Statistical Manual of Mental disorders IV (DSM IV-TR), and be under the active care of either a psychiatrist or Ph.D.-level psychologist.</p> <p>This benefit is payable only once per covered accident.</p>	\$200	\$100
<p>AMBULANCE/ AIR AMBULANCE</p> <p>If you require transportation to a hospital by a professional ambulance or air ambulance service within 90 days after a covered accident, we will pay the amount shown.</p>	\$200 ambulance \$1,000 air ambulance	\$100 ambulance \$500 air ambulance
<p>BLOOD/PLASMA</p> <p>If you are injured, and receive blood or plasma within 90 days after the covered accident, we will pay the benefit shown.</p>	\$100	\$50
<p>APPLIANCES</p> <p>If a doctor advises you to use a medical appliance, we will pay the benefit shown. <i>Medical appliance</i> means crutches, wheelchairs, leg braces, back braces, and walkers.</p>	\$100	\$50

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AFLAC SUPPLEMENTAL BENEFITS



GROUP KEY

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ADDITIONAL BENEFITS EMPLOYEE / SPOUSE / CHILD	HIGH	LOW
<p>INTERNAL INJURIES (resulting in open abdominal or thoracic surgery) We will pay the amount shown if a covered accident causes you internal injuries which require open abdominal or thoracic surgery.</p>	\$1,000	\$500
<p>ACCIDENT FOLLOW-UP TREATMENT We will pay this benefit for up to six treatments (one per day) per covered accident, per insured for follow-up treatment. You must have received initial treatment within 72 hours of the accident, and the follow-up treatment must begin within 30 days of the covered accident or discharge from the hospital. This benefit is not payable for the same visit that the Physical Therapy Benefit is paid.</p>	\$30	\$15
<p>EXPLORATORY SURGERY WITHOUT REPAIR (i.e., arthroscopy) We will pay the amount shown if a covered accident causes you internal injuries which require open abdominal or thoracic surgery.</p>	\$250	\$125
<p>WELLNESS BENEFIT (per 12-month period) After 12 months of paid premium and while coverage is in force, we will pay this benefit for preventive testing once each 12-month period. Benefits include and are payable (for each covered person) for annual physical exams, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopies, PSA tests, ultrasounds, and blood screenings.</p>	\$50	\$25
<p>PROSTHESIS We will pay this benefit if you require the use of a prosthetic device due to injuries received in a covered accident. We will pay this benefit for each prosthetic device you use. Hearing aids, wigs, dental aids, and false teeth are not covered.</p>	\$500	\$250
<p>PHYSICAL THERAPY We will pay this benefit for up to six doctor-prescribed physical therapy treatments per covered accident. You must have received initial treatment within 72 hours of the covered accident. The physical therapy treatment must begin within 30 days after the covered accident or discharge from the hospital and must take place within six months of the covered accident. This benefit is not payable for the same visit that the Accident Follow-Up Treatment Benefit is paid.</p>	\$30	\$15
<p>TRANSPORTATION We will pay this benefit if a doctor-recommended hospital treatment or diagnostic study is not available in your resident city. Transportation must begin within 90 days from the date of the covered accident. The distance to the hospital must be greater than 50 miles from your residence.</p>	\$300 (train/plane) \$150 (bus)	\$150 (train/plane) \$75 (bus)
<p>FAMILY LODGING BENEFIT (per night) We will pay this benefit for each night's lodging, up to 30 days, for an adult immediate family member's lodging if you are required to travel more than 100 miles from your resident home due to confinement in a hospital for treatment of an injury from a covered accident. This benefit is only payable while you remain confined to the hospital, and treatment must be prescribed by your local doctor.</p>	\$100	\$50
<p>REHABILITATION UNIT BENEFIT (per 12-month period) We will pay the amount shown for injuries received in a covered accident if you are admitted for a hospital confinement, are transferred to a bed in a rehabilitation unit of a hospital, and incur a charge. This benefit is limited to 30 days per period of hospital confinement. This benefit is also limited to a calendar year maximum of 60 days. We will not pay the Rehabilitation Unit Benefit for the same days that the Hospital Confinement Benefit is paid. We will pay the highest eligible benefit.</p>	\$75	\$37.50

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ACCIDENT ADVANTAGE PLUS INSURANCE

LIMITATIONS AND EXCLUSIONS
WHAT IS NOT COVERED, AND TERMS YOU NEED TO KNOW



LIMITATIONS AND EXCLUSIONS

If the coverage outlined in this summary will replace any existing coverage, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy.

WE WILL NOT PAY BENEFITS FOR INJURY, TOTAL DISABILITY, OR DEATH CONTRIBUTED TO, CAUSED BY, OR RESULTING FROM:

- War – participating in war or any act of war, declared or not; participating in the armed forces of, or contracting with, any country or international authority. We will return the prorated premium for any period not covered by this certificate when you are in such service.
- Suicide – committing or attempting to commit suicide, while sane or insane.
- Sickness – having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for any related medical/surgical treatment or diagnostic procedures for such illness.

- Self-Inflicted Injuries – injuring or attempting to injure yourself intentionally.
- Racing – riding in or driving any motor-driven vehicle in a race, stunt show, or speed test.
- Intoxication – being legally intoxicated, or being under the influence of any narcotic, unless taken under the direction of a doctor. *Legally intoxicated* means that condition as defined by the law of the jurisdiction in which the accident occurred.
- Illegal Acts – participating or attempting to participate in an illegal activity, or working at an illegal job.
- Sports – participating in any organized sport—professional or semi-professional.
- Cosmetic Surgery – having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of a covered accident.

TERMS YOU NEED TO KNOW

Accidental injury or injuries means bodily injury or injuries resulting from an unforeseen and unexpected traumatic event that meets the definition of *covered accident*.

Common carrier means an airline carrier that is licensed by the United States Federal Aviation Administration and operated by a licensed pilot on a regular schedule between established airports; a railroad train that is licensed and operated for passenger service only; or a boat or ship that is licensed for passenger service and operated on a regular schedule between established ports.

Covered accident means an unforeseen and unexpected traumatic event resulting in bodily injury. An event meets the qualifications of covered accident if it occurs on or after the plan's effective date, occurs while coverage is in force, and is not specifically excluded.

Dependent children are your or your spouse's natural children, step-children, legally adopted children, or children placed for adoption who are younger than age 26.

However, there is an exception to the age-26 limit listed above. This limit will not apply to any child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. You or your spouse must furnish proof of this incapacity and dependency to the company within 31 days following the child's 26th birthday.

Dismemberment means: loss of a hand – The hand is removed at or above the wrist joint; loss of a foot – The foot is removed at or above the ankle; or loss of sight – At least 80% of the vision in one eye is lost (such loss of sight must be permanent and irrecoverable); or loss of a finger/toe – The finger or toe is removed at or above the joint where it is attached to the hand or foot.

Doctor is defined as a person who is a legally qualified to practice medicine, licensed as a physician by the state where treatment is received, and licensed to treat the type of condition for which a claim is made. A doctor does not include you or your family member.

Employee means a person who is actively at work with the master policyholder, engaged in full-time work, and is included in the class of employees eligible for coverage.

Family member includes your spouse (who is defined as your legal wife or husband) as well as the following members of your immediate family: son, daughter, mother, father, sister, or brother.

This includes step-family members and family-members-in-law.

Hospital refers to a place that is legally licensed and operated as a hospital; provides overnight care of injured and sick people; is supervised by a doctor; has full-time nurses supervised by a registered nurse; has on-site or pre-arranged use of X-ray equipment, laboratory, and surgical facilities; and maintains permanent medical history records.

A hospital is not a nursing home; an extended-care facility; a convalescent home; a rest home or a home for the aged; a place for alcoholics or drug addicts; or a mental institution.

Hospital Intensive Care Unit refers to a specifically designed hospital facility that provides the highest level of medical care and is restricted to patients who are critically ill or injured. Hospital Intensive Care Units must be separate and apart from the surgical recovery room; separate and apart from rooms, beds, and wards customarily used for patient confinement; permanently equipped with special life-saving equipment to care for the critically ill or injured; and under constant and continuous observation by nursing staffs assigned to the Intensive Care Unit on an exclusive, full-time basis.

Rehabilitation Unit is a unit of a hospital providing coordinated multidisciplinary physical restorative services. These services must be provided to inpatients

under a doctor's direction. The doctor must be knowledgeable and experienced in rehabilitative medicine. Beds must be set up and staffed in a unit specifically designated for this service.

You and **Your** refer to an employee as defined in the plan.

We refers to Continental American Insurance Company.

Spouse means your legal wife or husband. Coverage may only be issued to your spouse if your spouse is over 18.

PORTABLE COVERAGE

When coverage is effective and would otherwise terminate because you end employment with the employer, coverage may be continued. You may continue the coverage that is in force on the date employment ends, including dependent coverage that is in effect. You must apply to us in writing within 31 days after the date that the insurance would terminate.

You may be allowed to continue the coverage until the earlier of the date you fail to pay the required premium, or the date the group master policy is terminated. Coverage may not be continued if you fail to pay any required premium or the group master policy terminates. Premium for ported coverage is paid directly by you.

TERMINATION

Your insurance will terminate on the date we terminate the plan, the 31st day after the premium due date, if the premium has not been paid, the date you no longer meet the plan's definition of an employee, or the date you no longer belong to an eligible class.

If the master policy and/or certificate terminates, we will provide coverage for claims arising from covered accidents that occurred while the plan was in force.

EFFECTIVE DATE

The effective date for you, the employee, is as follows: (1) Your insurance will be effective on the date shown on the certificate schedule, provided you are then actively at work. (2) If you are not actively at work on the date coverage would otherwise become effective, the effective date of your coverage will be the date on which you are first thereafter actively at work.

Continental American Insurance Company is not aware of whether you receive benefits from Medicare, Medicaid, or a state variation. If you or a dependent are subject to Medicare, Medicaid, or a state variation, any and all benefits under the plan could be assigned. This means that you may not receive any of the benefits outlined in the plan. Please check the coverage in all health insurance plans you already have or may have before you purchase the insurance outlined in this summary to verify the absence of any assignments or liens.

Notice to Consumer: The coverages provided by Continental American Insurance Company (CAIC) represent supplemental benefits only. They do not constitute comprehensive health insurance coverage and do not satisfy the requirement of minimum essential coverage under the Affordable Care Act. CAIC coverage is not intended to replace or be issued in lieu of major medical coverage. It is designed to supplement a major medical program.



AFLAC GROUP CRITICAL ILLNESS INSURANCE

Policy Series CAI2800



Aflac can help ease the financial stress of surviving a critical illness.

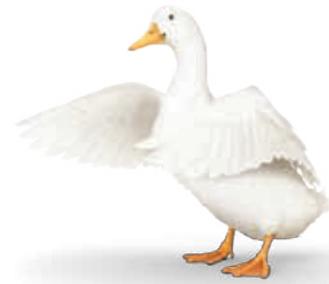
Chances are you may know someone who's been diagnosed with a critical illness. You can't help but notice the strain it's placed on the person's life—both physically and emotionally. What's not so obvious is the impact a critical illness may have on someone's personal finances.

That's because while a major medical plan may pay for a good portion of the costs associated with a critical illness, there are a lot of expenses that just aren't covered. And, during recovery, having to worry about out-of-pocket expenses is the last thing anyone needs.

That's the benefit of an Aflac group Critical Illness plan.

It can help with the treatment costs of covered critical illnesses, such as cancer, a heart attack or a stroke.

More importantly, the plan helps you focus on recuperation instead of the distraction and stress over out-of-pocket costs. With the Critical Illness plan, you receive cash benefits directly (unless otherwise assigned)—giving you the flexibility to help pay bills related to treatment or to help with everyday living expenses.



Understanding the facts can help you decide if the Aflac group Critical Illness plan makes sense for you.

ABOUT **1.67** MILLION

NEW CANCER CASES WERE EXPECTED TO BE DIAGNOSED IN 2014.*

*Cancer Facts & Figures 2014, American Cancer Society

Coverage underwritten by Continental American Insurance Company (CAIC)
A proud member of the Aflac family of insurers

AFLAC SUPPLEMENTAL BENEFITS



GROUP KEY

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Here's why the Aflac group Critical Illness plan may be right for you.

For almost 60 years, Aflac has been dedicated to helping provide individuals and families peace of mind and financial security when they've needed it most. The Aflac group Critical Illness plan is just another innovative way to help make sure you're well protected under our wing.

But it doesn't stop there. Having group Critical Illness insurance from Aflac means that you may have added financial resources to help with medical costs or ongoing living expenses.

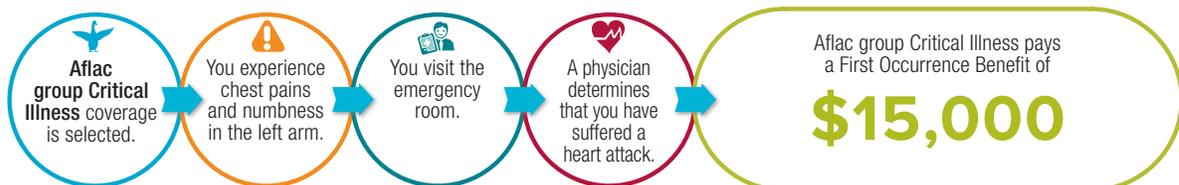
The Aflac group Critical Illness plan benefits include:

- Critical Illness Benefit payable for:
 - Cancer
 - Heart Attack (Myocardial Infarction)
 - Stroke
 - Major Organ Transplant
 - End-Stage Renal Failure
 - Coronary Artery Bypass Surgery
 - Carcinoma In Situ
- Health Screening Benefit

Features:

- Benefits are paid directly to you unless you choose otherwise.
- Coverage is available for you, your spouse, and dependent children.
- Coverage is portable (with certain stipulations). That means you can take it with you if you change jobs or retire.
- Fast claims payment. Most claims are processed in about four days.
- If you are deemed ineligible due to a previous medical condition, you still retain the ability to purchase spouse coverage.

How it works



Amount payable based on \$15,000 First Occurrence Benefit.

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For more information call 1.800.433.3036, or visit aflacgroupinsurance.com.

AFLAC SUPPLEMENTAL BENEFITS



Benefits Overview

COVERED CRITICAL ILLNESSES:

CANCER (Internal or Invasive)	100%
HEART ATTACK (Myocardial Infarction)	100%
STROKE (Apoplexy or Cerebral Vascular Accident)	100%
MAJOR ORGAN TRANSPLANT	100%
END-STAGE RENAL FAILURE	100%
CARCINOMA IN SITU (Payment of this benefit will reduce your benefit for cancer by 25%.)	25%
CORONARY ARTERY BYPASS SURGERY (Payment of this benefit will reduce your benefit for heart attack by 25%.)	25%

FIRST OCCURRENCE BENEFIT

After the waiting period, a lump sum benefit is payable upon initial diagnosis of a covered critical illness. Employee benefit amounts available are \$15,000 and \$30,000. Spouse coverage amounts available are \$7,500 and \$15,000, not to exceed one half of the employee's amount.

Recurrence of a previously diagnosed cancer is payable provided the diagnosis is made when the certificate is in-force, and provided the insured is free of any signs or symptoms of that cancer for 12 consecutive months, and has been treatment-free for that cancer for 12 consecutive months.

ADDITIONAL OCCURRENCE BENEFIT

If you collect full benefits for a critical illness under the plan and later are diagnosed with one of the remaining covered critical illnesses, then we will pay the full benefit amount for each additional illness. Occurrences must be separated by at least six months or for cancer at least six months treatment free.

REOCCURRENCE BENEFIT

If you collect full benefits for a covered condition and are later diagnosed with the same condition, we will pay the full benefit again. The two dates of diagnosis must be separated by at least 12 months, or for cancer at least 12 months treatment-free. Cancer that has spread (metastasized), even though there is a new tumor, will not be considered an additional occurrence unless you have gone treatment-free for 12 months.

CHILD COVERAGE AT NO ADDITIONAL COST

Each dependent child is covered at 50 percent of the primary insured's benefit amount at no additional charge.

HEALTH SCREENING BENEFIT (Employee and Spouse only)

After the waiting period, you may receive a maximum of \$50 for any one covered health screening test per calendar year. We will pay this benefit regardless of the results of the test. Payment of this benefit will not reduce the critical illness benefit payable under the plan. There is no limit to the number of years you can receive the Health Screening Benefit; it will be payable as long as coverage remains in force. This benefit is only payable for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. This benefit is payable for the covered employee and spouse. **This benefit is not paid for dependent children.**

COVERED HEALTH SCREENING TESTS INCLUDE:

- | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> • Mammography • Colonoscopy • Pap smear • Breast ultrasound • Chest X-ray • PSA (blood test for prostate cancer) • Stress test on a bicycle or treadmill • Bone marrow testing • CA 15-3 (blood test for breast cancer) | <ul style="list-style-type: none"> • CEA (blood test for colon cancer) • Flexible sigmoidoscopy • Hemocult stool analysis • Serum protein electrophoresis (blood test for myeloma) • Thermography • Fasting blood glucose test • Serum cholesterol test to determine level of HDL and LDL • Blood test for triglycerides |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

The plan has limitations and exclusions that may affect benefits payable. This brochure is for illustrative purposes only. Refer to your certificate for complete details, definitions, limitations, and exclusions.



CRITICAL ILLNESS INSURANCE

LIMITATIONS AND EXCLUSIONS,
WHAT IS NOT COVERED, AND TERMS YOU NEED TO KNOW



LIMITATIONS AND EXCLUSIONS

If the coverage outlined in this summary will replace any existing coverage, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy.

IF DIAGNOSIS OCCURS AFTER THE AGE OF 70, HALF OF THE BENEFIT IS PAYABLE.

The plan contains a 30-day waiting period. This means that no benefits are payable for anyone who has been diagnosed before your coverage has been in force 30 days from the effective date. If you are first diagnosed during the waiting period, benefits for treatment of that critical illness will apply only to loss starting after 12 months from the effective date or the employee can elect to void the coverage and receive a full refund of premium.

The applicable benefit amount will be paid if: the date of diagnosis is after the waiting period; the date of diagnosis occurs while the certificate is in force; and the cause of the illness is not excluded by name or specific description.

EXCLUSIONS

Benefits will not be paid for loss due to:

- Intentionally self-inflicted injury or action;
- Suicide or attempted suicide while sane or insane;
- Illegal activities or participation in an illegal occupation;
- War, whether declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence;

- Substance abuse; or
- Pre-Existing Conditions (except as stated below).

No benefits will be paid for loss which occurred prior to the effective date.

No benefits will be paid for diagnosis made or treatment received outside of the United States.

PRE-EXISTING CONDITION LIMITATION

Pre-Existing Condition means a sickness or physical condition which, within the 12-month period prior to the effective date, resulted in you receiving medical advice or treatment.

We will not pay benefits for any critical illness starting within 12 months of the effective date which is caused by, contributed to, or resulting from a pre-existing condition. A claim for benefits for loss starting after 12 months from the effective date will not be reduced or denied on the grounds that it is caused by a pre-existing condition. A critical illness will no longer be considered pre-existing at the end of 12 consecutive months starting and ending after the effective date.

Applicable to Cancer and/or Carcinoma in Situ: If all other plan provisions are met, recurrence of a previously diagnosed cancer will not be reduced or denied provided the diagnosis is made when the certificate is in-force, and provided the insured is free of any signs or symptoms of that cancer for 12 consecutive months, and has been treatment-free for that cancer for 12 consecutive months.

TERMS YOU NEED TO KNOW

The **Effective Date** of your insurance will be the date shown on the certificate schedule.

Employee means the insured as shown on the certificate schedule.

Spouse means your legal wife or husband.

Dependent Children means your natural children, step-children, foster children, legally adopted children or children placed for adoption, who are under age 26.

Your natural children born after the effective date of the rider will be covered from the moment of live birth. No notice or additional premium is required.

Coverage on dependent children will terminate on the child's 26th birthday. However, if any child is incapable of self-sustaining employment due to mental or physical handicap and is dependent on his parent(s) for support, the above age 26 shall not apply. Proof of such incapacity and dependency must be furnished to us within 31 days following such 26th birthday.

Treatment means consultation, care, or services provided by a physician, including diagnostic measures and taking prescribed drugs and medicines.

Treatment Free means a period of time without the consultation, care or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines. For the purpose of this definition treatment does not include maintenance drug therapy or routine follow-up visits to verify if cancer or carcinoma in situ has returned.

Maintenance Drug Therapy means ongoing hormonal therapy, immunotherapy or chemo-prevention therapy that may be given following the full remission of a cancer due to primary treatment. It is meant to decrease the risk of cancer recurrence rather than the palliative or suppression of a cancer that is still present.

Major Organ Transplant means undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney, or pancreas.

Myocardial Infarction (Heart Attack) means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. Heart attack does not include any other disease or injury involving the cardiovascular system. Cardiac arrest not caused by a myocardial infarction is not a heart attack. The diagnosis must include all of the following criteria:

1. New and serial electrocardiographic (EKG) findings consistent with myocardial infarction;
2. Elevation of cardiac enzymes above generally accepted

laboratory levels of normal in case of creatine phosphokinase (CPK), a CPK-MB measurement must be used; and 3. Confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms.

Stroke means apoplexy (due to rupture or acute occlusion of a cerebral artery), or a cerebral vascular accident or incident which begins on or after the coverage effective date. Stroke does not include transient ischemic attacks and attacks of vertebrobasilar ischemia. We will pay a benefit for stroke that produces permanent clinical neurological sequela following an initial diagnosis made after any applicable waiting period. We must receive evidence of the permanent neurological damage provided from computed axial tomography (CAT scan) or magnetic resonance imaging (MRI). Stroke does not mean head injury, transient ischemic attack, or chronic cerebrovascular insufficiency.

Cancer (Internal or Invasive) means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of distant tissue. Cancer includes leukemia. Excluded are cancers that are noninvasive, such as (1) Premalignant tumors or polyps; (2) Carcinoma in Situ; (3) Any skin cancers except melanomas; (4) Basal cell carcinoma and squamous cell carcinoma of the skin; and (5) Melanoma that is diagnosed as Clark's Level I or II or Breslow thickness less than .77 mm.

Cancer is also defined as a disease which meets the diagnosis criteria of malignancy established by The American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen.

Carcinoma in Situ means cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

End-Stage Renal Failure means the end-stage renal failure presenting as chronic, irreversible failure of both of your kidneys to function. The kidney failure must necessitate regular renal dialysis, hemodialysis or peritoneal dialysis (at least weekly); or which results in kidney transplantation. Renal failure is covered, provided it is not caused by a traumatic event, including surgical traumas.

Coronary Artery Bypass Surgery means undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, but excluding procedures such as, but not limited to balloon angioplasty, laser relief, stents or other nonsurgical procedures.

AFLAC SUPPLEMENTAL BENEFITS



GROUP KEY

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Doctor or Physician means any licensed practitioner of the healing arts acting within the scope of his license in treating a critical illness. It doesn't include an insured or their family member.

PORTABLE COVERAGE

When coverage would otherwise terminate because you end employment with the employer, coverage may be continued. You may continue the coverage that is in force on the date employment ends, including dependent coverage then in effect. You must apply to us in writing within 31 days after the date that the insurance would terminate.

You may be allowed to continue the coverage until the earlier of the date you fail to pay the required premium or the date the group master policy is terminated. Coverage may not be continued if you fail to pay any required premium or the group master policy terminates.

TERMINATION

Coverage will terminate on the earliest of: (1) The date the master policy is terminated; (2) The 31st day after the premium due date if the required premium has not been paid; (3) The date the insured ceases to meet the definition of an employee as defined in the master policy; or (4) The date the employee is no longer a member of the class eligible.

Coverage for an insured spouse or dependent child will terminate the earliest of: (1) the date the plan is terminated; (2) the date the spouse or dependent child ceases to be a dependent; (3) the premium due date following the date we receive your written request to terminate coverage for his or her spouse and/or all dependent children.

Continental American Insurance Company is not aware of whether you receive benefits from Medicare, Medicaid, or a state variation. If you or a dependent are subject to Medicare, Medicaid, or a state variation, any and all benefits under the plan could be assigned. This means that you may not receive any of the benefits outlined in the plan. Please check the coverage in all health insurance plans you already have or may have before you purchase the insurance outlined in this summary to verify the absence of any assignments or liens.

Notice to Consumer: The coverages provided by Continental American Insurance Company (CAIC) represent supplemental benefits only. They do not constitute comprehensive health insurance coverage and do not satisfy the requirement of minimum essential coverage under the Affordable Care Act. CAIC coverage is not intended to replace or be issued in lieu of major medical coverage. It is designed to supplement a major medical program.



State of Delaware

HIGH OPTION - 24 HOUR PLAN	Semimonthly (24pp/yr)
Employee	\$8.11
Employee and Spouse	\$12.28
Employee and Dependent Children	\$14.23
Family	\$18.40

Wellness Benefit included in Rates

LOW OPTION - 24 HOUR PLAN	Semimonthly (24pp/yr)
Employee	\$4.08
Employee and Spouse	\$6.18
Employee and Dependent Children	\$7.16
Family	\$9.26

Wellness Benefit included in Rates

Issue age: the age you are when your plan first goes into effect.

Please Note: Premiums and benefits shown are accurate as of publication. Rates are guaranteed through June, 31, 2028 then are subject to change.



We've got you under our wing.

aflacgroupinsurance.com | 1.800.433.3036

Underwritten by:
Continental American Insurance Company
One Continental Plaza | Columbia, South Carolina 29201

Published: Jan-15

AC78150123-165144 --- RB1-CU-DE-AC78-24PP-HIGH-24HR-WB - ZZXX54371

AFLAC SUPPLEMENTAL BENEFITS



GROUP KEY

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GROUP CRITICAL ILLNESS

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State of Delaware - Semimonthly (24pp/yr)

NONTOBACCO - Employee			
Issue Age	\$15,000	\$30,000	
18-29	\$ 3.04	\$	5.35
30-39	\$ 4.98	\$	9.23
40-49	\$ 9.35	\$	17.98
50-59	\$ 16.31	\$	31.90
60-69	\$ 25.73	\$	50.73

NONTOBACCO - Spouse			
Issue Age	\$7,500	\$15,000	
18-29	\$ 1.89	\$	3.04
30-39	\$ 2.85	\$	4.98
40-49	\$ 5.04	\$	9.35
50-59	\$ 8.52	\$	16.31
60-69	\$ 13.23	\$	25.73

TOBACCO - Employee			
Issue Age	\$15,000	\$30,000	
18-29	\$ 4.60	\$	8.48
30-39	\$ 8.04	\$	15.35
40-49	\$ 18.85	\$	36.98
50-59	\$ 31.98	\$	63.23
60-69	\$ 50.73	\$	100.73

TOBACCO - Spouse			
Issue Age	\$7,500	\$15,000	
18-29	\$ 2.67	\$	4.60
30-39	\$ 4.39	\$	8.04
40-49	\$ 9.79	\$	18.85
50-59	\$ 16.35	\$	31.98
60-69	\$ 25.73	\$	50.73

Rates include cancer benefit.

Rates include: \$50 Health Screening Benefit, and no additional riders

Issue Age: The age you are when your plan first goes into effect..

Please Note: Premiums shown are accurate as of publication. They are guaranteed through June 31, 2018 and then are subject to change.



**We've got you
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Underwritten by:
Continental American Insurance Company
3801 Devon Street | Columbia, SC 29204



FLEXIBLE SPENDING ACCOUNTS BY ASiflex HEALTH CARE AND DEPENDENT CHILD CARE

Flexible Spending Accounts (FSA) save you money on medical and child care expenses for you and your eligible dependents. FSA is your opportunity to set aside pre-tax dollars to pay for eligible child care and medical expenses like doctor's co-pays, deductibles and coinsurance, eye glasses and contacts, prescriptions and MORE! The more money you put in, the more tax you avoid. When you use the money in your account to pay for out-of-pocket family care expenses, you avoid paying taxes on those dollars. FSA accounts are exempt from federal income taxes, Social Security (FICA) taxes and, in most cases, state income taxes. Most people save at least 25% on each dollar that is set aside in the program. Sign up for a Flexible Spending Account (FSA) to save money!

HOW DOES THIS WORK?

FSA HEALTH CARE

When you enroll in the FSA plan, you estimate the amount of family care expenses you are sure you will incur during the plan year. You have that amount deducted from your paychecks in equal amounts throughout the year. For the Health Care Account you must choose a minimum annual election of \$50 and the maximum annual election is \$2,550.

DEPENDENT CHILD CARE

The Dependent Care Flexible Spending Account Plan allows a tax break on up to \$5,000 per year. Just as with the Health Care plan, estimate your dependent child care expenses for the plan year and choose an annual election. The maximum election per household is \$5,000 and the minimum is \$50.00.

HOW DO I ENROLL?

New employees must enroll by the first day of the month after completing the initial waiting period of 90 days to participate for the remainder of that plan year. If you fail to enroll within the time period described above, then you may not elect to participate in the Plan until the next Open Enrollment Period or until an event occurs that would justify a mid-year election change. Visit www.ben.omb.delaware.gov/fsa to complete the FSA Enrollment Agreement and visit www.asiflex.com to learn more about saving money with FSA!

DISABILITY INSURANCE PROGRAM (DIP)



GROUP KEY

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DISABILITY INSURANCE PROGRAM (DIP)

Employees hired into a position covered by the Delaware State Employees' Pension Plan are automatically enrolled in the DIP; a program that is insured and administered by The Hartford Insurance Company. By definition, disability insurance pays a portion of your income if you are unable to work because of a disabling illness or injury occurring on or off of the job.

The DIP is comprised of a Short Term Disability (STD) and a separate Long Term Disability (LTD) program with premiums that are paid in their entirety by the State of Delaware. Employees enrolled in the DIP who expect to be out of work for at least 30 calendar days are required to file an STD claim with The Hartford. For more information on how to file a claim, visit <http://ben.omb.delaware.gov/disability/index.shtml>. Please contact your organization's HR Office for confirmation of your enrollment in the DIP.

SHORT TERM DISABILITY (STD)

The STD program does not include a pre-existing conditions limitation clause. In order to be considered for "Total Disability" benefits, you must be prevented by:

- 1) Injury;
- 2) Sickness;
- 3) Mental Condition;
- 4) Substance Abuse;
- 5) Pregnancy; or
- 6) Loss of license due to medical condition;

from performing the essential duties of your occupation, and as a result, are earning 20% or less of your pre-disability salary.

Starting with your date of disability, STD benefits commence after completion of a 30 calendar day elimination period for up to a maximum period of 182 calendar days. If approved for STD benefits by The Hartford, you will receive a benefit of up to 75% of your pre-disability salary including hazardous duty pay that will be reduced by "Other Income Benefits" from the State of Delaware. Additionally, you may utilize earned sick leave (not to exceed your sick leave balance) to remain in paid status during the elimination period and to supplement the STD benefit up to 100% of your pre-disability salary. The plan also provides residual or partial disability benefits for eligible employees working on a part-time basis.

LONG TERM DISABILITY (LTD)

The LTD program contains a pre-existing conditions limitation for employees hired on or after January 1, 2006. If your claim is approved by The Hartford, LTD benefits begin on the 183rd calendar day of disability and continue for 24 months or until you are able to perform the essential duties of your occupation. After 24 months, LTD benefit payments can continue if you are unable to perform the essential duties of any occupation. The Hartford will pay LTD beneficiaries directly, up to 60% of pre-disability salary (as of the onset of your disability), including hazardous duty pay that will be reduced by "Other Income Benefits".

Current and former employees receiving STD and/or LTD benefits continue to be eligible for enrollment in a health care plan sponsored by the State of Delaware and continue to earn pension service credits. Learn more about "Other Income Benefits" and the Disability Insurance Program at <http://ben.omb.delaware.gov/disability/index.shtml>.

STATE OF DELAWARE DEFERRED COMPENSATION PLAN



GROUP KEY

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STATE OF DELAWARE 457(B) AND 403(B) DEFERRED COMPENSATION PLANS ADMINISTERED BY THE DELAWARE STATE TREASURY

Did you know there's a great way to help you save for retirement and a solid financial future right at your fingertips? One of the outstanding benefits you have available as a state employee is the ability to participate in the State of Delaware's Deferred Compensation Plans. The two plans available, the 457(b) plan and the 403(b) plan, offer a variety of benefits including the chance to reduce your current tax obligations and to invest your money in a tax-deferred savings plan. Contributions are made through pre-tax payroll deductions, in an amount designated by you to best meet your needs and goals! Whether you are just starting your career or nearing retirement, the Deferred Compensation Plans can help you secure a more solid financial future.

Enrollment is easy and open year-round, but the State's open enrollment benefit period is a great time to consider enrolling if you have not yet done so. If you are already enrolled, now is a great time to evaluate your current contribution level and investment selection to see if they still meet your needs and goals.

Many experts say you'll need anywhere from 80-100% of your current income level in retirement. Are you prepared? It's time: Earn – Save – Invest – PROSPER.

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	\$18,000 in 2015 (IRS may increase or decrease limit each year)	\$18,000 in 2015 (IRS may increase or decrease limit each year)
Age 50 and over Catch-up Limits	\$6,000 in 2015 (IRS may increase or decrease limit each year)	\$6,000 in 2015 (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, \$36,000 for 2015	No
Match Plan	\$10 per pay after 6 months of participation (Currently Suspended)	No
After Tax Roth Contributions	No	Yes
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

Please visit www.treasurer.delaware.gov/deferred_compensation/ to learn more about the plans.



STATE OF DELAWARE - SPOUSAL COORDINATION OF BENEFITS (COB) 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/pensioner's spouse is employed full-time or retired from another employer, and
- that employer/former employers offers group health insurance 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 health plans.

- If you are an employee or pensioner covering a spouse in a non-Medicare State of Delaware Group Health Insurance health plan, you are required to complete a new Spousal Coordination of Benefits form each year during Open Enrollment and anytime your spouse's employment or insurance status changes.
- If you are a pensioner and cover a spouse in the Highmark Delaware Special Medicfill Medicare Supplement plan, you do not need to complete a Spousal Coordination of Benefits form at this time, unless your spouse's employment or health insurance status has changed since July 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. When completing the form, be sure to check the box 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 employer rather than be covered under your spouse.
- **Failure to complete this form will result in a reduction of spousal benefits.**

State of Delaware Active Employees - Complete your spousal COB form through Employee Self Service at www.employeeselfservice.omb.delaware.gov.

After you login follow the navigation to the form:

Main Menu > Self Service > Benefits > Spousal Coordination of Benef.

State of Delaware Pensioners, Participating Group Employees and COBRA Participants - Complete your form online at www.ben.omb.delaware.gov/documents/cob.



DOUBLE STATE SHARE

In accordance with House Bill 81, signed into law on May 2, 2011, 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.

Who Carries the Benefits?

- While both spouses are active employees, the spouse whose birthday falls first in the calendar year should carry the coverage.
- While at least one spouse is an active employee, the active employee should carry the coverage.
- Once both spouses are pensioners, the younger spouse should carry the benefits.

Active employees eligible from Double State Share must notify their Human Resources/Benefits Office to make the appropriate changes.

Pensioners eligible for Double State Share and enrolled through the Office of Pensions should contact the Office of Pensions at 302-739-4208 or 1-800-722-7800 regarding monthly premiums.

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

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.

If enrolling a spouse or other dependent for the first time, you will be required to submit Birth, Marriage, Civil Union Certificate and Certification of Tax Dependent forms as applicable within 30 days of the request.

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.



DEPENDENT COVERAGE AND COORDINATION OF BENEFITS POLICY

State employees, pensioners, and employees enrolled in a health care insurance plan under the State Group Health Insurance Program (GHIP) may cover their dependent children to age 26 as primary in their State health care plan, dental plan and/or vision plan regardless if the adult dependent child is offered employer health coverage. Dependent children may be covered with no restriction on marital, employment, student, resident or tax status. Pursuant to the Group Health Insurance Program Eligibility and Enrollment Rules, an employee or pensioner's children are defined as sons, daughters, stepchildren and adopted children.

Please Note: Employees/pensioners with an Adult Dependent Child who has access to health coverage through his or her own employer:

- If a dependent child is also a benefit eligible employee of the State of Delaware or of a group designated through Delaware code to participate in the GHIP, the dependent child must enroll in his/her own State health care plan OR can be covered by the parent who is a benefit eligible employee/pensioner but cannot be enrolled in both as duplicate coverage is not permitted per the Group Health Plan Eligibility and Enrollment Rules.
- If a dependent child has coverage through his/her employer other than the State of Delaware or a group who participates in the State GHIP, the employee/pensioner may also cover the dependent child.
- A Dependent Coordination of Benefits form must be submitted to the health plan carrier to determine which coverage will process first.

DEPENDENT COORDINATION OF BENEFITS FORM

In accordance with the Group Health Insurance Program Eligibility and Enrollment Rules, Dependent Coordination of Benefits forms must be completed for each enrolled dependent regardless of age, upon:

- Enrollment in other health coverage,
- Any time other health coverage changes, or
- Upon request by the Statewide Benefits Office, Highmark Delaware or Aetna.

Additional information and the appropriate Aetna and Highmark Delaware forms can be found by visiting the appropriate link below (select the carrier administering your health plan benefits):

Aetna Members:

<http://ben.omb.delaware.gov/medical/aetna>

Highmark Delaware Members:

<http://ben.omb.delaware.gov/medical/bcbs>



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, 2015, and were revised as of March 1, 2015.
- 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/or 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.

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.



HEALTH CARE COVERAGE NOTICES AND OTHER IMPORTANT INFORMATION

Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

For Highmark Delaware members, the SBC is available at <http://ben.omb.delaware.gov/medical/bcbs>.

For Aetna members, the SBC is available at <http://ben.omb.delaware.gov/medical/aetna>.

A paper copy is also available, free of charge, by calling 1-800-489-8933.

Notice to Enrollees

Group health plans sponsored by State and local governmental employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from certain requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy.

The State of Delaware has elected to exempt the State of Delaware Group Health Insurance Program ("Plan") from the following requirement:

- Protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the Plan.

The Plan provides protections similar to the exempted requirement in accordance with Delaware State law, 18 Del. C. §3343(b).

The exemption from this Federal requirement will be in effect for the plan year beginning July 1, 2015 and ending June 30, 2016. The election may be renewed for subsequent plan years.



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, the Notice will be posted on the State of Delaware website at <http://ben.omb.delaware.gov/hipaa> no later than the effective date of the change and thereafter sent in the Plan’s next annual mailing. 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 on page 65).

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.



COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

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.

- **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.

• Other Uses and Disclosures of Your PHI Not Requiring 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. 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 response to a court order or administrative tribunal. 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.
 - **To workers’ compensation programs:** The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers’ compensation or other similar programs established by law.
- **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.

The Plan must generally obtain your written authorization before:

- using or disclosing psychotherapy notes about you from your psychotherapist (Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan is not likely to have access to or maintain these types of notes.).
- using or disclosing alcohol and substance abuse patient records.
- using or disclosing your PHI for marketing purposes (a communication that encourages you to purchase or use a product or service) if the Plan receives direct or indirect financial remuneration (payment) from the entity whose product or service is being marketed.
- receiving direct or indirect remuneration (payment or other benefit) in exchange for receipt of your PHI.



- 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, without your written authorization, 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 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 request a copy of this Notice: You have a right to request a paper copy of this Comprehensive Notice of Privacy Policy and Procedures at any time. This right applies even if you have agreed to receive the Notice electronically. In addition, a copy of this Notice is available on the State of Delaware website at <http://ben.omb.delaware.gov/hipaa>.

- 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 hardcopy or electronic form) in the possession of the Plan or its vendors if you put your request in writing. You may request your hardcopy or electronic information in a format that is convenient for you, and the Plan will honor that request to the extent possible. You also may request a summary of your PHI. If your PHI is maintained in an Electronic Health Record (EHR) system, you may obtain an electronic copy of your records. You may also instruct us in writing to send an electronic copy of your records to a third party. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. A single 30-day extension is allowed if the Plan is unable to comply with the deadline and if the Plan provides you with a notice of the reason for the delay and the expected date by which the requested information will be provided. 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, you may be charged a reasonable, cost-based fee for creating or copying the PHI, or preparing a summary of your PHI. However, the fee 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 permitted to be disclosed. 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 family. 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. If we maintain your records in an Electronic Health Record (EHR) system, you may request that it include disclosures for treatment, payment or health care operations. 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 (three years in the case of a disclosure involving an EHR). 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. Filing instructions are available at <http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html>. The law does not permit anyone to take retaliatory action against you 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 page 65). If you have any complaints about the Plan's privacy practices or handling of your PHI, please contact the Plan's Privacy Official (see page 65).



Privacy Official.

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

**Director of Human Resource Management and Benefits Administration,
Office of Management and Budget (OMB)
Telephone Number: (302) 739-8331**

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

**Human Resources Specialists, Statewide Benefits Unit, OMB (302) 739-8331
Information Systems Manager, PHRST (302) 739-2260
Human Resources Manager, PHRST Benefits (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**
- **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 Express Scripts 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.

Medicare-eligible retirees are generally eligible for prescription drug coverage through the Express Scripts Medicare Prescription Drug Plan for the State of Delaware and do not need to enroll in another Medicare Prescription Drug Plan. Please refer to the section on the next page called "What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?" for important information.

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 Express Scripts 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.



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, or Medicare-eligible dependent of a retiree, you are generally eligible for prescription drug coverage through the Express Scripts Medicare Prescription Drug Plan (PDP) for the State of Delaware. You cannot have coverage through another Medicare prescription drug plan and retain your coverage through the Express Scripts Medicare PDP for the State of Delaware. If you enroll in a Medicare prescription drug plan, other than the Express Scripts Medicare PDP for the State of Delaware, 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. Beginning in 2013, your coverage will be administered on a calendar year basis with open enrollment being held in October of each year. In order to enroll in the Express Scripts Medicare PDP for the State of Delaware during open enrollment, you must have terminated the other Medicare prescription drug coverage.

If you are a Medicare-eligible active employee, you cannot keep your prescription drug plan with the State of Delaware and enroll in a Medicare prescription drug plan. 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). In order to enroll during open enrollment, you must have terminated the other Medicare prescription drug coverage.

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 % 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 % 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.



**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.
- Call 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).**

PHONE NUMBERS AND WEBSITES



GROUP KEY

AS
NO
SM
PG
CB

Company Name	Phone Number	Website
Aetna	1-877-542-3862	www.aetna.com
Highmark Delaware	1-800-633-2563	www.highmarkbcbsde.com
HMS (Health Advocate) - Employee Assistance + Work/Life Program	1-800-343-2186	http://hms.healthadvocate.com/ Log In: Enter "State of Delaware" as the name of your organization.
Express Scripts	1-800-939-2142	www.express-scripts.com
EyeMed Vision Care	1-855-259-0490	www.eyemedvisioncare.com
Delta Dental	1-800-873-4165	https://www.deltadentalins.com/stateofdelaware/
Dominion Dental Services	1-888-518-5338	www.dominiondental.com
Blood Bank of Delmarva	302-737-8400 for Donor Scheduling, 302-737-8405 for General / Main # 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
Delaware Medical Assistance Bureau	1-800-336-9500	www.delawareinsurance.gov
Statewide Benefits Office, Office of Management and Budget	302-739-8331 or 1-800-489-8933	www.ben.omb.delaware.gov
Aflac	1-800-433-3036	www.delaware.hrntouch.com
Minnesota Life	1-877-215-1489	www.LifeBenefits.com