BENEFiTS

Statewide Benefits Office
SBO
Benefits Made Easy

OPEN ENROLLMENT 2016

MAY 9-26, 2016

GREAT SEAL OF THE STATE OF DELAWARE
LIBERTY AND INDEPENDENCE
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UNDERSTANDING THE GROUP KEY

We have made it easy 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.

AS
NO
SM
PG
CB

What do these symbols mean?

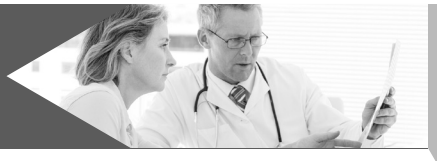
AS The letter code "**AS**" applies to **A**ctive **S**tate Employees.

NO The letter code "**NO**" applies to State **No**n-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**O**B**RA Participants.



AVAILABLE NOW:

New Consumerism Resource Link

- Visit www.ben.omb.delaware.gov/consumerism to learn more about how to:
  - Save both you and the State Group Health Plan money
  - Improve your health

EyeMed members have access to hearing care discounts through Amplifon (See pages 31 and 32 for more details)

- The discounts include: 40% off hearing exams at thousands of convenient locations nationwide, discounted set pricing on thousands of hearing aids, free batteries for 2 years with initial purchase and more.
  Call 1-844-526-5432 to find out more about their discount program.
- **The hearing discounts are effective now for all current members, as well as, for those enrolling during the open enrollment period.**

AVAILABLE BEGINNING JULY 1, 2016:

New Rates For Health, Dental and Vision (See pages 14, 30 and 32 for more details)

Be A Wise Health Care Consumer:

- **New savings opportunities** for HMO and PPO members:
  - **Reduced copay for urgent care services**
    (Current: HMO - $25 copay and PPO - $30 copay; Beginning July 1: HMO - $15 copay and PPO - $20 copay)
    - For less serious, non-life threatening situations (i.e., Minor accidents like burns, cuts, strains and sprains, or common medical problems like the flu, colds, earaches, sore throat, etc.), rather than going to the emergency room (ER) and paying a $150 copay, members are encouraged to visit an urgent care center and pay less.
  - **$0 copay for hi-tech imaging services**
    (CT/PET scans, MRI, MRA) when done at a **non-hospital freestanding facility** (a $35 savings to you!).

Dental Benefits - Delta Dental and Dominion Dental (See pages 29 and 30 for more details)

- Dental implants will be a covered benefit. Dental implants are an alternative to dentures and bridges to replace natural teeth and roots. However, not everyone is a candidate for an implant. Talk with your dentist to discuss your options and request a pre-treatment estimate.
- Under the Delta Dental PPO plan coverage is subject to applicable deductible, coinsurance and annual maximum limitations. Coverage under the Dominion Dental Select Plan is subject to applicable copayments.

Vision Benefits - EyeMed (See pages 31 and 32 for more details)

- The EyeMed Network for State of Delaware members will change from EyeMed's Access Network to EyeMed's **Insight Network**.
- Frequency: From "date of service" to "**plan year**"
  - Examination, frame, vision therapy evaluation, lenses or contact lenses = One time per **plan year**
  - Diabetic services = Two times during the **plan year** (once every six months)
  - Vision Therapy = Up to 10 visits per **plan year**
  - From **July 1, 2016** through **December 31, 2016** members get **exclusive savings on sunglasses from Sunglass Hut**. Sign up at www.eyemedvisioncare.com/sunperks within the timeframe noted. You'll immediately receive an email with a savings code. Use the savings code at Sunglass Hut locations or at www.sunglasshut.com. **The benefit only applies for the period of July 1, 2016 through December 31, 2016.**

2016 OPEN ENROLLMENT CHECKLIST!

- **READ** your Open Enrollment information in this booklet.
- **PLAN** to attend a Statewide Benefits Health Fair (see page 52 for dates, times and locations).
- **REVIEW** Open Enrollment Frequently Asked Questions (FAQs) at www.ben.omb.delaware.gov/oe.
- **READ** the complete Spousal Coordination of Benefits policy at www.ben.omb.delaware.gov/documents/cob if you cover your spouse in one of the medical plans (see page 38 for details).

Reminders:

- Open Enrollment is the only time during the year you can make changes to your benefit elections, unless you experience a qualifying event (see page 39 for details).
- If you are **not** making any changes to your current benefits and do **not** cover a spouse, **no** action is required.
- If you do cover a spouse, you **MUST** complete a new Spousal Coordination of Benefits Form each year during Open Enrollment and anytime your spouse's employment or insurance status changes.
- 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 verify, enroll or make changes in supplemental benefits by Aflac, go online to www.delaware.hrintouch.com by May 26, 2016. Benefit eligible active employees who are outside of their initial eligibility period will be considered "Late Enrollees" and may be subject to approval based on answers to health questions.
- To verify, enroll or make changes to your health, dental, vision or blood bank coverage, go online to www.ben.omb.delaware.gov/oe by May 26, 2016 to access the link to eBenefits.
- To verify, enroll or make changes to your Group Universal Life (GUL) coverage, go online to www.ben.omb.delaware.gov/life and follow the instructions. Benefit eligible active employees who are outside of their initial eligibility period will be required to provide proof of good health.
- Refer to the eBenefits Quick Reference Guide (online at www.ben.omb.delaware.gov/oe) for complete log in and enrollment instructions. **If you do not have access to a computer**, or have questions about your benefits or eligible dependents, contact your organization's Human Resources or Benefits Office.
- Complete your Spousal Coordination of Benefits Form online in Employee Self Service by May 26, 2016, if you cover your spouse on your health plan (see page 38 for details).
- **For assistance with Employee Self Service (such as password reset requests) including eBenefits enrollment, Spousal Coordination of Benefits form completion and Securian GUL online access**, go to www.employeeselfservice.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 Open Enrollment Help Desk at 1-800-489-8933 from 8:00 a.m. to 4:30 p.m. Monday through Friday.
- **Following Open Enrollment**, view your benefit elections by accessing the Benefits Summary section in Employee Self Service. Please refer to **eBenefits Quick Reference Guide** 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 by June 3, 2016. **No corrections will be made after June 3, 2016**.

NO SM Pensioners

- To enroll or make changes to your health, dental, vision or blood bank coverage, you **MUST** complete the necessary forms available on the Office of Pensions Website at www.delawarepensions.com or complete the applications included in the packet mailed to your home. You **MUST** submit your completed enrollment forms to the Office of Pensions by May 26, 2016. **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 reduce your current Securian GUL coverage, review the detailed instructions for Ported (Terminated or Retired) GUL Enrollees at www.ben.omb.delaware.gov/life.
- 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, you **MUST** complete the Spousal Coordination of Benefits – Electronic Form each year during Open Enrollment and anytime your spouse's employment or insurance status changes. The form is located online at www.ben.omb.delaware.gov/documents/cob (see page 38 for details). If you do not have access to a computer, complete the paper form (included in the packet mailed to your home), and submit to the Office of Pensions by May 26, 2016.
  - 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 during the Open Enrollment period.

PG Non-State Participating Group Employees

- Contact your Human Resources Office within your organization for forms to enroll, make changes or cancel current health or dental coverage.
- Complete your Spousal Coordination of Benefits – Electronic Form online at www.ben.omb.delaware.gov/documents/cob by May 26, 2016, if you cover your spouse on your health plan (see page 38 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 by May 26, 2016, if you cover your spouse on your health plan (see page 38 for details).
- If you have general benefits or enrollment questions, call the Open Enrollment Help Desk at 1-800-489-8933 from 8 a.m. to 4:30 p.m. Monday through Friday.

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.

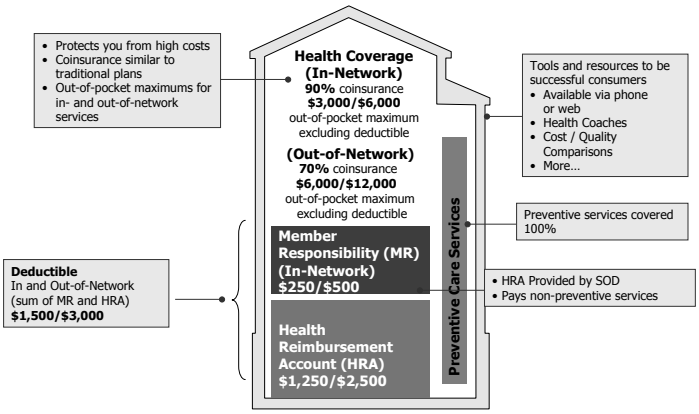
How Does the Consumer-Directed Health Gold Plan Work?

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.

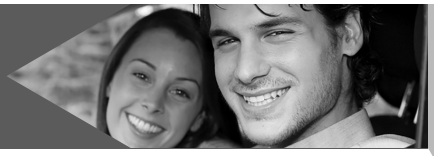


Added Financial Protection and Peace of Mind

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 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 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.**

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-Pocket Max: $2,000/$4,000** including deductible	Out-of-Network Benefits Deductible: $1,000/$2,000* Out-of-Pocket Max: $4,000/$8,000** including deductible
Inpatient Room & Board	90% after deductible	70% after deductible
Inpatient Physicians' and Surgeons' Services	90% after deductible	70% after deductible
Outpatient Services	90% after deductible	70% after deductible
Prenatal and Postnatal Care	90% after deductible	70% after deductible
Delivery Fee	90% after deductible	70% after deductible
Hospice	90% after deductible for up to 365 days	70% after deductible for up to 365 days
Home Care Services	90% after deductible for up to 240 days per plan year	70% after deductible for up to 240 days per plan year
Urgent Care	100% after $25 copay	100% after $25 copay
Emergency Services	90% after deductible	90% after deductible
MENTAL HEALTH CARE/SUBSTANCE ABUSE CARE	**In-Network**	**Out-of-Network**
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	**In-Network**	**Out-of-Network**
Durable Medical Equipment	90% after deductible	70% after deductible
Skilled Nursing Facility	120 days per benefit period. Benefits renew after 180 days without care	120 days per benefit period. Benefits renew after 180 days without care
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*****	**In-Network**	**Out-of-Network**
	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******	**In-Network**	**Out-of-Network**
	90% after deductible if "Blue Distinction Center for Bariatric Surgery" is used; 75% after deductible if an authorized hospital/surgical center is used	55% after deductible

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.***
******All Infertility Services and Bariatric Surgery services are excluded from Out-of-pocket maximums.***
Please note: Existing contracts and law supersede any discrepancies in this brief benefits overview.

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 - Hospital	$100 copay	$100 copay
Prenatal and Postnatal Care	100% after $25 initial copay (inpatient room and board copays do apply to hospital deliveries/birthing centers)	100% after $25 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	$15 copay	$15 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	$25 copay per visit	$15 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	Lessor of either $15 copay or 20% of the allowable charge	20% of the allowable charges for up to 60 consecutive days per condition
Allergy Testing/Allergy Treatment	$25 copay per visit (allergy testing)/ $5 copay per visit (allergy treatment)	$25 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* **	Non-Hospital (Freestanding) Based Facilities: $0 copay per visit Hospital Based Facilities: $35 copay per visit	Non-Hospital (Freestanding) Based Facilities: $0 copay per visit Hospital Based Facilities: $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.***
*****All Infertility Services and Bariatric Surgery services are excluded from Out-of-pocket maximums.***

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.

AETNA

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**	**$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**	**Out-of-Network**
Inpatient Acute/Partial Hospitalization	90% after deductible	70% after deductible
Outpatient	90% after deductible	70% after deductible
OTHER SERVICES	**In-Network**	**Out-of-Network**
Durable Medical Equipment	90% after deductible	70% after deductible
Skilled Nursing Facility	90% after deductible for up to 120 days per confinement	70% after deductible for up to 120 days per confinement
Emergency Ambulance	90% after deductible	70% after deductible
Physician Home/Office Visits (non-routine)	90% after deductible	70% after deductible
Specialist Care	90% after deductible	70% after deductible
Chiropractic Care	90% after deductible for up to 30 visits per plan year	75% after deductible for up to 30 visits per plan year
Allergy Testing/Allergy Treatment	90% after deductible	70% after deductible
X-Ray, MRI's , CT Scans, PET Scans*, Lab & Other Diagnostic Services**	90% after deductible	70% after deductible
Short-Term Therapies: Physical, Speech, Occupational	90% after deductible	70% after deductible
Annual GYN Exam/Pap Smear	100% 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**	**Out-of-Network**
	75% covered; $10,000 lifetime maximum for medical services 75% covered; $15,000 lifetime maximum for prescription service	55% covered; $10,000 lifetime maximum for medical services 55% covered; $15,000 lifetime maximum for prescription service
BARIATRIC SURGERY******	**In-Network**	**Out-of-Network**
	90% after deductible if "Institute of Excellence for Bariatric Surgery" is used; 75% after deductible if an authorized hospital/surgical center is used.	55% after deductible

Once the Family Deductible Limit is met, all family members will be considered as having met their deductible.
****Out-of-pocket maximums apply to each 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.***
******All Infertility Services and Bariatric Surgery services are excluded from Out-of-pocket maximums.***
Please note: Existing contracts and law supersede any discrepancies in this brief benefits overview.

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.

HIGHMARK DELAWARE

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**	**$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**	**Out-of-Network**
Inpatient Acute/Partial Hospitalization	90% after deductible	70% after deductible
Outpatient	90% after deductible	70% after deductible
OTHER SERVICES	**In-Network**	**Out-of-Network**
Durable Medical Equipment	90% after deductible	70% after deductible
Skilled Nursing Facility	120 days per benefit period. Benefits renew after 180 days without care	120 days per benefit period. Benefits renew after 180 days without care
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**	**Out-of-Network**
	75% covered; $10,000 lifetime maximum for medical services 75% covered; $15,000 lifetime maximum for prescription service	55% covered; $10,000 lifetime maximum for medical services 55% covered; $15,000 lifetime maximum for prescription service
BARIATRIC SURGERY******	**In-Network**	**Out-of-Network**
	90% after deductible if "Blue Distinction Center for Bariatric Surgery" is used; 75% after deductible if an authorized hospital/surgical center is used	55% after deductible

Once the Family Deductible Limit is met, all family members will be considered as having met their deductible.
****Out-of-pocket maximums apply to each 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.***
******All Infertility Services and Bariatric Surgery services are excluded from Out-of-pocket maximums.***
Please note: Existing contracts and law supersede any discrepancies in this brief benefits overview.

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-Pocket Max: $4,500/$9,000	Out-of-Network Benefits Deductible: $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 Services	$50 Ambulatory; $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	$20 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	**In-Network**	**Out-of-Network**
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	**In-Network**	**Out-of-Network**
Durable Medical Equipment	100%	80% after deductible
Skilled Nursing Facility	120 days per benefit period. Benefits renew after 180 days without care	120 days per benefit period. Benefits renew after 180 days without care
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: $30 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 per visit; MRI's, CT Scans and PET Scans: Non-Hospital (Freestanding) Based Facilities: $0 copay per visit Hospital Based Facilities: $35 copay per visit	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***	**In-Network**	**Out-of-Network**
	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***	**In-Network**	**Out-of-Network**
	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.***
******All Infertility Services and Bariatric Surgery services are excluded from Out-of-pocket maximums.***
Please note: Existing contracts and law supersede any discrepancies in this brief benefits overview.

HEALTH PLAN RATES EFFECTIVE JULY 1, 2016

	Total Monthly Rate	State Pays	Employee/Pensioner Contributions
Highmark First State Basic Plan *(includes prescription drug coverage at the same level as all other plans)* *Administered by Highmark Delaware*			
Employee/Pensioner	$695.36	$667.52	$27.84
Employee/Pensioner & Spouse	$1,438.68	$1,381.16	$57.52
Employee/Pensioner & Child(ren)	$1,057.02	$1,014.76	$42.26
Family	$1,798.42	$1,726.50	$71.92
Aetna CDH Gold *Administered by Aetna*			
Employee/Pensioner	$719.68	$683.70	$35.98
Employee/Pensioner & Spouse	$1,492.22	$1,417.64	$74.58
Employee/Pensioner & Child(ren)	$1,099.56	$1,044.60	$54.96
Family	$1,895.74	$1,800.96	$94.78
Highmark CDH Gold *Administered by Highmark Delaware*			
Employee/Pensioner	$719.68	$683.70	$35.98
Employee/Pensioner & Spouse	$1,492.22	$1,417.64	$74.58
Employee/Pensioner & Child(ren)	$1,099.56	$1,044.60	$54.96
Family	$1,895.74	$1,800.96	$94.78
Aetna HMO *Administered by Aetna*			
Employee/Pensioner	$725.94	$678.78	$47.16
Employee/Pensioner & Spouse	$1,530.58	$1,431.08	$99.50
Employee/Pensioner & Child(ren)	$1,110.52	$1,038.34	$72.18
Family	$1,909.82	$1,785.70	$124.12
Highmark Delaware IPA/HMO *Administered by Highmark Delaware*			
Employee/Pensioner	$726.52	$679.34	$47.18
Employee/Pensioner & Spouse	$1,535.42	$1,435.62	$99.80
Employee/Pensioner & Child(ren)	$1,111.64	$1,039.38	$72.26
Family	$1,915.68	$1,791.16	$124.52
Highmark Delaware Comprehensive PPO Plan *Administered by Highmark Delaware*			
Employee/Pensioner	$793.86	$688.68	$105.18
Employee/Pensioner & Spouse	$1,647.34	$1,429.08	$218.26
Employee/Pensioner & Child(ren)	$1,223.46	$1,061.38	$162.08
Family	$2,059.40	$1,786.54	$272.86

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.

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 Group Health Insurance Plan (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

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 Open 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%

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 Open Enrollment period available in October 2016 for calendar year 2017**.

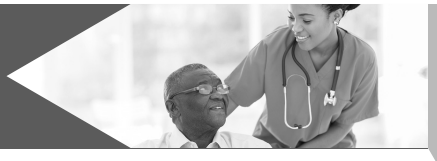
This plan supplements Medicare. Unless otherwise indicated on the Benefit Highlights pages included in this booklet, benefits will be paid as noted only after Medicare pays its full amount.

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

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 preventive medications covered under your prescription drug plan include:

- Aspirin
- 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 "How Can I Save On Costs?" to see Preventive Medications & Services.

NONCOVERED MEDICATIONS:

Erectile dysfunction medications are not 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

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

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.

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, visit www.ben.omb.delaware.gov/script/planinfo.shtml under **Benefit Descriptions > "How Can I Save On Costs?"**

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 a 90-day retail pharmacy that participates in the Express Scripts Network. To verify coverage at a particular pharmacy, check the Express Scripts website www.Express-Scripts.com or call 1-800-939-2142. For more information visit the Statewide Benefits website at www.ben.omb.delaware.gov/script/planinfo.shtml.
2. Through the Express Scripts Pharmacy (home delivery):
   - To get started go to the Express Scripts website www.Express-Scripts.com or call 1-800-939-2142 to speak with an Express Scripts Member Services representative.
   - If enrolled in Medicare call 1-877-680-4883 to speak with an Express Scripts Medicare 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. 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.

Dela*WELL* HEALTH MANAGEMENT PROGRAM OVERVIEW

All of your health, medical and wellness programs, services and information 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. 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 2016-2017 Dela***WELL*** 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 Dela***WELL*** Health Management Program is an effective way to help control health care costs for the State of Delaware and its members.

Call To Action

The State of Delaware is encouraging employees who are enrolled in either a Highmark Delaware Non-Medicare Plan or Aetna Plan to complete these two simple steps:

1. **Schedule and attend your Annual Physical Exam**
   Most preventive care is covered 100% (no charge to you). 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. **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.

Look for additional information on the services and programs offered through Highmark Delaware and Aetna on the next few pages of this booklet.

For complete details on the Dela***WELL*** Health Management Program, visit **www.ben.omb.delaware.gov/dela*well***.

Here you will find information on gym and wellness discounts, health 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.

Check out the **New Consumerism Resource Link** (**www.ben.omb.delaware.gov/consumerism**) for additional wellness/disease management information and resources.

WELLNESS AND DISEASE MANAGEMENT BENEFITS PROVIDED BY HIGHMARK DELAWARE

DelaWELL
Placing Delaware at the Forefront of Wellness

REGISTER ON THE HIGHMARK DELAWARE MEMBER WEBSITE

Being a wise health care consumer, involves registering on the Highmark Delaware member website. What's in it for you? Simply put, it makes it easy to manage your health and your health care coverage:

- View claims and know how much to pay
- View your explanation of benefits (EOB)
- Get cost estimates on common health care procedures and surgeries
- Find network doctors and other providers
- Get online discounts
- Use health, wellness and disease management resources

If you haven't done so yet, register today!

1. Go to the Highmark Delaware member website - **www.highmarkbcbsde.com**.
2. Click on "Register" and complete the steps.
3. Once registered on the Highmark Delaware member website, you can also access your **Highmark Delaware Account via Single Sign-On (SSO)*** in **Employee Self-Service (ESS)**: **www.employeeselfservice.omb.delaware.gov**. In Employee Self-Service, follow the navigation: Main Menu > Self Service > Benefits > Highmark Delaware. (Access through Employee Self-Service is available 24 hours after initial registration on the Highmark Delaware member website.)

View the Registration/SSO Frequently Asked Questions at http://ben.omb.delaware.gov/medical/bcbs/index.shtml.

*Benefit-eligible State, school district, charter school and higher education employees (with the exception of the University of Delaware) who are enrolled in a State of Delaware health plan administered by Highmark Delaware can access their Highmark Delaware Account via SSO in ESS. In instances where both spouses are state employees, only the employee who holds the coverage (policy/contract holder) can access SSO. Spouses are still encouraged to register on the Highmark Delaware member website and access their online tools and resources.

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, 2016:

4. **ANNUAL PHYSICAL EXAM:** Most preventive care is covered 100%. 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.**
5. **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 Call℠ Health Coaches 24 hours a day/7days a week, along with your member website **www.highmarkbcbsde.com**.

HIGHMARK® Delaware

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?

DelaWELL
Placing Delaware at the Forefront of Wellness

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.

HIGHMARK Delaware

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

DelaWELL
Placing Delaware at the Forefront of Wellness

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, 2016:

1. **ANNUAL PHYSICAL EXAM** (Well-Adult Exam or Well-Woman Exam)**:** Most preventive care is covered at 100%. 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.

aetna℠

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.

aetna℠

EMPLOYEE ASSISTANCE PROGRAM (EAP) + WORK/LIFE PROGRAM

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. Parents and parents-in-law are 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 ***Members for Lif***e 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 ***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** between May 9, 2016 and May 26, 2016.

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 no later than May 26, 2016.

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.

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.

DELTA DENTAL AND DOMINION DENTAL SERVICES ADMINISTER THE STATE'S DENTAL PROGRAMS

What's NEW beginning July 1, 2016:

- Dental implants will be a covered benefit. Dental implants are an alternative to dentures and bridges to replace natural teeth and roots. However, not everyone is a candidate for an implant. Talk with your dentist to discuss your options and request a pre-treatment estimate.
- Under the Delta Dental PPO plan coverage is subject to applicable deductible, coinsurance and annual maximum limitations. Coverage under the Dominion Dental Select Plan is subject to applicable copayments.

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.

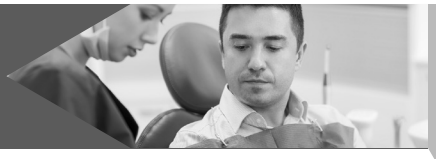
Delta Dental has the largest network of participating dentists in Delaware and the United States. Your Delta Dental program gives you access to two Delta Dental dentist networks at once that offer different degrees of savings. You can choose a dentist from the larger Delta Dental Premier® network or 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	$1,500	$1,500	$1,500
Plan Allowance	$900	$1,100	$1,350
Coinsurance Amount	50%	50%	50%
Plan Payment	$450	$550	$675
PATIENT PAYMENT	$450 ($900 - $450 =)	$550 ($1,100 - $550 =)	$825 ($1,500 - $675 =)

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.



DOMINION DENTAL SELECT PLAN (SAME AS A DHMO)

Dental Plan 705xsd

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 705xsd
Office Visit Copayment	$10
Deductibles	None
Maximum Annual Limit	No Limit
Maximum Lifetime Ortho	No Limit
Claim Forms	None
Benefits	Scheduled (Fixed Fees)
Pre-existing Condition	None
Waiting Periods	None

No Charge[1] For

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

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

- Dominion's Prevention Rewards program will pay subscribers $20 for each family member who gets two cleanings during the plan year between (7/1/16 and 9/1/17).
- Simply complete a brief member satisfaction survey (more information coming soon) and Dominion will send you a check upon confirmation of your cleanings.
- Dominion's Select Plan covers an extra cleaning for diabetics and expectant mothers.

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

State of DE Employees Enrolled With Dominion…
- Received an average of $1.35 in value for every $1.00 spent on dental premium[2]
- 99% of survey respondents rated the treatment by their dentist "Satisfactory to Excellent[4]"

[1] There is a $10 office visit fee.
[2] Dominion Dental Services, Inc. - based on annual review of utilization data.
[3] Based on the Healthcare 4U context fee schedule's 80th %ile fee information.
[4] Dominion Dental Services, Inc. Member Satisfaction Survey, 2015

Additional information can be viewed at www.ben.omb.delaware.gov/dental/dom or by calling Dominion's Customer Service at 1-888-518-5338.

DENTAL PLAN RATES

	Total Monthly Rate	State Pays	Employee/Pensioner Pays
Dominion Dental HMO *Administered by Dominion Dental*			
Employee/Pensioner	$24.52	$0.00	$24.52
Employee/Pensioner & Spouse	$45.62	$0.00	$45.62
Employee/Pensioner & Child(ren)	$49.16	$0.00	$49.16
Family	$66.76	$0.00	$66.76
Delta Dental PPO Plus Premier *Administered by Delta Dental*			
Employee/Pensioner	$35.86	$0.00	$35.86
Employee/Pensioner & Spouse	$73.18	$0.00	$73.18
Employee/Pensioner & Child(ren)	$71.84	$0.00	$71.84
Family	$119.88	$0.00	$119.88

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.

AVAILABLE NOW:

EyeMed members have access to hearing care discounts through Amplifon

- The discounts include: 40% off hearing exams at thousands of convenient locations nationwide, discounted set pricing on thousands of hearing aids, free batteries for 2 years with initial purchase and more. Call 1-844-526-5432 to find out more about their discount program.
- **The hearing discounts are effective now for all current members, as well as, for those enrolling during the open enrollment period.**

What's NEW beginning July 1, 2016

- The EyeMed Network for State of Delaware members will change from EyeMed's Access Network to EyeMed's **Insight Network**. We encourage members to review providers to ensure their preferred provider participates in the **Insight Network**. You can do this by calling your provider, by logging into www.eyemed.com and choosing the I**nsight Network** on EyeMed's provider locator or by calling EyeMed at 1-855-259-0490.
- The in-network out-of-pocket cost will remain the same, however, if members utilize the exam benefit at an out-of-network provider you will be reimbursed $30 rather than $35.
- State of Delaware EyeMed members will have a "new and improved" frequency schedule for services.
  - Frequency: From "date of service" to "**plan year**"
    - Examination, frame, vision therapy evaluation, lenses or contact lenses = One time per **plan year**
    - Diabetic services = Two times during the **plan year** (once every six months)
    - Vision Therapy = Up to 10 visits per **plan year**
- Check out more information on the EyeMed plan by visiting the Statewide Benefits website www.ben.omb.delaware.gov/vision.
- From **July 1, 2016** through **December 31, 2016** members get **exclusive savings on sunglasses from Sunglass Hut**. Sign up at www.eyemedvisioncare.com/sunperks within the timeframe noted. You'll immediately receive an email with a savings code. Use the savings code at Sunglass Hut locations or at www.sunglasshut.com. **The benefit only applies for the period of July 1, 2016 through December 31, 2016.**

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.

ABOUT YOUR VISION COVERAGE

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 anti-reflective (Tier 1)	$97	$57
Premium progressive lenses (Tier 2)	$230	$115
Total Cost	$575	$182

Yearly subscriber premiums*	**$77.52**
Your total expense	**$259.52**
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.eyemed.com and choose the **INSIGHT Network**, or call 1-855-259-0490. For LASIK providers, call 1-877-552-7376.

TOTAL MONTHLY RATES FOR EYEMED VISION PLAN:

Plan	Rate
Employee/Pensioner	$6.46
Employee/Pensioner + Spouse	$10.20
Employee/Pensioner + Children	$10.40
Family	$16.78

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***

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

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.eyemed.com
And click the Members tab.

MINNESOTA LIFE IS NOW SECURIAN FOR GROUP UNIVERSAL LIFE (GUL) INSURANCE

As of March 1, 2016, Minnesota Life, the provider of the State of Delaware's Group Universal Life (GUL) Insurance Program, adopted the brand of its parent company, Securian Financial Group, Inc. (Securian). Please note that "Minnesota Life Insurance Company" will continue to be the underwriter for the program and will be noted as such. Although you will see the new brand reflected in the materials you receive and on the SBO website (www.ben.omb.delaware.gov/life), you will not see any changes to your group life insurance coverage or premium rates as a result of this change.

What is Group Universal Life (GUL) Insurance?

Visit "Ellie", your Interactive Benefits Guide, to learn more about the GUL program. Every person has a different need when it comes to insurance protection. 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.

What coverage options are available to current and newly hired eligible employees?

Benefit eligible active State of Delaware and DSWA employees may purchase one to six times base annual salary up to $350,000. During your initial 90 calendar day eligibility period, newly hired benefit eligible active State of Delaware and DSWA employees may purchase one, two or three times annual base pay up to $200,000 without providing proof of good health to Securian or you may purchase four, five or six times annual base pay up to $350,000 with proof of good health to Securian. Your GUL and Accidental Death & Dismemberment (AD&D) coverage will be based on your "Highest Ever Salary". This means that if in the future, your base annual salary increases, your coverage will automatically be increased appropriately up to $350,000. Eligible employees purchasing the maximum guaranteed issue of $200,000 are not eligible for automatic coverage increases as a result of salary changes. Subsequently, if your base annual salary decreases (i.e., you change your position from full-time to part-time), your GUL and AD&D (for more information on AD&D visit www.ben.omb.delaware.gov/life) coverage amount will not decrease.

Enrollment in the GUL program is open throughout the year! Benefit eligible active State of Delaware and DSWA employees who have exhausted their initial eligibility period may apply at any time for enrollment in the program or change their current enrollment elections by simply applying and providing proof of good health to Securian.

How much does it cost?

Monthly rates as of July 1, 2015 for benefit eligible active employees.

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 Rates

Employees have the following Dependent Term Life options and costs to select from:

Spouse: $20,000 / $7.05 per month
Spouse: $10,000 / $3.08 per month

Child: $10,000 for each eligible child / $1.16 per month
(One rate covers all eligible children)

Spouse & Child: $20,000 (spouse) / $8.21 per month
Spouse & Child: $10,000 (spouse) / $4.24 per month

Ported (Terminated or Retired) GUL Enrollees may reduce their coverage amount.

MINNESOTA LIFE IS NOW SECURIAN FOR GROUP UNIVERSAL LIFE (GUL) INSURANCE

Does my GUL policy accrue cash value?

If you are enrolled in the GUL program, you have the option to make additional premium contributions that grow tax-deferred in a cash accumulation account. All additional premium contributions are deducted from your paycheck along with your premium for the cost of your life insurance protection. Each contribution made to your cash accumulation account is assessed a one-time administration charge of three percent. After that, your contribution earns a fixed rate of return, guaranteed not to fall below four percent. Any cash accumulated in your policy will pass on to your beneficiary (ies) income-tax free at your death. If you have contributed to the cash accumulation account and accumulated cash value, you may access your funds by withdrawal or loan, which will reduce the policy's total death benefit.

How do I enroll online and/or make coverage changes?

Benefit eligible active State of Delaware and DSWA employees increasing coverage or enrolling for the first time, or Ported (Terminated or Retired) GUL enrollees decreasing coverage amounts, should follow the steps located at **www.ben.omb.delaware.gov/life**.

Note: Benefit eligible active State of Delaware employees can access the Securian website using Single Sign-On through Employee Self Service (ESS) - www.employeeselfservice.omb.delaware.gov. Once logged in, follow the navigation to the
Securian website: Main Menu > Self Service > Benefits > Securian GUL.

AC^G | ACCIDENT

Accidents happen to all kinds of people every day.

38 million people – about 1 out of 8 – sought medical attention for an injury in 2012.*

What would the financial impact of an injury mean to you? Are you prepared for high medical costs in addition to everyday household expenditures and lost wages? Out-of-pocket expenses associated with an accident are unexpected, but an accident's impact on your finances and your well-being certainly can be reduced.

Aflac is here to help. If you have an accident, major medical insurance will help with many medical expenses, but you could be left with out-of-pocket expenses. You could also lose pay while you're out of work. And you can be sure that the bills will keep coming.

IT'S INSURANCE FOR DAILY LIVING:

Aflac pays cash benefits directly to you, unless otherwise assigned. This means that you will have added financial resources to help with medical costs or ongoing living expenses. Aflac group accident insurance plans** are designed to provide you with cash benefits throughout the different stages of care, such as the following:

- Emergency treatment
- Hospital admission
- Intensive care unit
- Ambulance transportation
- Travel expenses to distant treatment centers
- Everyday living expenses, like your rent or mortgage, utility bills, groceries, and more

ENROLL TODAY

To enroll visit: https://delaware.hrintouch.com

For more information visit: http://ben.omb.delaware.gov/aflac-supplemental-benefits.shtml

Aflac.

Injury Facts, 2014 Edition, National Safety Council.

**This is a brief product overview only. The plan has limitations and exclusions that may affect benefits payable. Refer to the plan for complete details, limitations, and exclusions.

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups sitused in California, group coverage is underwritten by Continental American Life Insurance Company. For groups sitused in New York, coverage is underwritten by American Family Life Assurance Company of New York.

Continental American Insurance Company • Columbia, South Carolina

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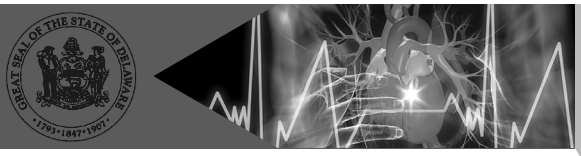


CI^G | CRITICAL ILLNESS

About 1 in every 6 healthcare dollars is spent on cardiovascular disease.*

Chances are you know someone who's been diagnosed with a critical illness such as cancer, a heart attack (myocardial infarction), or stroke. 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 on that person's personal finances. While the person is busy getting well, the bills may continue to pile up.

WOULD YOU HAVE THE MONEY TO COVER THE OUT-OF-POCKET EXPENSES SUCH AS:

- Transportation to a distant medical facility.
- Specialized treatment costs.
- Living expenses like rent, mortgage, and utility bills.

IT'S INSURANCE FOR DAILY LIVING:

Aflac pays cash benefits directly to you, unless otherwise assigned. This means that you will have added financial resources to help with medical costs or ongoing living expenses. Aflac group critical illness insurance plans** are designed to provide you with cash benefits, such as the following:

- Pays a lump sum benefit for a covered critical illness: cancer, heart attack, and stroke.

ENROLL TODAY

To enroll visit: https://delaware.hrintouch.com

For more information visit: http://ben.omb.delaware.gov/aflac-supplemental-benefits.shtml

Aflac®

*Business Pulse, Heart Health Infographic, 2016 CDC Foundation

**This is a brief product overview only. The plan has limitations and exclusions that may effect benefits payable. Refer to the plan for complete details, limitations, and exclusions.

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups sitused in California, group coverage is underwritten by Continental American Life Insurance Company. For groups sitused in New York, coverage is underwritten by American Family Life Assurance Company of New York.

AGC1600417 R1 Continental American Insurance Company • Columbia, South Carolina IV (4/16)

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

Did you know financial planning experts estimate a retiree may need as much as 80-100% of their current employment income to meet their needs in retirement? Your pension and social security payments may not be enough. The State of Delaware offers two retirement plans to help you prepare to be retirement ready.

State of Delaware employees that are full time and pension eligible can contribute to a 457(b) Deferred Compensation Plan. All public school district employees as well as employees of the Department of Education, Delaware Tech C.C., and Delaware State University can also contribute to the State of Delaware's 403(b) plan. Both plans allow for pre-tax contributions that grow tax deferred as well as after tax Roth contributions that grow tax free.*

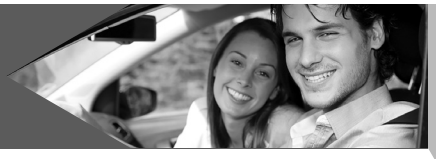
For a list of approved vendors and other important information regarding the plans please visit **http://treasurer.delaware.gov/deferred_compensation/**.

Enrollment is easy and open all year. The State's open enrollment period is a great time to start saving or to re-evaluate your current contribution amount. Are you retirement ready?

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 2016 (IRS may increase or decrease limit each year)	$18,000 in 2016 (IRS may increase or decrease limit each year)
Age 50 and over Catch-up Limits	$6,000 in 2016 (IRS may increase or decrease limit each year)	$6,000 in 2016 (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 2016	No
Match Plan	$10 per pay after 6 months of participation (Currently Suspended)	No
Roth Contributions	Yes	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)
Enroll or Make Changes	**www.fidelity.com/atwork**	**www.myretirementmanager.com/?delaware**

* Please consult your tax or investment professional to determine which plan is right for your personal goals and objectives.



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 be found at **www.ben.omb.delaware.gov/documents/cob.**

The Spousal Coordination of Benefits Policy Form **MUST** be completed each year during Open Enrollment and anytime your spouse's employment or insurance status changes, 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. You will be contacted if additional documentation regarding your spouse's coverage is required.

- 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, the spouse who carries the benefits **MUST** complete a new Spousal Coordination of Benefits form each year during Open Enrollment. 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 or provide additional documentation when required 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** no later than May 26, 2016.
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** no later than May 26, 2016.

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 you and your spouse have chosen to be enrolled in separate DSS contracts, you will both be charged $25 per month. 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 for Double State Share must make changes to their enrollment by logging onto eBenefits at http://www.employeeselfservice.omb.delaware.gov/ from May 9 to May 26, 2016 and making the appropriate changes. If you do not remember your password, click on Self-Service User Account Assistance on the left and submit an online request to reset your password.

Pensioners eligible for Double State Share and enrolled through the Office of Pensions 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	• Spouse's employment termination
• Marriage/Civil Union	• Child now eligible for coverage
• Divorce	• Death of a spouse or dependent
• Employment of spouse	• Spouse becomes a State of Delaware employee
• Involuntary loss of spouse coverage	

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, Social Security numbers, 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 http://ben.omb.delaware.gov/policies-procedures.shtml.

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 an adult 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 adult 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 an adult 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 adult dependent child as secondary.
- A Dependent Coordination of Benefits form must be submitted to the health plan carrier to determine which coverage will process first.

During Open Enrollment from May 9, 2016 to May 26, 2016, active State employees can enroll their dependents online through eBenefits.

- **State pensioners** should complete the necessary applications to enroll their dependent children and forward to the Pension Office no later than May 26, 2016.
- **Participating group members** should submit the appropriate applications to their Human Resource Office no later than May 26, 2016.
- **COBRA participants** should submit the appropriate applications to the Statewide Benefits Office no later than May 26, 2016.

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, including the appropriate Aetna and Highmark Delaware forms and instructions for submitting to the carrier, 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, 2016, and were revised as of March 1, 2016.
- Questions regarding these notices can be addressed to the Statewide Benefits Office at 1-800-489-8933 or at www.ben.omb.delaware.gov, or questions may be directed to additional contacts identified in the various notices.

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

Notice of Special Enrollment Rights

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

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

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

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

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

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.

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

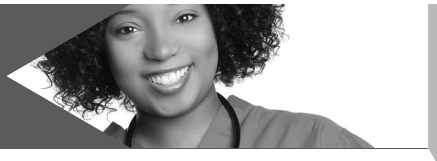
These plans comprise what is called an "Affiliated Covered Entity," and are treated as a single plan for purposes of this Notice and the privacy rules that require it. For purposes of this Notice, we'll refer to these plans as a single "Plan."

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, described below).

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.

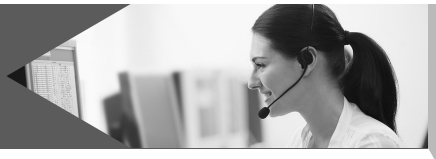
- **Uses and Disclosures Requiring You to have an Opportunity to Object:** The Plan may share PHI with your family, close personal friend or any other person you identify, without your written authorization, if that person is involved in your care and the information is relevant to your care. If the 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 below). If you have any complaints about the Plan's privacy practices or handling of your PHI, please contact the Plan's Privacy Official (see below).

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:

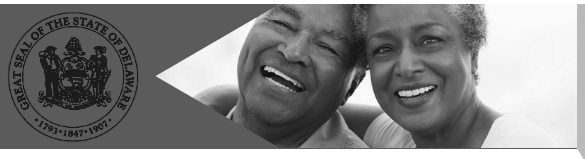
Human Resources Specialists, Statewide Benefits Unit, OMB (302) 739-8331
Information Systems Manager, PHRST (302) 739-2260
Human Resources Manager, PHRST Benefits (302) 739-2260

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. The open enrollment period for the Express Scripts Medicare PDP for the State of Delaware is usually 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).

MARK YOUR CALENDAR TO ATTEND A HEALTH FAIR!

To learn more about the programs and benefits available and to receive personalized assistance in helping you choose the best benefit plans for you and your family, plan to attend a benefit health fair scheduled at various site locations in each county. Health Fair dates and location information are listed below. Attend one of the fairs and be placed in a random drawing to **win a Special Prize Basket!**

Date	Event Time	Location	Address
New Castle County			
Tuesday, May 10, 2016	11 am - 6 pm	Delaware Technical Community College, **Stanton Campus** Conference Rooms A114 & A116	400 Stanton - Christiana Road Newark, DE 19713 **Directions:** https://www.dtcc.edu/our-campuses/stanton/directions
Wednesday, May 18, 2016	10 am - 2 pm	Carvel State Building 2nd Floor Mezzanine (Elevator is accessible)	820 N. French Street Wilmington, DE 19801 **Directions:** http://www.delawarepersonnel.com/admin/office/locations.shtml
Kent County			
Tuesday, May 17, 2016	11 am - 6 pm	Duncan Center 5th Floor Outlook Conference Center	500 W. Loockerman Street Dover, DE 19904 **Directions:** Google: The Duncan Center Dover DE
Sussex County			
Wednesday, May 11, 2016	10 am - 2 pm	Delaware Technical Community College, **Owens Campus** Carter Partnership Center Rooms 540 A-H	RT 18 21179 College Drive Georgetown, DE 19947 **Directions:** https://www.dtcc.edu/our-campuses/georgetown/directions

PHONE NUMBERS AND WEBSITES

Company Name	Phone Number	Website
Aetna	1-877-542-3862	www.aetna.com
Highmark Delaware	1-800-633-2563 (Note new number effective 6/15/2016: 1-844-459-6452)	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.eyemed.com
Delta Dental	1-800-873-4165	www.deltadentalins.com
Dominion Dental Services	1-888-518-5338	www.dominiondental.com/stateofdelaware
Blood Bank of Delmarva	302-737-8400 for Donor Scheduling, 302-737-8405 for General / Main # or 1-888-825-6638	www.delmarvablood.org
CONEXIS (A Division of WageWorks, Inc.) COBRA Administration	1-877-864-9546	https://cobrabenefits.wageworks.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
• **Resource Link - Being A Wise Health Care Consumer**		www.ben.omb.delaware.gov/consumerism/index.shtml
• **Get Connected - Check out the Mobile Apps page**		www.ben.omb.delaware.gov/mobile-apps.shtml
Aflac	1-800-433-3036	www.delaware.hrintouch.com
Securian	1-877-215-1489	www.LifeBenefits.com

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