Open Enrollment for DOE, K12 (School District and Charter School), DTCC & DSU Employees: May 1 - 13, 2017
Frequently Asked Questions (FAQs)

Please note:

- **This document was last updated on April 20, 2017. Please continue to check back for updates.**
- **Please read the "Important Background Information" document before viewing these FAQs**

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Pre-Open Enrollment To-Do's

(1) What should benefit-eligible employees do before Open Enrollment to ensure they are ready?

Prior to Open Enrollment, all benefit-eligible employees are *strongly encouraged* to access **Employee Self-Service (http://employeeselfservice.omb.delaware.gov/)** and complete the following steps to ensure you are ready:

Important:* *Have questions regarding Employee Self-Service navigation or password resets? Please email ePay_Security@state.de.us or call 1-866-751-7833. If leaving a message or sending an email, please include the following information: Full Name; Employee ID Number; Telephone Number; State Email Address; and Last four digits of your social security number.

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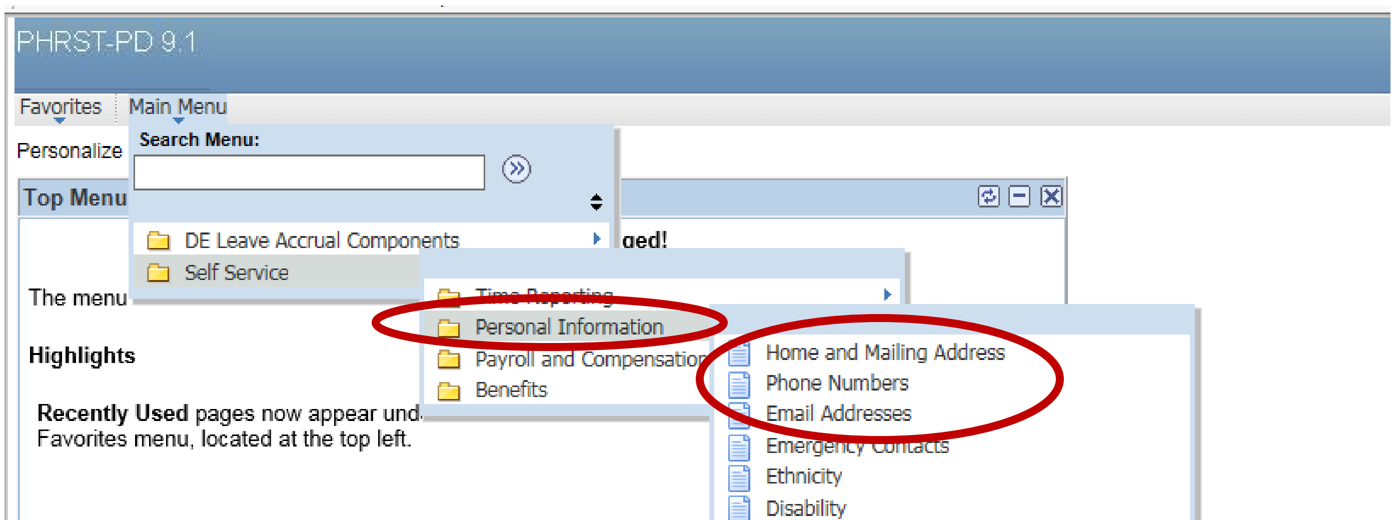
1. Make sure you can **Sign In**.
   - Check out the Employee Self-Service Assistance page (**http://employeeselfservice.omb.delaware.gov/**) for helpful tips and resources, including:
     - Accessing Delaware Single Sign-On
     - Employee Self-Service Features
     - First Time User to Delaware Single Sign-On
     - Forgot User ID/Forgot Password
     - Changing Password & Challenge Questions & Answers
     - Frequently Asked Questions
       - Browser Support – **Check to make sure your internet browser is supported by Delaware Single Sign-On.**
       - Contact Information
       - And more…

2. View your **Personal Information** (i.e., phone numbers, home and mailing addresses, etc.) to ensure all information is correct - Make updates as necessary. Having correct contact information is necessary in order for you to receive important materials like ID cards and outreach from your benefit plan providers.



3. Receive your Open Enrollment packet materials online next year rather than through U.S. mail by **consenting** in Employee Self-Service at http://www.employeeselfservice.omb.delaware.gov/.
   (Navigation: Main Menu > Self-Service > Benefits > Benefits Notices Consent)
   Viewing these documents online is convenient, reduces unnecessary paper and saves money in printing and postage. In 2016, the State of Delaware spent **over $100,000** on member packet mailings for Open Enrollment. *Please note:* Employees only need to consent **one time**. No action is required if you have already consented (anytime from 2015 through current date), as your consent will remain in effect and apply to all future benefits information released by the Statewide Benefits Office unless you withdraw

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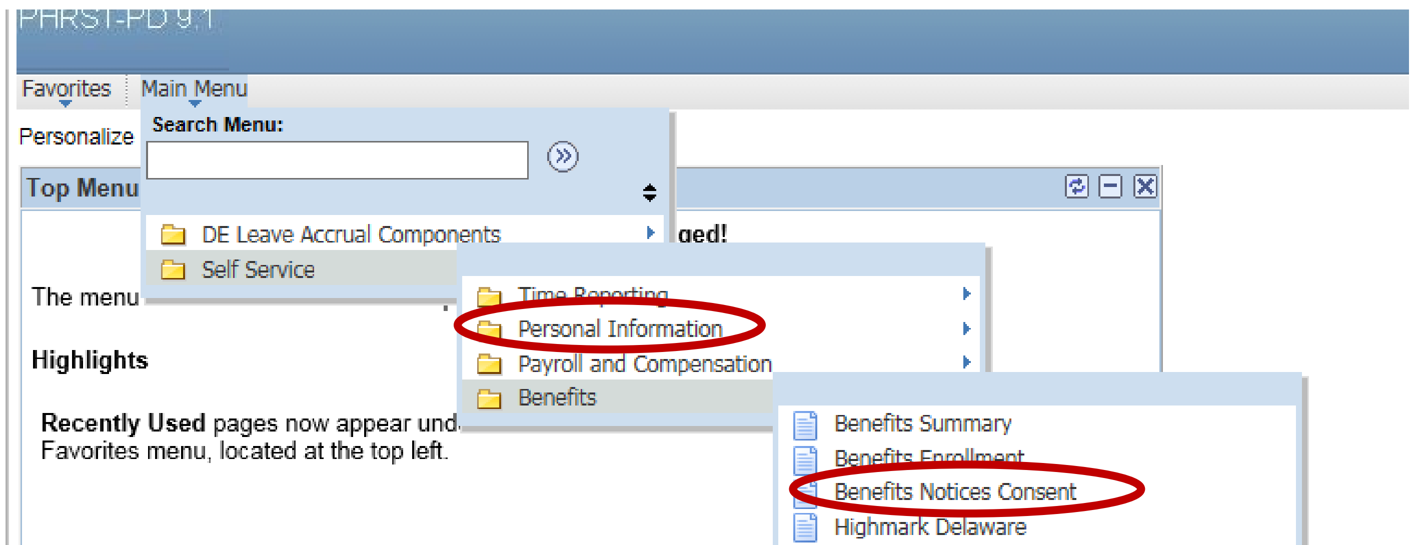
your consent to receive benefits information online.



(2) Who do employees contact with questions regarding Employee Self-Service navigation or password resets?

Please email **ePay_Security@state.de.us** or call 1-866-751-7833. If leaving a message or sending an email, please include the following information: Full Name; Employee ID Number; Telephone Number; State Email Address; and Last four digits of your social security number.

(3) How will benefit-eligible employees who consent to receive their benefits information, Open Enrollment materials and notices online be made aware that the information is available for viewing?

The Statewide Benefits Office will notify benefit-eligible employees via email through an SBO e-Newsletter when the materials are ready for viewing online. Employees must have State of Delaware email access in order to receive the SBO e-Newsletter. HR/Benefit Representatives and Managers should work within their organizations to send SBO e-Newsletters out to those benefit-eligible employees **without** email access.

(4) How long do employees have to consent in Employee Self-Service to receive their 2017 Open Enrollment packet materials and other benefits information online?

Benefit-eligible employees who consented to receive benefits information online by March 15, 2017, will not receive the 2017 Open Enrollment packet materials (i.e., rate sheet, list of health fairs and annual notices) through U.S. mail. Instead, these employees will receive an email notification when the 2017 Open Enrollment information and notices are available online. Employees who consent after March 15, 2017 will receive the 2017 Open Enrollment packet materials (i.e., rate sheet, list of health fairs and annual notices) through U.S. mail; however, all other future benefits information will be provided to the employees online through an email notification.

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(5) What do employees need to do in order to make sure they receive a confirmation email that their consent notice was received?
In order to receive a confirmation email that your consent notice was received by Statewide Benefits, please be sure to check that your email address is up-to-date and listed in Employee Self-Service (Main Menu → Self-Service → Personal Information → Email Addresses) prior to submitting your consent. If there is not one listed, you can select "Add Email Address", enter your email address and designate a Preferred email.

(6) What things do employees need (i.e., computer hardware, software, etc.) in order to access and retain the materials electronically?
To access your notices and other benefits information, you will need a valid e-mail address, a personal computer or other device that is capable of accessing the Internet and Adobe Acrobat Reader. If you wish to retain or save your notices, your access device must have the ability to download to your hard drive, or any external media storage, or to print the notices.

(7) What happens if employees change their mind after they complete the consent?
Benefit-eligible employees can access Employee Self-Service at http://employeeselfservice.omb.delaware.gov/ at any time to withdraw their consent to receive benefits information online.

New Features

(8) Why are the Highmark IPA/HMO and Highmark CDH Gold Plans no longer available as of July 1, 2017?
In December 2016, the SEBC approved the contract awards for the medical (health plan) third party administrators (TPAs) to serve the GHIP, effective July 1, 2017: Aetna to administer the Consumer Directed Health Plan (CDH) and HMO Plan; and Highmark Delaware to administer the First State Basic PPO Plan, Comprehensive PPO Plan, and Special Medicfill Medicare Supplement Plan (available only to Medicare pensioners). The recommendation for contract awards was the culmination of well over seven months of planning, education and discussion. Currently, employees and non-Medicare pensioners have six plans to choose from; however, there are two HMO and two CDH Gold plans with nearly identical plan designs and premiums. Decreasing the plan offerings from two HMO and CDH plans to one CDH and HMO plan allows for an easier decision making process for eligible members and increases administrative efficiency.

(9) How favorable is the provider network for the Aetna and Highmark Delaware plans?
Overall network access (i.e., access to any provider) is favorable in the areas where employees and pensioners reside. Across the State of Delaware Group Health Insurance Program (GHIP) entire population – 97.2% of in-network patients remain in Aetna's physician network; 99.6% in Aetna's facility network. This compares to Highmark at 99.9% and 100.0% respectively. In terms of key providers – PCPs, OB/GYNs, pediatricians & other specialists – desired access was 99.9%

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Specific to providers providing primary care services – PCP, family & general practice, OB/GYN, internal medicine, pediatric & geriatric medicine* (*direct access but not one where members can select as a PCP)

- Aetna network access is more than sufficient in all areas with providers who are accepting patients and/or taking patients with other insurance
- Disruption of current Highmark HMO membership for physicians in these categories is less than 2.0%. Aetna continues to actively outreach to providers not currently in their network who were identified as having more than 25 Highmark HMO and/or CDH Gold members.

(10) What will happen to members currently enrolled in the Highmark IPA/HMO Plan and Highmark CDH Gold Plan, since they are no longer available as of July 1, 2017?

The IPA/HMO Plan and CDH Gold Plan offered through Highmark Delaware will no longer be available effective July 1, 2017; therefore, these plans will not be available for selection during Open Enrollment. Employees currently enrolled in either plan will be **automatically defaulted at the start of Open Enrollment** into the Aetna equivalent plan.

Highmark IPA/HMO employees that log into Employee Self-Service will see their "New" and "Current" Coverage effective July 1, 2017 as being the Aetna HMO Plan, and the same will apply for Highmark CDH Gold Plan as they will be automatically moved to the Aetna CDH Plan, and keep the same coverage tier they are currently in (either employee only, employee and spouse, employee and child(ren) or family).

Employee Self-Service Screenshot Examples:

Enrollment Summary

Medical		Full Cost	Credits	Before Tax	After Tax	Edit
Current:	Aetna CDH Gold:Empl Only					
New:	Aetna CDH Gold:Empl Only	17.99	17.99	0.00		

Enrollment Summary

Medical		Full Cost	Credits	Before Tax	After Tax	Edit
Current:	Aetna HMO:Emp+Child					
New:	Aetna HMO:Emp+Child	36.09	36.09	0.00		

If employees take no action during Open Enrollment, they will **remain automatically defaulted** into the corresponding Aetna HMO or CDH Plan for the plan year that begins July 1, 2017. Their coverage will not be terminated if they take no action during Open Enrollment; however, these employees will lose the opportunity to consider other plans until the next Open Enrollment unless they experience a qualifying event during the plan year. Please see Question #14 about the importance of selecting a PCP for the Aetna HMO Plan.

(11) I am currently in the Highmark CDH Gold Plan and noticed that my ID card has PPO on it. Will I need to make a new health plan selection or be defaulted into the Aetna CDH plan?
Yes, employees who are enrolled in the Highmark IPA/HMO or CDH Gold Plan in the current plan year and take no action during Open Enrollment will have coverage in the corresponding Aetna HMO or CDH Plan for the plan year that begins July 1, 2017.

(12) What will happen to employees currently enrolled in the Highmark CDH Gold Plan who have unused HRA funds at the end of the plan year?
If you enroll in the Aetna CDH Gold plan effective July 1, 2017, and you were enrolled in either the Highmark or Aetna CDH Gold Plan through June 30, 2017, any unused HRA funds will rollover to the new plan year.

(13) What will happen if an employee is currently enrolled in the Highmark IPA/HMO or CDH Plan and chooses not to actively participate in Open Enrollment? Will they still be enrolled in a health plan for the plan year that begins on July 1, 2017?
Employees who are enrolled in the Highmark IPA/HMO or CDH Gold Plan in the current plan year and take no action during Open Enrollment will have coverage in the corresponding Aetna HMO or CDH Plan for the plan year that begins July 1, 2017. Their coverage will not be terminated if they take no action during Open Enrollment; however, these employees will lose the opportunity to consider other plans until the next Open Enrollment unless they experience a qualifying event during the plan year. Please see Question #14 about the importance of selecting a PCP for the Aetna HMO Plan.

(14) Do employees need to actively select a Primary Care Provider (PCP) if they are currently a Highmark IPA/HMO member and automatically default into the Aetna HMO plan?
Employees currently enrolled in the Highmark IPA/HMO plan will be automatically defaulted into the Aetna HMO plan at the start of Open Enrollment and will see “PCP NOT ON FILE” under Choose a Primary Care Provider ID when they log into Employee Self-Service. This is in part because Highmark and Aetna use different provider codes which systematically does not allow for a transfer of PCP information from one vendor to another.

Choose a Primary Care Provider ID

If you are enrolling in this plan for the first time, you must select a primary care provider for you and each dependent to be covered. Enter the provider's ID number from the provider listing. You must indicate whether or not you have already established a relationship with this provider, since some providers are not accepting new patients.

If you are already enrolled in this plan and you wish to change your primary care provider on file with the carrier, please do not enter the provider's information below. Contact the carrier directly at the phone number on the back of your insurance card or in your open enrollment booklet.

Specify a Primary Care Provider ID: PCP NOT ON FILE ✕ Select a Provider

☐ Check here if you have previously seen this provider

☐ Check here to use the same provider for all your dependents

Dependent Provider List

Update Elections | Discard Changes

Employees defaulting or enrolling in the Aetna HMO Plan are encouraged to use Aetna's DocFind during Open Enrollment to locate a PCP they want and select their chosen primary care provider in Employee Self-Service. Selecting a provider will change "PCP NOT ON FILE" to "PCP ON FILE."

DocFind Instructions:

1. Visit Aetna's DocFind.
2. Under Geographic Information, select **Zip code**, **City** or **County**.
   a. If using Zip code – Please provide 5 digit zip code and select distance/radius.
   b. If using City – Please provide City and State.
   c. If using County – Please provide County and State.
3. Under Provider Category, select **Medical Providers**.
4. Under Provider Type, select **Primary Care Physicians**.
5. Under Plan, select plan choice - either the **HMO** or **Aetna CDH Gold Plan**.
6. You can narrow your search by specialty, provider's name and other options by choosing the **More Options** button.
7. Click the **Start Search** button.
8. View your search results.
   *Note: A PCP ID must be entered in Employee Self-Service during Open Enrollment if you are enrolling or defaulting into the Aetna HMO Plan. The Primary Office # (Example - **Primary Office# 000000**) found in DocFind under your chosen provider is the number you enter in the "Specify a Primary Care Provider ID" textbox in Employee Self-Service.*

Employees currently enrolled in a Highmark IPA/HMO plan who automatically default into the Aetna HMO plan at the start of Open Enrollment and do not log into Employee Self-Service during Open Enrollment to select a PCP under the Aetna HMO plan, will have one automatically assigned to them by Aetna (based on location/proximity of the member to the provider's office). After Open Enrollment closes, employees wanting to change their Aetna PCP will need to contact Aetna directly at 1-877-542-3862.

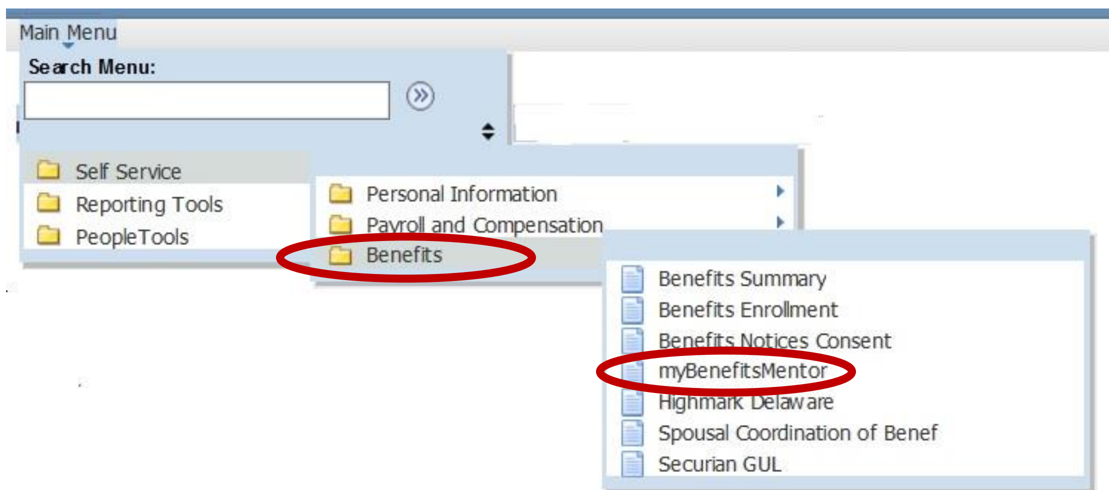
(15) What consumerism resources will be available prior to and during Open Enrollment to help employees make informed decisions?

During the week of April 3, SBO launched a curriculum of online mini-videos (5-10 minutes each) to educate employees and pensioners on What's New for Open Enrollment, the myBenefitsMentor consumer decision tool, the health plans offerings and the Coordination of Benefits policy. The myBenefitsMentor online tool went live the week of April 17 and employees and non-Medicare pensioners were mailed a welcome letter introducing them to the resource. During the week of April 24, SBO launched an online, Interactive Open Enrollment Benefits Guide which replaces the standard, static Open Enrollment PDF Booklet. Employees and pensioners are able to drive the user experience. The Interactive Open Enrollment Benefits Guide uses audio and screen interaction with employees and pensioners to help them learn about available benefits including navigation demos of the SBO website. SBO encourages benefit-eligible employees to use these consumerism resources (i.e., myBenefitsMentor, online mini-videos, Interactive Open Enrollment Benefits Guide, etc.) prior

to and during Open Enrollment, as a way to assist them in being a wise health care consumer when selecting the benefit plans that best meet their needs and the needs of their family.

(16) Where do I go to access and learn more about the mini-videos?
Visit de.gov/statewidebenefits (Select the "Open Enrollment" button, then choose the button for "DOE, K12, DTCC & DSU Employees"). Under Consumerism Resources, select the link for "Curriculum of Informational Mini-Videos."

(17) What is the myBenefitsMentor® Consumer Decision Tool?
The myBenefitsMentor consumer decision tool is designed to help you make the best selection from the four health plans offered by the State of Delaware. Your prior State of Delaware usage (if historical claims data is available) of health and prescription services, a recommendation on the most cost effective plan and other helpful tips are outlined in a personalized and confidential letter mailed to your address that is listed in Employee Self-Service. This information is also available in the online decision tool that is accessed through Employee Self-Service.



The myBenefitsMentor online solution also provides the ability to make adjustments in historical utilization based on anticipated health care needs in the year ahead. Employees and non-Medicare pensioners have the ability to add major healthcare services and view a customized enrollment guide that incorporates those expected health care needs, compares estimated total costs by plan and provides them with personal recommendations on the plan that is best for them and their family.

View an informational mini-video, additional FAQS and access the online tool at http://ben.omb.delaware.gov/oe/employees-benefits-mentor.shtml.

(18) What information is available in the myBenefitsMentor letter and online tool?
The myBenefitsMentor consumer decision tool welcome letter mailed to State of Delaware employees and non-Medicare pensioners in late April, demonstrates the State of Delaware's commitment to giving benefit eligible employees and pensioners access to information that

helps them to be wise healthcare consumers. The letter contains a summary of historic healthcare cost and service experience and personalized plan comparison information to help them make an informed decision about the health plan option most appropriate for them and their family. The online solution provides this information as well as the ability to make adjustments in historical utilization based on anticipated health care needs in the year ahead. Employees and non-Medicare pensioners have the ability to add major healthcare services and view a customized enrollment guide that incorporates those expected health care needs, compares estimated total costs by plan and provides them with personal recommendations on the plan that is best for them and their family. **Please note:** If you are a school district or charter school employee who receives flex credits to reduce your employee premiums for health care, these flex credits are not reflected in your share of the premiums shown in the letter or online tool.

(19) Where do I go to learn more about the myBenefitsMentor® Consumer Decision Tool?
View an informational mini-video, additional FAQS and access the online tool at http://ben.omb.delaware.gov/oe/employees-benefits-mentor.shtml.

(20) Do employees have to use the myBenefitsMentor online consumer decision tool to make their plan selections?
myBenefitsMentor is an online consumer decision tool that is a new feature available in Employee Self-Service in the Benefits tab. It is separate from Benefits Enrollment where employees make their plan elections or changes to their existing plan elections. SBO is *encouraging* all benefit-eligible employees to utilize this tool in order to help them determine which medical (health) plan is right for them. It is not mandatory that they utilize this tool and employees can make their Open Enrollment plan elections without accessing this tool.

Plan Changes And Rates

(21) Are there changes to the 2017 benefit plan design and rates?
On March 6, 2017, the State Employee Benefits Committee (SEBC) voted to make no changes to the rates or plan designs of the health plans available to State of Delaware employees and non-Medicare pensioners for the plan year that begins on July 1, 2017. The SEBC will revisit as needed, changes to the Group Health Insurance Program (GHIP) health plans and rates based on Governor Carney's Budget Reset.

(22) Where can I find the 2017 benefit plan rates?
The Health, Dental and Vision Rate Sheet effective July 1, 2017 is available online at de.gov/statewidebenefits (Select the "Open Enrollment" button, then choose the button for "DOE, K12, DTCC & DSU Employees").

(23) Where can I go to view a side-by-side comparison of the health plan options available to me and my family for the plan year that begins on July 1, 2017?
A Health Plan Comparison Chart is available online at de.gov/statewidebenefits (Select the “Open Enrollment” button, then choose the button for “DOE, K12, DTCC & DSU Employees”). Under Consumerism Resources, select the link for “Health Plan Comparison Chart.”

(24) I heard that Governor Carney's FY18 Budget Proposal recommends increasing member cost share for health plan coverage, as well as eliminating the double state share benefit. Do these recommendations impact this May's Open Enrollment and my coverage for the plan year that begins July 1, 2017?
Governor Carney's budget proposal released on March 23, 2017 includes recommendations to adjust the cost share in employee health plans and to eliminate double state share. These recommendations would require legislation that must be passed by the General Assembly and signed into law by the Governor; therefore, these recommendations are **not** part of the changes outlined in this May's Open Enrollment for the plan year that begins July 1, 2017. If legislation is introduced and passed that adjusts cost share or eliminates double state share, a separate "Special Enrollment" opportunity will be communicated and made available to any impacted employees and pensioners at least 60 days in advance of the effective date of the changes to allow them the chance to make changes to their current benefit elections or to drop coverage if they wish to do so.

Enrollment

(25) When is Open Enrollment?
The Open Enrollment period for DOE, K12 (School District and Charter School), DTCC and DSU employees is May 1 - 13, 2017.

(26) Do all employees have to complete Open Enrollment this year, regardless of whether they are making any changes?
All benefit-eligible employees are *strongly encouraged* prior to the start of Open Enrollment to log into Employee Self Service http://employeeselfservice.omb.delaware.gov/:

- to review and update Personal Information (address, phone number, email address) and
- under the Benefits tab, consider electing to receive Benefits Notices electronically through the Benefits Notices Consent option

During Open Enrollment, benefit-eligible employees are *strongly encouraged* to access the features available in the Benefits tab of Employee Self-Service–

- Benefits Enrollment to review current benefit elections and make changes,
- Spousal Coordination of Benefits Form if they will cover a spouse for the plan year that begins July 1, 2017
- To use a new feature, the myBenefitsMentor consumer decision tool to determine which available medical health plan is right for them, and
- Benefits Summary to review and confirm that their benefit elections are correct

State medical (health), dental and vision plan enrollment for the current plan year will continue or carry over into the new plan year which begins on July 1, 2017 if the employee does not log into Benefits Enrollment to review their current benefit elections and authorize elections by clicking Submit to submit and process their choices. Employees currently enrolled in the Highmark IPA/HMO and Highmark CDH plans (which will be discontinued after June 30, 2017) who do not access Benefits Enrollment during Open Enrollment will be defaulted into the same plan type and tier offered by Aetna.

(27) Do employees receive a Confirmation Statement after Open Enrollment?

Confirmation Statements are **not** mailed to active employees. Employees are responsible for reviewing their elections from the Employee Self-Service Benefit Summary by logging onto eBenefits as you did to enroll and click Benefits Summary instead of Open Enrollment. By entering the date of 07/01/2017, employees will be able to view their elections as of that date including the dependents covered. **Benefit changes made in eBenefits CANNOT be viewed until the following business day.**

(28) Are employees able to make corrections to their benefit elections after Open Enrollment ends on May 13?

Employees who notice an error on their Benefits Summary after Open Enrollment ends on May 13 must contact their Human Resources/ Benefits Office with the necessary changes no later than June 2, 2017. **No corrections will be made after June 2, 2017 including requests made to Human Resources/Benefit Offices after ID cards are received or members try to use services after the start of the plan year.**

(29) If I am currently on a Leave of Absence for any reason, do I need to complete the eBenefits online enrollment process?

You are required to complete the eBenefits online enrollment process if you wish to enroll, make changes or cancel your health, dental or vision coverage. If you wish to enroll in the supplemental benefits through Aflac, you must contact Aflac within **30 days** of returning from your leave of absence. See Aflac FAQs at www.ben.omb.delaware.gov/aflac-supplemental-benefits for more details.

(30) Why can I no longer make an election regarding Blood Bank in eBenefits?

The Blood Bank of Delmarva's Members for Life is not a group benefit administered by the State of Delaware. Employees interested in participating in Members for Life can create an account with Blood Bank of Delmarva at www.delmarvablood.org and click "Donate" or visit one of Blood Bank of Delmarva's conveniently located Blood Donation Sites.

(31) Why can I not make changes to my Dental, Vision, Supplemental Life or LTD benefits?

Certain School District/Higher Education sponsored programs are not open for this year's open enrollment. Please contact your District's Benefits Office for additional information.

Events

(32) Is the State of Delaware offering Open Enrollment Employee Education Sessions and Health Fairs again this year?
Yes, details on the dates, times and locations of these events can be found at de.gov/statewidebenefits (Select the "Open Enrollment" button).

(33) What are the Statewide Benefit Open Enrollment Employee Education Sessions and Health Fairs?
Employee Education Sessions provide employees an opportunity to engage, ask questions and learn about: What's changing in the health plan offerings on July 1, 2017; and how to engage in this Open Enrollment and take advantage of new and exciting consumerism tools Representatives from the various benefit vendors will be available 30 minutes before and after the event for employees to visit their information tables to ask questions and pick up materials/giveaways. Register online at de.gov/statewidebenefits (Select the "Open Enrollment" button) to attend one of the sessions.

The Statewide Benefit Health Fairs provide an opportunity for employees to explore the benefit vendor booths and learn more about their options. No registration is required.

You are welcome to attend the education sessions and health fairs if you are enrolled or are eligible to enroll in the State of Delaware Group Health Insurance Program (GHIP).

(34) Can my spouse and/or dependents attend the Statewide Benefit Open Enrollment Employee Education Sessions and Health Fairs?
Due to limited seating available, the employee education sessions are not offered to spouses and dependents. Spouses and dependents who are enrolled or eligible to enroll in the GHIP are welcome to attend the health fairs.

Covering a Spouse or Other Dependent(s)

(35) Who can an employee cover?
An eligible employee can cover a legal spouse and children under age 26. For more details about eligibility refer to the "Group Health Insurance Eligibility and Enrollment Rules" available at de.gov/statewidebenefits**.**

(36) What do I need to do if I choose to cover or continue to cover my spouse by electing "Employee & Spouse" or "Family" health coverage?
Active Employees can change or add spousal information by using the eBenefits online enrollment process at www.employeeselfservice.omb.delaware.gov from May 1, 2017 through May 13, 2017. If covering a spouse for the FIRST TIME due to marriage, be sure to check the relationship of spouse when adding the dependent in eBenefits. If covering a spouse for the FIRST TIME, due to civil union, be sure to check the appropriate relationship – IRS Qualified Spouse or IRS Non-Qualified Spouse when adding the dependent in eBenefits to ensure your

premiums and imputed income calculates correctly. Additional information about benefit coverage for spouses due to civil union can be found at www.ben.omb.delaware.gov/cusgm.

If you are covering a spouse for the **FIRST TIME**, or wish to continue covering a spouse in one of the State of Delaware Group Health Insurance health plans through "Employee and Spouse" or "Family" coverage; you MUST complete a new Spousal Coordination of Benefits form each year during Open Enrollment and anytime your spouse's employment or insurance status changes.

Active Employees MUST complete the form through Employee Self-service at www.employeeselfservice.omb.delaware.gov by May 13, 2017. Failure to submit a new Spousal COB form each year will result in a reduction of spousal benefits.

(37) What will happen if I don't submit the Spousal Coordination of Benefits form?

Failure to complete a new Spousal Coordination of Benefits (COB) form by May 13, 2017 will result in a reduction of spousal benefits.

(38) What do I need to provide if I am covering a spouse or other dependent for the FIRST TIME?

Proof of eligibility must be provided for anyone covering a spouse or dependent for the **FIRST TIME**.

- Proof of eligibility for a spouse is a copy of the Marriage Certificate/Civil Union Certificate.
- Proof of eligibility for a dependent is a Birth Certificate or other legal document.*
- Social Security Card must be provided in order to confirm a spouse or dependent's Social Security Number
- Complete a Child Dependent Coordination Benefits form if your dependent child has other health coverage. The appropriate Highmark Delaware and Aetna forms and instructions are available at www.ben.omb.delaware.gov/medical.
- Complete a Certification of Tax Dependent Status form if covering a spouse due to civil union or other dependents due to civil union.

**This information is not forwarded to the carriers. Your Human Resources/Benefits Office will maintain this documentation.*

(39) What do I need to do if I choose to cover my children due to civil union for the FIRST TIME?

Active Employees can add dependent information by using the eBenefits online enrollment process at www.employeeselfservice.omb.delaware.gov from May 1, 2017 through May 13, 2017. If covering a child for the **FIRST TIME** due to civil union for the FIRST TIME, be sure to check the appropriate relationship – IRS Qualified Child or IRS Non-Qualified Child when adding the dependent in eBenefits to ensure your premiums and imputed income calculates correctly. Additional information about benefit coverage for spouses due to civil union can be found at www.ben.omb.delaware.gov/cusgm.

(40) What if my spouse or dependent child(ren) have other coverage?
The Spousal Coordination of Benefits (SCOB) form **MUST** be completed if you are covering your spouse in one of the State of Delaware Group Health Insurance health plans through "Employee & Spouse" or "Family" coverage. 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. Your health insurance carrier will then coordinate benefits if there is other insurance coverage. To ensure the highest level of coverage for your dependents, you must notify your carrier if your dependent has other coverage. Additional information regarding the coordination of benefits is available online at www.ben.omb.delaware.gov/documents/cob.

(41) What happens when my dependent reaches the age of 26?
You are responsible for notifying your Human Resources/Benefits Office within your organization within **30 days** of the time when your dependent is no longer eligible for coverage. Dependent coverage is available until the end of the month in which your eligible dependent turns 26. As long as you notify your Human Resources/Benefits Office that your dependent is no longer eligible for coverage in the time frame listed above your dependent will be eligible to elect COBRA continuation coverage.

After I Enroll

(42) When will the new coverage take effect?
The new coverage and rates, or the termination of existing coverage will take effect on July 1, 2017.

(43) When will the deductions begin for these new plans or the new rates?
The State of Delaware benefit deductions are lagged in PHRST, the State's payroll system. The first deduction for new coverage or changes to coverage beginning July 1, 2017 will be taken on the July 21, 2017 paycheck.

(44) Will I get Member ID cards?

Health*:

- *Aetna*

  All members (new and current) in the HMO Plan and CDH Gold Plan will receive new ID cards. Aetna is partnering with Carelink CareNow for health and disease management for HMO members. Carelink CareNow contact information will be listed on the back of Aetna HMO ID cards.

- *Highmark Delaware*

  All members (new and current) in the First State Basic PPO Plan and Comprehensive PPO Plan will receive new ID cards.

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Prescription*:

- *Express Scripts*

  Members who move to new health plans will receive new ID cards. ID cards do not auto generate for coverage tier changes.

**Please note that Health and Prescription ID cards will not be generated by vendors until the June 2nd interface files have been processed by vendors. ID Cards will be mailed mid to late June 2017.*

Dental:**

- *Delta Dental*

  Only new members will receive ID cards. ID cards do not auto generate for coverage tier changes.

- *Dominion National*

  Only new members will receive ID cards. ID cards do not auto generate for coverage tier changes.

Vision:**

- *EyeMed Vision Care*
  Only new members will receive ID cards. ID cards do not auto generate for coverage tier changes.

***Please note that Dental and Vision ID cards are generated by vendors after each weekly file processes.*

Supplemental:

- *Aflac*
  Member ID cards are **not** issued for the supplemental benefits offered by Aflac.