Open Enrollment

2011

Health • Prescription • Vision • Dental

State of Delaware

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Introduction & What's New!

2011 Benefits Open Enrollment

The State Employee Benefits Committee is pleased to present your 2011 Open Enrollment information. The comprehensive benefits package offered to all benefit eligible State of Delaware employees and pensioners, as well as their dependents, covers all your health, dental, vision and prescription needs. We are also pleased to announce that employee premiums for health plans have not been increased for the 2011-2012 plan year. So, please take the time to review all of the information, as there are significant changes for you to consider during this Open Enrollment period, including new Consumer-Directed Health Plan options through both Blue Cross Blue Shield and Aetna. Being an informed consumer of health care can help control costs for you and the State.

Because Open Enrollment - May 9th to 25th - is your once-a-year opportunity to enroll, make changes or terminate coverage in your health, dental and vision plans, it is important to choose the plans that are right for you. Please visit ***www.ben.omb.delaware.gov****. or contact the Statewide Benefits Office or Office of Pensions if you have additional questions (contact information on last page.)*

Statewide Benefits Office Mission Statement

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

What's New!

Consumer-Directed Health Plans

- *Both Aetna and Blue Cross Blue Shield of Delaware (BCBSD) are offering a Consumer-Directed Health Gold Plan effective July 1, 2011. These plans offer attractive premium rates and include a state-funded Health Reimbursement Account (HRA) to offset the majority of the deductible. Consider these plans when making your choices for the 2011-2012 plan year.*

New State Vision Plan

- *The EyeMed Vision Care plan will replace the VSP Vision Plan (previously offered as part of the Supplemental Benefit Program, terminating June 30, 2011) as of July 1, 2011. The EyeMed Vision Care Plan offers state employees, pensioners and their dependents access to valuable savings on vision care at affordable reduced rates.*

Coverage of Adult Dependent Children to Age 26

- *The State Group Health Insurance Program will include coverage for adult children up to age 26 as directed under the Patient Protection and Affordable Care Act (otherwise known as Federal Health Care Reform). You may enroll your adult dependent children up to age 26 in your health, dental and vision plans during open enrollment and through June 9, 2011. An Adult Dependent Coordination of Benefits Form must be completed with your enrollment. Detailed information is available at* ***www.ben.omb.delaware.gov/documents/cob****.*

Mental Health Parity

- *Outpatient mental health provider co-payments have been changed in the BCBSD Blue Care and Comprehensive PPO plans to comply with the Mental Health Parity and Equity Act. Please see the summary plan pages for details.*

Chiropractic Coverage

- *In compliance with State of Delaware legislation effective July 1, 2011, member responsibility for chiropractic charges shall be the lesser of the deductible, co-payment or co-insurance applicable for a primary care physician under your health plan or 25 percent of the allowable fee paid to the doctor of chiropractic under your health plan. Please refer to the summary plan pages for details on your plan.*

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

What's New!

Prescription Plan Changes

The following coverage management programs will be effective July 1, 2011. You will be contacted by Medco if this program impacts your current prescription drug usage.

- *A prior authorization will be required to obtain the antibiotic medication, Solodyn, which is primarily used to treat acne.*
- *Lyrica will become part of the Step Therapy Program. Lyrica treats the partial onset of seizures in adults and manages fibromyalgia-related pain and neuropathic pain, such as diabetic peripheral neuropathy and postherpetic neuralgia.*
- *A prior authorization for quantity duration will be required to obtain the antibiotic medication, Xifaxan, which is primarily used to treat traveler's diarrhea or hepatic encephalopathy in patients age 12 years and older.*

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

The benefits you elect during the Open Enrollment period will take effect July 1, 2011.

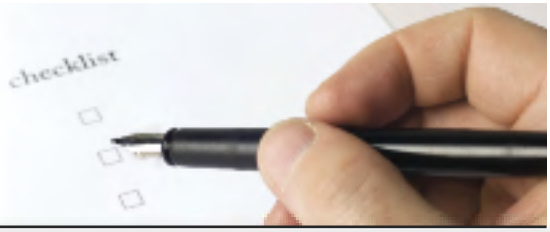
Remember:

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

*You **MUST** complete the form online at* ***www.ben.omb.delaware.gov/documents/cob*** *no later than May 25, 2011. If you do not have access to a computer, contact your Human Resources or Benefits Office.*

Go to page 27 for complete details.

2011 Enrollment Action Checklist



OPEN ENROLLMENT is May 9 - May 25, 2011

- ❑ Read all Open Enrollment information contained in this booklet.
- ❑ Mark your calendar to attend one of the Statewide Benefit Health Fairs (see page 48 for dates, times and locations).
- ❑ Review Open Enrollment Frequently Asked Questions (FAQ) located on the Statewide Benefits website at **www.ben.omb.delaware.gov/oe**.
- ❑ **If you cover your spouse in one of the State of Delaware Group Health Insurance medical plans, go to page 27** for complete details on the Spousal Coordination of Benefits policy and required form.
- ❑ **If you wish to enroll an adult dependent to age 26** in a health, dental or vision plan, go to Page 28 for complete details on the Administration of Adult Dependent to Age 26 Policy and the required Adult Dependent Coordination of Benefits form.
- ❑ **REMEMBER:** Supplemental benefits through Motivano, including the VSP Vision Plan, will end effective June 30, 2011. If you wish to have vision coverage effective July 1, 2011, you must enroll in the new EyeMed Vision Care plan.
- ❑ **If you are not making any changes and do not cover a spouse or adult dependent** under your State of Delaware Group Health Insurance medical plan, no action is required.

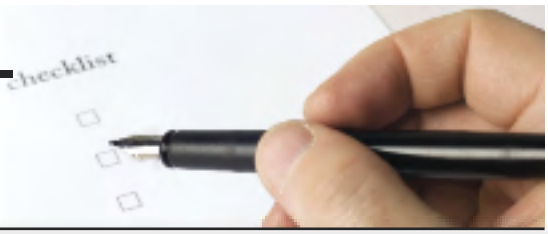
If you are enrolling in any plan or enrolling a spouse or dependent for the first time:

- ❑ If enrolling in an HMO (health or dental) plan for the FIRST TIME, make sure that **before you enroll** your health or dental provider participates in the plan you select and enter their provider information online when you enroll.
  REMEMBER: You cannot change plans during the plan year if your provider decides to no longer participate in the plan.
- ❑ If enrolling a spouse for the FIRST TIME: You **MUST** supply a copy of your marriage 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 in the Blood Bank for the FIRST TIME: You **MUST** complete a Blood Bank application to submit to your organization's Human Resources or Benefits Office, or to the Office of Pensions, as applicable. Active employees must also enroll online through eBenefits.

Active Employees - Action Steps:

- ❑ Review Open Enrollment Checklist above.
- ❑ To enroll or make changes to your health, dental, vision or blood bank coverage, go online to eBenefits at **https://eapps.erp.delaware.gov/** by May 25, 2011.
  - ❑ Refer to the eBenefits Quick Reference Guide (online at **www.ben.omb.delaware.gov/oe**) for complete log in and enrollment instructions.
  - ❑ **If you have general online enrollment or benefits questions**, call the Open Enrollment Help Desk at 1-800-489-8933 from 8 a.m. to 4:30 p.m. Monday through Friday during the Open Enrollment period.
  - ❑ **If you do not have access to a computer**, or have questions about your benefits or eligible dependents, contact your organization's Human Resources or Benefits Office.
  - ❑ **If you need your password reset** - go to **www.omb.delaware.gov/epay**, click on **USER ACCOUNT ASSISTANCE** (located on the left hand side), click on "Submit an online request" and complete and submit the form to have your password reset. For additional information, refer to the last page of the eBenefits Quick Reference Guide at **www.ben.omb.delaware.gov/oe**.

2011 Enrollment Action Checklist - Action Steps!



Active Employees - Action Steps (cont):

- ❑ Complete your Spousal Coordination of Benefits Form online by May 25, 2011, if you cover your spouse on your health plan (see page 27 for details).
- ❑ Submit your Adult Dependent Coordination of Benefits Form to your Human Resources/Benefits Office by June 9, 2011 if you are covering a dependent who turned 21 prior to the end of 2010 (see page 28 for details).
- ❑ **Following Open Enrollment**, view your benefits elections by accessing the Benefits Summary section under Employee Self Service in (PHRST). Please refer to the eBenefits Quick Reference Guide (www.ben.omb.delaware.gov/oe), for more detailed instructions. If an error has been made, you **MUST** contact your organization's Human Resources/Benefits Office to correct the error by June 9, 2011. **No corrections will be made after June 9, 2011.**

Pensioners - Action Steps:

- ❑ Review Open Enrollment Checklist on page 3.
- ❑ **To enroll or make changes to your health, dental, vision or blood bank coverage:**
  You must complete the necessary forms available on the Office of Pensions Website at **www.delawarepensions.com** or complete the health, dental and vision applications included in the packet mailing sent to your home. You must submit your completed enrollment forms to the Office of Pensions by May 25, 2011.
  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
  302-739-4208 or 1-800-722-7300
- ❑ Contact the Office of Pensions at 302-739-4208 or (toll-free) 1-800-722-7300 for the forms to cancel medical or dental coverage.
- ❑ Contact the Office of Pensions if you, your spouse or your dependents are Medicare eligible and not enrolled in the Special Medicfill Medicare Supplement health plan.
- ❑ Complete the Spousal Coordination of Benefits Form and mail to the Office of Pensions by May 25, 2011, if you cover your spouse in one of the State of Delaware Group Health Insurance medical plans. Go to page 27 for complete details on the Spousal Coordination of Benefits policy and required form.
- ❑ If you cover your spouse under the BCBSD Special Medicfill Medicare supplement plan, you are not required to complete a Spousal Coordination of Benefits form.
- ❑ Submit your Adult Dependent Coordination of Benefits Form to the Office of Pensions by June 9, 2011 if you are covering a dependent who turned 21 prior to the end of 2010 (see page 28 for details).
- ❑ If you have questions about your health benefits, please call the Office of Pensions at 302-739-4208 or 1-800-722-7300 from 8 a.m. to 4:30 p.m. Monday through Friday during the Open Enrollment period or attend a health fair. The health fair schedule can be found on page 48.

Non-State Participating Groups - Action Steps:

- ❑ Review Open Enrollment Checklist on page 3.
- ❑ Contact your Human Resources Office within your organization for forms to enroll, make changes or cancel current health or dental coverage.
- ❑ Complete your Spousal Coordination of Benefits Form online by May 25, 2011, if you cover your spouse on your health plan (see page 27 for details).
- ❑ Submit your Adult Dependent Coordination of Benefits Form to your Human Resources/Benefits Office by June 9, 2011 if you are covering a dependent who turned 21 prior to the end of 2010 (see page 28 for details).

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

New Consumer-Directed Health Plans

The State Employee Benefits Committee is committed to providing access to comprehensive and competitive health coverage for its employees and their families at a cost that is manageable for both the State and our employees/pensioners. Meeting this commitment has grown increasingly challenging in recent years as healthcare costs continue to rise faster than inflation.

In order to meet this challenge, Aetna and Blue Cross Blue Shield of Delaware (BCBSD) will offer the Consumer-Directed Health Plan (CDH Gold) for the 2011 – 2012 plan year. The CDH Gold Plan provides access to quality, comprehensive health care coverage – and it gives you more control over your health and how your healthcare dollars are spent. While the addition of the CDH Gold Plan enables us to meet our commitment in the upcoming plan year, the only way we can continue to meet this challenge over time is with your involvement, so below you will find some valuable information on how the new plan works and why it may be a good fit for you.

How Does the Consumer-Directed Health Plan Work?

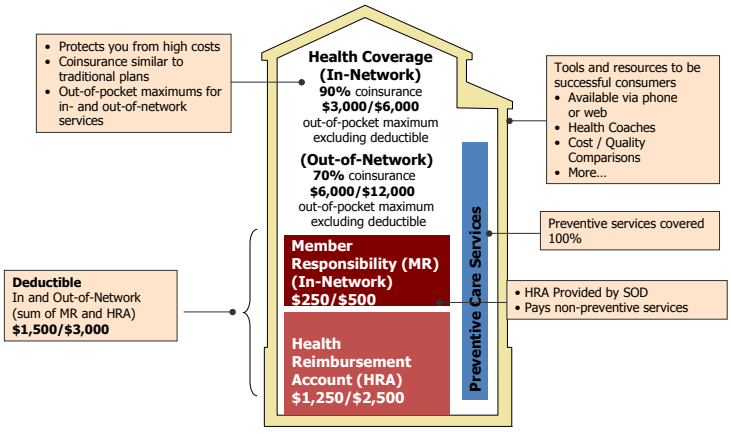
A Consumer-Directed Health (CDH) Plan is similar to any other type of health plan that provides in- and out-of-network benefits. You and your family will receive higher benefits if you see providers within the Aetna and BCBSD networks. The plans include an annual deductible you must meet before the plan pays in full. These plans include a fund, called a Health Reimbursement Account (HRA), for you to pay eligible medical expenses and meet the required deductible. The State provides the funding; however, 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. 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.

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

How the HRA Fund Works

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

CDH Gold Plan Components



Added Financial Protection and Peace of Mind

The CDH Gold Plan also provides extra financial protection through an annual out-of-pocket maximum. This means there is a limit on the amount you pay out of your pocket after you meet the deductible during the plan year. Once you meet your out-of-pocket limit within a 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

Because you will want to make a health plan choice that best fits your needs, it is time to compare the specifics of your options. Accepting responsibility for plan choice is the first step in taking charge of your own healthy future! The following pages highlight each of the plans offered through the State of Delaware Group Health Insurance Program and provide more information on how the CDH Gold Plan offered by Aetna and BCBSD compares to the other plans available. In addition, visit **www.ben.omb.delaware.gov/oe** to view the Aetna and BCBSD information on the CDH Gold Plan as well as examples of how the CDH Gold can work for you and your family.

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

Health Plan Descriptions

Aetna
Simple, Smart and Save…Choose Aetna this Open Enrollment!

Two Plans to choose from:
Aetna HMO Plan

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

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

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:

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 CDH Gold Plan, you can't take the fund with you.

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!

Your Health Plan:

Once you meet your deductible, your health plan pays its share for eligible expenses. You pay a smaller share of these costs from your own pocket.

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

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

Tip: Considering an HMO?

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

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

Health Plan Descriptions

Blue Cross Blue Shield of Delaware: First State Basic Plan

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

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

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

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

Blue Cross Blue Shield of Delaware: Blue Care® HMO

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

Blue Cross Blue Shield of Delaware: CDH Gold **New**

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

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

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

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

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

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

Summary of Benefits

First State Basic Plan

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

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

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

Summary of Benefits

HMO Plans

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

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

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

Summary of Benefits

Aetna CDH Gold Plan

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

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

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

Summary of Benefits

Blue Cross Blue Shield of Delaware CDH Gold Plan

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

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

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

Summary of Benefits

Comprehensive Preferred Provider Organization

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

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

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

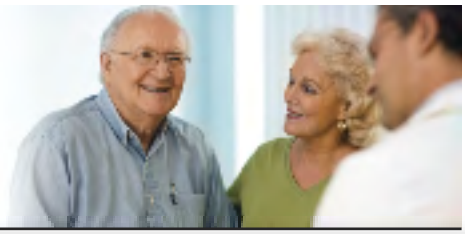
2011 Health Plan Rates

	Total Monthly Rate	State Pays	Employee/Pensioner Pays
First State Basic Plan *(includes prescription drug coverage at the same level as all other plans)* *Administered by Blue Cross Blue Shield of Delaware*			
Employee	$514.56	$514.56	$0.00
Employee & Spouse	$1,064.66	$1,064.66	$0.00
Employee & Child(ren)	$782.20	$782.20	$0.00
Family	$1,330.86	$1,330.86	$0.00
Aetna CDH Gold *Administered by Aetna*			
Employee	$532.56	$514.56	$18.00
Employee & Spouse	$1,104.26	$1,064.66	$39.60
Employee & Child(ren)	$813.70	$782.20	$31.50
Family	$1,402.86	$1,330.86	$72.00
BCBSD CDH Gold *Administered by Blue Cross Blue Shield of Delaware*			
Employee	$532.56	$514.56	$18.00
Employee & Spouse	$1,104.26	$1,064.66	$39.60
Employee & Child(ren)	$813.70	$782.20	$31.50
Family	$1,402.86	$1,330.86	$72.00
Aetna HMO *Administered by Aetna*			
Employee	$537.22	$514.56	$22.66
Employee & Spouse	$1,132.64	$1,064.66	$67.98
Employee & Child(ren)	$821.80	$782.20	$39.60
Family	$1,413.30	$1,330.86	$82.44
BlueCARE® HMO *Administered by Blue Cross Blue Shield of Delaware*			
Employee	$537.66	$514.56	$23.10
Employee & Spouse	$1,136.22	$1,064.66	$71.56
Employee & Child(ren)	$822.62	$782.20	$40.42
Family	$1,417.62	$1,330.86	$86.76
Comprehensive PPO Plan *Administered by Blue Cross Blue Shield of Delaware*			
Employee	$587.46	$514.56	$72.90
Employee & Spouse	$1,219.04	$1,064.66	$154.38
Employee & Child(ren)	$905.38	$782.20	$123.18
Family	$1,523.98	$1,330.86	$193.12

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

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

Health Care Coverage for Medicare Eligible Retirees



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. Medicare Part B (Medical Insurance) helps cover doctors' 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 a Medicare Part B Supplement Plan, when eligible, based on age or disability.

Part D Prescription Drug Coverage

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

Special Medicare Supplement Plan and Benefits

More About Medicare

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

Important Notice for Pensioners

Even if you are under the age of 65, Delaware Law mandates that you, your spouse, and eligible dependents, elect Medicare Parts A & B when eligible.

To obtain Medicare eligibility information, please call the Social Security Administration office at 1-800-772-1213.You **MUST** contact the Office of Pensions upon receipt of your Medicare card. **Failure to elect will result in termination of coverage through the State of Delaware Group Health Insurance Program.**

Health Care Coverage for Medicare Eligible Retirees

2011 Medicare Supplement Health Plan Rates

	Total Monthly Rate	State Pays	Pensioner Pays
Medicare Supplement Administered by Blue Cross Blue Shield of Delaware			
Special Medicfill With Prescription	$414.26	$414.26	$0
Special Medicfill WITHOUT Prescription*	$191.76	$191.76	$0

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

Updated Directories

Updated Provider Directories for the BCBSD Special Medicfill Medicare Supplement plan are available online at **www.ben.omb.delaware.gov** or by contacting Blue Cross Blue Shield of Delaware at 1-800-633-2563.

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 coverage if elected.

The following portion of the "State Share" will be paid by the State.

Years Service	% of the State Share
Less than 10 yrs	0%
10 yrs less than 15 yrs	50%
15 yrs less than 20 yrs	75%
20 yrs or more	100%

Health Care Coverage for Medicare Eligible Retirees

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

(Administered by Blue Cross Blue Shield of Delaware)

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

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

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

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

Health Care Coverage for Medicare Eligible Retirees

Description of Benefit	Medicare	Special Medicfill
Specialist Care/Chiropractic Care	80% of the reasonable charges** after the Medicare Part B deductible	Covers Part B deductible and 20% of the reasonable charges**
Emergency Ambulance	80% of the reasonable charges** after the Medicare Part B deductible	Covers Part B deductible and 20% of the reasonable charges**
X-ray, Lab & other Diagnostic Services, Radiation Therapy	80% of the reasonable charges** after the Medicare Part B deductible	Covers Part B deductible and 20% of the reasonable charges**
Outpatient Rehabilitation Services, Occupational Therapy, Physical Therapy, Speech Therapy	80% of the reasonable charges** after the Medicare Part B deductible	Covers Part B deductible and 20% of the reasonable charges**
Routine GYN exam, Pap Smear, Mammogram	Covers 80% of the reasonable charges,** for routine GYN exam and mammogram. You pay $0 for Pap smear once every 3 years, annually if high risk. Mammograms covered once every12 months age 40 and older	Covers 20% of the reasonable charges.** One routine exam and Pap Smear is covered in a 12-month period.
Prostate Cancer Screening Exams (age 50 & over)	Covers 100% for approved lab services. Covers 80% of the reasonable charges** for other related services after the Part B deductible	Covers Part B deductible and 20% of the reasonable charges**
Periodic Physical Exams	Covers one exam every 12 months at 100% of reasonable charges**, if doctor accepts the assignment	Coverage at 100% of Blue Cross allowable, based on age guidelines published by American Medical Association after Medicare pays
Flu & Pneumococcal Pneumonia Vaccines	Covers 100% of reasonable charges.** **Pneumonia**–check with physician for frequency. **Flu**–once per year	**Pneumonia**–once at age 65 and up **Flu**–once per calendar year for age 65 and over
Routine Vision Care	Not covered	Not covered

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

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

Prescription Coverage

Medco

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

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

2011 Prescription Copay Rates

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

No Changes to Copays in 2011

Maintenance Medication Program

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

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

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

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

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

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

Personalized Medicine Program – Coumadin/Warfarin and Tamoxifen

When a member receives a new prescription for Coumadin, or its generic Warfarin (blood thinners), or a new prescription for Tamoxifen (used to prevent recurrence of breast cancer), the member will be provided the opportunity to voluntarily participate in Medco's Personalized Medicine program. This program provides genetic testing to members using either of these medications to ensure that the medication is effective in treating the member's medical condition in accordance with the member's genetic characteristics. For more information on Personalized Medicine, visit **www.ben.omb.delaware.gov/script**.

Diabetic Program

Diabetic supplies (lancets, test strips, syringes/needles) provided at a retail participating pharmacy, a 90-day participating pharmacy or the Medco Pharmacy (mail order) at no cost to the member. Diabetic medications purchased at the same time at a 90-day participating pharmacy or the Medco Pharmacy (mail order) may be obtained for one copay. For more information on the Diabetic Program, visit **www.ben.omb.delaware.gov/script**.

Prescription Coverage

CHANGES TO PRESCRIPTION PLAN AS OF JULY 1, 2011

Solodyn – This antibiotic used to primarily treat acne in teenage children will require a Prior Authorization. For more information on the Prior Authorization process, visit **www.ben.omb.delaware.gov/script**.

Xifaxan – This antibiotic is used primarily to treat traveler's diarrhea in patients 12 years of age and older, treat hepatic encephalopathy, or to reduce the risk of overt hepatic encephalopathy recurrence in patients 18 years of age or older. Patients will be required to have a coverage review conducted to receive a dosage of more than 550 mg twice daily for three days. For more information on the Coverage Review process, visit **www.ben.omb.delaware.gov/script**.

Lyrica – This anticonvulsant medication, used to treat the partial onset seizures in adults and to manage fibromyalgia related pain and neuropathic pain such as diabetic peripheral neuropathy and postherpetic neuralgia, will become part of the Step Therapy program. For more information on Step Therapy, visit **www.ben.omb.delaware.gov/script**.

The Coverage Review Process

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

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

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

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

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

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

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

Questions About Your Prescription Coverage

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

Dela*WELL* Health Management Program

Wellness Benefits with Dela*WELL*

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

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

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

Follow These Simple Steps to Participate Starting July 1, 2011

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

- **Attend a DelaWELL Health Screening** – Visit the DelaWELL Health Portal and sign up for a FREE Health Screening Appointment provided at various State of Delaware locations during the 2011 - 2012 plan year.

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

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

$100 - $200 Incentive Program

Benefit eligible state agency, school district, charter school and higher education employees, as well as state non-Medicare eligible pensioners, who are currently enrolled in a State of Delaware Group Health Plan, can earn incentives for participating in program activities from July 1,2011 through May 31,2012.

- **Silver Level:** Complete an annual Wellness Assessment AND Health Screening to earn a **$100 Incentive**.

- **Gold Level:** Complete a Wellness Assessment, Health Screening AND actively participate in a Health Coaching or Condition Care Program to earn a **$200 incentive** (Low risk individuals who don't qualify for and don't enroll in a health coaching program must participate in a Healthy Living Program).

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

Employee Assistance Program (EAP)

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

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

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

- **Log into the HMS website using the following:**

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

Blood Bank of Delmarva

FIRST FACT!

"350 donors are needed every day on Delmarva". Every 3 seconds someone needs blood. One pint of blood can save 3 lives.

Blood Bank of Delmarva

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

Membership in the Blood Bank covers you, your spouse, and your dependents providing unlimited blood replacement coverage anywhere in the United States. Pensioners can continue their membership even if they no longer live in the Delmarva area. In return, the Blood Bank will ask that you "provide" a pint of blood about once every 18-20 months. You may donate in one of three ways: give the blood yourself; have a friend or loved one give for you; or pay the current cost of one pint of blood in our area, which is $30. No donation obligation for pensioners age 75 and older.

Active State employees enrolling in the Blood Bank for the first time must enroll online through eBenefits and also complete the paper Blood Bank application available from your organization's Human Resources Office or from the Statewide Benefits, OMB website at **www.ben.omb.delaware.gov/blood**. The completed Blood Bank application ***MUST*** be returned to your Human Resources or Benefits Office no later than May 25, 2011.

Pensioners not currently enrolled in the Blood Bank, may enroll by contacting the Office of Pensions to complete an application.

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

About Your Dental Plans

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

Remember:

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

Delta Dental PPO℠ Plus Premier Plan

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

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

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

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

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

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

About Your Dental Plans

Dominion Dental HMO Plan (same as a DHMO)

Dental Plan 605xs

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

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

No Charge[1] For

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

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

New For 2011:

- Dominion's new preventive incentive program will pay subscribers $20 for each family member who gets two cleanings during the plan year (between 7/1/11 and 8/1/12). 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 now covers an extra cleaning for diabetics and expectant mothers.
- Several new offices to choose from.

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

State of DE Employees Enrolled With Dominion…

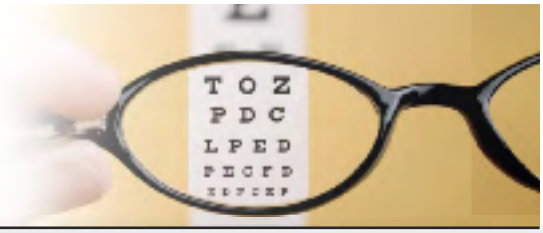
- Received $1.32 in value for every $1.00 spent on dental premium[2]
- 97% of survey respondents rated the treatment by their dentist "Satisfactory to Excellent[4]"

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

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

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

About Your Vision Coverage



EyeMed VISION CARE®

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

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

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

See the Savings!

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

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

How To Enroll

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

Pensioners: You must complete the EyeMed vision care enrollment form provided in the packet of information you received in the mail and also available on the Office of Pensions Website at www.delawarepensions.com. Completed enrollment form must be submitted to the Office of Pensions by May 25, 2011.

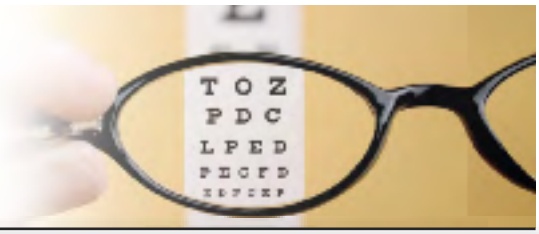
*State vision plan does not apply to participating non-state groups.

Enroll in EyeMed Vision Care Today!

Private Practitioners · LensCrafters · Pearle Vision · Sears Optical · Target Optical · JCPenney Optical

The member is responsible for any sales tax.

About Your Vision Coverage



EyeMed Vision Care®

State of Delaware

Vision Care Services	Member Cost	Out-Of-Network Reimbursement
Exam with Dilation as Necessary	$10 Copay	$35
Diabetic Care Services	Call EyeMed Customer Service at 1-855-259-0490 for details	N/A
Vision Therapy Services	Call EyeMed Customer Service at 1-855-259-0490 for details	N/A
Exam Options:		
Standard Contact Lens Fit and Follow-Up:	Up to $55	N/A
Premium Contact Lens Fit and Follow-Up:	10% off Retail	N/A
Frames:		
Any available frame at provider location	$0 Copay, $160 Allowance; 20% off balance over $160	$45
Standard Plastic Lenses:		
Single Vision	$20 Copay	$25
Bifocal	$20 Copay	$40
Trifocal	$20 Copay	$55
Lenticular	$20 Copay	$55
Standard Progressive Lens	$85 Copay	$40
Premium Progressive Lens	Fixed Pricing Available. Call EyeMed Customer Service at 1-855-259-0490 for details.	$40
Lens Options:		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$0	$5
Standard Polycarbonate - Adults	$40	N/A
Standard Polycarbonate - Kids under 19	$0	$5
Standard Anti-Reflective Coating	$45	N/A
Premium Anti-Reflective Coating	Fixed Pricing Available. Call EyeMed Customer Service at 1-855-259-0490 for details.	N/A
Other Premium Anti-Reflective Coatings	80% of charge	N/A
Polarized	20% Discount off Retail Price	N/A
Photocromatic / Transitions Plastic	$75	N/A
Other Add-Ons and Services	20% off Retail Price	N/A
Contact Lenses: (Contact lens allowance includes materials only)		
Conventional	$0 Copay, $160 Allowance, 15% off balance over $160	$105
Disposable	$0 Copay, $160 Allowance, plus balance over $160	$105
Medically Necessary	$0 Copay, Paid-in-Full	$200
LASIK and PRK Vision Correction Procedures:		
LASIK or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A

Frequency:	
Examination	Once every 12 months
Lenses or Contact Lenses	Once every 12 months
Frame	Once every 12 months
Monthly Rate:	
Subscriber	$6.12
Subscriber + Spouse	$9.64
Subscriber + Child(ren)	$9.84
Subscriber + Family	$15.88

Additional Discounts:
Member receives a 20% discount on items not covered by the plan at network Providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision. After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. The contact lens benefit allowance is not applicable to this service. Benefit Allowances provide no remaining balance for future use within the same Benefit Frequency. For certain brand name Vision Materials, a manufacturer may impose a no-discount practice. Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, Fidelity Security Life Policy number VC-19/VC-20, form number M-9083.

Plan Exclusions:
1) Subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear 4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; 5) Plano (non-prescription) lenses and/or contact lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care; 9) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order. 10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

State of Delaware Deferred Compensation Plan

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

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

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

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

Feature	457(b) Deferred Compensation	403(b) TSA Plan
Eligible Participants	State employees who are pension eligible (Casual-Seasonal employees are not eligible)	All employees working in a public school, charter school, DTCC, DSU and the Dept of Education regardless of pension eligibility
Basic Contribution Limits	$16,500 in 2011 (IRS may increase or decrease limit each year)	$16,500 in 2011 (IRS may increase or decrease limit each year)
Age 50 and over Catch-up Limits	$5,500 in 2011 (IRS may increase or decrease limit each year)	$5,500 in 2011 (IRS may increase or decrease limit each year)
Other Catch-up Limits	Recapture option Allows employees who are at least 3 years from obtaining normal retirement age the option to increase the amount deferred, up to twice the yearly maximum	No
Match Plan	$10 per pay after 6 months of participation (Currently Suspended)	No
Distribution of Funds	Age 70 1/2, Upon separation from employment, Unforeseeable Emergency Withdrawal, QDRO, Death	Age 59 1/2, Upon separation from employment, Becomes disabled, Hardship, QDRO, Death
Rollover	Can roll previous employer's pre-tax plans such as 401k, 403b, IRA or 457(b) into the State's 457(b)	Can roll previous employer's pre-tax plans such as 401k, 403b, IRA or 457(b) into the State's 457(b)
Trustee-to-Trustee Transfer (To buy State service)	Yes	Yes
Enroll or Make Changes	**www.fidelity.com/atwork**	**www.myretirementmanager.com/?delaware**

State of Delaware – Spousal Coordination Of Benefits Policy

The State of Delaware Spousal Coordination of Benefits Policy was instituted on January 1, 1993. The policy states that **if**:

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

The Spousal Coordination of Benefits Policy form must be completed in order to cover your spouse in one of the State of Delaware Group Health Insurance health plans. The completed form is used to determine a spouse's eligibility to receive primary coverage through the State of Delaware health benefits.

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

You MUST complete the form online at www.ben.omb.delaware.gov/documents/cob no later than May 25, 2011. If you do not have access to the internet, contact your Human Resources or Benefits Office for assistance. The form must be completed no later than May 25, 2011.

* If you and your spouse are both benefit-eligible State of Delaware employees or pensioners, you must still complete a Spousal Coordination of Benefits form for the health care carrier's records. A checkbox is located on the Spousal Coordination of Benefits form to confirm your spouse is a benefit eligible State of Delaware employee or pensioner.

* If you cover your spouse under the BCBSD Special Medicfill Medicare supplement plan, you are not required to complete a Spousal Coordination of Benefits form.

* If you are a Participating Group employee, married to a State of Delaware employee who is enrolled in the State's Group Health Insurance Program, you MUST elect coverage for yourself through your organization. For additional information, visit **www.ben.omb.delaware.gov/nonpayroll**.

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

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

Policies

Adult Dependent Coverage to Age 26 Policy

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

State employees, pensioners, and employees of those groups designated through Delaware Code to participate in the GHIP may enroll their adult dependent children to age 26 in their State health care plan from May 9 through June 9, 2011. Enrollment in a State dental plan, vision plan, and health care flexible spending account*- is also available to eligible members. Adult dependent children may be enrolled with no restriction on marital, employment, student, resident or tax status. For purposes of extension to age 26, an employee's children are defined by federal law as sons, daughters, stepchildren and adopted children. During Open Enrollment from May 9, 2011 to May 25, 2011, active State employees should enroll their dependents online through eBenefits. From May 26 through June 9th, active State employees should contact their Human Resources/Benefits Office to enroll their dependents. State pensioners should complete the necessary applications to enroll their adult dependent children and forward to the Office of Pensions no later than June 9, 2011. Participating group members should submit the appropriate applications to their Human Resource Office no later than June 9, 2011. COBRA participants should submit the appropriate applications to the Statewide Benefits Office no later than June 9, 2011.

Members are responsible for enrolling their adult dependent children and completing the Adult Dependent Coordination of Benefits Form, (AD-COB form follows policy), when enrolling each adult dependent child who turned 21 prior to the end of the preceding calendar year. The form is also required within 30 days of any change to the adult dependent's employment which impacts benefit eligibility, at the end of the calendar year in which an enrolled adult dependent child turns 21 and during subsequent open enrollment periods. A hard copy of the AD-COB form must be completed and submitted to the member's Human Resources/Benefits Office no later than June 9, 2011. Members who do not complete and submit the required AD-COB form will have claims for the adult dependent child processed at 20% of allowable charges from July 1, 2011, until the AD-COB form is received and processed by the appropriate health care provider.

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

- The adult dependent is less than 21 or turned/turning 21 in the current calendar year (2011), or
- The adult dependent is less than 24 and is a full-time student; or
- The adult dependent does not work full-time; or
- The adult dependent is not eligible to participate under his/her employer's health care plan because he/she has not satisfied his/her employer's requirement as to the number of hours worked; or
- The adult dependent's employer requires an employee contribution of more than 50% of the premium for the lowest health care plan available; or
- The adult dependent's employer does not provide health care coverage.

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

Policies

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

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

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

For some adult dependents his/her employer will not have open enrollment until after July 1, 2011. In these cases, the member may cover the adult dependent until open enrollment of the adult dependent's employer provided the employer's open enrollment occurs on or before June 30, 2012. If the adult dependent is not enrolled in his/her employer's health care plan by June 30, 2012, the member's coverage will process claims for the adult dependent at 20% of the allowable charge.

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

*** Health Care Flexible Spending Account (FSA) Program and Adult Dependent Children (Ages 21 to 26)**
Active State employees may also enroll or modify their annual election in the Health Care FSA Program based on the extension of coverage for adult dependent children to 26. Eligible health care expenses for an adult dependent child may be submitted for reimbursement until the end of the month in which the adult child turns 26. Members certify that the adult child is an eligible dependent when signing the reimbursement request form or using the Benny Card.

To enroll, print and complete FSA Election Change Form at **www.ben.omb.delaware.gov/fsa/**. The top portion of the form must be completed as well as the box entitled "Dependent satisfies or ceases to satisfy eligibility. Explain ____". The completed form must be faxed to Statewide Benefits Office at 302-739-8339 between May 9 and June 9, 2011.

Note: IRS Regulations do not provide for pensioners to participate in FSA. Participating Group employees are not eligible for enrollment in the State of Delaware's Health Care FSA Program.

Adult Dependent Coordination of Benefits Form

State of Delaware

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

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

EMPLOYER INFORMATION

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

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

AUTHORIZATION

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

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

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

- Adult dependents who are full-time students under age 24, or
- Adult dependents who are not working full time, or
- Adult dependents whose employer does not offer health care coverage, or
- Adult dependents whose employers require a contribution of more than 50% of the premium for the lowest benefit employee only plan available.

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

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

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

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

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

4/1/2011

Double State Share

If you and your spouse are both benefit-eligible State of Delaware employees/pensioners you are eligible for Double State Share (D.S.S.). (Medical plan names beginning with "D.S.S." are Double State Share Plans).

- Husband and wife eligible for Double State Share may choose two individual plans, an employee/spouse plan, or a family plan. **Please Note: No individual may be covered under more than one State of Delaware Group Health Insurance Plan.**
- When electing an "Employee and Spouse" or "Family" medical plan and you choose a D.S.S. plan the Employee Share portion of the medical plan with the State of Delaware is at no cost to you.
- The spouse whose birthday occurs first in the calendar year will carry the coverage and must enroll online through eBenefits and the other spouse must choose the "waive" coverage option when selecting a health benefit. This selection will not impact their enrollment under their spouse's plan.

Delaware Code states that the increment of cost for the options selected by the two employees, which exceeds the cost of two First State Basic family plans, shall be deducted from their salary or pension. Please note: At this time, no two combinations of options that may be chosen exceed the cost of two First State Basic family plans; therefore, there is no cost to the employee eligible for Double State Share.

Any changes to D.S.S. due to the passage of House Bill 81 will not become effective for those employees currently eligible for D.S.S. until July 1, 2012. Changes to D.S.S. for newly eligible employees will be effective January 1, 2012. Additional information regarding these changes are available at* ***www.ben.omb.delaware.gov**.*

Policies

Qualifying Events

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

Qualifying events include, but may not be limited to:

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

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

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

Notices

Extension of Dependent Coverage to Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the State of Delaware Group Health Insurance Program. Individuals may request enrollment for such children from May 9, 2011 through June 9, 2011. Enrollment will be effective July 1, 2011. For more information contact the Statewide Benefits Office at 1-800-489-8933 or visit **www.ben.omb.delaware.gov**

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 your organization's Human Resources or Benefits Office.

*Requests for special enrollment rights must be made within 30 days of the date of the qualifying event.

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

Notices

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

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, the State of Delaware Group Health plans provide coverage for:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles, coinsurance provisions, or copays as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

Grandfathered Health Plan

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

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

Questions regarding the notices provided above can be addressed to the Statewide Benefits Office at 1-800-489-8933 or at **www.ben.omb.delaware.gov**.

Effective Date.
The effective date of these Notices is: May 2011
Last Modified: May 2011

Notices

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

Early Retiree Reinsurance Program

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

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

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

Questions regarding this notice can be addressed to the Statewide Benefits Office at 1-800-489-8933 or at **www.ben.omb.delaware.gov**.

Effective Date.
The effective date of this Notice is: May 2011
Last Modified: May 2011

IMPORTANT NOTICE

COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

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

This Notice is provided to you on behalf of:

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

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

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

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

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

Notices

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

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

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

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.

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.

Notices

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.

Uses and Disclosures Requiring Written Authorization

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

Uses and Disclosures Requiring You to have an Opportunity to Object

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

Notices

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 copy of this Comprehensive Notice of Privacy Policy and Procedures at any time. In addition, a copy of this Notice is available on the State of Delaware website at **http://ben.omb.delaware.gov/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 the possession of the Plan or its vendors if you put your request in writing. 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. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but 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. 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).

Notices

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

Director, Benefits Administration, Office of Management and Budget (OMB)
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
Dominion Dental Services, Inc.
Delta Dental
The State of Delaware Employee Assistance Program
The State of Delaware Employee Flexible Benefits Plan
The State of Delaware Employee Pharmacy Care Plan
The State of Delaware Employee Vision Care Plan

Effective Date.
The effective date of this Notice is: May 2011
Last Modified: May 2011

NOTICE OF CREDITABLE COVERAGE

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

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You may have wondered how this coverage, known as Medicare Part D, affects you and whether or not there is anything you need to do.

We're pleased to let you know that the coverage you have now—provided by the State of Delaware Group Health Insurance Program—is, on average, for all participants (actives and retirees) at least as good as standard Medicare Part D coverage. This is called "creditable coverage."

This letter is your Notice of Creditable Coverage. Be sure to read this notice carefully and keep it in a safe place where you can find it. This notice answers common questions regarding creditable coverage and about your options under Medicare's prescription drug coverage. It can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

Please note that if you are not eligible for Medicare, the information below is not applicable.

What do I need to do?

To stay with your current prescription drug coverage from the State of Delaware, you don't have to do anything. Just keep using the coverage you have now. You can still use the same pharmacy network, you'll keep the same affordable copayments for your prescription drugs and you don't need to go through an enrollment process. You're already enrolled in your current plan, which provides you with coverage that is, on average, at least as good as that offered under Medicare Part D. If you do not want to continue to receive prescription drug coverage from the State of Delaware, you will want to select a commercial Medicare prescription drug plan. A summary of the Medicare plans available to you, as well as how to enroll in one of these plans, can be found on the internet at **www.medicare.gov**.

Why do I need to keep my notice of creditable coverage?

If you are satisfied with your prescription drug coverage from the State of Delaware, just keep using it as you do now. However, if you consider enrolling in one of the many Medicare Part D prescription drug plans, you may be asked for a copy of this notice. This notice will let a Medicare Part D plan know that you have creditable coverage now, and are not required to pay a late enrollment penalty, which could result in a higher premium on your new coverage. Remember, the coverage you have now through the State of Delaware is creditable coverage. That is, your current coverage is, on average, at least as good as that offered by Medicare Part D.

Notices

What if I lose my notice of creditable coverage?
If you need another copy of your notice of creditable coverage, please call the State Pension Office at 1-800-722-7300 or the Statewide Benefits Office at 1-800-489-8933. You may also write to us at:

Statewide Benefits Office
The Duncan Center
500 W. Loockerman St., Ste 320
Dover, DE 19904

State Pension Office
McArdle Building
860 Silver Lake Blvd., Ste. 1
Dover, DE 19904-2402

Do I have to enroll in a Medicare Part D plan?
No. You do not have to enroll in a Medicare Part D plan if you are satisfied with your current coverage. But you do have the option to enroll in one of Medicare many prescription drug plans from November 15th to December 31st each year or when you first become eligible for Medicare.

If I enroll in a Medicare prescription drug plan, can I keep my prescription drug plan with the State of Delaware?
If you are a Medicare-eligible retiree, you cannot have a Medicare prescription drug plan and retain your coverage with the State of Delaware. If you enroll in a Medicare prescription drug plan, prescription drug coverage through the State of Delaware for you and your eligible dependents will terminate. You will not be able to re-enroll in the State of Delaware's Prescription Drug Program until the state's open enrollment period (usually May in each year).

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

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

What if I drop my coverage with the State of Delaware, but don't enroll in a Medicare Part D plan?
If you drop your current coverage but do not enroll in a prescription drug plan approved by Medicare after your current coverage ends, you will have to pay full price for your prescription drugs.

You may also have to pay more for Medicare prescription drug coverage later. If you go for 63 continuous days or longer without coverage that is, on average, at least as good as Medicare's prescription drug coverage, your monthly premium under a Medicare plan will increase at least 1% for each month that you did not have coverage. This increase will be effective as long as you have Medicare prescription coverage.

[1]Please note that plans cannot drop coverage of their active employees who enroll in Part D. Doing so would be a violation of the Medicare Secondary Payer (MSP) rules.

For example, if you do not have coverage for 19 months before enrolling in Medicare prescription drug coverage, your Medicare premium will always be 19% higher than the Medicare base beneficiary premium. Also, you may have to wait until the next November 15 to enroll.

If I keep my current coverage with the State of Delaware, can I enroll in a Medicare Part D plan later?

Yes. You will have the opportunity to enroll in a Medicare Part D prescription drug plan every year from November 15 to December 31. However, if you decide you want to enroll in a Medicare Part D prescription drug plan after December 31, be sure you're covered under your current plan until your Medicare Part D coverage becomes effective. If you choose to enroll in a Medicare Part D plan without having creditable coverage with another plan like this one, you may have to pay an increased premium, as explained above. If you are a retiree, once you are covered by Medicare Part D, you will not be covered by the prescription plan through the State of Delaware Group Health Insurance Program.

How can I get more information?

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.
If you would like more information, you can find it by:

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

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration Web site at **www.socialsecurity.gov**, or call them at 1-800-772-1213. TTY users should call 1-800-325-0778.

Be sure to keep this notice. You may be asked for a copy of this notice if you enroll in one of the new prescription drug plans approved by Medicare after May 15, 2006. This notice will let your new plan know that you are not required to pay a higher premium amount.

As in all cases, the State of Delaware Group Health Insurance Program reserves the right to modify benefits at any time, in accordance with applicable law.

Effective Date.
The effective date of this Notice is: May 2011
Last Modified: May 2011

Statewide Benefits Health Fairs

Mark Your Calendar to Attend a Health Fair!

If you have questions about the 2011 Open Enrollment or your benefits, please attend a benefit health fair scheduled at various site locations in each county. Health Fair dates and location information are listed below:

Date	Time	Location	Address
New Castle County			
Friday, May 13, 2011	10 a.m. - 2 p.m.	Carvel State Building ***2nd Floor Mezzanine*** ***(Elevator is accessible)***	820 N. French Street Wilmington, DE 19801 ***Directions:*** http://omb.delaware.gov/admin/locations.shtml
Wednesday, May 18, 2011	4 p.m. - 7 p.m.	Stanton Middle School ***Gymnasium***	1800 Limestone Road, Wilmington, DE 19804 ***Directions:*** http://www.stanton.redclay.k12.de.us/index.html
Kent County			
Wednesday, May 11, 2011	10 a.m. - 2 p.m.	Delaware Technical and Community College, Terry Campus ***Corporate Training Center – Rooms 400 A-B***	100 Campus Drive • Dover, DE 19901 ***Directions:*** www.dtcc.edu/terry/pages/directions.html
Monday, May 16, 2011	4 p.m. - 7 p.m.	The Duncan Center ***The Outlook Conference Room*** ***5th Floor*** ***(Elevator is accessible)***	500 W. Loockerman Street Dover, DE 19904 ***Directions:*** www.theduncancenter.com
Sussex County			
Monday, May 9, 2011	10 a.m. - 2 p.m.	Delaware Technical and Community College, Owens Campus ***Carter Partnership Center- Rooms 540 A-H***	RT 18, Georgetown, DE 19947 ***Directions:*** www.dtcc.edu/owens/directions
Friday, May 20, 2011	4 p.m. - 7 p.m.	Cape Henlopen High School ***School Lobby & Cafeteria***	1250 Kings Highway, Lewes, DE 19958 ***Directions:*** http://www.doe.k12.de.us/gmaps/cape-henlopen-hs.shtml

Phone Numbers and Websites

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