

Health • Prescription • Dental



2008 Open Enrollment
Pensioners



State of Delaware

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Introduction

2008 Benefits Open Enrollment

The State Employee Benefits Committee is pleased to present your 2008 Open Enrollment information. The Open Enrollment period from May 5, 2008 through May 21, 2008 is your once-a-year opportunity to review your health, dental, VSP vision, and ARAG Group Legal coverage to make the choices that are right for you!

During the Open Enrollment period, it's important to consider:

- **Your health and dental coverage**—Do the plans in which you are currently enrolled still fit your personal situation? Have your dependents changed during the last year? **Open Enrollment is the only time during the year you can change your health and dental coverage.**
- **VSP vision and ARAG Group Legal coverage available through the Statewide Supplemental Benefits Program**—If you are not currently enrolled in vision or legal coverage, **Open Enrollment is your only opportunity during the year to join or drop these plans.** You may want to think about any upcoming needs for these plans.
- **Blood Bank membership**—Open Enrollment is also a good time to evaluate any upcoming needs you or your family members may have. See page 20 for more information on Blood Bank membership.
- **Other Supplemental Benefits (Long-Term Care, Auto and Homeowners and Pet Insurance)**—Although you can enroll in these plans throughout the year, Open Enrollment is a good time to review your personal situation and anticipate any future coverage needs.

This booklet features important information about your benefit options and what you need to do to enroll for benefits. Please read it carefully and share it with your family. In addition, you may want to make time in your schedule to attend a health fair at a location near you. See page 45 for upcoming Benefit Health Fair dates, times and locations.

If there is any 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.

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.



Important Reminders:

- **Review the action checklist on page 4** of this booklet to make certain you have taken all the necessary steps to make changes to or enroll in your benefit coverage.
- **If you cover your spouse under any State of Delaware Non-Medicare Group Health Insurance Medical Plan, you must** complete and return a new **Spousal Coordination of Benefits** form each year during Open Enrollment and anytime your spouse's employment or insurance coverage changes. The benefits you elect during the Open Enrollment Period will take effect July 1, 2008. **Failure to complete this form will result in a reduction of spousal benefits. The completed form must be submitted no later than May 21, 2008.** See page 4 for more details. If you or your spouse is covered by the BCBS Special Medicfill Medicare supplement plan, **no action is required for your spouse.**

We hope you will make the most of this information and choose the benefit coverages that fit your personal situation. No matter which plans you choose, remember to check the Statewide Benefits Office website at www.ben.omb.delaware.gov and the provider websites for detailed information about the plans. You can use this information to understand your benefits thoroughly and be an informed health care consumer.

The benefits you elect during the Open Enrollment Period will take effect July 1, 2008.

Please keep this booklet as a reference to use throughout the plan year.

What's New!

In keeping with our mission statement, each year we review our benefits program to make certain that it truly supports employees and pensioners. Part of that support includes offering benefits that assist you in being an informed health care consumer and that offer you the opportunity to make appropriate choices for your personal situation. For 2008, we have made the following enhancements to our health plans to offer you more flexibility in receiving care and to assist you in maintaining your overall health.

Because...

- For many minor injuries or illnesses, such as a bee sting or ear infection, receiving urgent care makes better practical and financial sense than going to the Emergency Room...**the urgent care copay in the HMO plans has been reduced to \$20.** Please see the HMO materials for the definition of and procedures for seeking urgent care.
- It is important for a diabetic's overall health to monitor blood sugar and to maintain a regular medication schedule... **the copay on diabetic supplies through Medco has been reduced to \$0.** Please refer to the Medco materials, www.medco.com or call 1-800-939-2142 for details on covered supplies.

2008 Benefits Overview

Medicare Supplement Plan

- Blue Cross Blue Shield Special Medicfill

Non-Medicare Health Care Plans

- Aetna HMO
- Blue Cross Blue Shield of Delaware (BCBSD)
 - First State Basic Plan
 - Comprehensive Preferred Provider Organization (PPO)
 - Blue Care® HMO

See the section “About Your Health Care Coverage” starting on page 6 for complete details on health plans.

If you cover your spouse in one of the State of Delaware Non-Medicare 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 may complete the Spousal Coordination of Benefits form online at www.ben.omb.delaware.gov/documents/cob or you may complete the form on page 43 and submit it to the State Pension Office. The form must be completed online no later than May 21, 2008.

Reminder: If you or your spouse is covered by the BCBS Special Medicfill Medicare supplement plan, **no action is required for your spouse.**

Dental Plans

- Dominion Dental HMO
- Delta Dental PPO Plus Premier

See page 21 for complete details on dental plans.

Statewide Supplemental Benefits Enrollment

- Vision Insurance – VSP
- Legal Insurance Plan – ARAG
- Auto/Home Insurance – Liberty Mutual
- Pet Insurance – PetCare®
- Long-Term Care – John Hancock

If you would like to enroll in any of the Statewide Supplemental Benefit Plans: Go to www.motivano.com. Click on Member Sign In. Then click on Account Login and finally click on SmartSavings Marketplace. **Username:** Delaware **Password:** Delaware05 **OR** call Motivano’s Customer Care Team at 1-866-664-4603 or the insurance companies directly (toll-free numbers are on page 24 of this booklet).

2008 Enrollment Action Checklist

DEADLINE: All completed Open Enrollment Forms MUST be submitted to the State Pension Office by May 21, 2008

- Read all Open Enrollment information contained in this booklet.
- Mark your calendar to attend one of the Statewide Benefit Health Fairs (see page 45 for dates, times, & locations).
- Review “Open Enrollment Frequently Asked Questions” (FAQ) section on the Statewide Benefits website at www.ben.omb.delaware.gov.
- If your spouse is covered by the BCBSD Special Medicfill Medicare supplement plan, **no action is required for your spouse.**
- If you are **not eligible** for Medicare Parts A & B, see page 11 for your Health Care Plans.
- If you cover your spouse **in one of the State of Delaware Non-Medicare 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. You may complete this form online at www.ben.omb.delaware.gov/documents/cob. If you do not have internet access, you may complete the form on page 43 of this booklet and return it to the State Pension Office **no later than May 21, 2008.**

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

If enrolling in an HMO (health or dental) plan for the FIRST TIME, make sure **before you enroll** that your health or dental provider participates in the plan you select. 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 the State Pension Office.
- If enrolling a dependent** for the FIRST TIME: You MUST submit a copy of Birth Certificate or other legal document to the State Pension Office.
- If enrolling in the Blood Bank** for the FIRST TIME: You MUST complete a Blood Bank application and submit to the State Pension Office



To enroll or make changes in your health, dental, or blood bank coverage:

- You must complete the necessary forms available on the Pension Website at www.delawarepensions.com or complete the health and dental applications included in this booklet on pages 39 and 41. You must submit your completed enrollment forms to the Pension Office by May 21, 2008.

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**

- You **must** contact the State Pension Office at 302-739-4208 or toll-free, 1-800-722-7300 for the forms to **cancel** current coverage.
- You **must** contact the State Pension Office if you, your spouse, or your dependents are Medicare eligible and **not enrolled** in the Special Medicfill Medicare Supplement health plan.
- If you have questions about the enrollment process**, or have general benefits questions, call the State Pension Office 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 one of the Statewide Benefit Health Fairs.

About Your Health Care Coverage

Notice of Special Enrollment Rights

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

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. To request special enrollment or obtain more information, contact the State Pension Office.

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

See page 31 for more information on qualifying events.

Adult Dependent Program (ages 21 to 24)

The Adult Dependent Program is available to members of the State of Delaware's Group Health Insurance program to provide a period of health care coverage to adult dependents between the ages of 21 and 24 who are no longer eligible to be covered under the parent or legal guardian's State of Delaware plan due to age and non-student status.

An Adult Dependent must enroll in the same plan which provides coverage to their parent or legal guardian who has Group Health Insurance through the State of Delaware. Contact the appropriate health care carrier (Blue Cross Blue Shield of Delaware or Aetna) directly for more detailed information on eligibility, enrollment and payment requirements.

Enrollment is available during Open Enrollment or within 30 days of loss of coverage under the parent or legal guardian's State of Delaware plan.

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.

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: See "Notice of Creditable Coverage" on page 37.

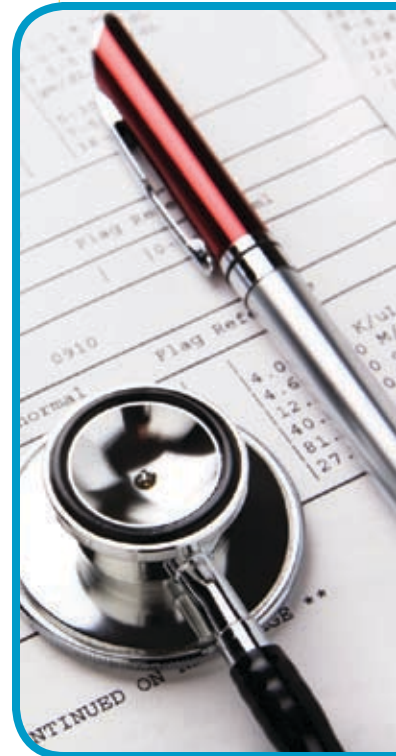
Special Medicare Supplement Plan and Benefits

More About Medicare

See page 8 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

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. Please contact the State Pension Office upon receipt of your Medicare card. **Failure to elect will result in termination of coverage through the State of Delaware Group Health Insurance Program.**



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 brochure, 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. You'll receive an updated Summary Plan Booklet delivered to your home address.

Description of Benefits	Medicare	Special Medicfill
Inpatient Hospital		
<i>Days 1-60</i>	Pays all but the Part A deductible	Covers the Part A deductible
<i>Days 61-90</i>	Pays all but a specified dollar amount of coinsurance per day	Covers the specified dollar amount of the coinsurance
<i>Days 91-120</i>	Pays nothing*	Covers care in a general hospital (except mental & nervous). These days may be used before Medicare's 60 lifetimes reserved days. Covers coinsurance amount
<i>Days 121-365</i>	Pays nothing*	Covers care in a general hospital (except mental & nervous). These days may be used before Medicare's 60 lifetimes reserved 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**

Description of Benefits	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. Mammogram based on age guidelines	Covers 20% of the reasonable charges.** One routine exam and Pap Smear is covered in a 12-month period. Mammogram for age 40 and above covered at 100%
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	You pay 100% for routine physical exams	Coverage at 100% of Blue Cross allowable, based on age guidelines published by American Medical Association
Flu & Pneumoccal 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.

2008 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	\$358.68	\$358.68	\$0
Special Medicfill WITHOUT Prescription*	\$171.24	\$171.24	\$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%

Non-Medicare Health Plans Descriptions

Aetna HMO

Here Are Three Reasons to Choose Aetna's HMO:

- 1. Large National and Local Network:** It's easy to find your current doctor or choose one using Aetna DocFind® by logging on to: <http://www.aetna.com/docfind/index.html>.
- 2. Local Customer Service:** Located in Dover, Delaware at Blue Hen Corporate Center.
- 3. Great Benefits:** Additional health and benefits information on line **exclusively** yours at no extra cost!

Access and Choice. It's Up to You! Aetna's HMO offers all the advantages of a national health plan and local customer service. Choose any primary care physician (PCP) from Aetna's broad network of providers. Aetna's HMO plan offers direct access for emergency and urgent care, well baby care, routine OB/GYN care, eye examinations and a host of health, wellness and educational programs.

Easy to Find Information. Making good decisions about your health is a lot easier when information is easy to find. Assistance is available by using Aetna's **online tools** and resources, or call a local Dover customer service representative at 1-877-54-AETNA (1-877-542-3862).

Find a Doctor—DocFind Makes it Easy! Customize your search by specialty and location. It's all here—plus maps and directions to a doctor's office. DocFind even lets you search by a doctor's gender and languages spoken.

Aetna Navigator™. Aetna's members-only website can help you better manage your health. Want to print an ID card? Track a claim? You can also e-mail an Aetna customer service representative 24/7. It's all here at your fingertips, anytime.

Have a Health Question in the Middle of the Night? Call our Informed Health Line at 1-800-556-1555. Anytime, night or day, registered nurses can provide information that may help you work with your doctor to make health care decisions that are right for you.

Exclusively Yours! Aetna's Personal Health Record (PHR) is an online tool that houses all of **your essential health information**. The PHR is **one** record to keep and access all health information about you and your family. To learn more, log on to <http://www.aetna.com/phr/video/>.

Blue Cross Blue Shield of Delaware: First State Basic Plan

This plan provides the freedom of choice you experience with a Preferred Provider Organization (PPO) that allows you to receive both in and out of network benefits.

In-network services will have a deductible of \$500 per individual and \$1000 per family. The plan will then pay at 90% of the BCBSD allowable charge. There is also a coinsurance limit of \$1500 per individual and \$3000 per family and once this is met the plan will pay at 100% of the allowable charge. Therefore, your total out

FIRST FACT!

Under the non-Medicare health plans, your eligible preventive care services are covered at 100%. Copays and the use of in-network providers may apply.

FIRST FACT!

Considering an HMO? Go to the Statewide Benefits, 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 "DocFind Instructions" for Aetna to check on which health care professionals are on their approved providers lists.

of pocket costs will be \$2000 per individual and \$4000 per family, plus any copays and non-covered charges. Please note that pharmacy benefit expenses do not accumulate toward meeting the deductible or coinsurance amounts.

Out-of-network services will be subject to a deductible of \$1000 per individual and \$2000 per family and then the plan will pay at 70% of the allowable charge. The out of network coinsurance limit is set at \$3000 per individual and \$6000 per family, after which services are paid at 100%. Out of pocket costs for non-network services will total \$4000 for individual and \$8000 for family, plus any non-covered charges. Please note that pharmacy benefit expenses do not accumulate toward meeting the deductible or coinsurance amounts.

Preventive services are covered in network at 100% of the allowable charge and are not subject to a deductible or coinsurance. Preventive services are covered out of network at 70% of the allowable charge and are not subject to a deductible or coinsurance.

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

This plan provides the freedom of choice that you experience with a Traditional Comprehensive Plan. When participants obtain services In-Network, they pay a small copay/coinsurance with no deductible, but they may also use an Out-of-Network provider to obtain benefits at a reduced level.

The plan provides an expansive national network of participating providers. If the member uses out-of-network providers, they must meet a \$300 per person/\$600 per family plan year deductible unless otherwise noted. The out-of-pocket maximum is \$1800 per person/\$3600 per family (including the deductible) per plan year. The out-of-pocket maximum applies to medical services only. Copayments for prescription medication 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 selects a primary care physician (PCP) to coordinate his/her health care needs. Blue Care members gain access to the BCBSD provider network for covered services with a PCP referral and the BCBSD nationwide network for emergency care. Blue Care® also includes coverage for services such as: outpatient, inpatient, prenatal and postnatal care, emergency, mental health care, lab, x-ray, vision, chiropractic, and many others.

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

Summary of Non-Medicare Benefits

First State Basic Plan

This Summary of Benefits is intended as a highlight of the health plans available. After your health plan selection, you'll receive a Summary Plan Booklet delivered to your home address. All percentages listed below refer to Blue Cross Blue Shield of Delaware's allowable charges.

Description of Benefit	In-Network Benefits Deductible: \$500/\$1000*	Out-of-Network Benefits Deductible: \$1000/\$2000*
	Out-of-Pocket Max: \$2000/\$4000** including deductible	Out-of-Pocket Max: \$4000/\$8000** 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 240 days	70% after deductible for up to 240 days
Home Care Services	90% after deductible for up to 240 visits per plan year	70% after deductible for up to 240 visits per plan year
Urgent Care	100% after \$25 copay	100% after \$25 copay
Emergency Services	90% after deductible	70% after deductible

MENTAL HEALTH SERVICES

Inpatient Acute	90% after deductible for up to 60 days (subject to authorization)	70% after deductible up to 60 days
Partial Hospitalization	90% after deductible up to 120 partial days (subject to authorization)	70% after deductible to 120 partial days
Outpatient	90% after deductible (subject to authorization)	70% after deductible

MENTAL HEALTH CARE (Defined by DE Code, Title 18, Chapter 33, Section 3343)/SUBSTANCE ABUSE CARE

Inpatient Acute	90% after deductible	70% after deductible up to 30 days for substance abuse and up to 60 days for serious MH
Outpatient	90% after deductible (subject to authorization)	70% after deductible

OTHER SERVICES

Durable Medical Equipment	90% after deductible	70% after deductible
Skilled Nursing Facility	90% 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	70% after deductible for up to 30 visits per plan year
Allergy Testing/Allergy Treatment	90% after deductible	70% after deductible
X-Ray, Lab & Other Diagnostic Services	90% after deductible	70% after deductible
Short-Term Therapies: Physical, Speech, Occupational	90% after deductible (subject to authorization)	70% after deductible (subject to authorization)
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 18	70% after deductible, under age 18

*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.

Summary of Non-Medicare Benefits

Comprehensive Preferred Provider Organization

This Summary of Benefits is intended as a highlight of the health plans available. After your health plan selection, you'll receive a Summary Plan Booklet delivered to your home address. All percentages listed below refer to Blue Cross Blue Shield of Delaware's allowable charges.

Description of Benefit	In-Network Benefits	Out-of-Network Benefits Deductible: \$300/\$600*
		Out-Of-Pocket Max: \$1800/\$3600 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%	80% after deductible up to 240 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: 80% after deductible

MENTAL HEALTH SERVICES

Inpatient Acute	100% up to 60 days (subject to authorization and copays)	80% up to 60 days
Partial Hospitalization	100% up to 120 days (subject to authorization)	80% up to 120 days
Outpatient	100% after \$25 copay (subject to authorization)	80% after deductible

MENTAL HEALTH CARE (Defined by DE Code, Title 18, Chapter 33, Section 3343)/SUBSTANCE ABUSE CARE

Inpatient Acute	\$100 copay/day with max of \$200/adm.	80% up to 60 days (120 days for serious MH)
Outpatient	100% after \$25 copay (subject to authorization)	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	\$25 copay/\$5 copay	80% after deductible
X-Ray, 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	\$15 copay \$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 18	80% after deductible, under age 18

*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.

Summary of Non-Medicare Benefits

HMO Plans

This Summary of Benefits is intended as a highlight of the health plans available. After your health plan selection, you'll receive a Summary Plan Booklet delivered to your home address. All percentages listed below refer to Blue Cross Blue Shield of Delaware's or Aetna's allowable charges.

Description of Benefits	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–OR Dept 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 240 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 SERVICES		
Inpatient Acute	80% up to 30 days per plan year	80% up to 31 days per plan year
Partial Hospitalization	80%	80% up to 31 days per plan year
Outpatient	\$20 copay per visit/30 visits per plan year	\$20 copay per visits/20 visits per plan year
MENTAL HEALTH CARE (Defined by DE Code, Title 18, Chapter 33, Section 3343)/SUBSTANCE ABUSE CARE		
Inpatient Acute	\$100 copay/day with max. of \$200/hospitalization	\$100 copay/day with max. of \$200/hospitalization
Outpatient	\$20 copay per visit for up to 20 visits per plan year	\$20 copay per visit for up to 20 visits per plan year
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 visit
Specialist Care	\$20 copay per visit	\$20 copay per visit
Chiropractic Care	\$20 copay per visit	\$20 copay first visit, then 80% up to 60 visits per plan year
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
MRIs, CT Scans, PT 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 \$15 office visit copay (one exam every 24 months)	100% after \$15 office visit copay (one exam every 24 months)
Hearing Tests	100% after office visit copay	100% after office visit copay
Hearing Aids	80%, under age 18	80%, under age 18

2008 Health Plan Rates

	Total Monthly Rate	State Pays	Pensioner Pays
Aetna HMO <i>Administered by Aetna</i>			
Pensioner	\$487.22	\$472.12	\$15.10
Pensioner & Spouse	\$1,022.18	\$976.86	\$45.32
Pensioner & Child(ren)	\$744.10	\$717.70	\$26.40
Family	\$1,276.06	\$1,221.10	\$54.96
First State Basic Plan <i>Administered by Blue Cross Blue Shield of Delaware</i>			
Pensioner	\$472.12	\$472.12	\$0
Pensioner & Spouse	\$976.86	\$976.86	\$0
Pensioner & Child(ren)	\$717.70	\$717.70	\$0
Family	\$1,221.10	\$1,221.10	\$0
Blue CARE[®] HMO <i>Administered by Blue Cross Blue Shield of Delaware</i>			
Pensioner	\$487.52	\$472.12	\$15.40
Pensioner & Spouse	\$1,024.56	\$976.86	\$47.70
Pensioner & Child(ren)	\$744.64	\$717.70	\$26.94
Family	\$1,278.94	\$1,221.10	\$57.84
Comprehensive PPO Plan <i>Administered by Blue Cross Blue Shield of Delaware</i>			
Pensioner	\$520.72	\$472.12	\$48.60
Pensioner & Spouse	\$1,079.78	\$976.86	\$102.92
Pensioner & Child(ren)	\$799.82	\$717.70	\$82.12
Family	\$1,349.84	\$1,221.10	\$128.74

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

Prescriptions

Prescription Coverage

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 only exception is the Special Medicfill plan without Prescription coverage for those pensioners who have chosen to enroll in Medicare Part D for their prescription coverage. 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.

Medco

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. However, if you purchase diabetic supplies, you will not be charged a copay.

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.

2008 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 2008
"Preferred" = Formulary*

The Coverage Review Process

The Coverage Review Process is 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 prescriptions with your doctor before the prescription is filled if additional



FIRST FACT!

Generic drugs are copies of brand-name drugs that have exactly the same dosage, intended use, effects, side effects, route of administration, risks, safety, and strength as the original drug. In other words, their pharmacological effects are exactly the same as those of their brand-name counterparts.

www.MedicineNet.com

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: 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.

Smart Prior Authorization and Step Therapy are automated processes used to determine whether you qualify for coverage using factors 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. For Step Therapy, certain medications may not be covered unless you have first tried another medication or therapy. These medications are part of this process: Forteo, Revatio, COX-II Inhibitors such as Celebrex, injectable rheumatoid arthritis medications, select Proton Pump Inhibitors such as Aciphex or Prevacid, and Select Antidepressants such as Lexapro.

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, selected antifungal medications such as Sporanox and Lamisil, selected migraine medications such as Imitrex and Maxalt, selected nausea medication such as Anzemet and Zofran, 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 cost.

Please note that you are required to fill a 30-day supply prior to a 90-day supply of a new medication at both retail maintenance and mail order. Medications are considered new if you have not filled this same strength and formulation of medication in the last 180 days. 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.

FIRST FACT!

Generic drugs are only cheaper because the manufacturers have not had the expenses of developing and marketing a new drug.

www.MedicineNet.com

Employee Assistance Program (EAP)

[Non-Medicare Health Plans Only]

If you and your dependents are enrolled in a non-Medicare health plan, you have access to the services of the Employee Assistance Program (EAP). The EAP offers information, face-to-face assessment, and confidential counseling services to employees and their families for:

- 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

A professional counselor is available to provide fast, confidential service 24 hours a day, every day of the year at 1-800-343-2186. For more details, visit HMS online at www.hmsincorp.com to access EAP or Work/Life services.

Best Doctors[®]—Second Opinion Program

We know that when you or a family member is faced with a serious health issue, the decisions you need to make can be extremely difficult, confusing and stressful. To help give you peace of mind as you make important health care decisions, the State of Delaware offers all pensioners enrolled in a health plan the Best Doctors service. Through Best Doctors, you have the extraordinary opportunity to have a world-renowned doctor review your medical case and ensure you have the right diagnosis and treatment plan—and you can access it without stepping away from your home.

If you're uncertain about a serious diagnosis or your treatment options, Best Doctors can provide you answers to ensure your diagnosis and treatment are on target. The service is entirely voluntary and confidential—and it is provided at no additional cost to you.

Best Doctors gathers all of your medical information, and identifies the expert doctor from their database who is best qualified to evaluate your case. After the expert doctor has reviewed your case, you and your treating physician will receive a comprehensive report with recommendations on your diagnosis and treatment plan. Together, you, your loved ones and your doctor will have the answers you deserve to confidently choose the most appropriate next steps for you.



FIRST FACT!

Ultimately, your health is your responsibility. Your primary prevention management activities should include healthy choices, eating a well-balanced diet, exercising, not using tobacco, limiting use of alcohol and other drugs, and managing your stress.

www.Welcoa.com

One phone call sets it all in motion. When you call the Best Doctors member line at 1-866-904-0910, you will be connected to a Best Doctors nurse who is ready to listen and to answer your questions about your medical situation and the Best Doctors service.

If you're unsure, call: Best Doctors at 1-866-904-0910, or visit them on the web at www.bestdoctors.com. If you are enrolled in a non-Medicare health plan, you are eligible to access the services of Best Doctors.

Blood Bank of Delmarva

The State of Delaware provides Blood Bank of Delmarva membership to Pensioners as a paid benefit.

Membership in the Blood Bank covers you, your spouse, and your dependents for any amount of blood needed. In return, the Blood Bank will ask that you "provide" a pint of blood about once every 22 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.

Pensioners need to complete the Blood Bank application, if not currently enrolled in the Blood Bank. The application is available from the State Pension Office website, www.delawarepensions.com. The completed application must be returned to the State Pension Office no later than May 21, 2008.

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 1-888-825-6638, or in New Castle County, 1-302-737-8400. If you are not currently enrolled in the Blood Bank, you may enroll by completing the Blood Bank application online, or ask the State Pension Office for an application.

FIRST FACT!

*Every 3 seconds
someone needs
blood. One pint of
blood can save
3 lives. It only takes
1 hour to give blood.*

**Blood Bank of
Delmarva**

About Your Dental Plan

Delta Dental and Dominion Dental Services will continue to administer the State's dental programs for the 2008 plan year.

Remember:

Enrollment in any of these dental plans is a **Binding Election** until next year's open enrollment. If you are enrolling in a managed care plan – Dominion Dental HMO, **before you enroll** make sure your dentist participates in the plan you select. 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 dental plan allows you to visit any dentist you choose and receive applicable benefits. But you'll save the most if you visit a dentist who participates with Delta Dental. With Delta Dental, you do not have to pick a primary care dentist. You are free to choose any dentist from any network for any covered service at any time.

The dental program available to you—known as **Delta Dental PPO Plus Premier**—provides three tiers of coverage and three levels of savings, depending on the dentist you see.

Delta Dental has the largest network of participating dentists in Delaware and the United States, giving you more opportunities to save money than ever before. Your Delta Dental program gives you access to two Delta Dental dentist networks at once that offer different degrees of savings. You are free to choose any dentist from any network for any covered service at any time. You can choose a dentist from the larger **Delta Dental Premier**[®] network or a dentist from the smaller **Delta Dental PPO** network, which features lower allowances and lower out-of-pocket costs for you. You also can choose a dentist who does not participate with Delta Dental. Your choice of dentist 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 \$1500 per plan year per participant. Delta Dental dentists cannot balance bill above the allowed amount for covered services. You are free to visit any general dentist or specialist that you choose. You can find conveniently located participating dentists by visiting Delta Dental's online dentist directory at www.deltadentalins.com/stateofdelaware, or by contacting customer service at 1-800-873-4165.

FIRST FACT!

Recent studies make a direct connection between longevity and teeth flossing. Flossing your teeth every day could add 6.4 years to your life.

www.health-fitness-tips.com



Dominion Dental HMO Plan

Dental Plan 605xs

Dominion's Dental Health Maintenance Organization (DHMO) plan emphasizes prevention and early detection of dental problems. As a managed care dental plan, carefully selected, established members of the dental community are contracted to deliver quality dental services.

Benefits Include:

- No Deductibles
- No Waiting Periods
- No Pre-authorization Paperwork
- No Maximum Annual Dollar Limits
- No Pre-existing Condition Exclusions
- No Claim Forms

Select any general dentist from the list of participating providers to receive care. Benefits include no charge for oral examinations, routine semi-annual cleanings, bitewing X-rays, and topical fluoride for children after the \$10 office visit copay. These procedures account for over 65% of dental services most frequently performed for adults, and almost 90% of the most frequently performed services for children¹. More extensive care (fillings, crowns, dentures, root canals, periodontal care, oral surgery, orthodontics, etc.) is covered at fees up to 65% lower than usual and customary charges. Specialty care is provided at the listed copayment whether performed by a participating general dentist or a participating specialist. Referrals to a specialist must be made by the member's participating general dentist.

Please contact Dominion Dental Services, Inc at www.dominiondental.com or by calling 1-888-518-5338. See page 41 for a dental application.

¹Based on utilization data provided by independent actuaries.



2008 Dental Coverage Rates

	Total Monthly Rate	State Pays	Pensioner Pays
Dominion Dental HMO <i>Administered by Dominion Dental</i>			
Pensioner	\$20.36	\$0.00	\$20.36
Pensioner & Spouse	\$34.10	\$0.00	\$34.10
Pensioner & Child(ren)	\$41.30	\$0.00	\$41.30
Family	\$48.50	\$0.00	\$48.50
Delta Dental PPO Plus Premier <i>Administered by Delta Dental</i>			
Pensioner	\$24.48	\$0.00	\$24.48
Pensioner & Spouse	\$49.96	\$0.00	\$49.96
Pensioner & Child(ren)	\$49.04	\$0.00	\$49.04
Family	\$81.84	\$0.00	\$81.84

About Your Statewide Supplemental Benefits Plan

These plans are available to all benefit eligible Pensioners. **Long-Term Care and Auto/Home insurance are also available to eligible family members.**

If you are already enrolled in any of the Statewide Supplemental Benefit plans, your re-enrollment is automatic, which means your coverage will continue unless you choose to terminate coverage.

If you wish to terminate coverage, you may do so at any time by contacting the insurance company directly (see page 24 of this booklet for contact numbers) **except** for the plans as indicated below:

- ARAG (Group Legal) and
- VSP (Vision Plan)

Group legal and vision coverage are **binding elections**. Once enrolled, you may not drop coverage during the plan year and must **wait** until the next open enrollment period to terminate coverage.

Information regarding your Statewide Supplemental Benefit options are explained in this section. The benefit options available through this program are as follows:

- **Vision Insurance through VSP**—Enrollment during **Open Enrollment only**.
- **Legal Insurance Plan through ARAG**—Enrollment during **Open Enrollment only**.
- **Auto/Home Insurance through Liberty Mutual**—Enrollment open year long.
- **Pet Care Insurance through PetCare®**—Enrollment open year long.
- **Long-Term Care Insurance through John Hancock**—Enrollment open after initial eligibility period with proof of insurability.

Motivano's SmartSavings Marketplace

SmartSavings is a members only discount marketplace that provides you with access to hundreds of brand name retailers and local merchants—all from one website. SmartSavings negotiates the best deals, offers exclusive access to special offers and discounts, and regularly updates the offers to help you stretch your hard-earned dollars. From clothing to vacations, event tickets and computers, you'll find it all on SmartSavings!

To access SmartSavings:

1. Go to www.motivano.com.
2. Click on Account Login, SmartSavings Marketplace:
 - Username: delaware
 - Password: delaware05

FIRST FACT!

If your muscles ache immediately after you've exercised, try icing whatever muscle it is that you worked. You may also want to try a cool shower.

www.webmd.com

If you need assistance please call Motivano’s Customer Care Team at 1-866-664-4603 and press #7. Customer Care hours are Monday through Friday from 8:30 a.m. to 8:30 p.m. ET. You can also email us at CustomerCare@Motivano.com.

Insurance Company	Benefits Offering	Toll-Free Number	Payment Options
Liberty Mutual	Auto and Home Insurance	1-800-730-6901	<ul style="list-style-type: none"> • Payroll deduction • Direct bill • Automatic transfer from your personal checking or savings account
John Hancock	Long-Term Care Insurance	1-800-432-9724	<ul style="list-style-type: none"> • Payroll deduction
ARAG	Legal Services	1-800-247-4184	<ul style="list-style-type: none"> • Payroll deduction
VSP	Vision Insurance	1-800-877-7195	<ul style="list-style-type: none"> • Payroll deduction
PetCare	Pet Insurance	1-866-275-Pets (1-866-275-7387)	<ul style="list-style-type: none"> • Payroll deduction • Direct payment from your banking or credit card account

FIRST FACT!

Although it’s true that carrots are rich in vitamin A, which is essential for sight, many other foods (asparagus, apricots, nectarines, and milk, for example) also contain vitamin A. So, a well-balanced diet can provide the vitamin A needed for good vision.

The American Academy of Ophthalmology

Vision Benefits through VSP

You only want the best for your eyes and VSP can keep them healthy.

Good health and clear vision don’t just happen. You need personalized care with annual eye exams, the right glasses or contacts and a continuous program to catch and treat problems before they become serious health issues.

With VSP coverage, you’ll keep your eyes healthy while getting great savings on glasses, contacts and laser vision correction.

Enrolling in VSP is Easy:

- Currently enrolled? Your re-enrollment is automatic.
- New Enrollee? Complete the online enrollment form at www.EnrollVSP.com/Delaware.
- Call Admin America (who handles VSP enrollments) at 1-866-896-1273 to speak with an Enrollment Services Representative Monday through Friday 8:00 a.m. to 9:00 p.m. and Saturday 9:00 a.m. to 3:00 p.m. EST.

Following the Open Enrollment period, you’ll receive a welcome letter from VSP mailed to your home confirming your enrollment.

Enrollment in the VSP Vision Plan is a Binding Election—once enrolled, you may not drop coverage during the plan year. You must wait until the next Open Enrollment period to terminate coverage.

Advantages of VSP Coverage*

	Without VSP*	With VSP*
Exams	\$123	\$10
Frames	\$120	\$20
Lenses (Single Vision)	\$84	\$0
Anti-reflective coating	\$100	\$61
Lenses that transition	\$90	\$62
Pensioner-only annual contribution	\$0	\$109.08
TOTAL	\$517	\$262.08

Which total would you rather see? 49% Savings!

*Comparison based on statistical average and most commonly dispensed brands.

Estimated average pensioner-only savings with VSP: \$254.92. Estimated family savings are higher.

Don't miss your chance to enroll.

Open enrollment is May 5–May 21. If you don't enroll during open enrollment, you'll have to wait until the next open enrollment period in 2009 to enroll. This is a **Binding Election**, so you may not drop coverage during the plan year.

If you want to terminate your coverage, you must do so during open enrollment at www.EnrollVSP.com/Delaware or call Admin America at 1-866-896-1273. Your termination will be effective July 1, 2008.

QUESTIONS? Online: www.vsp.com/go/stateofdelaware — Call: 1-800-877-7195

When visiting a VSP doctor, you'll receive:

Your Coverage From a VSP Doctor

Type of Coverage & Cost	Frequency
Well Vision Exam focuses on your eyes and overall wellness \$10 copay	every 12 months
Prescription Glasses LENSES • Single vision, lined bifocal and lined trifocal lenses • Polycarbonate lenses for dependent children FRAMES • Frame of your choice covered up to \$120 • 20% off amount over your allowance	every 12 months
OR	
Contacts • No copay • \$105 allowance for contacts and contact lens exam (fitting and evaluation)	every 12 months
Vision Therapy Covers supplemental evaluation and treatment plan to correct or improve severe visual problems associated with sensory and/or muscular deficiencies of the eye. Coverage is limited and subject to verification.	Call VSP at 1-800-877-7195 for more information



Extra Discounts and Savings	
Glasses and Sunglasses	<ul style="list-style-type: none"> • Average 30% savings on lens options, like progressives and scratch-resistant and anti-reflective coatings • 20% off additional glasses, sunglasses (including non-prescription), and lens options
Contacts	<ul style="list-style-type: none"> • 15% off contact lens exam (fitting and evaluation)
Laser Vision Correction	<ul style="list-style-type: none"> • Average 15% off the regular price or 5% off the promotional price from contracted facilities • After surgery, use your frame benefit (if eligible) for non-prescription sunglasses from any VSP doctor

Your Monthly Contributions	
Pensioner Only	\$9.09
Pensioner + Spouse	\$14.32
Pensioner + Children	\$14.62
Pensioner + Family	\$23.58

VSP guarantees service from VSP doctors only. In the event of a conflict between this information and your organization’s contract with VSP, the terms of the contract will prevail.

Legal Insurance Plan through ARAG®

Affordable, Flexible Legal Protection

As a valued pensioner of the State of Delaware, you have the opportunity to enroll in a legal plan from ARAG®. Just like buying homeowners or any other kind of insurance, you want to protect yourself against a future loss. A legal plan from ARAG can help protect your family, finances and future.

State of Delaware Legal Expense Insurance Plan—Full-Time Legal Protection at Your Fingertips

As a State of Delaware Legal Expense Insurance Plan member, you have access to professional attorneys, financial planners and other valuable resources to help you protect all that you work so hard to maintain. Attorney fees for most covered matters are 100% paid in full. Your legal plan is designed to cover your everyday legal needs.

Additional Services Available Through the State of Delaware Legal Expense Insurance Plan:

- Legal Advice and Consultation
- Legal Tools and Resources
- Identity Theft Services
- Immigration Services
- Financial Education and Counseling Services
- Caregiving Services

For more information or to enroll in the State of Delaware Legal Expense Insurance Plan, call 1-800-247-4184 or visit <http://members.ARAGgroup.com/Delaware>.

- Pensioner Only: \$18.00 per month
- Family: \$22.32 per month

Your enrollment period for the plan is May 5–May 21, 2008. This is a binding election so, you may not drop coverage during the plan year. If you wish to terminate your coverage during the open enrollment period, you must contact ARAG directly (no later than May 21, 2008). If you are currently enrolled, re-enrollment is automatic.

Limitations and exclusions apply.

Insurance products are underwritten by ARAG® Insurance Company of Des Moines, Iowa, GuideOne® Mutual Insurance Company of West Des Moines, Iowa or GuideOne Specialty Mutual Insurance Company of West Des Moines, Iowa. Service products are provided by ARAG, LLC, ARAG Services, LLC or Advisory Communication Systems, Inc., depending on the product and state. Some products are only available through membership in the ARAG Association, LLC. This material is for illustration purposes only and is not a contract. For terms, benefits or exclusions, call our toll-free number at 1-800-247-4184.

Auto & Homeowners Insurance through Liberty Mutual

State of Delaware pensioners qualify for auto, home and renters insurance discounts through Liberty Mutual's Group Savings Plus® program.

You could receive a discount of up to 10%* off Liberty Mutual's auto and home insurance rates. This is possible through Group Savings Plus®—a program that provides an exclusive group discount to pensioners.

With Group Savings Plus®, you'll enjoy:

- Rates guaranteed for 12 months.
- Convenient payment plans, including payroll deduction, automatic checking account deduction or direct billing at home.
- Additional savings may apply based on your age, driving experience and auto equipment (such as anti-lock brakes and airbags).
- Round-the-clock claims service.
- 24-Hour Emergency Roadside Assistance.**
- Optional Identity Fraud coverage.
- Personalized service and special savings from a company that has been helping people live safer, more secure lives since 1912.

**Discounts and credits are available where state laws and regulations allow, and may vary by state. Certain discounts apply to specific coverages only. To the extent permitted by law, applicants are individually underwritten; not all applications may qualify.*

***Service applies to auto policyholders and is provided by Cross Country Motor Club of Boston, Inc., Boston, MA or through Cross Country Motor Club of California, Inc., Boston, MA. A consumer report from a consumer-reporting agency and/or motor vehicle report, on all drivers listed on your policy may be obtained where state laws and regulations allow. Contact Liberty Mutual directly with questions. Coverage provided underwritten by Liberty Mutual Insurance Company and its affiliates.*



Enroll Now! Here's How...

- Meet with Liberty Mutual at an upcoming Health Fair in May
- Call Liberty Mutual today at 1-800-730-6901
- Visit Liberty Mutual online at www.libertymutual.com/lm/delaware

Please mention client #110361 when you contact Liberty Mutual.

Note: You may enroll in this benefit at ANYTIME during the year!

Pet Insurance through PetCare®

Don't forget about the medical needs of your beloved family dog or cat. One in three pets will need emergency veterinary treatment each year. PetCare Pet Insurance offers you the most flexible, affordable way to eliminate the financial stress of paying for your pet's unexpected medical costs. Enjoy a 10% group discount.

Enroll online at www.motivano.com.

1. Click on SmartSavings Marketplace using:

- Username: delaware
- Password: delaware05

2. Click PetCare Insurance

3. You have two different options for your method of payment:

- Payroll deduction: promotion code: br987-276
- Direct Payment from your banking or credit card account: promotion code: br987-277

You can learn about additional pet care plans, get your questions answered or enroll by calling 1-866-275-PETS (1-866-275-7387)



Long-Term Care Insurance through John Hancock

Long-Term care insurance is a benefit offered through John Hancock that can help you protect your financial resources and provide peace of mind to you and your family, should you or a family member need care. This plan is designed to offer access to affordable coverage that will provide benefits for most long-term care expenses.

This important benefit is available to State of Delaware pensioners receiving a pension check, and their eligible family members. Eligible family members include spouses, parents and parents-in-law of eligible pensioners; adult children/spouses of adult children and siblings/spouses of siblings of eligible pensioners and of their spouses; and surviving spouses receiving pension checks.

Applicants must provide proof of good health when applying at any time. Long-term care insurance premiums are based on your actual age on your effective date.

Pensioners and their spouses/surviving spouses will have their premium payments deducted from the pension check at group rates.

If you have any questions or would like to request an enrollment kit, please call John Hancock's Customer Service at 1-800-432-9724 or visit our website, dedicated to the State of Delaware, at <http://delaware.jhancock.com> (username: delaware; password: delaware05). The website and the enrollment kit include details about plan provisions and exclusions, as well as applications and premiums rates.



Final Considerations

Are You and Your Spouse Eligible for Double State Share?

In order to be eligible for Double State Share (DSS), employee and spouse must be either: permanent full-time active State of Delaware employees (regularly scheduled to work 30 or more hours per week) with greater than three full calendar months of State service, or receiving a State pension check. Husband and wife eligible for Double State Share may choose two individual plans, an employee/spouse plan, or a family plan.

No spouse or other dependent may be enrolled more than once under the State of Delaware Group Health Insurance Program. When an employee/spouse or family contract is chosen, the spouse whose birthday occurs first in the calendar year will be the subscriber to the account. In the event the birth dates are the same, the employee with the longest service will be the subscriber to the account.

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 which may be chosen exceed the cost of two First State Basic family plans; therefore, there is no cost to the pensioners eligible for Double State Share.

Long-Term Disability Health Care Coverage

Former State of Delaware employees who are receiving Long-Term disability benefits are entitled to continued health/dental with state share or double state share. As a program requirement, employees can choose to apply for LTD or they can retire—but not both.

FIRST FACT!

There's a definitive connection between living well and healthfully and having a cheerful outlook on life.

www.health-fitness-tips.com

Important Reminders

- **Open Enrollment is May 5–May 21, 2008.** There's no better time than NOW to make your benefit changes.
- **You may not make changes to your health, dental, vision or group legal coverage at any other time during the year** unless you experience a *Qualifying Event* (see below). Therefore, if you want to make any changes in your coverage, Open Enrollment is the time to do it.
- If you do not make any changes in your benefits, your benefit coverage for health, dental, vision, and legal coverage will continue into the next plan year, July 1, 2008 through June 30, 2009.
- If you cover your spouse in one of the State of Delaware Non-Medicare 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. The completed form must be submitted no later than May 21, 2008.** You may complete the form online at www.ben.omb.delaware.gov/documents/cob or you may complete the form on page 43 and submit it to the State Pension Office. If you or your spouse is covered by the BCBS Special Medicfill supplemental plan, **no action is required for your spouse.**

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 the State Pension 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 Rules and Guidelines at www.ben.omb.delaware.gov.



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, the provision of health care to you, or payment for the health care is considered “Protected Health Information” (“PHI”). The Plan is required by law to extend certain protections to your PHI, and to give you this Notice about its privacy practices that explains how, when and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

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

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.
- **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.
 - **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 other person involved in your care, or payment for your care. 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).

Your Rights Regarding Your Protected Health Information.

You have the following rights relating to your protected health information:

- **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.
- **To choose how the Plan contacts you:** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.
- **To inspect and copy your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but 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. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain about the Plan's Privacy Practices.

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

Contact Person for Information, or to Submit a Complaint.

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

Privacy Official.

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

Director, 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: April 14, 2003.

Last Modified: February 19, 2008

May 2008



NOTICE OF CREDITABLE COVERAGE

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

This notice has information about your current prescription drug coverage with the State of Delaware and about your options under Medicare's prescription drug coverage. Please read this notice carefully and keep it where you can find it. This information 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.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The State of Delaware has determined that the prescription drug coverage offered by the State of Delaware Medical and Prescription Drug Plans, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) for as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) because you lost creditable coverage. In addition, if you decide to leave the State of Delaware-sponsored coverage; you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period. Before you enroll in a Part D plan, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

Your current State of Delaware coverage pays for other health expenses in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

IMPORTANT: If you do decide to join a Medicare drug plan and drop your existing prescription drug coverage through the State of Delaware Medical and Prescription Drug Plans, be aware that you and your dependents may not be able to get this coverage back.

You should also know that if you drop or lose your State of Delaware health care coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you

go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) for as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For more information about this notice or your current prescription drug coverage...

Contact Medicare for further information about this notice or 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. Lookerman Street, Suite 300
Dover, DE 19904

State Pension Office

McArdle Building
860 Silver Lake Boulevard, Suite 1
Dover, DE 19904-2402

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through State of Delaware changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. If you are eligible for Medicare, you'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date: May 2008

Name of Entity/Sender: State of Delaware Group Health Insurance Program

May 2008

Statewide Benefits Office
Office of Management and Budget
500 W. Lookerman Street, Suite 320
Dover, DE 19904
302-739-8331

**STATE OF DELAWARE OFFICE OF PENSIONS
APPLICATION FOR HEALTH CARE COVERAGE**

A. REASON FOR APPLICATION

ADD DEPENDENTS DUE TO: <input type="checkbox"/> New coverage <input type="checkbox"/> Change coverage <input type="checkbox"/> Information change <input type="checkbox"/> Medicare Eligible <input type="checkbox"/> Refuse coverage (see Section E) Date of event checked: _____	CANCEL DEPENDENTS DUE TO: <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption/Guardianship <input type="checkbox"/> Non-voluntary coverage loss <input type="checkbox"/> Other Date of event checked: _____	REINSTATE COVERAGE DUE TO: <input type="checkbox"/> Administrative error <input type="checkbox"/> Other Date of event checked: _____
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B. PERSONAL INFORMATION

Male <input type="checkbox"/> Female <input type="checkbox"/> Retiree <input type="checkbox"/> Surviving spouse <input type="checkbox"/> Non-employee <input type="checkbox"/>	Social Security Number _____	Agency or School District PENSION OFFICE
Date of Retirement (month, day, year) _____	Home Phone (include area code) _____	Business Phone (include area code) _____
First Name _____ M.I. _____	Date of Birth (month, day, year) _____	State _____ Zip Code _____
Last Name _____	City _____	State _____ Zip Code _____

C. HEALTH CARE COVERAGE CHOICES

COVERAGE IS FOR: Individual Individual & Spouse
 Individual & child(ren) Family

PLEASE MAKE ONE HEALTH CARE COVERAGE CHOICE:
 BCBS First State Basic Blue Care (HMO) Aetna (HMO) BCBS Comprehensive
OR
 BCBS First State Basic Blue Care (HMO) Aetna (HMO) BCBS Comprehensive

MEDICARE SUPPLEMENT COVERAGE CHOICE:
 BCBS Special Medicfill Special Medicfill without prescription

MEDICARE INFORMATION: Must enroll if eligible
 Please include copy of Medicare card with this application.

Applicant's Medicare #: _____
 Part A Effective Date: _____
 Part B Effective Date: _____

D. ELIGIBLE DEPENDENTS TO BE COVERED / PRIMARY CARE PHYSICIAN SELECTION

***If you choose Blue Care (HMO) coverage or Aetna, you MUST select a primary care physician (PCP) for yourself, spouse and all eligible dependents. If more space is needed to list dependents, please use a separate sheet of paper and attach it to this application.**

Name of Your Primary Care Physician		Physician's ID Number		Is this your current physician?	
Spouse's First Name	Last Name (if different), Jr., Sr.	Birth Date	Spouse's Social Security Number	Spouse's Primary Care Physician	Physician's ID Number
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	M.I. _____	____/____/____	____-____-____	Spouse's current physician? <input type="checkbox"/> Y <input type="checkbox"/> N	____-____-____
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	Dependent's First Name <input type="checkbox"/> Fulltime student <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Handicapped	____/____/____	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	Dependent's First Name <input type="checkbox"/> Fulltime student <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Handicapped	____/____/____	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	Dependent's First Name <input type="checkbox"/> Fulltime student <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Handicapped	____/____/____	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number

E. OTHER COVERAGE INFORMATION

Anyone covered by other health insurance? If YES, and the coverage is through an employer, list name of employer: _____
 I am My spouse My dependent child(ren)

Transferring your coverage from another Blue Cross Blue Shield contract? Y N

F. TERMS OF AGREEMENT

I understand that: 1) Rights to service are subject to acceptance of this application and to the terms and conditions specified in the present contract and any future contract between my employer, association and Blue Cross Blue Shield of Delaware (BCBSD) or Aetna. 2) I certify that all representations and information supplied by me are true. My coverage shall be void if any or part of this application is false or incomplete. 3) I authorize my employer, as my agent, if applicable to collect the premiums by payroll deduction or otherwise, for remittance to BCBSD or Aetna, with the understanding that payment will not be complete until actually received. 4) I, on behalf of myself and my covered dependents, authorize any physician, hospital or any other health care provider to release information available to them concerning any diagnosis, treatment or other health care services they render to me or my covered dependents its designee for purposes reasonably related to this contract. 5) I, on behalf of myself and my covered dependents, authorize BCBSD or Aetna to release appropriate demographic information, diagnostic and medical conditions to other persons, entities or organizations for audits, claims processing, coordination of benefits, disease management programs, member satisfaction surveys, other party/liability, utilization review, case management, quality improvement and assurance and other reasonably related purposes for the administration of this contract or as required by law.

I ELECT to participate in the State Health Insurance and do agree to the above terms. **I elect NOT** to participate in the State Health Insurance.

State Of Delaware Office Of Pensions Dental Application



Effective Date

M	M	D	D	Y	Y	Y	Y

Please check the applicable box or boxes.

<input type="checkbox"/> New enrollment	<input type="checkbox"/> Name Change	<input type="checkbox"/> Change of dependents
<input type="checkbox"/> Coverage Change	<input type="checkbox"/> Address Change	<input type="checkbox"/> Termination

Please select who coverage is for: Please select one dental plan of your choice:

<input type="checkbox"/> Employee	<input type="checkbox"/> Delta Dental #1260-0001
<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/> Dominion Dental #15339-*Must provide Dentist
<input type="checkbox"/> Employee & Child(ren)	
<input type="checkbox"/> Family	

NOTE: INCOMPLETE INFORMATION ON THIS FORM WILL DELAY YOUR ENROLLMENT. PLEASE PRINT CLEARLY.

Social Security Number	Employee Name (Last, First, Middle Initial)	Date of Birth
Home Address		Home Phone
City	State	Zip Code
Date of Marriage	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	
Agency PENSION OFFICE		

PLEASE LIST HERE ALL FAMILY MEMBERS TO BE COVERED BY THIS ENROLLMENT

Last Name	First Name	MI	Sex	Date of Birth	Social Security	*Primary Care Dentist Name	*Primary Care Dentist Code
Self				/ /	- -		
Spouse				/ /	- -		
Child <input type="checkbox"/> fulltime student <input type="checkbox"/> handicapped				/ /	- -		
Child <input type="checkbox"/> fulltime student <input type="checkbox"/> handicapped				/ /	- -		
Child <input type="checkbox"/> fulltime student <input type="checkbox"/> handicapped				/ /	- -		

IMPORTANT: Do you or your dependent(s) have other Group Dental Coverage? YES NO

If your answer to the above question is yes, please complete the following information.

Name of Insured	Insurance Company	Policy Number
Name of Insured	Insurance Company	Policy Number
Name of Insured	Insurance Company	Policy Number

Employee's Signature _____ Date _____

Spousal Coordination of Benefits Policy Form



State of Delaware

Please PRINT all information requested

Check carrier: Blue Cross Aetna

YOUR FULL NAME - Last, First, Middle Initial		YOUR HOME PHONE - Include area code	
YOUR SOCIAL SECURITY NUMBER	Are you and your spouse both benefit eligible State of Delaware employees or retirees? <input type="checkbox"/> Yes <input type="checkbox"/> No		
SPOUSE'S FULL NAME - Last, First, Middle Initial	SPOUSE'S SOCIAL SECURITY NUMBER	<input type="checkbox"/> Male <input type="checkbox"/> Female	SPOUSE'S BIRTH DATE / /

Spouse information

My spouse is: Not Employed Employed Full-time Employed Part-time Self-employed Retired

NAME AND ADDRESS OF SPOUSE'S EMPLOYER (If spouse is a benefit eligible State of Delaware employee, simply write State of Delaware in this box and sign/date form)		SPOUSE'S EMPLOYER PHONE NUMBER Include Area Code
Does your spouse's employer offer medical insurance to employees? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is your spouse enrolled in medical insurance through his or her employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not enrolled, what percentage of the premium of the lowest benefit employee only plan would your spouse be required to pay?*
What is the name of your spouse's medical insurance carrier'?	What is your spouse's plan policy number? Effective Date:	Annual plan renewal date for your spouse's employer: Month: Day:
Does your spouse's medical plan cover prescription drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	Your additional comments:	

If you are completing this form due to your spouse's loss of coverage please indicate the termination date of that coverage.
Date:

Authorization

I understand that the following policy applies to spouses who regularly work full-time and are eligible for medical coverage through their own employers:

- This information will be shared with the State of Delaware's plan administrator(s).
- If spouses take advantage of their own employer's medical coverage, their 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 spouses do not take advantage of their own employer's medical coverage, the State will pay 20% of covered services provided by the employee's State of Delaware benefit plan.

I understand this form must be completed in order to cover my spouse on my State of Delaware Group Health Insurance plan. The form is used to determine a spouse's eligibility to receive primary State of Delaware health benefits. Generally, the following spouses are eligible for primary coverage:

- Spouses not working full time, or
- Spouses whose employer does not offer medical coverage, or
- Spouses 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.

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 spouse's employer. It is fraudulent to fill out this form with any information which is false or to omit important facts. Providing false information may result in disciplinary action.

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

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT Employee's Signature	Date: / /
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A complete copy of the State of Delaware's Spousal Coordination of Benefits Policy can be found online at www.ben.omb.delaware.gov/documents/cob

Statewide Benefit Health Fairs

Mark your Calendar to Attend a Health Fair!

You are encouraged to attend any of the health fairs scheduled at the various site locations if you are enrolled, or eligible to enroll, in the State of Delaware Group Health Insurance Program. Vendors will be on site at each health fair location to answer any questions you may have about your benefits. Health screenings may be available. Directions are available online at www.ben.omb.delaware.gov.

Date	Time	Location	Address
Kent County			
Monday May 5, 2008	10 a.m. – 2 p.m.	Delaware Technical and Community College, Terry Campus Education and Technology Building- Room 727	100 Campus Drive Dover, DE 19901
Monday May 12, 2008	2 p.m. – 6 p.m.	The Duncan Center The Outlook Room on the 5th Floor	500 West Loockerman Street Dover, DE 19904
Sussex County			
Wednesday May 7, 2008	10 a.m. – 2 p.m.	Delaware Technical and Community College, Owens Campus Carter Partnership Center - Room 540 A-H	RT 18 Georgetown, DE 19947
Friday May 16, 2008	2 p.m. – 6 p.m.	DHSS Stockley Center All-Star Building	RT 113 Georgetown, DE 19947
New Castle County			
Friday May 9, 2008	10 a.m. – 2 p.m.	Delaware Technical and Community College, Stanton Campus Conference Rooms A116/A114	400 Stanton Christiana Road Newark, DE 19713
Wednesday May 14, 2008	2 p.m. – 6 p.m.	Chase Center on the Riverfront Governor's Hall	800 S. Madison Street Wilmington, DE 19801

Phone Numbers and Websites

Company Name	Phone Number	Website
Aetna	1-877-542-3862	www.aetna.com
Blue Cross Blue Shield of Delaware	302-429-0260 or 1-800-633-2563	www.bcbsde.com
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
Delta Dental	1-800-873-4165	www.deltadentalins.com/ stateofdelaware
Dominion Dental Services	1-888-518-5338	www.dominiondental.com
Best Doctors®	1-866-904-0910	www.bestdoctors.com
Blood Bank of Delmarva	302-737-8400 or 1-888-825-6638	www.delmarvablood.org
Motivano Statewide Supplemental Benefits Administrator	1-866-664-4603	www.motivano.com USERNAME: Delaware PASSWORD: Delaware05
COBRAServ	1-800-877-7994	www.ceridian-benefits.com
Office of Pensions	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

