Statewide Benefits Office
Benefits Made Easy

January 1, 2019

Dear Employee,

Enclosed is a Notice entitled "New Health Insurance Marketplace Coverage Options and Your Health Coverage." The health care reform law known as the Affordable Care Act ("ACA") requires that employers provide this Notice to all new employees within 14 days of hire. The Notice provides information about the new Health Insurance Marketplace ("Marketplace"), as well as information regarding the health coverage offered by the State of Delaware ("the State").

As a full time employee, you are eligible to participate in the State's Group Health Insurance Program ("the Plan"), and therefore do not need to shop for different or additional insurance through the Marketplace. The State's coverage meets the individual mandate standard, and is expected to be a better value than Marketplace coverage.

Here is how the Plan measures up under ACA criteria for determining whether a plan's coverage is adequate and affordable for its participants:

- In general, coverage is considered "minimum value" under ACA if the benefits the plan provides cover at least 60% of eligible expenses. The Plan's medical plans meet the ACA minimum value standard.

- In general, coverage is considered "affordable" under the ACA if the premium cost for participant-only coverage is not more than 9.56% of your household income. (This percentage is for plan years beginning in 2018). For example, if your household income (including your wages) is $40,000, your coverage would be considered affordable if your employee-only coverage does not cost you more than $3,800 a year. The Plan's coverage is designed to be affordable.

The Notice mentions that you may be eligible for federal premium subsidies if you purchase coverage on the Marketplace, and that, if you do purchase a Marketplace plan, you may lose your employer contribution (if any) to the plan. Because the Plan meets the minimum value standard, you and your eligible family members would not qualify for a premium assistance tax credit to buy coverage through the Marketplace (if otherwise eligible based on your income and other factors) unless the Plan's required contribution for self-only coverage made the coverage unaffordable.

STATE OF DELAWARE STATEWIDE BENEFITS OFFICE

97 Commerce Way, Suite 201, Dover DE 19904 (D620E)
Phone: 1-800-489-8933 • Fax: (302) 739-8339 • Email: benefits@state.de.us • Website: de.gov/statewidebenefits

We encourage you to contact the Statewide Benefits Office if you have questions about the information in this letter or the enclosed Notice. You can call 1-800-489-8933 or go to the Statewide Benefits Office's website at de.gov/statewidebenefits. You can also go to the State of Delaware website, www.ChooseHealthDE.com or the federal government's website, www.HealthCare.gov.

Sincerely,

Faith L. Rentz
Director, Statewide Benefits and Insurance Coverage

Enclosure

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description, contact the Statewide Benefits Office at 1-800-489-8933 or go to the Statewide Benefits Office's website at de.gov/statewidebenefits.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit healthcare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information about Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name **State of Delaware**		4. Employer Identification Number (EIN) **516000279**
5. Employer address **97 Commerce Way, Suite 201**		6. Employer phone number **1-800-489-8933**
7. City **Dover**	8. State **DE**	9. ZIP code **19904**
10. Who can we contact about employee health coverage at this job? **Statewide Benefits Office**		
11. Phone number (if different from above) **1-800-489-8933**	12. Email address **benefits@state.de.us**	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☑ Some employees. Eligible employees are:

All full-time, part-time, and limited term employees who meet the meet the requirement

- With respect to dependents:

☑ We do offer coverage. Eligible dependents are:

Spouses and eligible children (to age 26) who meet the requirements for eligibility.

☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

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As a part time employee, you are eligible to participate in the State's Group Health Insurance Program ("the Plan"). The Plan meets the individual mandate standard.

Here is how the Plan measures up under ACA criteria for determining whether a plan's coverage is adequate and affordable for its participants:

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- In general, coverage is considered "affordable" under the ACA if the premium cost for participant-only coverage is not more than 9.56% of your household income. (This percentage is for plan years beginning in 2018). For example, if your household income (including your wages) is $20,000, your coverage would be considered affordable if your employee-only coverage does not cost you more than $1,900 a year. Depending upon your income, the Plan's coverage may not meet the affordability standard.

The Notice mentions that you may be eligible for federal premium subsidies if you purchase coverage on the Marketplace, and that, if you do purchase a Marketplace plan, you may lose your employer contribution (if any) to the plan. Because the Plan meets the minimum value standard, you and your eligible family members would not qualify for a premium assistance tax credit to buy coverage through the Marketplace (if otherwise eligible based on your income and other factors) unless the Plan's required contribution for self-only coverage made the coverage unaffordable.

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Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

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- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☑ Some employees. Eligible employees are:

All full-time, part-time, and limited term employees who meet the meet the requirement

- With respect to dependents:

☑ We do offer coverage. Eligible dependents are:

Spouses and eligible children (to age 26) who meet the requirements for eligibility.

☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

CHRISTINA SCHOOL DISTRICT

BENEFITS/SERVICES AVAILABLE

ENROLLMENT DEADLINE

The Benefit Enrollment Packet must be completed and **returned as soon as possible but no later than 30 days** from pre-employment date. If enrollment forms and documents are not signed and returned within 30 days, benefits will be "waived" in accordance with 3.01 of State of Delaware regulations.

STATE OF DELAWARE BENEFITS

For more information on the below benefits/services, visit the Statewide Benefits Office website: https://dhr.delaware.gov/benefits/ and select DOE, K12, DTCC & DCU Employees Group

Medical Insurance with Prescription – Aetna or Highmark: The State of Delaware provides a state share for permanent employees working 30 hours or more per week, after 3 months of service. The District will pay a medical stipend (flex credit) starting the first day of the month following the hire date based on negotiated contractual agreements. **Prescription coverage** through Express Scripts is automatic with your Aetna or Highmark Health Plans at no extra cost.

Contributory Pension Plan – State Pension Plan provides Service and Vested Pensions. Employees become vested after completing 10 years of State of Delaware service. Employees are required to contribute 5% of earnings above $6,000.00 annually.

State Disability Insurance – The Hartford: Short-term and Long-term benefits provided by the State at no cost to the employee.

State Group Life Insurance – Securian Life Insurance: Employees can purchase 1x to 6x annual salary. Eligible after 3 months of service. Dependent insurance is also available. Rates vary based on age and coverage elections.

Supplemental Insurance – AFLAC: Group Accident Advantage Insurance and Group Critical Illness Insurance are options available to employees. Rates vary based on age and coverage elections. Must apply within 60 days of becoming eligible for benefits.

457(b) State Deferred Compensation Plan – Voya: A State sponsored retirement savings plan available to all pension-eligible employees. There are no age or length of service requirements.

Flexible Spending Account – ASI Flex: Two distinct flexible spending account (FSA) options for benefit-eligible State of Delaware employees: **Health Care FSA** qualified expenses include medical, dental, vision and prescriptions for you & your dependents. **Dependent Care FSA** qualified expenses include care for the protection and well-being of a child (under age 13) or elder dependent while you work. Examples include before and after school care, child daycare and camps, and elder care. Benefit eligible employees may enroll after completing the **initial waiting period of 90 days.**

Employee Assistance Program (EAP) – Health Advocate: Offers confidential assistance to employees and their dependent(s) enrolled in the health insurance plan.

BENEFITS/SERVICES AVAILABLE

CHRISTINA SCHOOL DISTRICT - LOCAL BENEFITS

The Summary Plan Description, informational videos, enrollment forms and participating provider directories can be found online: http://www.schooldistrictbenefits.com/christina/

Dental Insurance – Cigna: Coverage pays benefits for many preventive and corrective dental services for the employee and eligible dependents. There are two (2) plan options available. Your member number is 000 + Your Employee ID #.

Vision Insurance – EyeMed: Coverage pays for services such as exams, lenses, frames and contacts for the employee and eligible dependents. Your member number is 000 + Your Employee ID #.

Group Life/Accidental Death & Dismemberment Insurance – Prudential Life Insurance: Covers only the employee for an amount up to 2x the annual salary (up to age 65). Coverage amount decreases after 65 years of age.

Group Long Term Disability Insurance – Cigna: Enhances State long-term disability plan by providing the employee with a 6 2/3% buy-up option, after meeting the 182-day elimination period and approval.

403(b) TSA Retirement Plan – Voya: a voluntary plan available to all employees working in a public school, charter school, DTCC, DSU and the Dept. of Education regardless of pension eligibility. There are no age or length of service requirements.

OTHER SERVICES OFFERED

Credit Union – New Castle County School Employees Federal Credit Union: Located at 113 W 6th St, New Castle, DE 19720. Checking/Savings accounts, reduced rate interest loans, Visa Credit Card Accounts, Vacation/Christmas Club Accounts and many more. Additional information available at https://www.edufcu.org/ or by phone at 302-613-5330.

DEPENDENT ELIGIBILITY/AGE LIMITS

An employee's dependent (son, daughter, stepchild and/or adopted child) is eligible for Medical/Express Scripts Prescription, Dental, and Vision coverage through the end of the month age 26 is reached.

IMPORTANT NOTICE

COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The effective date of this Notice of The State of Delaware Health Information Privacy Practices (the "Notice" is March 1, 2019.)

This Notice is provided to you on behalf of:

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

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

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

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

The Plan is required by law to follow the privacy practices described in this Notice currently in effect, though it reserves the right to change those practices and the terms of this Notice at any time. If it does so, and the change is material, the Notice will be posted on the State of Delaware website at de.gov/statewidebenefits no later than the effective date of the change and thereafter sent in the Plan's next annual mailing. This Notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan's Privacy Official, described below).

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

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

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative. e.g., a person who is your custodian, guardian, or has your power-of-

attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

- **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.**
  - **Treatment:** Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.
  - **Payment:** Another important function of the Plan is that it pays for all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans, in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan, and your spouse's plan, or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.
  - **Health care operations:** The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received, or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverage.
- **Other Uses and Disclosures of Your PHI Not Requiring Authorization.** The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:
  - **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as State of Delaware) who sponsor or maintain for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage and other disputes related to the Plan's provision of benefits; The State Insurance Department for the purpose of reviewing the state's insured plans.
  - **Required by law:** The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order or administrative tribunal. Your PHI may be disclosed for law enforcement purposes under some conditions. It must also disclose PHI to authorities who monitor compliance with these privacy requirements.
  - **National Priority Uses and Disclosures:** When permitted by law, the Plan may use or disclose medical information for various activities that are recognized as "national priorities." In other words, the Federal government has determined that under certain circumstances (described below) it is so important to disclose medical information that it is acceptable to disclose it without

the individual's authorization. We will only disclose medical information about you in the following circumstances when we are permitted to do so by law:

- **For public health activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
- **For health oversight activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
- **Relating to decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- **For research purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research. Research means a systematic investigation designed to develop or contribute to generalized knowledge.
- **To avert threat to health or safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- **For specific government functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.
- **To workers' compensation programs.** The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

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

The Plan must generally obtain your written authorization before:

- using or disclosing psychotherapy notes about you from your psychotherapist (Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan is not likely to have access to or maintain these types of notes.)

- using or disclosing alcohol and substance abuse patient records.

- using or disclosing your PHI for marketing purposes (a communication that encourages you to purchase or use a product or service) if the Plan receives direct or indirect financial remuneration (payment) from the entity whose product or service is being marketed.

- receiving direct or indirect remuneration (payment or other benefit) in exchange for receipt of your PHI.

- **Uses and Disclosures Requiring You to have an Opportunity to Object:** The Plan may share PHI with your family, close personal friend or any other person you identify, without your written authorization, if that person is involved in your care and the information is relevant to your care. If the patient is a minor, we may disclose PHI about the minor to a parent, guardian or other person responsible for the

minor except in limited circumstances. We may also provide PHI about your location, general condition, or death to assist in the notification of a family member, or personal representative or other person responsible for your care. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

- **Uses and Disclosures of genetic information for underwriting purposes.** The Plan is prohibited from using or disclosing PHI that is genetic information about you or your dependents for underwriting purposes. Genetic information for purposes of this prohibition means information about (i) your genetic tests; (ii) genetic tests of your family members; (iii) family medical history.

Breach of Unsecured PHI. You must be notified in the event of a breach of unsecured PHI. A "breach" is the acquisition, access, use, or disclosure of PHI in a manner that compromises the security or privacy of the PHI. PHI is considered compromised when the breach poses a significant risk of financial harm, damage to your reputation, or other harm to you. This does not include good faith or inadvertent disclosures or when there is no reasonable way to retain the information. You must receive a notice of the breach as soon as possible and no later than 60 days after the discovery of the breach.

Your Rights Regarding Your Protected Health Information.

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

- **To request a copy of this Notice:** You have a right to request a paper copy of this Comprehensive Notice of Privacy Policy and Procedures at any time. This right applies even if you have agreed to receive the Notice electronically. In addition, a copy of this Notice is available on the State of Delaware website at de.gov/statewidebenefits.
- **To request restrictions on uses and disclosures:** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law. In addition, you have the right to restrict disclosure of PHI to the Plan for payment or healthcare operations (but not for carrying out treatment) in situations where you have paid the healthcare provider out-of-pocket in full. In this case, the Plan is required to implement the restrictions that you request.
- **To choose how the Plan contacts you:** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.
- **To inspect and copy your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI (in hardcopy or electronic form) in the possession of the Plan or its vendors if you put your request in writing. You may request your hardcopy or electronic information in a format that is convenient for you, and the Plan will honor that request to the extent possible. You also may request a summary of your PHI. If your PHI is maintained in an Electronic Health Record (EHR) system, you may obtain an electronic copy of your records. You may also instruct us in writing to send an electronic copy of your records to a third party. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. A single 30-day extension is allowed if the Plan is unable to comply with the deadline and if the Plan provides you with a notice of

the reason for the delay and the expected date by which the requested information will be provided. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, you may be charged a reasonable, cost-based fee for creating or copying the PHI, or preparing a summary of your PHI. However, the fee may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.

- **To request amendment of your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors, you may request, in writing, that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.
- **To find out what disclosures have been made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. If we maintain your records in an Electronic Health Record (EHR) system, you may request that it include disclosures for treatment, payment or health care operations. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years (three years in the case of a disclosure involving an EHR). There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain about the Plan's Privacy Practices.

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

***Contact Person for Information, or to Submit a Complaint*.**

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

Privacy Official.

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

Director of Statewide Benefits and Insurance Coverage,
Department of Human Resources (DHR)
Telephone Number: 1-800-489-8933

This notice is effective March 1, 2019, and was revised as of March 1, 2019.

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

Human Resources Specialists, Statewide Benefits Unit, DHR 1-800-489-8933
Information Systems Manager, PHRST (302) 739-2260
Human Resources Manager, PHRST Benefits (302) 739-2260

Organized Health Care Arrangement Designation.

The Plan participates in what the federal privacy rules call an "Organized Health Care Arrangement." The purpose of that participation is that it allows PHI to be shared between the members of the Arrangement, without authorization by the persons whose PHI is shared, for health care operations. Primarily, the designation is useful to the Plan because it allows the insurers who participate in the Arrangement to share PHI with the Plan for purposes such as shopping for other insurance bids.

The members of the Organized Health Care Arrangement are:

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

This notice is effective March 1, 2019, and was revised as of March 1, 2019.

CHRISTINA SCHOOL DISTRICT

Coordination of Benefits Information

Spousal Coordination of Benefits:

If you elect to cover your spouse in one of the State of Delaware Group Health Insurance medical plans, you must read the Spousal Coordination of Benefits Policy.
https://dhr.delaware.gov/benefits/cob/education.shtml

Then complete the Spousal Coordination of Benefits form online at through Employee Self Service:
https://employeeselfservice.omb.delaware.gov/
(Benefit packet must be returned prior to accessing this form)

Dependent Coordination of Benefits:

If you are covering a child(ren) in one of the State of Delaware Group Health Insurance medical plans that has more than one health care coverage, you must complete a Dependent Coordination of Benefits form:

Highmark Dependent Coordination of Benefits

https://dhr.delaware.gov/benefits/cob/documents/highmark-cob-form.pdf

Aetna Dependent Coordination of Benefits

https://dhr.delaware.gov/benefits/cob/documents/aetna-dependent-cob.pdf

Revised 02/13/2020

STATE OF DELAWARE GROUP HEALTH INSURANCE RATES EFFECTIVE JULY 01, 2019

	Total Monthly Rate	State Pays Monthly		Employee Pays Monthly	Employee Pays Per Pay
Highmark Delaware First State Basic PPO Plan					
Employee	$695.36	$667.52		$27.84	$13.92
Employee & Spouse	$1,438.68	$1,381.16		$57.52	$28.76
Employee & Child(ren)	$1,057.02	$1,014.76		$42.26	$21.13
Family	$1,798.42	$1,726.50		$71.92	$35.96
Aetna CDH Gold Plan					
Employee	$719.68	$683.70		$35.98	$17.99
Employee & Spouse	$1,492.22	$1,417.64		$74.58	$37.29
Employee & Child(ren)	$1,099.56	$1,044.60		$54.96	$27.48
Family	$1,895.74	$1,800.96		$94.78	$47.39
Aetna HMO Plan					
Employee	$725.94	$678.78		$47.16	$23.58
Employee & Spouse	$1,530.58	$1,431.08		$99.50	$49.75
Employee & Child(ren)	$1,110.52	$1,038.34		$72.18	$36.09
Family	$1,909.82	$1,785.70		$124.12	$62.06
Highmark Delaware Comprehensive PPO Plan					
Employee	$793.86	$688.68		$105.18	$52.59
Employee & Spouse	$1,647.34	$1,429.08		$218.26	$109.13
Employee & Child(ren)	$1,223.46	$1,061.38		$162.08	$81.04
Family	$2,059.40	$1,786.54		$272.86	$136.43

CHRISTINA SCHOOL DISTRICT INSURANCE RATES EFFECTIVE JULY 01, 2019

DENTAL - CIGNA

	PLAN A			PLAN B	
	Total Monthly Rate	Per Pay		Total Monthly Rate	Per Pay
Employee	$60.10	$30.05		$46.98	$23.49
Employee & Spouse	$94.62	$47.31		$73.24	$36.62
Employee & Child(ren)	$117.52	$58.76		$90.84	$45.42
Family	$161.00	$80.50		$124.50	$62.25

VISION - EYEMED

	Total Monthly Rate	Per Pay			
Employee	$12.76	$6.38			
Employee & Spouse	$23.92	$11.96			
Employee & Child(ren)	$21.66	$10.83			
Family	$33.26	$16.63			

DISTRICT LIFE INSURANCE - PRUDENTIAL

Rate to buy up to 2 times the Annual Salaryis $0.12 per $1,000

Ex. Annual Salary	X 2.0	by 1,000	X 0.12	÷ by 2
$28,000	= $56,000	= 56.0	= $6.72	= $3.36 **Per Pay**

DISTRICT LONG-TERM DISABILITY BUY UP - CIGNA

Rate to buy up to 66 2/3%, beginning on the 182nd day of disability is $0.233 per $1,000 of covered payroll

Ex. Annual Salary	÷ by 12	÷ by 100	X 0.133	÷ by 2
$28,000	= 2,333.33	= 23.33	= 3.10	= $1.55 **Per Pay**

(The LTD benefit is capped at $8,000 per month)

Revised 06.01.2019

CHRISTINA SCHOOL DISTRICT

Together, Educating Every Student for Excellence

REQUIRED BENEFIT FORMS CHECKLIST

THE ATTACHED PACKET MUST BE COMPLETED AND RETURNED TO THE BENEFITS OFFICE AS SOON AS POSSIBLE, BUT NO LATER THAN 30 DAYS FROM ORIENTATION DATE.

Detach and retain this checklist for your records!

_____ Benefit Enrollment and Change Form * – **Return with following required documentation if covering dependents**

- _____ Copy of Marriage Certificate if enrolling a spouse
- _____ Copy of Birth certificate for each dependent child you are enrolling for the first time
- _____ Copy of Social Security Card for Spouse and each Dependent child

_____ Electronic Spousal Coordination of Benefits Form

Must complete the electronic Spousal Coordination of Benefits Form if covering a spouse to insure your spouse is fully covered https://dhr.delaware.gov/benefits/cob/education.shtml

_____ Dependent Coordination of Benefits Form

Must complete and mail or fax to selected carrier if you are covering a dependent child that is enrolled in other health coverage https://dhr.delaware.gov/benefits/cob/education.shtml

_____ District Life/AD&D Beneficiary Form - complete, sign, date, & return if electing District Life Ins.

_____ Pension Actuarial Information Form *

_____ Federal W-4 Form *

_____ State of Delaware W-4 Form *

_____ Direct Deposit Form * – **(Form is a mandatory condition of employment)**

* These forms MUST be completed, signed, dated, and returned to:

Anne Hardesty (Last Name A-K): Anne.Hardesty@Christina.k12.de.us
Tirzha Brown (Last Name L-Z): Tirzha.Brown@Christina.k12.de.us
Carol Quinn (Administrators): Carol.Quinn@Christina.k12.de.us

REQUIRED INFORMATION: Benefits will not be processed if information/signatures are missing from the enrollment form or if any of the required documents/forms are not submitted. Failure to submit required forms can result in a delay of your paycheck.

Over ------->>

CHRISTINA SCHOOL DISTRICT

Together, Educating Every Student for Excellence

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 coverage, you may in the future 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 you or your dependents' other coverage). However, you must request enrollment within 30 days after other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a change of employment status, new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Note: A federal law called HIPAA requires the State of Delaware Group Health Plan (the "Plan") provide a Certificate of Creditable Coverage (a "Certificate") to each individual who requests one so long as it is requested while the individual is covered under the Plan or within 24 months after the individual's coverage under the Plan ends. The Procedure to Request a Certificate of Creditable Coverage is available by contacting your Benefits Office.

State/District Policy: I understand after this date, I will not be able to make changes to any State and/or District Benefit Plans (Health, Dental, Vision, Life or Disability) for the remainder of the benefit period unless I experience one of the following "Qualifying Events":

- Change in employment status (1/2 time to full time, full time to ½ time, teacher to administrator)
- Change in Marital Status or Dependent Status (birth/adoption)
- Spouse's loss of coverage

I understand that it is my responsibility to notify the Benefits Office within 30 days of a "qualifying event" to make changes to my Benefit Plans. Failure to notify the Benefits Office within 30 days of the "Qualifying event" will result in waiting until the next Annual Open Enrollment Period to make changes.

Detach and retain this information for your records!