Your Summary Plan Description

Updated April 2005

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PROGRAM OVERVIEW

Your State of Delaware Benefits

The State of Delaware provides you with the opportunity to elect medical coverage (including Express Scripts) and enroll in health care and dependent care flexible spending accounts. You may also apply for coverage in the Group Life Insurance Program, or increase or decrease your multiple coverages at any time. You may also enroll in the Blood Bank program or a number of voluntary benefits programs.

Your School District Benefits

Please review the following chart, which lists the plans offered by the School District and the vendors that provide these benefits:

Plan	Carrier
Prescription Drug Coverage	CAREMARK
Dental - Plans A, B, and C	Aetna
Vision Care Coverage	Vision Benefits of America
Life and AD&D Insurance	Prudential
Long-Term Disability Insurance	Prudential

Eligibility

Eligibility Under Your State of Delaware Plans

You are eligible for coverage under the State plans if you are a(n):

- **Permanent full-time employee** (regularly scheduled to work 30 or more hours per week or 130 or more hours per month)
- **Elected or appointed official**
- **Permanent part-time employee** (regularly scheduled to work less than 130 hours per month)
- **Pensioner** receiving or eligible to receive a pension from the State

Eligibility Under Your School District Plans

Full-time and part-time employees are eligible for coverage under the plans based on negotiated contracts.

- For **dental, prescription drug** and **vision care benefits**, you are eligible on the first of the month on or after your date of hire.
- For **life and accidental death & dismemberment (AD&D)** and **long-term disability (LTD) benefits**, you are eligible on your date of hire. If you are absent from work because of an illness or injury on the day your insurance becomes effective, coverage will not begin until the day you return to work. For LTD coverage, pre-existing condition exclusions may apply.

Dependent Coverage

Dependent Coverage Under Your State of Delaware Plans

Coverage for your dependents under the State of Delaware Plans varies depending on the type of plan:

- For medical coverage, your dependents are covered through the end of the year in which they reach age 21, or through the end of the month they reach age 24 if they are a full-time college student.
- If you enroll in the Blood Bank program, you or anyone covered by your membership are eligible.
- You may elect coverage for your dependents with the State Group Life Insurance Plan.

Dependent Coverage Under Your School District Plans

Dental, prescription drug and vision care coverages apply to you and your eligible family members.

- Eligible family members for dental and vision care coverage include your spouse and unmarried children age 19 and younger, or up to age 23 if they attend school full-time (including adopted and step children, living with you in a parent/child relationship, and foster children living with you in a parent/child relationship supported primarily by you). Coverage for dependents extends to the end of the plan year in which they reach age 19. Coverage for full-time students is dropped at the end of the month in which full-time status is lost or the dependent reaches age 23.
- Eligible family members for prescription drug coverage include your spouse and unmarried children age 19 and younger (including adopted, step and foster children living with you in a parent/child relationship supported primarily by you). Coverage for dependent children continues through the plan year in which they reach age 19.

Enrollment

To elect coverage, you must complete an enrollment form within 30 days of the date you are first eligible.

If you do not enroll within 30 days, you may need to submit evidence of good health to elect life and accidental death & dismemberment coverage during a later open enrollment period.

Changing Your Benefits (Life Events)

Once you have made your benefit selections, no changes will be permitted unless you experience a life event, including but not limited to one of the following:

- You experience a change in employment status
- You experience a change in marital status
- Your dependent changes his/her status
- Your spouse experiences a change in employment status resulting in loss of coverage, or your spouse's benefits are terminated.

If you experience one of these life events, you will have 30 days to make changes to your benefits. If you fail to contact the Employee Benefits Office within 30 days of the event, you will have to wait until the next open enrollment period.

Your Flex Credits Benefit/Benefits Costs

As a School District employee, you receive two local flex credits:

- The first flex credit (OptnFlexCr) may be used for the State's medical plan cost only.
- The second flex credit (ProgFlexCr) may cover any remaining expenses for medical plan costs that are not covered by the first flex credit. The second flex credit may also be used for dental, prescription drug, vision care, life and AD&D coverage and long-term disability.

The amount of your flex credits are in accordance with the current negotiated contract or are based on special Board action.

Be sure to review the cost information for each benefit you have chosen and the final cost after your flex credits have been subtracted.

For all employees: When you select your benefits, if the cost of your benefits exceeds your flex credits, you will have to pay the excess through payroll deductions.

For employees whose spouse is also employed by the School District: When you select your benefits, you are limited to your own flex credit benefits amounts. Because the cost for family dental is the most expensive benefit, you should consider having one spouse elect employee coverage and the other spouse elect employee and children coverage.

YOUR STATE BENEFITS

Your State Medical/Express Scripts Plan

The State offers medical coverage for you and your family through Coventry Health Care and Blue Cross Blue Shield. Here are your options:

- Coventry Health Care
- Blue Cross Blue Shield of Delaware:
  - Basic
  - First State
  - Comprehensive PPO
  - Blue Care HMO

Your dependents are covered through the end of the year in which they reach age 21, or through the end of the month they reach age 24, if they are full-time college students.

When you enroll in a State medical plan, you are automatically enrolled in prescription drug coverage through Express Scripts. The Basic Plan does not include prescription drug coverage.

Your State Blood Bank Program

The Blood Bank of Delmarva is a non-profit organization that provides more than 100,000 units of blood each year to the hospitals in Delaware and the Eastern Shore of Maryland.

If you enroll in the Blood Bank program, and you or anyone covered by your membership uses blood, the Blood Bank will replace it or pay the cost of replacing it. While health insurance plans cover testing and processing fees, the cost of the blood is usually not covered.

The Blood Bank's annual fee of $5 is paid by the State for employees who work more than 30 hours per week.

Your State Group Life Insurance Plan

Life insurance is an important part of your family's overall financial security. Even if no one depends on you for financial support, life insurance benefits may be necessary to settle your estate. That's why the State of Delaware offers you and your eligible dependents Group Life Insurance through Minnesota Life. Under the plan, you may elect coverage for yourself of one to six times base pay to a maximum of $350,000.

Cost of Coverage

The cost for coverage depends on your age. The state calculates your premium based on your current age and salary. Please refer to the table below to determine your cost:

Age	Monthly Rate (per $1,000)	Age	Monthly Rate (per $1,000)
Less than 25	$.05	86	$5.35
25 to 29	$.05	87	$5.74
30 to 34	$.06	88	$6.15
35 to 39	$.07	89	$6.60
40 to 44	$.11	90	$7.10
45 to 49	$.16	91	$7.66
50 to 54	$.28	92	$8.30
55 to 59	$.42	93	$9.05
60 to 64	$.66	94	$9.92
65 to 69	$1.16	95	$11.31
70 to 74	$2.08	96	$13.58
75 to 79	$3.19	97	$17.49
80 to 84	$4.90	98	$24.12
85	$4.99	99	$25.91

Dependent Life Coverage

You can elect life insurance coverage for your dependents. You have three options (coverage levels and costs detailed below):

Option	Coverage	Cost
Option 1	$10,000 for spouse only	$2.00 per month
Option 2	$10,000 for spouse/ $6,000 per child	$2.75 per month*
Option 3	$6,000 per child	$0.85 per month*

*These rates cover all eligible children in your family.

Your State Flexible Spending Accounts

The Flexible Spending Accounts provide you with a way to pay for eligible uninsured medical, dental and dependent care expenses with tax-free money. Two Flexible Spending Accounts are available:

- Health Care Spending Account
- Dependent Care Spending Account

By directing "pre-tax" money from your paycheck into one or both of these accounts, you can put up to 41% of the money you are spending on eligible expenses back into your pocket.

- You can use the money in your Health Care Spending Account to reimburse yourself for out-of-pocket medical, dental and prescription drug expenses incurred by you or your eligible dependent(s).
- You can use the money in your Dependent Care Spending Account to reimburse yourself for any eligible day care expenses.

You should estimate your expenses carefully since any money you deposit into your account that you do not spend must be forfeited at the end of the year.

NOTE: According to IRS regulations, Flexible Spending Accounts can be used for yourself and your tax-qualified dependents only. If you have questions about Flexible Spending Accounts, please call ASI at 1-800-659-3035. ASI administers the Flexible Spending Accounts.

Health Care Spending Account

Chances are you have at least some out-of-pocket health care expenses each year such as deductibles, copayments and other expenses, which are not covered by any benefit plan. If this is the case, you may want to consider the Health Care Spending Account.

With a Health Care Spending Account, you can set aside from $50 to $3,000 annually on a pre-tax basis to help pay for eligible out-of-pocket medical, dental, and vision expenses. (To be eligible, the expense must at minimum qualify as a medical deduction on your federal income tax return.) The amount you choose should be based upon anticipated out-of-pocket health care expenses for you and your dependents. Once an eligible service is performed, complete an Expense Reimbursement Request Form, attach your receipt or explanation of benefits, and mail to the plan administrator.

Medical expenses reimbursed through the account cannot also be claimed as a deduction for income tax purposes.

For more information about eligible expenses, please consult IRS Publication 502, under the headings "What Medical Expenses Are Includible?" and "What Expenses Are Not Includible?" for details regarding what are and are not eligible expenses. But use caution when referring to Publication 502, because it is meant only to help taxpayers determine their tax deductions, not describe the expenses that are reimbursable under a health care flexible spending account. For example, the publication states that you may get a deduction for expenses *paid* during the year. For purposes of your Health Care Spending Account, you may be reimbursed for expenses you *incur* during the year - no matter when you pay for them. (Expenses are incurred on the date you receive the healthcare services, that is, the date you see the doctor or other healthcare provider.) As another example, health insurance premiums, long-term care contracts and long-term care

services are listed as deductible expenses in the publication; however, they generally are not reimbursable from your Health Care Spending Account. Publication 502 is available from your nearest IRS office or by calling the IRS at 1-800-829-3676. You also may obtain a copy online by accessing http://www.irs.gov. If you have any questions regarding the eligibility of an expense, call ASI at 1-800-659-3035.

Dependent Care Spending Account

The Dependent Care Spending Account lets you use pre-tax dollars to reimburse yourself for the cost of eligible child or dependent care expenses that are necessary for you - or, if you are married, you and your spouse - to work or to attend school full-time. With a Dependent Care Spending Account, you can set aside from $50 to $5,000 annually on a pre-tax basis to cover dependent care expenses for the year. (The annual amount reimbursed cannot exceed the earned income of the lower-paid spouse or $5,000, whichever is less. If married and filing separate tax returns, it cannot exceed $2,500.) To be eligible to use this account, you must be at work during the time your eligible dependents are receiving care.

You qualify to use a Dependent Care Spending Account if:

- You are a single parent
- You have a working spouse
- Your spouse is a full-time student for at least five months during the year while you are working
- Your spouse is disabled and unable to provide for his or her own care

Eligible dependents include:

- Your children up to age 13 whom you claim as dependents for tax purposes
- Adult dependents who normally spend at least eight hours in your home each day and are not able to care for themselves because of disability.

A complete list of reimbursable expenses is available in IRS Publication 503, "Child and Dependent Care Expenses." Please review this list before you decide to elect a Dependent Care Spending Account. Also, when making your election be sure to consider your back-up day care usage. Publication 503 is available from your nearest IRS office or by calling the IRS at 1-800-829-3676. You also may obtain a copy online by accessing http://www.irs.gov. If you have any questions regarding the eligibility of an expense, call ASI at 1-800-659-3035.

Your State Employee Assistance Program (EAP)

The State offers employees access to an Employee Assistance Program (EAP), administered by Human Management Services Inc. The EAP helps employees and their dependents find answers for personal and family problems. All employees who are enrolled in the State of Delaware non-Medicare health insurance plans, their dependents, and pensioners who do not have Medicare, may use the EAP.

Confidentiality

Information shared with the EAP is confidential. It will not be disclosed to anyone without the individual's specific written consent, except in cases of imminent threat of harm to self or others, or as otherwise required by law or court order. **EAP records DO NOT become part of an employee's personnel file.**

Cost of Coverage

There is no cost to eligible employees, pensioners and dependents (participants) for the initial assessment or short-term counseling services provided by the EAP. Fees charged by providers to whom you may be referred are your responsibility in coordination with your health insurance. The EAP professional will make every effort to coordinate care through your State of Delaware health plan. EAP providers are conveniently located within a reasonable distance from your home or worksite. Day or evening appointments can be arranged to accommodate your work schedule. In case of emergency, an EAP counselor is available by phone 24 hours-a-day, 7 days a week.

For more information or to arrange for a confidential appointment, call the number listed below. The company code for the State of Delaware plan is "StateDE."

Human Management Services, Inc.
1-800-343-2186
www.hmsincorp.com

Your State Supplemental Benefits

(These benefits may not be purchased through District Flex Credits. This means these benefits are 100% employee paid through payroll deduction)

You may elect to participate in a number of voluntary benefits programs, offered through the State. A Statewide Supplemental Benefits Booklet with information on each program and instructions on how to enroll will be mailed to each eligible employee during the open enrollment period and will be available in each new hire packet. More information will also be available on the State Personnel Office website at www.delawarepersonnel.com/benefits.

- *Auto/Homeowners Insurance* includes coverage for cars, boats, motor homes, motorcycles, homeowners and renters.
- *Long Term Care Insurance* protects you and your loved ones in the event that extended care is needed during your life.
- *Group Legal Services* give you and your family access to professional legal representation for issues ranging from consumer protection to wills and estate planning.
- Additional *Vision Insurance* (not VBA) includes exam, lenses and frames or contacts.
- *Pet Insurance* provides medical coverage for dogs, cats, birds and other animals.

YOUR SCHOOL DISTRICT BENEFITS

Your School District Dental Plan

Routine, professional dental care is an important part of your family's health care. The School District's Dental Plan offers three choices of dental coverage through Aetna. All three cover a variety of preventive, basic, and major services.

These choices allow you to choose a plan that best meets your family's needs. The plan options differ in the level of coverage they provide and the amount you pay for each option. Your choices include:

- Plan A: High Option with Preferred Provider Organization (PPO)
- Plan B: Moderate Option with Dental Maintenance Organization (DMO)
- Plan C: Basic Option

Plan A: High Option

Plan A offers the highest level of dental coverage. This plan stresses preventive care to help you and your family avoid serious dental problems. The plan pays 100% of the covered cost (reasonable and customary charges) of preventive and basic services. It also pays 80% of the covered cost (reasonable and customary charges) of major services and orthodontia care. The maximum benefit you can receive under this plan each year is $2,000 per person, with the exception of orthodontia care which carries a separate $1,000 per person lifetime maximum.

Plan A also includes a Preferred Provider Organization (PPO) feature, which gives you the option of receiving care from PPO participating dental care providers and paying less out-of-pocket.

Participating dentists agree to charge negotiated rates. These rates are typically lower than the rates charged by non-participating dentists. This means that when you visit a participating dentist, your out-of-pocket costs may be less. Remember, when you visit a non-participating dentist, you are responsible for a percentage of the reasonable and customary charges for major services. In addition, you pay any amount above the reasonable and customary limit for all services. Here's an example of how you might save money using a participating dentist compared to a non-participating dentist.

HERE'S AN EXAMPLE

Let's assume you need a major procedure that's covered at 80%:

	Participating Dentist	Non-participating Dentist
Provider's Regular Fee	$575	$575
Negotiated Fee	$400	N/A
Reasonable & Customary Limit	N/A	$450
Provider Pays	80% of $400 = $320	80% of $450 = $360
You Pay	20% of $400 = $80	$215 (20% of $450 = $90 PLUS $125 amount over R&C limit)
Savings obtained by using a participating provider = $135		

NOTE: This chart is for illustrative purposes only.

To locate a participating provider in your area, visit www.aetna.com or call 1-877-238-6200 to request a provider directory.

Plan B: Moderate Option

Plan B offers a moderate level of dental coverage. If you elect Plan B, you may enroll in either the Aetna Alternate Dental Plan℠ or the Aetna Dental Maintenance Organization (DMO®). Under the Alternate Plan℠, you may receive care from any dentist you choose, but you receive a lower level of coverage for basic services and you are subject to a $1,000 annual benefit maximum. You may elect either plan for a minimum period of one calendar month. All eligible family members must be enrolled in the same plan during the same period of time. You have the option of changing plans, or changing your DMO® dentist, by calling 1-877-238-6200 by the 15th of the current month. Any change you make will be effective on the first day of the following month. If you make your selection after the 15th, the change will become effective on the first day of the second month following your election. There is no limit to the number of times you may change your plan or your dentist.

The Aetna DMO® plan provides a higher level of benefit coverage if you use a network of participating dentists. This includes an unlimited orthodontia lifetime maximum. To enroll in the DMO®, you will need to select a participating dentist from the Directory of Dentists available through the School District's Employee Benefits Office or by calling 1-877-238-6200.

If you enrolled in the DMO® and receive care from a non-participating dentist, the plan will cover you at a lower benefit level, based on a fee schedule. If your actual charges exceed the amount payable under the plan, you pay the difference. Also, services provided by a non-participating dentist are subject to a $100 deductible, with the exception of emergency care.

If you are enrolled in the Alternate PlanSM and receive care from a participating dentist in the DMO® network, you will receive the lower level of benefits under the Alternate Plan℠, not the higher level of benefits under the DMO® network.

Plan C: Basic Option

Plan C provides you and your family with a basic level of dental coverage. Like the other two plans, Plan C covers ongoing preventive and basic care, as well as benefits for major services such as dentures and crowns. However, Plan C pays only 50% of the covered cost (reasonable and customary charges) for basic and major services after a deductible has been met, and preventive services are based on a fee schedule. (See the Aetna Fee Schedule for corresponding dollar amounts.) Orthodontia care is not covered.

A deductible of $25 per person and $50 per family must be met before the plan pays any benefits. If your actual charges exceed the amount payable under the plan, you pay the difference. The maximum benefit you can receive each year under this plan is $1,500 per person.

Comparison of Dental Plans

	Plan A		Plan B			
			Aetna DMO®		Aetna Alternate Plan℠	Plan C
	Participating	Non-Participating[1]	Participating	Non-Participating		
Deductible	None	None	None	$100 (Waived for emergency care)	None	$25 per individual/$50 per family (Waived for preventive services)
Preventive Services	100%	100% of reasonable & customary charge	100%	According to fee schedule[2]	100% of reasonable & customary charge	According to fee schedule[2]
Basic Services	100%	100% of reasonable & customary charge	100%	According to fee schedule[2]	80% of reasonable & customary charge	50% of reasonable & customary charge
Major Services	80%	80% of reasonable & customary charge	75%	According to fee schedule[2]	According to fee schedule[2]	50% of reasonable & customary charge
Orthodontia Services	80%	80% of reasonable & customary charge	50%	50% of reasonable & customary charge	50% of reasonable & customary charge	Not covered
Annual Benefit Maximum	$2,000	$2,000	Unlimited	Unlimited	$1,000	$1,500
Lifetime Orthodontia Maximum	$1,000	$1,000	Unlimited	$800	$1,000	N/A

[1]Plans only pay benefits for charges that are within reasonable and customary limits. This is an amount generally charged for similar services within your geographic area. If the fee is higher than the reasonable and customary charge, you are responsible for the remaining percentage of the charge, as well as charges above the reasonable and customary limit.

[2]See the Plan B Fee Schedule or Plan C Fee Schedule on the Benefits Web Site for corresponding dollar amounts.

What Is Covered

The plans pay for many of the preventive, basic and major services you and your family receive. The following services are covered under each of the three plans.

PREVENTIVE SERVICES

- Routine oral exams twice a year
- Teeth cleaning twice a year (including scaling and polishing for covered members age 14 and over)
- Fluoride application for children under age 18 once a year
- Bitewing X-rays twice a year
- Full mouth series or panoramic X-rays once every three years
- Preventive services for members enrolled in the DMO® under Plan B include sealants, oral hygiene instruction, and routine oral exams four times a year

BASIC SERVICES

- Emergency care
- Consultation with specialists
- X-ray and pathology
- Oral surgery (including anesthesia and routine postoperative care) for extractions, impacted teeth (major service under the DMO®), alveolar or gingival reconstruction, and odontogenic cysts and neoplasms
- General anesthetics in conjunction with surgical procedures
- Periodontics, endodontics, and root canals (molar teeth under the DMO® is a major service) for impaired teeth only (excluding final restoration)
- Restorative dentistry including fillings, pins, stainless steel crowns, denture repairs, adding teeth to partial dentures (that replace natural teeth), recementation, and repairs to bridges and crowns
- Space maintainers

MAJOR SERVICES

- Restorative care including inlays, onlays, and crowns (gold restoration and crowns are covered only when teeth cannot be restored with other material or the tooth abuts a fixed bridge)
- Prosthodontics, including bridge abutments, artificial teeth, and removable bridges
- Full and partial dentures and relining, including an adjustment within six months of installation (excluding specialized techniques or characterizations)

What Is Not Covered

It is important to understand what your plan covers and how much of your benefits it will pay. When your dentist estimates that your total cost of dental treatment will exceed $300 or more and you are not covered under the DMO plan, you can request a Pre-Determination of Benefits with your insurance company that lets you know up front how much the plan will pay. To request a Pre-Determination of Benefits, simply have your dentist complete a claim form prior to administering services or treatment, and then submit it to the insurance company. Advance claim review helps you understand what your copayment will be and any other cost for which you may be responsible.

The following is a list of exclusions and limitations under your dental plan. Please refer to the actual plan documents or contact Aetna at 1-877-238-6200 for more details on limitations and exclusions:

- Services that are not considered reasonable and customary
- Services not performed by a dentist, with the exception of licensed dental hygienists and routine x-rays
- Services performed by or for the government unless payment of the charge is required by law
- Services that would have been covered by the government, except for Medicaid
- Replacement or modification of dentures, bridges, crowns, or gold restoration within five years of installation

- Dentures or bridges that replace natural teeth when the teeth were missing before you were covered. This does not apply if the denture or bridge also replaces a natural tooth that was removed while you are covered and was not an abutment to a partial denture or bridge installed in the last five years.
- Appliances, services, or supplies ordered while you were not covered
- Cosmetic services including crown facing or the facing of artificial teeth behind the second bicuspid, except for certain eligible expenses. Eligible expenses include cosmetic services needed as a result of accidental injuries suffered while you are covered.
- Treatment for jaw joint problems if you are covered by the DMO® under Plan B
- Appliances, restorations, or procedures needed to alter vertical dimensions, restore biting, or correct attrition or abrasion
- Replacement of lost or stolen dental appliances
- Injuries or diseases covered by Workers' Compensation or other occupational laws
- Charges for treatment that is deemed not medically necessary
- Any charge above the copayment percentage based on reasonable and customary charges. Where benefits are based on a schedule, the dental plans do not pay any amount that exceeds the scheduled benefits.

Orthodontia

Orthodontia benefits for you and your eligible family members are covered under Plan A and Plan B. These plans provide benefits for the following:

- Services or supplies provided for an orthodontia procedure during the term of treatment
- Active appliances inserted while covered under the plan
- Services that correct overbites, overjets, faulty alignment, or crossbites
- Services your dentist submitted for pre-approval with the insurance company and were approved

When Coverage Ends

Your coverage generally ends on the earliest of the:

- Last day of the month in which your employment ends
- Date you are no longer eligible for benefits
- Last day of the period for which you have made the required contributions
- Date coverage is cancelled

Coverage for your family generally ends when your coverage ends or when a dependent is no longer eligible.

Continuation Of Coverage

In certain circumstances, you may continue dental coverage for yourself and your family when your coverage ends.

Coordination Of Benefits

If you have dental coverage through your spouse's employer or another source, and have coverage through the School District's plan, a provision known as Coordination of Benefits may reduce your benefits under the School District's plan so your combined benefits will not be more than the expenses recognized by both plans. It is important that you understand the Coordination of Benefits guidelines that determine which of your plans pays benefits first.

Appealing A Claim

For dental benefits, if your claim is denied in whole or part, you will be notified in writing. The notification will include the reasons for the denial and any additional information required if you want to appeal. Learn when and how to appeal your claim on page 36.

Glossary

The following explanations will help you understand how the dental plans work.

Annual Benefit Maximum. For each plan year, each plan pays a maximum dollar amount toward your covered dental expenses (with the exception of the DMO® under Plan B which has no maximum). Once your dental benefits reach this dollar maximum, you are not eligible for dental benefits until the beginning of the next school year.

Copayment. After the plan pays a percentage of the reasonable and customary fee for dental services, the remaining cost is your copayment. For example, if the plan pays 80% of a basic or major service, the remaining 20% is your copayment. Keep in mind, the actual charges may be greater than what the insurance company defines as a reasonable and customary charge. If so, you are responsible for payment of any amounts over the reasonable and customary limits.

Deductible. This is the amount that you and your family must pay for covered basic and major services before the plan will pay any benefits under Plan C. You may also pay a deductible for services performed by a non-participating dentist if you are enrolled in the DMO® under Plan B.

Dentist. For the purposes of these plans, a dentist must be licensed and acting within the scope of his/her profession. Any other doctor or professional providing dental services must also operate within the scope of services he/she is licensed to perform.

Participating Dentist. A dentist who is a member of the PPO network under Plan A or DMO® network under Plan B. Keep in mind, you receive a higher level of benefits by coordinating your care through a dentist who is in the network. To obtain a directory of participating dentists, call Aetna at 1-877-238-6200.

Reasonable and Customary (R&C). The plans only pay benefits for charges that are within reasonable and customary limits. This is an amount generally charged for similar services within your geographic area. If the fee is higher than the reasonable and customary charge, you are responsible for the remaining percentage of the charge (your copayment), as well as the charges above the reasonable and customary limit.

Your School District Prescription Drug Plan

Prescription drug benefits are a valuable part of your coverage and are designed to help you obtain prescriptions at reduced out-of-pocket costs. The Prescription Drug Plan is offered through CAREMARK. The CAREMARK Prescription Drug Plan supplements the prescription drug benefits available through the State's medical plans. You may elect coverage under this plan even if you do not elect coverage under the School District's Medical Plan.

The Prescription Drug Plan has two components:

- Prescription Card Program for medications that treat acute illnesses or injuries
- Mail Service Program for maintenance medications – medications you take on a long-term basis.

Prescription Card Program

The prescription card program is best utilized when your doctor prescribes medication for treatment of a short-term (acute) illness or injury. In this case, you can have your prescription filled at any pharmacy that participates in the CAREMARK program. (Most national drug store chains as well as many independent pharmacies are members of the program.)

When you have a prescription filled, you pay $5 per prescription for generic drugs and $10 per prescription for brand name drugs. Your benefit maximum under the prescription card program is a supply of 34 days for acute care drugs, and 100 units for drugs to treat a chronic condition.

The maximum annual benefit you may receive is $1,000 for each covered family member up to a $10,000 maximum. For example, a family of three would be covered for up to $3,000, while a family of twelve will be covered for up to only $10,000.

Mail Service Program

The CAREMARK mail service program is best utilized for medication taken on an ongoing basis if you have a chronic condition. For example, the mail service program works well for people who use maintenance drugs for conditions such as diabetes, arthritis, ulcers, high blood pressure, or heart conditions. With the mail service program, you pay $5 per prescription for generic drugs and $10 for brand name drugs up to the greater of 100 units or a 90-day supply.

To purchase prescription drugs through the mail service program, you will need to complete an order form and patient profile (for your first order only).

It is your responsibility to keep your pharmacy and mail-order receipts and to know whether or not you have reached the annual benefit maximum.

What Is Not Covered

Your prescription drug benefit generally covers any medical substance that can be dispensed only by a prescription (including injectable insulin). Your prescription drug benefit does not cover:

- Drugs dispensed by a hospital, nursing home, clinic, ambulatory surgical center, or other institution while you or your covered family members are being treated in that institution
- Charges to administer prescription drugs
- Devices used to administer prescription drugs (such as hypodermic needles, syringes, or support garments)

- Infertility drugs or drugs used to prevent conception
- Refills in excess of your doctor's specified number
- Immunization agents, biological sera, blood, or blood plasma
- Experimental and certain biotech drugs
- Prescriptions over one year old (or less than one year old if covered by law)

When Coverage Ends

Your prescription drug coverage generally ends on the earliest of the:

- Last day of the month in which your employment ends
- Date you are no longer eligible for benefits
- Last day of the period for which you have made the required contributions
- Date coverage is cancelled

Coverage for your family generally ends when your coverage ends or when a dependent is no longer eligible.

Continuation Of Coverage

In certain circumstances, you may continue prescription drug coverage for yourself and your family when your coverage ends.

Coordination Of Benefits

If you have prescription drug coverage through the State or another source, and have coverage through the School District's plan, you need to understand how both plans compare to each other in order to minimize the amount you pay. It is important that you understand the Coordination of Benefits guidelines that determine which of your plans pays greater benefits.

Appealing A Claim

For prescription drug benefits, if your claim is denied in whole or part, you will be notified in writing. The notification will include the reasons for the denial and any additional information required if you want to appeal your claim.

Your School District Vision Care Plan

The Vision Care Plan is administered by Vision Benefits of America (VBA). If you enroll in the plan, you may choose to receive care from a VBA-participating provider and receive a higher level of benefits, including 100% coverage for a vision exam and lenses. Alternatively, you may choose to receive care from a non-participating provider and have treatment reimbursed at a reduced level.

Your dependents are eligible to participate in this plan provided they are under age 19, or 23 if a full-time student. Coverage for dependents extends to the end of the Plan year in which they reach 19. Coverage for full-time students extends to the end of the month in which full-time status is lost or dependent reaches 23.

How the Vision Care Plan Works

Each time you or a covered spouse or dependent needs vision care, you must call VBA's Customer Service Department at 1-800-432-4966 before making an appointment. If you are eligible, VBA will send a benefit form and a current list of participating providers to your home within one week of your request. If you select a participating provider, you must present the VBA benefit form on your first visit.

What Is Covered

Whether or not you choose a VBA-participating provider, vision care benefits include a vision exam, standard lenses and a pair of frames once every 12 months. You and your covered spouse and dependents are eligible for the following benefits:

Benefit	Frequency	VBA Participating Provider	Non-Participating Provider
Vision Exam	Once every 12 months	Covered 100%	$35 Reimbursement
Clear Standard Lenses			
Single Vision	Once every 12 months	Covered 100%	$40 Reimbursement
Bifocal			$50 Reimbursement
Trifocal			$75 Reimbursement
Lenticular			$100 Reimbursement
Progressive Multifocal			Not covered
Polycarbonate Lenses			Not covered
Tints/UV Protective/ Scratch Resistant Coatings			Not covered
Frames	Once every 12 months	Covered 100% up to $60 wholesale allowance (approximately $120 to $150 retail)	$60 Reimbursement

CONTACT LENSES

If contacts are medically required, VBA will pay 100% of the UCR fee* if you use a VBA-participating provider and $250 if you use a non-participating provider. When chosen in lieu of glasses (not medically required), contacts and a contact lens exam are reimbursed up to a combined maximum of $150.

ADDITIONAL VISION CARE BENEFITS

The following options are supplementary cosmetic benefits available through the Vision Care Plan for an additional cost. All fees for additional benefits are set by VBA.

- Photochromic lenses
- Rimless frames
- Lamination of a lens or lenses
- Contact lenses or frames in excess of what is covered by the plan
- Anti-Reflective coating of the lens or lenses

Call VBA's Customer Service Department at 1-800-432-4966 or visit the VBA Web site for information about these benefits.

NOTE: When you use a VBA provider, you must present a VBA benefit form on your first visit.
* The UCR (usual, customary and reasonable) fee is charged by other providers in a specific geographic area.

What Is Not Covered

Your vision care benefit does not cover the following:

- Orthoptics or vision training
- Two pair of glasses in lieu of bifocals
- Services or materials provided as a result of any Workers' Compensation Law (or similar legislation)
- Replacement of lost or broken lenses or frames provided under this plan other than the normal intervals when services are otherwise available
- Non-prescription lenses
- Medical or surgical treatment of the eyes
- Any eye examination, or corrective eyewear, required by an employer as a condition of employment
- Glasses and contact lenses during the same eligibility period (once in 12 months)

If you use a VBA-participating provider, but do not provide the VBA benefit form on your first visit, your vision care services may not be covered under VBA's higher level of benefits for using network providers. In this instance, the VBA-participating provider may elect to charge his or her UCR fees.*
* The UCR (usual, customary and reasonable) fee is charged by other providers in a specific geographic area.

When Coverage Ends

Your coverage generally ends on the earliest of the:

- Date your employment ends
- Date you are no longer eligible for benefits
- Last day of the period for which you have made the required contributions
- Date coverage is cancelled

Coverage for your family generally ends when your coverage ends or when a dependent is no longer eligible.

Continuation Of Coverage

In certain circumstances, you may continue vision coverage for yourself and your family when your coverage ends.

Coordination Of Benefits

If you have vision coverage through the State or another source, and have coverage through the School District's plan, you need to understand how both plans compare to each other in order to minimize the amount you pay. It is important that you understand the Coordination of Benefits guidelines that determine which of your plans pays benefits first.

Appealing A Claim

For vision coverage benefits, if your claim is denied in whole or part, you will be notified in writing. The notification will include the reasons for the denial and any additional information required if you want to appeal. Learn when and how to appeal your claim on page 36.

Your School District Life and AD&D Insurance Plan

The Life and Accidental Death and Dismemberment (AD&D) Insurance Plan provides valuable benefits for you and your family if you become seriously injured or die while you are insured.

Recognizing that benefits needs can change, the School District has included several options in your life and accident insurance coverage to protect your family from financial hardship. One option offers you the ability to continue your coverage if you become totally disabled. You may also elect to receive part of your life insurance coverage while you are still living if you become terminally ill. In addition, under certain conditions, you may convert your life insurance to an individual policy if you leave the School District.

Life Insurance Benefits

A life insurance benefit is paid to your beneficiary in the event you die while you are insured. Your life insurance benefit depends on your age and is equal to the amount shown on the following table up to a maximum of $250,000.

Age	Benefit*
Up to age 65	One and one-half times your annual earnings
Age 65-69	One times your annual earnings
Age 70-74	Half of your annual earnings
Age 75+	$5,000

*The amount of your life insurance benefit is rounded up to the next $500.

In all cases, the minimum benefit your beneficiary will receive is $5,000.

Accidental Death & Dismemberment (AD&D) Benefits

AD&D coverage pays benefits to either your beneficiary for the loss of your life or to you for the loss of your sight, hand, foot, hearing or speech as the result of an accident. AD&D benefits are in addition to your life insurance through the School District. Benefits are paid only if you are insured at the time of the loss, the loss is within 90 days of the accident that caused it, and the loss results directly from the accident and from no other cause.

The following table shows the AD&D benefit amounts for each specific type of loss:

Type of Loss	Amount of Benefit*	Benefit Recipient
Life	100% of your life insurance benefit	Your beneficiary
Both hands, both feet, or sight in both eyes	100% of your life insurance benefit	You
Both hearing and speech	100% of your life insurance benefit	You
Quadriplegia	100% of your life insurance benefit	You
Hearing or speech	50% of your life insurance benefit	You
One hand, one foot, or sight in one eye	50% of your life insurance benefit	You
Paraplegia or hemiplegia	50% of your life insurance benefit	You
Thumb and index finger of the same hand	25% of your life insurance benefit	You
Uniplegia	25% of your life insurance benefit	You

*The maximum AD&D benefit payable for all losses resulting from a single accident is the full amount of your life insurance benefit depending on your age at the time of loss.

WHAT IS NOT COVERED BY AD&D INSURANCE

This coverage is for losses caused by accidents. No benefits are payable for a loss caused or contributed to by:

- A bodily or mental infirmity
- A disease, ptomaine, or bacterial infection, unless the infection results directly from the injury
- Medical or surgical treatment, unless the surgery is needed because of the injury
- Suicide or attempted suicide (while sane or insane)
- An intentionally self-inflicted injury
- A war or any act of war (declared or undeclared)
- Inhalation of poisonous gases
- Commission of or attempt to commit a criminal act
- Use of alcohol, intoxicants, or drugs, except as prescribed by a physician. An accident in which the blood alcohol level of the operator of the motor vehicle meets or exceeds the level at which intoxication would be presumed under the law of the state where the accident occurred shall be deemed to be caused by the use of alcohol
- Business travel
- Intended or accidental contact with nuclear or atomic energy by explosion and/or release
- Air or space travel. This does not apply if a person is a passenger, with no duties at all, on an aircraft being used only to carry passengers (with or without cargo)

Beneficiaries/Payment of Benefits

When you enroll for coverage, you will be asked to complete a form naming your beneficiary. You may name any person(s), trust, estate, or charity as your beneficiary. The beneficiary you elect for life insurance will be the same beneficiary for death benefits under your AD&D coverage. It is important to keep your beneficiary designation up to date.

You have the right to change your beneficiary at any time by making a written request (appropriate forms are available from your Employee Benefits Office). It is important to notify the School District's Employee Benefits Office promptly of any beneficiary change.

If you choose more than one person as your beneficiary and do not specify how you would like your insurance to be shared among the beneficiaries, they will share equally.

If you do not choose a beneficiary, your benefits will be paid to your estate.

PAYMENT OF YOUR BENEFITS TO YOUR BENEFICIARY

You may elect to have your life insurance paid to your beneficiary in installments rather than in a lump sum. Before you make this decision, you may want to discuss these alternatives with a financial advisor. Once you elect an installment option, the insurance company can only pay the benefits according to your instructions. Because your beneficiary's needs may change, an option you choose in advance may not be appropriate when the insurance benefit is actually paid. If you do not choose an option in advance, your beneficiary may elect an option at the time benefits are paid.

As soon as the School District is notified of your death, your beneficiary will be contacted about the benefits available and what forms are needed to process the claim. A claim must be filed within 90 days after the end of the calendar year of your death. If a claim is already pending, contact the School District's Employee Benefits Office for an explanation of the claim procedure.

If You Become Disabled

If you become totally disabled, your life insurance coverage may be extended but your AD&D benefit will be discontinued. Your life insurance will not be extended if you are more than age 70 when your disability begins.

You must continue life insurance payments for the first nine months following your date of disability. You are considered totally disabled if you are not working at any job for wage or profit, and you are not able to perform the material and substantial duties of any job for which you are reasonably qualified by your education, training, or experience.

Your benefit amount is equal to the life insurance benefit you would be entitled to if you had not become disabled. Generally, you need to provide evidence once a year that you continue to be totally disabled in order to remain insured. Your extension of life insurance benefits ends:

- When your total disability ends,
- If you do not provide written evidence of your total disability, or
- If you decline a medical exam from doctors named at the insurance company's request.

If You Become Terminally Ill

If you become terminally ill, you may elect to receive 50% of your life insurance benefit while you are still living. By electing to receive a part of the benefit in advance, you forfeit that portion of the benefit amount that would have been paid to your beneficiary after your death. It is important to note that if, while you are receiving this benefit, your age changes to make you eligible for another age group, your benefit amount will be reduced accordingly. Your benefit will be paid to you in one lump sum unless you elect to be paid in six equal installments.

You are eligible to receive a portion of your benefit if:

- You provide written evidence, including doctor certification, that your life expectancy is six months or less
- You choose this option in writing
- You are under age 65
- Your life insurance is not assigned
- You voluntarily elect to receive this benefit

NOTE: You are not eligible for this benefit if you are required to use this option to meet creditor claims, such as bankruptcy; or if you are required by a government agency to apply, receive, or keep government benefits.

If You Leave the School District

If you leave the School District, your life insurance and AD&D benefits stop. You may convert all or part of your life insurance to an individual policy during the 30 days following the date your employment ends. AD&D coverage cannot be converted. You will not need a medical exam or evidence of insurability to convert your life insurance coverage. If you die within the 30 days after your employment ends, your life insurance benefit through the School District will be paid to your

beneficiary. The benefit is equal to the same amount you would be entitled to if you had not left the School District.

The premium for the individual policy will be based on your age at the time you convert and for an amount that does not exceed your coverage in effect before your employment ended. Special conversion rules apply if coverage is terminated for all participants in your class.

You must pay the first premium on the later of either the 31st day after your employment ends or the 15th day after you have been given written notice of your right to convert your insurance policy.

When you retire, you can convert all or part of your life insurance to an individual policy just as you could have had you left the School District for any reason.

Your School District Long-Term Disability Plan

Your good health - and ability to work - are two things that should not be taken for granted. The School District's Long-Term Disability (LTD) Plan protects you and your family from financial hardship should an illness or injury prevent you from working for an extended period of time. Through this plan, you are provided with a basic level of monthly benefits after you have been totally disabled for a certain length of time.

What Is a Disability?

There are three types of disability:

Total Disability exists when, due to an illness or accidental injury:

- You are not able to perform, for the first two years of your disability, the material and substantial duties of your occupation for wage or profit
- You are not able to perform the material and substantial duties of any job for which you are reasonably qualified based on training, education and experience
- You are presently not working at any job for wage or profit
- You are under the regular care of a physician for the condition causing your disability

Successive Disability exists when, due to an illness or accidental injury:

- You receive LTD benefits, return to work, and become disabled again from the same or a related cause
- The periods of disability are separated by less than six months of employment

Partial Disability exists when:

- You have already experienced a period of total disability
- You are not able to perform, for wage or profit, the material and substantial duties of your occupation on a full-time basis, or your disability has caused you to reduce the number of hours you work
- You are under the regular care of a physician for the condition causing your disability

LTD benefits will be paid up to age 70 if you are age 69 or younger and on an approved disability. If you are age 70 or older, your LTD benefits will be paid for 12 months.

How LTD Works

The LTD Plan pays you a monthly benefit after you have been totally disabled for an extended period of time. This time, or waiting period, is called the elimination period. The usual elimination period is 90 days. However, you also have the option of reducing the amount you pay for LTD benefits by extending your elimination period beyond 90 days. You may want to consider the amount of sick/vacation leave you have afterward when making this decision.

You may select a longer elimination period – 180 or 360 days – during the annual Open Enrollment period. If you select a longer elimination period, you pay less for LTD coverage.

If you become disabled, you should contact the Employee Benefits Office as soon as possible. After you have been totally disabled for at least 45 days and you anticipate your disability will last beyond 90 days, you will be able to file an LTD claim. You must contact the office within 90 days of the date your disability begins to be eligible for benefits.

How LTD Works – Benefits for Total Disability

Your LTD benefits for total disability are two thirds of your basic monthly earnings (excluding overtime and other compensation) up to a maximum monthly benefit of $7,500. (See definition for total disability on page 18.) Your total disability income from the LTD Plan and all other sources, plus family Social Security disability benefits, cannot be more than two thirds of your basic monthly earnings at the time you become disabled. The minimum monthly benefit, regardless of your income from other sources and family Social Security, is $100.

Coordination with Social Security

You may be entitled to Social Security after you have been disabled for five months. Because the amount of your LTD benefit depends in part on your Social Security benefit, your LTD benefit cannot be correctly calculated until you apply for Social Security. You, or a member of your family, must contact the local Social Security office to start the claim process at the same time you begin your LTD claim process through the School District.

While your Social Security benefit is being determined, the insurance company will pay your LTD benefit without taking into account what you may receive from Social Security. You will need to first complete and return a reimbursement agreement stating that you will repay the insurance company for any overpayment you receive from a retroactive Social Security benefit. If you do not return the reimbursement agreement, the insurance company will either reduce your benefit by an amount estimated to be your Social Security benefit or suspend your benefits.

Note that once you're receiving LTD benefits, any cost of living increase in your Social Security will not reduce your future LTD payments. This means you will receive the advantage of any increases in Social Security.

Medical Examination

Under the LTD plan, the insurance company can require that you be examined at any time by a physician of its choice to determine if LTD benefits should be awarded, or whether they should continue.

Your monthly benefit will be reduced by any income payable to you from these sources:

- Loss-of-time benefits from workers' compensation or a similar law
- Local, state, provincial, or federal government disability plan or law
- Salary or wage continuance plan provided by the School District
- Insurance benefits you receive voluntarily through the School District that pay for all or part of your coverage
- Social Security disability benefits
- Periodic Social Security benefits after you reach age 62 (with the exception of benefits to a former spouse or children living with a former spouse). This offset is meant to apply to social security retirement and would offset social security benefits.
- Any work-loss provision in the mandatory part of a no-fault auto insurance plan
- Delaware State Employee Pension Plan benefits

How LTD Works – Benefits for Successive Disability

If you return to full-time employment and within six months of your return become disabled again for the same reason that caused your previous disability, you are eligible to receive successive disability benefits right away without having to satisfy an additional elimination period.

However, if you return to work and become disabled after working six months, you will have to satisfy another elimination period before LTD benefits are payable. Successive disability benefits are equal to those you receive when you are totally disabled.

How LTD Works – Benefits for Partial Disability

If you are not able to perform your job on a full-time basis or you have to reduce the amount of hours you normally work, you can receive partial disability benefits. Under these circumstances, your benefit will be reduced to reflect the earnings you receive while working on a partial disability basis. While you work, you will receive your partial disability earnings, as well as a benefit equal to the proportion of your full-time disability benefit that corresponds to the difference between your previous monthly earnings and your partial disability earnings. In all cases, your partial disability benefit will never be less than the minimum monthly benefit of $100.

Partial Disability

For example, suppose your disability benefit is $500 and your earnings from working on a partial disability basis are $300. Your partial disability offset would be 60% of $300 or $180. That means, your total monthly income would equal:

$500 (your full disability benefit)
Less
$180 (your partial disability offset-60% of monthly earnings)
Equals
$320 (your partial disability benefit)

Total Monthly Income = $320 + $300 = $620

How LTD Works – Rehabilitation Benefits

Benefits may be available to cover the cost of rehabilitation programs. The insurance company will consult with your physician before authorizing coverage for expenses. After rehabilitation has been approved, it is up to you to decide if you want to enter the rehabilitation program. Benefits are provided for all approved expenses, unless the program is available at no cost to you or is provided under another plan sponsored by the School District.

Appealing A Claim

For LTD benefits, if your claim is denied in whole or part, you will be notified in writing. The notification will include the reasons for the denial and any additional information required if you want to appeal. Learn when and how to appeal a claim on page 36.

What Is Covered

Waiver of Premium

The insurance company waives all premiums while you are receiving LTD benefits so you will not have to contribute to the cost of your LTD coverage. However, while you are satisfying the elimination period, your premium payments must continue.

EXTENDED BENEFITS

If the group LTD Plan terminates while you are receiving benefits, you will continue to receive payments for as long as you remain totally disabled.

What Is Not Covered

The LTD Plan does not cover disabilities caused by:

- Attempted suicide or intentionally self-inflicted injury
- A pre-existing condition due to a sickness or injury during the first 12 months of employment for which you were under a physician's care or receiving treatment within three months prior to the date you became covered under the plan. If disability begins after 12 months of employment, benefits will be payable for conditions in existence on the date of your employment.
- War (declared or undeclared)
- An illness or injury that occurs outside the United States
- An illness or injury that occurs in a local, municipal, provincial or federal prison

If your disability is caused by a mental, pyschoneurotic, or personality disorder, benefits are limited to 24 months. After 24 months, benefits are payable only if you have been confined to a hospital for at least 14 consecutive days. In this case, benefits will be payable for the duration of your confinement and for three months following your confinement.

If you are incarcerated, benefits are excluded for that period of time when you are actually in prison.

When Coverage Ends

Your coverage generally ends on the earlier of the:

- Last day of the month in which your employment with the School District ends
- Date of your retirement
- Date of your death
- Date the School District terminates the Plan

NOTE: Your coverage will also end if you stop making any of the required contributions. If you drop LTD coverage and later choose to re-enroll, you may be required to submit evidence of good health.

WORK AND FAMILY LIFE CHANGES

As your life changes, your benefits status and needs may change. This section can help you when you experience a major life change. It highlights your benefits status, options and issues to consider if you marry, have or adopt a child, retire, etc.

Typical changes are listed below:

- You are hired
- You get married or have/adopt a child
- You become disabled
- You retire
- You die while employed
- You end employment

You Are Hired

The chart below illustrates what happens to your benefits **when you are hired** (and scheduled to work 10 or more hours a week):

Plan	Eligibility	Coverage Available	Benefits Include
Dental	You are eligible on the first of the month on or after your hire date.	For you, your spouse, and your dependent children through the end of the calendar year in which they reach age 19. • Dental and Vision Care coverage for full-time students may be continued until the end of the month in which they reach age 23 or lose full-time status. • Prescription Drug coverage ends at age 19 regardless of student status.	Three dental plan choices. All include preventive, basic, and some major services. Two include orthodontia.
Prescription Drug			Prescription card program for medications that treat acute illnesses or injuries and a mail service program for maintenance medications – medications you take on a long-term basis.
Vision Care			Vision care benefits through VBA.
Life and Accidental Death & Dismemberment	You are eligible on your hire date	For you	**Life Insurance.** Up to one and a half times your annual earnings to a maximum of $250,000, depending on your age. **AD&D.** Up to 100% of your life benefit, depending on your injury.
Long-Term Disability			Two thirds of your basic monthly earnings to a maximum of $7,500 per month.

You Get Married Or Have/Adopt A Child

The chart below illustrates what happens to your benefits when **you get married or have/adopt a child:**

Plan	What You Need To Do
Dental	You have up to 30 days to add a dependent. Otherwise, you must wait until the next open enrollment period.
Prescription Drug	You have up to 30 days to add a dependent. Otherwise, you must wait until the next open enrollment period.
Vision Care	You have up to 30 days to add a dependent. Otherwise, you must wait until the next open enrollment period
Life and Accidental Death & Dismemberment	You may want to change your beneficiary designation.
Long-Term Disability	N/A

You Become Disabled

The chart below illustrates what happens to your benefits when **you become disabled:**

Plan	What You Need To Do
Dental	You can continue coverage for up to 18 months by paying the full cost plus 2%.
Prescription Drug	You can continue coverage for up to 18 months by paying the full cost plus 2%.
Vision Care	You can continue coverage for up to 18 months by paying the full cost plus 2%.
Life and Accidental Death & Dismemberment	Your life insurance coverage may continue at no cost to you after you have been disabled for nine months, provided you are under age 70. AD&D coverage is discontinued.
Long-Term Disability	Depending on the level of coverage you choose, you may begin to receive benefits after you have been totally disabled for 90, 180 or 360 consecutive days.

NOTE: If you become disabled, you should contact the Employee Benefits Office as soon as possible. After you have been totally disabled for at least 45 days and you anticipate your disability will last beyond 90 days, you will be able to file an LTD claim. You must contact the office within 90 days of the date your disability begins to be eligible for benefits.

You Die While Employed

The chart below illustrates what happens to your benefits when **you die while employed**:

Plan	What You Need To Do
Dental	Your dependent(s) can continue coverage for up to 18 months by paying the full cost plus 2%.
Prescription Drug	Your dependent(s) can continue coverage for up to 18 months by paying the full cost plus 2%.
Vision Care	Your dependent(s) can continue coverage for up to 18 months by paying the full cost plus 2%.
Life and Accidental Death & Dismemberment	Your beneficiary will receive your life and, if applicable, AD&D benefit.
Long-Term Disability	N/A

You End Employment or Retire

The chart below illustrates what happens to your benefits when **you end employment**:

Plan	What You Need To Do
Dental	You can continue coverage for up to 18 months by paying the full cost plus 2%.
Prescription Drug	You can continue coverage for up to 18 months by paying the full cost plus 2%.
Vision Care	You can continue coverage for up to 18 months by paying the full cost plus 2%.
Life and Accidental Death & Dismemberment	Your life and AD&D benefits end. Life insurance benefits may be converted to an individual policy within 30 days of the date you end employment.
Long-Term Disability	Your LTD coverage ends.

OTHER IMPORTANT INFORMATION ABOUT THE SCHOOL DISTRICT PLANS

This section contains information about important matters pertinent to certain benefit plans offered by the School District. You should read this section carefully. The information may be needed for filing claims and other inquiries about your benefits.

In this section, you'll find information about:

- Continuation of Coverage (COBRA)
- Coordination of Benefits
- Appealing a Claim
- Plan Funding

Other Important Information About State of Delaware Plans

For other important information about the plans offered by the State of Delaware, please visit the Delaware State Personnel Office Web site at www.delawarepersonnel.com.

Continuation of Coverage (COBRA)

Continuation coverage is available to you and your covered family members if coverage under the School District's dental, vision, or prescription drug plans ends because of one of the qualifying events described below. To continue coverage, you or your covered family members must apply and pay for continuation coverage before the deadline for payment.

If you have any questions about COBRA or its application, please contact the School District's Employee Benefits Office, 1000 Pennsylvania Ave., Claymont, DE 19703, 302-793-5023. All notices described below should be addressed to the School District's Employee Benefits Office. Also, if you have changed your marital status, or you or your spouse have changed addresses, or a dependent ceases to be a dependent eligible for coverage under the terms of the plan, you must notify the Employee Benefits Office as soon as you become aware of the event.

COBRA Eligibility

You and your covered spouse and dependents (referred to as "qualified beneficiaries" under COBRA) may purchase continued coverage for up to 18 months if you lose coverage under the plan due to:

- Termination of your employment (for reasons other than gross misconduct), **or**
- A reduction of your work hours.

PREEXISTING CONDITION LIMITATION

Once you have elected COBRA, if you or your covered spouse or dependent become covered under another group plan and are affected by a preexisting condition limitation under that plan, COBRA coverage may continue until you have satisfied the preexisting condition limitations under your new plan (at which point your COBRA coverage may be terminated).

IN CASE OF DISABILITY

You and your covered spouse and dependents may be eligible for a total of 29 months of continued coverage if you or a covered family member is determined by the Social Security Administration to be disabled (for Social Security disability purposes) at the time of your termination of employment or within 60 days of the qualifying event. This 11-month extension is available to all family members who are qualified beneficiaries due to termination or reduction in hours of employment, including those who are not disabled. You must notify the School District's Employee Benefits Office in writing that you or a covered family member is disabled within the initial 18-month coverage period and within 60 days of Social Security's disability determination. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The qualified beneficiary must provide the written determination of disability from the Social Security Administration to the Employee Benefits Office within 60 days of the latest of:

- the date of the disability determination by the Social Security Administration,
- the date of the qualifying event, or
- the benefit determination date.

You will be required to pay up to 150% of the group rate during the 11-month extension. Your verbal notice is not binding until confirmed in writing and until a copy of the determination from the Social Security Administration is provided to the Employee Benefits Office.

If during continued coverage, the Social Security Administration determines that you or the family member is no longer disabled, you or your family member must inform the School District's Employee Benefits Office of this redetermination within 30 days of the date it is made. If another qualifying event occurs within the 29-month continuation period, then the maximum continued coverage period is 36 months after the termination of employment or reduction in hours.

Continued Coverage for Dependents

Your covered spouse and dependents may purchase continued coverage under the School District's plans for 36 months, if they lose coverage as a result of your:

- Death,
- Divorce or legal separation,
- Entitlement to Medicare, or
- Dependent child ceasing to be a dependent as defined by the plan.

If you become entitled to Medicare while you are an active associate and you later experience a qualifying event (e.g., terminate your employment), your dependents may be eligible for continued coverage until the later of:

- 36 months from the date you first became covered by Medicare, or
- The maximum coverage period for the qualifying event (18 months in the case of termination of employment).

SEPARATE ELECTIONS

You and your covered spouse and dependents can elect COBRA coverage independently. For example, a spouse or dependent child may elect continuation coverage even if you do not elect continuation coverage.

NEWBORN AND ADOPTED CHILDREN

If you give birth or adopt a child while you are on COBRA continuation coverage, you may enroll your new child for COBRA coverage immediately. Your newborn or adopted child will be a "qualified beneficiary." This means that the child will have independent election rights and multiple qualifying event rights.

Multiple Qualifying Events

Should your spouse or dependents experience more than one qualifying event, they may be eligible for an additional period of continued coverage not to exceed a total of 36 months from the date of the first qualifying event. For example, if you terminate employment, you and your spouse or dependents may be eligible for 18 months of continued coverage. If during this 18-month period, your spouse or dependent child ceases to be a dependent under the plan (a second qualifying event), your child may be eligible for an additional period of continued coverage. This additional period may not exceed a total of 36 months from the date of your termination (the first qualifying event).

How to Get Continued Coverage

Both you and the School District have responsibilities if qualifying events occur that make you or your covered dependents eligible for continued coverage.

You or your covered dependents must notify the School District's Employee Benefits Office in writing within 60 days of the date of the qualifying event or the date coverage ceased under the plan, whichever is later, when one of these events occurs:

- You become divorced or legally separated, or
- Your dependent child is no longer considered an eligible dependent as defined by the plan.

This notice must include the name of the employee, the name of the qualified beneficiaries entitled to COBRA, and the date of the event giving rise to COBRA entitlement. This 60-day period is different from the 30-day period you have to notify the School District when you have experienced a life event in order to change your coverage status. If notification is not provided during this 60-day period, any covered dependent who loses coverage will not be permitted to elect COBRA coverage.

The School District will notify you or your covered dependents of the right to elect continued coverage should the following events occur:

- Termination of employment,
- Reduction in work hours, or
- Your death.

ELECTION PERIOD

You and covered dependents will have a 60-day period in which to elect continued coverage, beginning on the later of:

- The date your coverage terminates by reason of the qualifying event, or
- The date you or your covered dependents are sent notification of the right to elect continued coverage.

TYPE OF COVERAGE

If you choose continued coverage, you will have the same coverage that you had the day before your qualifying event. You will not be asked to furnish evidence of good health.

Cost of Continued Coverage

You and your covered dependents may be required to pay up to 102% of the full group cost for your continued coverage. You will be asked to pay for coverage in monthly installments, and you must make your first payment no later than 45 days after the date you elected continued coverage. Subsequent payments will be due on the first of each month, with a 30-day grace period. If the cost of benefits changes in the future for active employees, these changes will also affect continued coverage under COBRA on an annual basis. You will be notified in advance of any changes in the cost of coverage.

Termination of Continued Coverage

Your right to purchase continued group coverage may end before the expiration of the 18-, 29- or 36-month coverage period if:

- You or your covered dependents fail to make the required payment on time,
- The School District terminates the plan for all employees,
- You or your spouse becomes entitled to Medicare after the date COBRA is elected,
- You or your covered dependents become covered under another group health plan after the date COBRA is elected (Your continued coverage with the School
- District will not be terminated if you or a covered dependent has a preexisting condition that is not covered under the other plan due to a preexisting condition limitation clause), or
- Coverage has been extended for up to 29 months due to disability and there has been a final determination that you or a covered spouse or dependent are no longer disabled.

NOTE: Coverage under COBRA will be provided as required by law. If the law changes, your rights will also change.

Coordination of Benefits

For Dental and Vision Coverage

If you have dental and vision care coverage through your spouse's employer or another source, and have coverage through the School District's plan, a provision known as Coordination of Benefits may reduce your benefits under the School District's plan. This is to ensure that your combined benefits will not be more than the expenses recognized by both plans. Your benefits from the other plan will be taken into account when your benefits through the School District are determined. Coordination of benefits does not apply to any individual policy you have.

Other sources that provide dental benefits include the following:

- Government plan except for Medicaid
- Any group coverage (whether insured or not)
- Motor vehicle no-fault coverage

The following guidelines determine which plan pays benefits first:

- The plan covering you as an active employee of the School District pays first
- For dependent children, the plan of the parent whose birthday comes first in the calendar year pays first, unless the parents are legally divorced or separated

- If the parents are legally divorced or separated, the benefits for the child are determined as follows (except when a court decrees otherwise):
  - First, the plan of the parent with legal custody pays
  - Then, the plan of the spouse of the parent with legal custody pays
  - Finally, the plan of the parent without legal custody pays
- If you are receiving continuation coverage under the School District's plan, and you are also covered another plan, the other plan pays first
- If the other plan does not agree with the School District's plan on the order of benefit payment, the rule of the other plan will prevail
- If none of the above apply, the plan that has covered the individual for the longest time pays first

There is an exception to this policy in the case of vision benefits. If both you and your spouse are covered under each other's vision benefits plan, you can receive benefits under both plans. The Coordination of Benefits will not apply.

If the claims administrator determines that payments exceed the coordination of benefits provision, the administrator has the right to recover the overpayment from the other insurance company, the other plan sponsor, or you.

For Prescription Drug Coverage

The Coordination of Benefits provisions also apply if you have prescription drug coverage through another source. If your additional coverage is provided through a source other than the State plan, the guidelines shown above for dental benefits determine which plan pays benefits first. If you are enrolled in the School District's supplemental plan and the State's medical plan, either plan can be used at any time provided you do not exceed the annual maximum benefit amount.

By using the School District's plan up to the maximum benefit allowed for generic equivalents, you can reduce the amount you pay out-of-pocket. The following guidelines help you determine which plan pays the greater benefit.

If you have exceeded the $1,000 or $10,000 annual maximum under the School District's plan, submit your prescription drug expenses to the State's medical plan, which has an unlimited maximum benefit amount. You will be responsible for a copay as follows:

For a 30-day supply of medications to treat acute illnesses or injuries:	For a 90-day supply of maintenance medications:
Generic: $8.50	Generic: $17
Preferred Brand: $20	Preferred Brand: $40
Non-Preferred Brand: $45	Non-Preferred Brand: $90

If you have not exceeded the $1,000 or $10,000 annual maximum under the School District's plan, determine which plan best meets your needs. Under the School District plan, you will be responsible for a copay as follows:

For medications to treat acute illnesses or injuries and maintenance medications:
Generic: $5.00
Brand Name: $10.00

Appealing a Claim

For dental, vision care, life insurance and AD&D, and long-term disability benefits, if your claim is denied in whole or part, you will be notified in writing. The notification will include the reasons for the denial and any additional information required if you want to appeal.

You are entitled to appeal a claim that is denied. To appeal a claim, write to the insurance company within 60 days of the date you receive the denial notice and state the reasons why you believe your claim should not have been denied. Include any additional documentation that supports your claim. You may also submit questions or comments you think are appropriate, and you may review relevant documents. Generally, you will receive a written decision on your appeal within 60 days of the date your insurance company receives your request. If special circumstances require a delay, you will be notified of the extension during the 60 days following the receipt of your request.

Plan Funding

The plans described in this booklet are fully insured and paid for by employer and employee contributions.

Name and Type of Plan	Name of Insurer or Administrator of Plan Services
The Dental Plan	Aetna
The Prescription Drug Plan	CAREMARK
The Vision Care Plan	Vision Benefits of America (VBA)
The Life and AD&D Plan	The Prudential Insurance Company of America
The LTD Plan	The Prudential Insurance Company of America

NOTE: The plan year for all plans is July 1 to June 30.

Other Important Messages

"Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours)."