



2027

DRBA
DELAWARE RIVER & BAY AUTHORITY

BENEFITS OVERVIEW

Pre-65 Retirees

Connections that Move You; Benefits that Protect You

WELCOME TO YOUR BENEFITS!

ABOUT THE BENEFITS OVERVIEW

The ***Benefits Overview*** describes the benefit plans available to you as a Retiree of the Authority. Keep the *Benefits*

The details of these plans are contained in the official Plan Documents, including some insurance contracts. The *Benefits*

If there is ever a question about one of these plans, or if there is a conflict between the information in the *Benefits Overview*
and the formal language of the Plan Documents or insurance contracts, the formal wording in the Plan

Please note that the benefits described in the *Benefits Overview* may be changed at any time and do not represent a

ELIGIBILITY OF RETIREE

Retirees who are covered under the Authority's core health plans for active employees on the day prior to their retirement are eligible to continue their core benefits plans upon retirement. Core benefits include health (medical and prescription drugs), dental, vision and life insurance.

ELIGIBILITY OF RETIREE'S DEPENDENTS

The eligible dependent of a retiree who had been hired **prior to March 1, 2005**, and was covered as an eligible dependent while the retiree was an active employee, are eligible for coverage under the retiree's health (medical and prescription drugs), dental and vision plans. Eligible dependents include the retiree's legal spouse and dependent children up to age 26 who were covered by the employee on the day prior to their retirement. No new dependent may be added to the retiree plans following retirement.

Dependents of a retiree who had been hired on or **after March 1, 2005** are not eligible under the Authority's

***Note: If you divorce a covered spouse after the date you retire, then you must notify the DRBA Benefits Office as soon as possible, but no later than 30-days from the divorce date, so your spouse can be removed from the retiree plans promptly. Ex-spouses are NOT eligible for dependent benefits under the program. If you fail to notify DRBA within 30-days of the divorce date, then the change (termination of coverage) will be made retroactive to the divorce date, and you may be responsible to reimburse the Authority or the plan provider for any claims that were paid on behalf of your ex-spouse after the date of the divorce.**

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COST OF RETIREE HEALTH PLANS

Retirees who were hired or rehired prior to January 1, 2015, are not required to contribute to the cost of their retiree health plans.

Retirees hired or rehired on or after January 1, 2015, are required to contribute toward the cost of their retiree health plans (medical & prescription drug) based on a percentage tied to the number of whole years that the retiree worked for the DRBA as shown below. However, no contribution is required for retiree dental, vision, or life

Years of Service	Retiree Contribution	Employer Contribution	PPO - 2027 Retiree Contribution (per month)	EPO - 2027 Retiree Contribution (per month)
10	60%	40%	$931.58	$669.19
11	57%	43%	$885.00	$635.73
12	54%	46%	$838.42	$602.27
13	51%	49%	$791.84	$568.81
14	48%	52%	$745.26	$535.35
15	45%	55%	$698.68	$501.89
16	42%	58%	$652.10	$468.43
17	39%	61%	$605.53	$434.97
18	36%	64%	$558.95	$401.51
19	33%	67%	$512.37	$368.05
20	30%	70%	$465.79	$334.59
21	27%	73%	$419.21	$301.13
22	24%	76%	$372.63	$267.67
23	21%	79%	$326.05	$234.22
24	18%	82%	$279.47	$200.76
25+	15%	85%	$232.89	$167.30

IMPORTANT LEGAL NOTICES

In addition to the *Benefits Overview,* this booklet includes ***Important Legal Notices*** that the Authority is required to provide. Please review the Notices, found at the back of this booklet, carefully and keep them with your benefits records for future reference.



PRE-65 RETIREE HEALTH PLAN

The Medical portion of the retiree health plan is administered by Highmark Delaware. The plans are supported by a Blue Cross/Blue Shield national network of medical providers and allow you to seek the care of any physician or facility without the need to choose a primary care physician (PCP) or seek referrals. If you were enrolled in one of the two plans noted below, PPO or EPO, then that is the plan that will be continued in retirement.

- **Preferred Provider Organization (PPO) plan:** The PPO will provide low out-of-pocket expenses at point-of-service.
  Services provided by in-network providers are covered at higher rates than out-of-network providers.
- **Exclusive Provider Organization (EPO) plan:** The EPO will result in higher out-of-pocket expenses at point-of- service. If you use a doctor or facility that isn't in the national network, you will have to pay the full cost of the services provided. Members are covered for emergency care – even from non-network providers – in their local service area or when away from home.

On the next page is a brief side-by-side comparison of the Medical Plans. For more details, refer to the Summary of Benefits and Coverage (SBC) for each plan which are enclosed. If there is any discrepancy between the following comparison and the insurance summaries or booklets, the provisions in the insurance summaries and booklets will prevail.



Benefits Major Medical[3]	PPO In-Network	PPO Out-of-Network[1]	EPO In-Network Only[2]
Deductible - Ind./Family	N/A	$300/$900	$200/$400
Out-of-Pocket Maximum (Medical & Pharmacy Copays Only)	N/A	$1,500 $4,500	N/A
Total OOP Maximum[4]- Ind./Family (Medical & Pharmacy Combined)	$12,000/$24,000	N/A	$12,000/$24,000
Lifetime Benefit Maximum	Unlimited	Unlimited	Unlimited
Physician Office Visits	$15 copay	80%	$15 copay
Specialist Office Visits	$20 copay	80%	$35 copay
Diagnostic X-Ray			
Hospital Facility	$80 copay	80%	$80 copay
Non-Hospital Facility	$20 copay	80%	$20 copay
Lab Services			
Hospital Facility	$80 copay	80%	$80 copay
Non-Hospital Facility	$20 copay	80%	$20 copay
MRIs, CT scans, and PT Scans			
Hospital Facility	$225 copay	80%	$225 copay
Non-Hospital Facility	$75 copay	80%	$75 copay
Routine Care Routine	100%	80%	100%
Annual Physical Periodic	100%	80%	100%
Hearing Exam	100%	80%	100%
Well-Child Care (includes immunizations)	100%	80%	100%
Annual GYN. Exam (including Pap Test)	100%	80%	100%
Routine Mammograms	100%	80%	100%
PSA Test	100%	80%	100%
Periodic Vision Exam	$20 copay	Not covered	$35 copay
Therapies			
Physical/Occupational & Speech Therapy	80%*	80%*	80%*
Radiation Therapy & Chemotherapy	100%	80%	100%
Hospital Benefits[5]			
Inpatient (including maternity/delivery)	$75/day; $300 max	80%	100% AD
Outpatient	100%	80%	100% AD
Emergency Room (waived if admitted)	$150 copay	$150 copay	$150 copay
Urgent Care Center/Medical Aid Unit	$20 copay	80%	$35 copay
Ambulance Service	$25 copay	$25 copay	$25 copay
Miscellaneous			
Maternity (Prenatal and Postnatal)	100%	80%	100% AD
Inpatient Mental Health, Substance Abuse, & Intensive Outpatient Care	$75/day; $300 max	80%	100% AD
Chiropractic Care - max. 30	$20 copay	80%	$35 copay

AD = After Deductible

1. All Out-of-Network benefits are subject to balance billing. 80% Coinsurance, after the deductible is met.
2. There are no Out-of-Network benefits in either the EPO or HDHP, such expenses are the sole responsibility of the member.
3. All Deductibles and Out-of-Pocket Maximums are reset every January 1st.
4. The in-network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include medical and prescription drug deductibles, coinsurance, and copays.
5. Most non-emergency hospital stays, and voluntary surgical procedures must be pre-authorized.

* 60 visits per condition per calendar year.

PRE-65 RETIREE HEALTH PLAN (continued)

AGE 65 HEALTH PLAN TRANSITION:

Retirees and/or their covered spouses will be moved to a Medicare Advantage Plan upon reaching age 65, effective upon retirement or upon their 65th birthday, whichever is later. To qualify for the AMA plan, individuals must enroll in Medicare (Parts A and B) and pay the Part B premiums that may apply. Typically, Part B premiums are deducted from the individual's Social Security Retirement annuity, or they can be paid directly to the Center for Medicaid and

The Medicare Advantage plan is fully insured through the Aetna Insurance Company. The Aetna Medicare Advantage

Note: A covered spouse is moved to the AMA plan as an individual subscriber, however, the covered spouse will remain

PRESCRIPTION DRUG BENEFITS:

The Prescription drug portion of the retiree health plan is provided through Rx Benefits/Express Scripts and is included with each of the medical plans noted above. The Prescription co-pays are based on Drug Tier as shown in the table below.

Drug Tier	PPO / EPO
Retail Pharmacy - Generic (per 30-day supply)	$10 copay
Retail Pharmacy - Preferred Brand (per 30-day supply)	$20 copay
Retail Pharmacy - Non-Preferred Brand (per 30-day supply)	$35 copay
Mail Order (up to 90-day supply)	Same as 1 x retail copay
Drug Tier for GLP-1	**PPO / EPO**
GLP-1 Medication for Weight Loss Only	Coinsurance 20%
GLP-1 Medication for Medical Diagnosis Retail – Preferred Brand	$20 copay
GLP-1 Medication for Medical Diagnosis Retail – Non-Preferred Brand	$35 copay

The Authority subscribes to ***Rx Benefits/Express Scripts Generic Preferred Program.*** If you have a prescription for a brand name drug and a chemically equivalent generic drug is available, the generic will be supplied. ***You will have the option of choosing either the generic equivalent or the brand name drug but if you choose the brand name drug, you will pay the brand name co-pay plus the difference in cost between the generic and the brand name drug.***

The Authority also subscribes to ***Rx Benefits/Express Scripts Advantage-Plus Utilization Management program*** which includes the following requirements for certain prescription drugs: Select Home Delivery – Incentive Choice, Quantity Management, Prior Authorization, and Step Therapy. ***Your pharmacist will advise you if your prescription is subject to one of these requirements.***

1. Under the ***Select Home Delivery – Incentive Choice (SHD-IC)*** option, The Authority is encouraging participants to utilize Mail-Order services to re-fill maintenance drug prescriptions rather than re-fill maintenance drugs at the Pharmacy. If you re-fill a maintenance drug at the Pharmacy, you will have to pay a copay for each 30-day supply. You will pay 1x the applicable copay for a 30-day supply; 2x copay for a 60-day supply; and 3x copay for a 90-day supply at the Pharmacy. Through Mail-Order you can fill 30, 60 or 90-day supplies and pay only 1x copay. Rx Benefits/Express Scripts will send letters to members who are affected. You will be allowed two (2) refills at the Pharmacy before the higher copay levels will apply.
2. ***Drug Quantity Management (DQM)*** will limit how much medicine a member can obtain at one time for certain prescriptions (like opioids) while ensuring that the member receives the safest, most effective medicine available. This also helps lower overall drug costs by reducing the waste of unused medications.
3. Under ***Prior Authorization (PA),*** certain prescriptions will require review by Rx Benefits/Express Scripts before the drug can be filled and covered by the Plan. Member's doctor will need to provide Rx Benefits/Express Scripts with detailed information about the member's drug treatment plan to ensure its use falls within the Plan rules. The purpose of this requirement is to make sure members get the safest, most effective medicine available at reasonable cost to you and the Plan.

PRE-65 RETIREE HEALTH PLAN (continued)

4. Under Step Therapy (ST), certain prescriptions will no longer be covered without a trial of preferred alternatives first and will cost the member more. Member's doctor will need to provide Express Scripts with confirmation that preferred alternatives were tried and failed before the prescription will be filled and covered by the Plan. Preferred generics or lower-cost brand medicines work just as well for most people and typically cost a lot less. You can find a list of the 2021 National Preferred Alternatives on the ESS Benefits Enrollment website.

In addition, the Authority utilizes a *mandated specialty pharmacy service through ESI, in partnership with Accredo,* which will provide specialized support and service to employees and dependents taking specialty medications, including manufacturer discount offers that may reduce your co-pay to $0 through an additional partnership with Saveon. Information will be mailed to your home containing detailed information if you or your dependent qualify for the specialty pharmacy service or a manufacturers' discount.

TELEMEDICINE

Additional telemedicine services are provided to retirees through Teladoc. This program is ***provided at no cost to retirees and their covered dependents enrolled in one of the Authority's health plans.*** This benefit is a convenient alternative to urgent care or emergency room visits for non-emergency medical issues. You can access U.S. board-certified physicians in internal medicine, family practice, emergency medicine or pediatrics who resolve most non-emergency medical issues via phone or online video with no copay. The physician can diagnose and prescribe medication, if medically necessary, electronically to the pharmacy of choice.

There is no Consultant co-pay required when you use Teladoc services if you are enrolled in either the PPO or EPO

You must register on the Teladoc website or call customer service and complete a profile for yourself and each covered dependent to use the plan. You can access Teladoc online at www.teladoc.com or call at **1-800-835-2362** to complete a profile.

RETIREE DENTAL BENEFITS

Retiree dental coverage is provided under a self-funded plan by the Authority and is administered by Delta Dental. The plan allows you the flexibility to choose your own dentist. The Authority's coverage through Delta Dental's PPO-Plus Premier plan offers three (3) levels of providers

- **Out-of-Network Providers:** These providers do not participate with Delta. You will receive the same level of coverage (i.e., 100% reimbursement for Preventive Services, 80% for Basic Services, etc.) but their services are not discounted; ***these dentists may bill you for the balance.***
- **Premier Providers:** These providers have agreed to a nominal discount to their services, and they have agreed not to bill participants for the balance. It is better to go to a Premier Provider than an Out-of-Network provider to get **more** out of your dental benefits.
- **Preferred Provider Organization (PPO) Providers:** These providers have agreed to a steeper discount to acquire more patients, and they will also not bill patients for the balance. It is best to go to a PPO Provider to get the **most** out of your dental benefits.

Benefits[1]	Delta Dental PPO Dentists[2]	Non- PPO Dentists[2] (Delta Dental Premier® & Non-Delta Dental Dentists)
Deductible	N/A	N/A
Annual Maximum *Resets every January 1st*	$1,500	$1,500
Preventative	100%	100%
Basic	80%	80%
Major	50%	50%
Orthodontia – Max. Age 19	50%	50%
Orthodontia Max. Lifetime	$3,000	$3,000

1 Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.
2 Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists, and Premier contracted fees for non- Delta Dental dentists.

THE CHOICE IS YOURS

Save the most with PPO

The Delaware River and Bay Authority Claims Example	Most claims savings	Some claims savings	No claims savings
	Delta Dental PPO	Delta Dental Premier	Non-Delta Dental Dentists
Dentist's Charge for a Crown	$1,200	$1,200	$1,200
Plan Allowance	$800	$950	$950
Percentage Paid by Plan	50%	50%	50%
Plan Payment	$400	$475	$475
PATIENT PAYMENT	**$400** **($800- $400 =)**	**$475** **($950 - $475 =)**	**$725** **($1,200 - $475 =)**

Note: Amounts listed for illustrative purposes only. Assumes no maximum or deductibles are applicable.

VISION BENEFITS

Retire vision coverage is provided under a fully insured plan through EyeMed. EyeMed is a leading vision provider, and the plan will allow you to take advantage of their large national provider network. ***If you stay within the EyeMed network of providers, you will pay a copay for services and supplies. If you seek care outside of the EyeMed network, you will be eligible for a small reimbursement of your claim. Call EyeMed for instructions on filing an out-of-network vision claim.*** You can find the in-network copays and the out-of-network reimbursement limits in the chart below.

Benefits **Once every 12 months**	**Vision Care Services** **In-Network**	 **Out-of-Network** (Reimbursement)
Exams	$20 copay	Up to $40
Retinal Imaging	Up to $39	N/A
Frames	$0 copay, $100 allowance, 20% off balance over $100	Up to $70
Standard Plastic Lenses		
Single Vision	$25 copay	Up to $30
Bifocal	$25 copay	Up to $50
Trifocal	$25 copay	Up to $70
Lenticular	$25 copay	Up to $70
Contact Lenses (allowance includes material only)		
Conventional	$0 copay, $100 allowance, 15% off balance over $100	Up to $100
Disposable	$0 copay, $100 allowance, plus balance over $100	Up to $100
Medically Necessary	$0 copay	Up to $210
Contact Lenses Fit and Follow-up		
Standard Lens	$40 copay	N/A
Premium Lens	10% off retail price	N/A
Laser Vision Correction		
LASIK or PRK from U.S. Laser Network	15% off retail price or, 5% off promotional price	N/A



VISION BENEFITS (continued)

In addition to Vision benefits, you can also obtain discounts on hearing tests, aids, and supplies through EyeMed and their partnership with Amplifon Hearing Health Care. Call Amplifon at **877-203-0675** to obtain more

HEARING DISCOUNTS

The sweet sounds of life



Have you heard? Vision and hearing loss often go hand-in-hand. Mature adults[1] and diabetics[2] are likely to experience both sensory impairments. Research also shows an increase of adults in their 20s and 30s with hearing loss.[3]

At EyeMed, we're all eyes and ears about your employees' health and wellness. That's why we teamed up with Amplifon, the nation's largest independent hearing discount network, to add affordable hearing care to every EyeMed vision benefits package.

OUR HEARING DISCOUNT THROUGH AMPLIFON PROVIDES:

- 40% off hearing exams at thousands of locations around the country
- Discounted, set pricing on thousands of hearing aids, including the latest technology to hit the market
- Low price guarantee — if your employees find the same product at a lower price, Amplifon will beat it by 5%
- 60-day hearing aid trial period with no restocking fees
- 1-year free follow-up care with unlimited appointments
- Free batteries for 2 years with initial purchase
- 3-year warranty and loss and damage coverage



65% of those with hearing loss are younger than retirement age[5]

[1] Archives of Ophthalmology, Oct. 2006 [2] Health Day, U.S. News: http://health.usnews.com/health-news/news/articles/2012/11/16/hearing-loss-tied-to-diabetes -in-study [3] JAMA Internal Medicine, "Prevalence of Hearing Loss and Differences by Demographic Characteristics Among US Adults" [5] Ibid

See — and hear — life to the fullest —
Contact your EyeMed rep or visit **starthere.eyemed.com**

amplifon Hearing Health Care

S-1904-CB-356

RETIREE LIFE INSURANCE PLAN

FOR RETIREES HIRED PRIOR TO JANUARY 1, 2015:

Retiree Life Insurance is provided under a Group Term Life insurance policy underwritten by Unum Insurance Company. Please note that there is no cash value under a Group Term Life Insurance policy.

Upon retiring from the Authority, you are provided with Retiree life insurance in an amount equal to 50% of the employee

The coverage amount of Retiree life insurance is reduced by another 50% upon reaching your 70th birthday. If you retired

FOR RETIREES HIRED ON/AFTER JANUARY 1, 2015:

Upon retiring from the Authority, you are provided with Retiree Life Insurance in the flat amount of $10,000 provided under a Group Term Life insurance policy underwritten by Unum Insurance Company.

The coverage is not subject to any age-

BENEFICIARY UPDATES

If you want to update your Beneficiaries under the Retiree Life Insurance plan, you must submit a new Unum Life Beneficiary Designation form. Please call the Benefits Office at **302-571-6470** to obtain the Unum form and



CONTACT INFORMATION

If you have a benefits or claims question, call the provider first. If they cannot assist you, then call the benefits office.

Medical **Highmark Delaware**	www.highmarkbcbsde.com	800-633-2563
Prescription Drugs **RX Benefits/Express**	member.rxbenefits.com	800-707-7052
Telemedicine **Teladoc**	www.teladoc.com	855-835-2362
Dental (All Retirees) **Delta Dental**	www.deltadentalins.co	800-932-0783
Vision (All Retirees) **EyeMed** **EyeMed/Amplifon Hearing Health Care**	www.eyemed.co	866-804-0982 877-203-0675
Life/AD&D **Unum Insurance Company**	www.unum.com/employee	866-679-3054
Defined Benefit Plan (Pension) **Delaware River and Bay Authority Employees' Retirement Plan**		U.S. Bank 800-806-7009
Defined Contribution 401(a) and Deferred Compensation 457(b) **Voya Financial**	www.voya.com	800-584-6001
Grandfathered Retirement Savings Plans: **MetLife 457(b)** **First Allmerica**	Press *3 to speak with a person	800-560-5001 800-799-6981

DRBA Benefits Office **Pension & Benefits Manager** **HR Specialist, Pension & Benefits**	Betsy Dupon at 302-571-6337 (x16337) Lacey Adams at 302-571-6470 (x16470)



IMPORTANT LEGAL NOTICES (for pre-65 Retirees)

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Refer to your SBCs and plan summaries for more information.

NEWBORNS ACT DISCLOSURE - FEDERAL

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

ADA NOTICE REGARDING WELLNESS

Well-Being is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personal identifiable health information. Although the wellness program and Delaware River and Bay Authority may use aggregate information it collects to design a program based on identified health risks in the workplace, wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) the health coaches in order to provide you with services under the wellness program.
In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Delaware River and Bay Authority Benefits office.

HIPAA WELLNESS PROGRAM DISCLOSURE

Your health plan is committed to helping you achieve your best health. Participation in a wellness program is available to all employees on a voluntary basis.

PATIENT PROTECTION MODEL DISCLOSURE

You do not need prior authorization from Highmark Delaware or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Highmark Delaware at www.highmarkbcbsde.com or 800-633-2563.

MICHELLE'S LAW DISCLOSURE

Under the ACA, dependent children are covered by the group health plan until age 26. To obtain more information, contact person listed at the end of this summary.

CONTACT INFORMATION

Questions regarding any of this information can be

Charlotte L Crowell, SPHR, SHRM-SCP
Chief Human Resources Officer
Delaware River & Bay Authority
P.O. Box 71
New Castle, DE 19720
Phone: (302) 571- 6392
charlotte.crowell@drba.net

IMPORTANT LEGAL NOTICES continued

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.

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

YOUR RIGHTS

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

IMPORTANT LEGAL NOTICES continued

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no,” for example, if it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

IMPORTANT LEGAL NOTICES continued

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. And in all cases, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

IMPORTANT LEGAL NOTICES continued

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- Contact HR at (302) 571-6392

IMPORTANT LEGAL NOTICES continued

IMPORTANT NOTICE FROM DELAWARE RIVER & BAY AUTHORITY ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Delaware River & Bay Authority and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium. by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **Delaware River & Bay Authority has determined that the prescription drug coverage offered by the Delaware River & Bay Authority Medical Plan for the plan year 2027 is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, the following options may apply:

- You may stay in the Delaware River & Bay Authority Medical Plan and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
  - During the Medicare prescription drug annual enrollment period, or
  - If you lose Delaware River & Bay Authority Medical Plan creditable coverage.
- You may stay in the Delaware River & Bay Authority Medical Plan and also enroll in a Medicare prescription drug plan. The Delaware River & Bay Authority Medical Plan will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage in the Delaware River & Bay Authority Medical Plan and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the Delaware River & Bay Authority Medical Plan, be aware that you and your dependents will not be able to get this pre-65 retiree coverage back..

IMPORTANT LEGAL NOTICES continued

When Will You Pay a Higher Premium (Penalty) To Join a Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Delaware River & Bay Authority and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…
Contact the person listed below for further information or call HR at (302) 571-6392. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through **Delaware River & Bay Authority** changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" hand- book. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether you have maintained creditable coverage and, therefore, whether you are required to pay a higher premium (a penalty).

Date:	9/16/2026
Name of Entity/Sender:	Delaware River & Bay Authority
Contact--Position/Office:	Human Resources
Address:	P.O. Box 71, New Castle, DE 19720
Phone Number:	(302) 571-6392

IMPORTANT LEGAL NOTICES continued

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.
If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website:
http://myalhipp.com/ Phone:
1-855-692-5447

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://health.alaska.gov/dpa/Pages/default. aspx

CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP)
Program http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program
(HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insur- ance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/ third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: (678) 564-1162, Press 2

Illinois – Medicaid
Illinois Medicaid Premium Assistance Information
Medicaid application website: https://abe.illinois.gov
HIPP Hotline Number: 217-524-8268
HIPP Email: hfs.boc.hipp@illinois.gov

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid
Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki Hawki
Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medic-aid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Pro- gram (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana
Medicaid Customer Service Line: 1-888-342-6207
Louisiana Medicaid email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP) Website:https://www.ldh.la.gov/lahipp
LaHIPP phone: 1-877-697-6703
LaHIPP email: La.HIPP@la.gov
LaHIPP fax: 1-888-716-9787
LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/ben-efits/s/?language=en_US Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
TTY: (617) 886-8102

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-fam- ilies/health-care/health-care-programs/programs-and-services/ other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp. htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/ HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone:

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP
Medicaid Website: https://www.nj.gov/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid Website: https://medicaid.ncdhhs.gov/ Phone: 1-919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa. gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website:
https://www.scdhhs.gov Phone:

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP)
Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov Phone: 1-888-222-2542
Adult Expansion Website:
https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website:
https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT– Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid Website:
https://www.hca.wa.gov/ Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website:
https://health.wyo.gov/healthcarefin/medicaid/pro- grams-and-eligibility/

To see if any other states have added a premium assistance program since July 31, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 5/31/2029)

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: GENERAL INFORMATION

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

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 is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution – as well as your employee contribution to employment-based coverage – is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all these factors in determining whether to purchase a health plan through the Marketplace.

1. Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
2. An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.is no less than 60 percent of such costs.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023, and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.description.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023, and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description.

Name of Entity/Sender:	Delaware River & Bay Authority
Contact--Position/Office:	Charlotte L Crowell, SPHR, SHRM-SCP (Chief Human Resources Officer)
Address:	P.O. Box 71, New Castle, DE 19720
Phone Number:	302-571-6392

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.

NOTES

Prepared on behalf of The Delaware River and Bay Authority by USI Insurance

The Benefits Overview describes the benefit plans available to you as a Retiree of the Authority. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. We reserve the right to amend, suspend or terminate any benefit plan, in whole or in part, at anytime. The authority to make such changes rests with the plan administrator. v.9.26