

Health Care Coverage Notices and Other Important Information

- These Notices relate to the University of Delaware Group Health Insurance Plan (the “**Plan**”).
- These Notices are effective July 1, 2026.
- These Notices are also available online at udel.edu/benefits.
- Questions regarding these Notices can be addressed to the Human Resources Benefits Office at 302-831-2171 or at hrhelp@udel.edu or questions may be directed to additional contacts identified in the various notices.

If you and/or your dependents have Medicare or will become eligible for Medicare in the next 12 months, Federal law gives you more choices about your prescription drug coverage. Please see the enclosed “Notice of Creditable Coverage” for more details.

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that major medical plans provide special mid-year enrollment opportunities to certain employees and their dependents when there is (i) a loss of other coverage, (ii) an acquisition of a new dependent, (iii) a loss of coverage under Medicaid or a state's Children's Health Insurance Program (CHIP) because of loss of eligibility for such coverage, or (iv) a gain of eligibility for premium assistance under Medicaid or CHIP to help pay for medical coverage under the Plan. Enrollment under these special enrollment rules is not a late enrollment.

If you are covered under another group health plan and involuntarily lose that coverage you or your eligible dependents may be permitted to enroll in the Plan under special mid-year enrollment rights. However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you acquire a new spouse or eligible dependent, by marriage, birth, adoption, or placement for adoption, you may be permitted to enroll yourself and the new eligible dependent in the Plan under special mid-year enrollment rights. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Requests for special enrollment rights must be made within 30 days of the date of the qualifying event. Qualifying events are the loss of eligibility for other coverage (or if the employer stops contributing to the other coverage), or gaining a new dependent through marriage, birth, adoption, or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents are covered under Medicaid or a state CHIP, and you or your dependents experience a loss of eligibility for such coverage, and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to a medical coverage option under the Plan (including under any waiver or demonstration project conducted under or in relation to Medicaid or CHIP) and you request enrollment within 60 days after the determination of eligibility for such assistance.

Note: The 60-day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 30-day period applies to most HIPAA special enrollments.

To request special enrollment or obtain more information, contact the Human Resources Benefits Office at 1-302-831-2171 or at hrhelp@udel.edu.

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

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 the Plan. To view deductibles and coinsurance amounts for non-Medicare health plans included in the Plan, contact the Human Resources Benefits Office at 1-302-831-2171 or at hrhelp@udel.edu.

Mental Health Parity and Addiction Equity Act Notice

If any group health plans under the Plan provide and administer mental health or substance use disorder benefits, the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), generally prevents the Plan and any health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. A group health plan may not set annual or lifetime dollar limits on mental health or substance use disorder benefits that are lower than any such dollar limits for medical and surgical benefits, and if a group health plan imposes no annual or lifetime dollar limit on medical and surgical benefits, such group health plan may not impose an annual or lifetime dollar limit on mental health or substance use disorder benefits. The MHPAEA does not require employers to provide mental health or substance use disorder benefits under employer-sponsored healthcare plans. Because mental health and substance use disorder benefits are provided under the Plan, the Plan will therefore comply with the requirements of MHPAEA. For more information about the Plan's group health plans and their compliance under the MHPAEA, please contact the Human Resources Benefits Office at 1-302-831-2171 or at hrhelp@udel.edu.

Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in case of illness or injury.

The Plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, the Plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

For Highmark Delaware members and for Aetna members, the SBCs are available at hrhelp@udel.edu. A paper copy is also available, free of charge, by calling 1-302-831-2171.

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 January 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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+)	FLORIDA – Medicaid
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	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
<p>GA HIPP Website: https://medicaid.georgia.gov/health-insurance-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</p>	<p>Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/df/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584</p>
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
<p>Medicaid Website: iowa Medicaid ½ Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki – Healthy and Well Kids in Iowa ½ Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Payment (HIPP) ½ Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562</p>	<p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
KENTUCKY – Medicaid	LOUISIANA – Medicaid
<p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.asp 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/agencies/dms</p>	<p>Website: www.medicaid.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, LA 30084</p>
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
<p>Enrollment Website: https://www.mymaineconnection.gov/benefits/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</p>	<p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
MINNESOTA – Medicaid	MISSOURI – Medicaid
<p>Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672</p>	<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>

MONTANA – Medicaid	NEBRASKA – Medicaid
<p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP P Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov</p>	<p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-471-6521 Omaha: 402-595-1178</p>
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
<p>Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900</p>	<p>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</p>
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
<p>Medicaid Website: http://www.state.nj.us/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)</p>	<p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
<p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>	<p>Website: http://www.hhs.nd.gov/healthcare/ Phone: 1-844-854-4825</p>
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid
<p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>	<p>Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075</p>
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
<p>Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)</p>	<p>Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)</p>
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
<p>Website: https://www.scdhhs.gov</p>	<p>Website: http://dss.sd.gov</p>

Phone: 1-888-549-0820	Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	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	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhr.wv.gov/bms/ https://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 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.

OMB Control Number 1210-0137 (expires 3/31/2026)

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.

NOTICE OF PRIVACY PRACTICES

The Legal Duty of the University of Delaware Group Health Insurance Plan

The University of Delaware sponsors the following health benefits plans:

Highmark Blue Choice Deductible PPO Plan
Aetna HMO
Aetna CDH Gold
Highmark Blue Choice PPO Plan
CVS Caremark/SilverScript Prescription Drug
MetLife Dental
National Vision Administrators (NVA)
Health Advocate - Employee Assistance Program (EAP)
Flexible Spending Accounts (FSA)

These health benefit plans participate in an “Organized Health Care Arrangement” which permits them to share information between them for certain health care operations purposes, described below. These plans are referred to collectively in this Notice as the “Plan.”

The Plan is required by applicable federal and state laws, including the federal Health Insurance Portability and Accountability Act (“HIPAA”), to maintain the privacy of your personal health plan information, otherwise known as “protected health information” (“PHI”), and to notify you in the event of a breach of unsecured PHI. The Plan is also required to give you this Notice about its privacy practices, its legal duties regarding PHI, and your rights and the rights of your dependents concerning their PHI. The Plan must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on July 1, 2026.

The Plan reserves the right to change its privacy practices, and the terms of this Notice, at any time, according to applicable law. Before the Plan makes a material change in its privacy practices, the Plan will change this Notice and provide the new notice (or notice of the changes) to you if you remain enrolled in its health plans at the time of the change. You may request a copy of this Notice at any time. For more information about the Plan’s privacy practices, or to request an additional copy of this Notice, please contact Human Resources or the Plan’s Privacy Official (described below). The Notice is also available on the Plan’s website at udel.edu/benefits.

Protected Health Information

Protected health information, also known as “PHI”, is a special term defined by government regulation to include any information, including genetic information, that: (i) is created or maintained by a health plan or certain other entities; (ii) relates to the past, present or future physical or mental health or condition of an individual or the provision of and/or payment for the provision of health care to an individual; and (iii) identifies the individual or provides a reasonable basis to believe that the individual could be identified. PHI may be received or maintained in any form, including oral statements. The Plan may receive PHI about you and your family members from enrollment forms and from other sources, such as employers, health care providers, federal and state agencies, or its vendors. Except as described below, the Plan will provide access to your PHI only to you, your authorized representative, and those persons who need the information to aid the Plan in the conduct of its business (its “Business Associates”) or as you specifically authorize the Plan to do so as explained later in this Notice. When using or disclosing PHI, the Plan will make reasonable efforts to limit the use and disclosure of that information to the minimum amount necessary to accomplish the intended purpose. The Plan maintains physical, technical, and procedural safeguards to protect PHI. The law and the Plan’s agreements with its Business Associates also require them to limit their uses and disclosures of PHI to those required for the purposes that the PHI was obtained or created.

Plan Uses and Disclosures of PHI

The Plan is permitted to use and to disclose PHI to aid in your treatment, make payment for health care services provided to you, and conduct its own “health care operations,” described below. Under limited circumstances, the Plan may be able to provide PHI for the health care operations of other providers and health plans. The Plan may use your PHI for purposes of treatment, payment, and health care operations without your authorization. The Plan’s Business Associates will assist the Plan in these functions, for example, by processing your claims for benefits. Specific examples of the ways in which PHI may be used and disclosed are provided below. This list is representative only and does not include every use and disclosure in a category.

Treatment: Although the Plan does not engage in treatment activities, it may disclose your PHI to a doctor or a hospital if requested by them to assist in your treatment.

Payment: The Plan may use and disclose your PHI for a variety of permitted payment activities that include, but are not limited to, paying claims from doctors, hospitals, and other providers for services delivered to you that are covered by your health plan.

- **Eligibility, Enrollment, and Contributions:** At the time of your enrollment, the Plan receives enrollment information about you including your name, address, Social Security number, and birth date. This “enrollment information” is used by the Plan to provide coverage for health care benefits and for eligibility determinations. The Plan will use this information to determine if you qualify for benefits and provide you with appropriate notices. The Plan may share enrollment information with the “plan sponsor,” which is the University of Delaware. The plan sponsor may use this information to, for example, determine how much each person subscribing to the Plan (a “Member”) must contribute toward the cost of coverage.
- **Benefits and Claims:** The Plan will use and disclose PHI to process claims and appeals and pay

benefits. In doing so, the Plan may request PHI from or disclose PHI to your health care provider or share PHI with an independent medical reviewer to obtain its clinical view as to the medical necessity or experimental nature of a medical treatment. The Plan will send Explanations of Benefits containing PHI to notify Members about claim determinations. The Plan may also use and disclose PHI for precertification and medical necessity reviews, claims management, and billing and collection activities. For example, the Plan may provide information to the billing agent of a health care provider.

- Coordination of Benefits, Adjudication, Subrogation: The Plan and other health plans use and disclose PHI to coordinate the payment of benefits with other health plans (e.g., Medicare or a spouse's health insurance plan). It may be necessary for the Plan to disclose PHI to the other plan to determine which plan should pay first and how much the secondary plan should pay. The Plan may also share information with an automobile carrier, Workers' Compensation carrier, or other relevant person in determining if a third-party should be liable for your medical expenses. Depending on the situation, this may be called third-party reimbursement of subrogation.

Health Care Operations: The Plan may use and disclose your PHI for health care operations. The Plan's health care operations encompass a broad range of activities. For example, the Plan may use and disclose PHI to rate the Plan's risk and determine the premiums for your health plan, to conduct quality assessment and improvement activities, to engage in care coordination or case management, and to properly conduct Plan business.

Disclosures to You and Uses and Disclosures with Your Authorization

The Plan must disclose your PHI to you, as described below in the Member's Rights section of this Notice. For uses and disclosures beyond treatment, payment, and health care operations purposes, and for reasons not included in one of the exceptions described below, the Plan is required to have your written authorization. You may, subject to the Plan's policy for authorizations, give written authorization to use PHI or to disclose your PHI to anyone for any purpose. In this case, the Plan will be permitted (but not required) to use or disclose PHI, as stated in the written authorization. You may revoke your authorization in writing at any time; however, such revocation will not affect any uses or disclosures that were made under the authorization while it was in effect. PHI disclosed pursuant to your written authorization has the potential to be redisclosed by the recipient and in such case would no longer be protected. Questions regarding authorization or revocation may be directed to the Privacy Official identified at the end of this Notice.

- It is unlikely that the Plan will obtain psychotherapy notes, but it is required to obtain your written authorization for almost every type of use or disclosure that the Plan might undertake with such information.
- The Plan would also need to obtain your written authorization before using or disclosing your PHI for marketing purposes other than in face-to-face meetings with you or providing you with a nominal promotional gift.
- The Plan would need to obtain your written authorization before a disclosure that is regarded as a sale of PHI.

- The Plan must obtain your written authorization for any use or disclosure that is not for treatment, payment, health care operations or other purpose described in this Notice.

Except with regard to long term care plans, the regulations strictly prohibit the use and disclosure of PHI that is genetic information for underwriting purposes, even if authorization is provided.

Other Uses and Disclosures of PHI Not Requiring Authorization

There are situations other than treatment, payment, or health care operations where the Plan may use or disclose your PHI without requiring your written authorization. In some instances, different state and federal laws will apply.

Personal Representatives: The Plan will treat your personal representative as if he/she were you for purposes of disclosing PHI. A “personal representative” is a parent of an unemancipated child, or a person who, as evidenced by a valid legal document under state law, is designated to make medical decisions on behalf of an individual. Personal representatives include court-appointed guardians; persons appointed in “living wills” or medical directives; persons with powers of attorney that extend to medical decisions; and/or executors/administrators of estates.

Parents and Minors: As a general rule, parents or other legal guardians (persons acting *in loco parentis*) have the right to access the PHI of an otherwise unemancipated minor child (defined by Delaware law as a person under the age of 18). However, Delaware law allows a minor to obtain some services without parental consent (e.g., diagnosis and treatment for sexually transmitted diseases). When Delaware law gives a minor the authority to control parental or other access to the PHI pertaining to such health care services, a parent will need to obtain authorization from the minor before the Plan will release this type of information.

Health Oversight Activities: The Plan may share PHI as provided by law with Health Oversight Agencies, regulatory authorities or their appointed designees and reporting agencies. Examples of such “Health Oversight Agencies” include, but are not limited to, Centers for Medicare and Medicaid Services, and the Delaware Department of Health and Social Services.

Substance use disorder treatment records. Though it is unlikely the Plan will have access to or content of these records, they shall not be used or disclosed in civil, criminal, administrative, or legislative proceedings against the individual unless based on written consent, or a court order after notice and an opportunity to be heard is provided to the individual or the holder of the record, as provided in [42 CFR part 2](#). A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.

Business Associates: The Plan works with many entities that perform a wide variety of services on behalf of the Plan. For example, the Plan works with auditors, attorneys, actuaries, consultants, and other health care plans that act as third-party administrators for the Plan. The Plan will ensure that appropriate agreements are in place to govern the permitted and required uses and disclosures of Member information by its Business Associates, to require its Business Associates’ compliance with applicable privacy laws, and to require its Business Associates to apply reasonable safeguards to the PHI they obtain or create in the services that they provide with regard to the Plan.

To Individuals Involved in Your Care or Payment for Your Care: The Plan generally will not disclose PHI to your family members, close friends or others without your written Authorization. However, under certain circumstances, the Plan may disclose PHI to such persons. For example, if you appear at the Plan office with your spouse and ask for PHI, the Plan may ask you if it can provide you with your PHI in front of your spouse or even, as appropriate, infer that it is permissible because you have brought your spouse with you. However, this non-written authorization applies only to the particular disclosure; future disclosures of PHI to family members will require a new authorization (written or otherwise).

The Plan may also disclose PHI to your family members, close friends, or others in cases of a medical emergency where you are unable to provide authorization. In such cases, the Plan will disclose PHI to another person if it determines, using professional judgment, that the disclosure would be in your best interest. In such cases, the Plan will disclose only the PHI that is relevant to that person's involvement with your health care.

Disaster Relief: The Plan may use or disclose your name, location, and general condition or death to a public or private organization authorized by law or by its charter to assist in disaster relief efforts, such as the American Red Cross.

Plan Sponsor: The Plan may disclose eligibility, enrollment, and limited disenrollment information to the plan sponsor to permit it to perform its plan administration functions on behalf of the Plan. The Plan may provide the plan sponsor with information as to your enrollment or disenrollment for coverage.

The Plan may also disclose summary health information about you and the participants in your group health plan to the plan sponsor for it to use to obtain premium bids for the health insurance coverage offered through your group health plan and/or to decide whether to modify, amend, or terminate your group health plan. This summary health information may contain claims history, claims expenses, or types of claims experienced by the participants in the Plan. However, it will be stripped of demographic information (e.g., name and address) other than your zip code information. In order to obtain any of the above information, the plan sponsor will be required to certify that the plan document has been amended to provide that the confidentiality of the information will be protected and that the information will not be used in any employment-related decisions. No other information will be shared with the plan sponsor without your Authorization, executed according to the Plan's Authorization policy.

Public Health and Communicable Disease Reporting: The Plan may disclose your PHI to a public health authority who is permitted by law to collect or receive the information. The reporting may be made to prevent or control disease, injury or disability, or report child abuse or neglect. The Plan may notify a person who may have been exposed to a disease or may be at risk for contracting a disease or condition. The Plan may notify appropriate law enforcement officials or other appropriate government authority if the Plan believes a Member has been the victim of abuse, neglect, or domestic violence. The Plan may use or disclose PHI to assist in certain other public health activities unless the sole basis of the report of abuse, neglect, or domestic violence is the provision or facilitation of reproductive health care.

Research, Death, Organ Donation: The Plan may use or disclose PHI for research purposes, in limited circumstances and with certain safeguards. The Plan may also disclose the PHI of a deceased person

to a coroner, medical examiner, funeral director, or organ procurement organization for certain purposes.

Required by Law: The Plan may use or disclose your PHI when it is required to do so by law. For example, the Plan is required by federal law to disclose PHI to the U.S. Department of Health and Human Services if it asks to see it for purposes of determining whether the Plan complies with federal privacy laws. The Plan may also disclose your PHI when authorized by Workers' Compensation or similar laws. The Plan is permitted to make other disclosures when required by law.

Litigation or Administrative Proceedings. Even when the Plan is not party to a lawsuit or other judicial or administrative proceeding, it may disclose PHI lawfully requested, for example, through a subpoena, as part of that proceeding. For example, a Member may be engaged in a lawsuit that that does not generally pertain to the Plan, but for which Plan records are relevant.

To Law Enforcement and for Public Safety: Under certain circumstances, the Plan may disclose your PHI for law enforcement purposes. Examples of such situations include responding to court orders, warrants, or grand jury subpoenas; providing limited PHI in response to requests by law enforcement officials for the identification and/or location of a suspect, witness, or certain other individuals; responding to inquiries by law enforcement relating to victims of crime; and providing information to law enforcement with respect to crimes occurring on the Plan's premises. In addition, under some circumstances, the Plan may disclose your PHI to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. This may include providing information to law enforcement authorities to apprehend a suspect or fugitive or advising individuals about threats made against them. Finally, the Plan may disclose your PHI if you are an inmate or other person in lawful custody and we are requested to do so by an appropriate law enforcement official or correctional institution.

Military and National Security: Under certain circumstances, the Plan may disclose the PHI of armed forces personnel to military authorities. The Plan may also disclose PHI to authorized federal officials for lawful intelligence, counterintelligence, and other national security activities.

Member Rights

As a Member of the Plan, you have the following rights regarding your PHI. Contact the Privacy Official by using the contact information found at the end of this Notice to exercise any of these rights.

- **Right to Inspect and Copy:** With limited exceptions, you have the right to inspect and/or obtain a copy of your PHI that the Plan maintains in a designated record set. A "designated record set" consists of all records used by the Plan to make health plan decisions about you, including documentation relating to your enrollment, payment, claims adjudication, and case or medical management (e.g., disease management). You may request that the Plan provide copies of your PHI to you in hardcopy or electronically in a format that is convenient to you. If the Plan can readily produce the PHI in that format, it will do so. You may also clearly designate another person to receive this PHI and request that the Plan send the PHI to that person directly.

The Plan will respond to your written request within 30 days after receipt. A single, 30-day extension is allowed if the Plan is unable to comply with the deadline and if the Plan provides you

with a notice of the reason for the delay and the expected date by which the requested information will be provided. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. The Plan may charge you a reasonable cost-based fee to process and fulfill your request. If you prefer, you may request that the Plan prepare a summary or an explanation of your PHI for a fee.

To obtain information about your treatment, you may wish to contact your treating physician, facility, or other provider that created and/or maintains the records.

- **Right to Amend:** You have the right to request that the Plan amend the PHI that it has created and that is maintained in your designated record set. Your request must be in writing, and it must explain why the information should be amended. The Plan cannot amend demographic information, treatment records, or any other information created by others. If you would like to amend any demographic information, please contact the Human Resources Benefits Office at hrhelp@udel.edu. If you would like to amend your treatment records, you must contact the treating physician, facility or other provider that created those records.

The Plan will act on a request for an amendment within 60 days of receipt or provide a written statement of the reason why it cannot do so and the date by which the Plan will complete action on the request. If the amendment is accepted, the Plan will advise you and make reasonable efforts to inform others who have the relevant record, including people you name, of the amendment and to include the changes in any future disclosures of that information.

The Plan may deny your request if (1) the Plan did not create the information you want amended; (2) the information is not part of the designated record set maintained by the Plan; (3) you do not have access rights to the information; or (4) the Plan believes the information is accurate and complete. If the Plan denies your request, the Plan will provide a written explanation for the denial and your rights regarding the denial.

- **Right to an Accounting of Disclosures:** You have the right to receive an accounting of certain specific instances in which the Plan or its Business Associates have disclosed your PHI. The accounting will review disclosures made over the past six years. The Plan will provide you with the date on which it made a disclosure, the name of the person or entity to whom we disclosed your PHI (unless this information is PHI about another member), a brief description of the information disclosed, the reason for the disclosure, and certain other information. Certain disclosures, including the most routine disclosures (e.g., those made for treatment, payment or health care operations or made in accordance with your written authorization) are not subject to this requirement and will not appear in the accounting.

Your request for an accounting must be made in writing. The Plan will act on your request within 30 days of receipt or will provide you with a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request an accounting more than once in a 12-month period the Plan may charge you a reasonable, cost-based fee for responding to these additional requests. You will have the opportunity, in writing, to withdraw or modify your request for any subsequent accounting to avoid or reduce the fee. You may contact the Plan for a full explanation of the fee structure.

- **Right to Request Restrictions:** You have the right to request that the Plan place additional restrictions on the use or disclosure of your PHI for treatment, payment, health care operations purposes, and for disclosures made to persons involved in your care. Your request must be in writing. The Plan is not required to agree, and for administrative and other reasons, the Plan generally will not agree to these additional restrictions. However, if the Plan does agree, the Plan will abide by the written agreement (except in an emergency). If the Plan does agree to a restriction, the agreement will always be in writing and signed by the Privacy Officer. If the Plan agrees to a restriction, it reserves the right to terminate that agreement by providing you with written notice of that termination.
- **Right to Request Confidential Communications:** You have the right to request that the Plan communicate with you in confidence about your PHI by using “alternative means” or an “alternative location” if the disclosure of all or part of that information to another person could endanger you. The Plan will accommodate such a request in situations where you clearly advise it in your request that the usual means of communication could endanger you and if your request for an alternative is reasonable. Your request must, among other things, continue to permit the Plan to collect premiums and pay claims under the health plan.

To request confidential communication changes, you must make your request in writing, you must specify the alternative means or location for communication, and you must clearly state that the information could endanger you if it is not communicated in confidence as you request.

- **Right to Complain about the Plan’s Privacy Practices:** If you think the Plan or one of its Business Associates or other vendors have violated your privacy rights, or if you disagree with a decision made by the Plan or a Business Associate or other vendor about access to your PHI, use the contact information found at the end of this Notice. You may also file a written complaint with the Secretary of the U.S. Department of Health and Humans Services. Filing instructions are available at <http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html>. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Contact Person for Information or to Submit a Complaint

If you have questions about this Notice or want to submit a complaint, please contact the Plan’s Privacy Official. The Plan’s Privacy Official is the person responsible for ensuring compliance with this Notice.

The University of Delaware Chief Privacy Officer
Office of the General Counsel
112 Hullahen Hall
Newark, DE 19716
302-831-7263
privacyoffice@udel.edu

NOTICE OF CREDITABLE COVERAGE

Important Notice from the University of Delaware 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 the Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether 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.

Medicare-eligible retirees are generally eligible for prescription drug coverage through the Plan and do not need to enroll in another Medicare Prescription Drug Plan. Please refer to the section on the next page called "What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?" for important information.

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.**
- 2. The University of Delaware has determined the prescription drug coverage offered by the Plan 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, your current University of Delaware prescription drug coverage will be affected. If you are a Medicare-eligible retiree, or Medicare-eligible dependent of a retiree, you are generally eligible for prescription drug coverage through the University of Delaware Prescription Drug Plan. You cannot have coverage through another Medicare prescription drug plan *and* retain your coverage through the University of Delaware Prescription Drug Plan. If you enroll in a Medicare prescription drug plan, other than the University of Delaware Prescription Drug Plan, prescription drug coverage through the University of Delaware for you and your eligible dependents will terminate. You will not be able to re-enroll in the University of Delaware Prescription Drug Program until the Plan's Open Enrollment period.*

If you are a Medicare-eligible active employee, you cannot keep your prescription drug plan with the University of Delaware and enroll in a Medicare prescription drug plan. If you enroll in a Medicare prescription drug plan, prescription drug coverage through the Plan for you and your eligible dependents will terminate. You will not be able to re-enroll in the University of Delaware's Prescription Drug Program until Plan's Open Enrollment period (which is usually during May each year). To enroll during Open Enrollment, you must have terminated the other Medicare prescription drug coverage.

It is important that you compare your current plan, including which drugs are covered, with the coverage and costs of Medicare Part D plans in your area before making these decisions. If you consider enrolling in a Medicare prescription drug plan, check with Human Resources Benefit Office at 302-831-2171 or hrhelp@udel.edu before you enroll.

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 prescription coverage with the Plan and do not 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 you did not have that coverage. For example, if you go 19 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 Of Your Current Prescription Drug Coverage...

Contact the Human Resource Benefit Office listed below for further information.

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 coverage through the Plan changes. You also may request a copy of this notice at any time from:

Human Resources Office
550 S. College Ave. Suite 201
Newark, DE 19713
302-831-2171
Email: hrhelp@udel.edu

For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

For more information about Medicare prescription drug coverage:

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

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

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

Notice of Nondiscrimination and Accessibility

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Human Resources Benefits at hrhelp@udel.edu.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Human Resources Benefit Office at 302-831-2171 or hrhelp@udel.edu is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at or by mail or phone at

U.S. Department of Health and Human Services 200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Notice Regarding Wellness Program

Wellness programs the Plan may offer are voluntary programs available to all benefit-eligible employees, non-Medicare pensioners and their covered spouses and dependent children. The programs are 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. If you choose to participate in any of the wellness programs you will be asked a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). There are currently no financial incentives related to your participation in the wellness program.

The information you disclose will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness programs, such as health coaching. You also are encouraged to share your concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness programs and the Plan may use aggregate information it collects to design a program based on identified health risks in the workplace, your personal information will not be disclosed publicly or to the University of Delaware, 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 programs. Anyone who receives your information for purposes of providing you services as part of the wellness programs will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is a health coach to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness programs will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness programs 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 programs, 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 programs, 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 Human Resources Benefit Office at 302-831-2171 or at hrhelp@udel.edu.