aetna®

State of Delaware

Health Maintenance Organization (HMO) Booklet

Effective July 1, 2024
Aetna.com

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STATE-DE-00023 (07/24)

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Welcome

This health care plan was selected by the State Employee Benefits Committee of the State of Delaware for members of the State's Group Health Insurance Program. Our goal is your good health. To achieve this goal, we encourage preventive care in addition to covering you when you are sick or injured.

The Aetna HMO plan includes coverage for services such as: outpatient, inpatient, prenatal and postnatal care, emergency, mental health care, lab, x-ray, vision, chiropractic and many others call the Aetna One Advisor team or review the SPD to learn more about what is covered.

As used in this Booklet, “HMO” refers to HMO type benefits that are self-funded by the State of Delaware and administered by Aetna.

This Plan Description is not a contract. It explains your plan for easy reference. This Plan Description describes your health plan in effect as of July 1, 2024. It replaces all previous plan descriptions.

We wish you the best of health!

How To Use Your Booklet

This booklet is your guide to the benefits available through your health plan. Please read it carefully and refer to it when you need information about this HMO, to determine what to do in an emergency situation, and to find out how to handle service issues. It is also an excellent source for learning about special programs and value added benefits available through your health plan.

If you cannot find an answer to your question(s) in the booklet, call the Aetna One Advisor toll free number on your ID card. A trained Advisor will be happy to help you.

This booklet is not a contract. It explains your plan for easy reference. The benefits and terms and conditions of your plan are in an Account Contract on file with the the State of Delaware Department of Human Resources, Statewide Benefits Office. The Account Contract is the final determination of the benefits and rules of your plan.

Tips for New Plan Participants:

- Keep this booklet where you can easily refer to it
- Keep your ID card(s) in your wallet - always show your card when you receive care
- Post your Primary Care Physician's name and number near the telephone
- Emergencies are covered anytime, anywhere, 24 hours a day. See Medical Emergency section for guidelines
- Select your PCP during Open Enrollment

Aetna One Advisor staff are ready to answer your questions

Here are some reasons you may need to call:

- Choosing your Primary Care Physician (PCP)
- Changing a new PCP
- Asking questions about this plan
- Reporting a lost or stolen ID card
- Ordering a new ID card
- Checking on the status of a referral or the status of approval
- Asking about a claim

You may call or write Aetna.

Dedicated State of Delaware Aetna One Advisor number:
1-877-54-AETNA or
1-877-542-3862 (TTY: 711)

State of Delaware Website:
MyAetnaNetwork.com

Aetna One® Advisor

Aetna One Advisor Team

Aetna One Advisors are trained to answer your questions and to assist you in using the Plan properly and efficiently.

Call the Aetna One Advisor toll-free number on your ID card **(1-877-54-AETNA or 1-877-542-3862)** to:

- Ask questions about benefits and coverage;
- Notify Aetna of changes in your name or telephone number;
- Change your PCP; or
- Notify Aetna about an emergency.

Please call your PCP's office directly with questions about appointments, hours of service or medical matters.

Clinical Policy Bulletins

Aetna uses Clinical Policy Bulletins (CPBs) as a guide when making clinical determinations about health care coverage. CPBs are written on selected clinical issues, especially addressing new technologies, new treatment approaches, and procedures. The CPBs are posted on Aetna's website at **Aetna.com**

Aetna member website

In one easy-to-use website, you can perform a variety of self-service functions and take advantage of a vast amount of health information from the Aetna member website. Access the Aetna dedicated State of Delaware website home page, through the Aetna website home page, or directly via **Aetna.com**

With the Aetna member website, you can:

- Print instant eligibility information
- Request a replacement ID card
- Select a physician who participates in the Aetna network
- Check the status of a claim
- Link to a voluntary Health Risk Assessment tool
- Use the hospital comparison tool to compare hospital outcome information for medical care provided by hospitals in your area
- Estimate the cost of common health care services
- Contact Aetna One Advisor team
- Find answers to common questions
- Change your PCP

Provider Information

You may obtain, without charge, a listing of network providers from your Plan Administrator, or by calling the toll-free Aetna One Advisor number on your ID card.

It is easy to obtain information about providers in Aetna's network using the Internet. You can conduct an online search for participating doctors, hospitals and other providers using the provider search directory at **MyAetnaNetwork.com**. Select the appropriate provider category and follow the instructions provided to select a provider based on specialty, geographic location and/or hospital affiliation.

Your ID Card

When you join the Plan, you will receive an ID card that lists the covered members of your family. Your ID card lists the telephone number of the Aetna Primary Care Physician (PCP) you have chosen. You may change your PCP at any time by calling Aetna One Advisor Team at the toll-free number on your ID card **(1-877-54-AETNA (TTY: 711) or 1-877-542-3862)**. If you change your PCP, you will automatically receive a new card displaying the change.

Always carry your ID card with you. It identifies you as a Plan participant when you receive services from participating providers or when you receive emergency services at nonparticipating facilities. If your card is lost or stolen, please notify Aetna immediately.

How the Plan Works

How the Plan Works

Members have access to a network of participating Primary Care Physicians (PCPs), specialists and hospitals that meet Aetna's requirements for quality and service. These providers are independent physicians and facilities that are monitored for quality of care, patient satisfaction, cost-effectiveness of treatment, office standards and ongoing training.

Each member of the Plan must select a Primary Care Physician (PCP) when they enroll. Your PCP serves as your guide to care in today's complex medical system and will help you access appropriate care.

The Primary Care Physician

As a member of the Plan, you will become a partner with your participating PCP in preventive medicine. Consult your PCP whenever you have questions about your health. Your PCP will provide your primary care and, when medically necessary, your PCP will refer you to other doctors or facilities for treatment. The referral is important because it is how your PCP arranges for you to receive necessary, appropriate care and follow-up treatment. Except for PCP, direct access and emergency services, **you must have a prior written or electronic referral from your PCP to receive coverage for all services and any necessary follow-up treatment**.

Participating specialists are required to send reports back to your PCP to keep your PCP informed of any treatment plans ordered by the specialist.

For PCP's in New Castle County Delaware, prior to seeking care for Podiatry, Radiology and Physical Therapy Services please contact your PCP. Your PCP will refer you to the designated capitated servicing provider.

Primary and Preventive Care

Your PCP can provide preventive care and treat you for illnesses and injuries. The Plan covers routine physical exams, well-baby care, immunizations and allergy shots provided by your PCP. You may also obtain routine vision exams and gynecological exams from participating providers without a referral from your PCP. You are responsible for the copayment shown in the "Copayment Schedule."

Physician Visits

Covered medical expenses include charges made by a physician or other licensed health care practitioner during a visit to treat an illness or injury. The visit may be at the physician's office, in your home, in a hospital or other facility during your stay or in an outpatient facility.

Specialty and Facility Care

Your PCP may refer you to a specialist or facility for treatment or for covered care services, when medically necessary. **Except for those benefits described in this Plan Description as direct access benefits and emergency care, you must have a prior written or electronic referral from your PCP in order to receive coverage for any services the specialist or facility provides**.

When your PCP refers you to a participating specialist or facility for covered services, you will be responsible for the copayment shown in the "Copayment Schedule."

For inpatient expenses and surgery performed in an outpatient facility, you must pay a portion of the covered expenses you incur. Your share of covered expenses is called your copay.

To avoid costly and unnecessary bills, follow these steps:

- Consult your PCP first when you need routine medical care. If your PCP deems it medically necessary, you will get a written or electronic referral to a participating specialist or facility. Referrals are valid for 90 days, as long as you remain an eligible member in the Plan. For direct access benefits, you may contact the participating provider directly, without a referral.
- Certain services require both a referral from your PCP and prior authorization from Aetna. Your PCP is responsible for obtaining authorization from Aetna for in-network covered services.
- Review the referral with your PCP. Understand what specialist services are being recommended and why.
- Present the referral to the participating provider. Except for direct access benefits, any additional treatments or tests that are covered benefits require another referral from your PCP. The referral is necessary to have these services approved for payment. **Without the referral, you are responsible for payment for these services**.

- If it is not an emergency and you go to a doctor or facility **without your PCP's prior written or electronic referral, you must pay the bill yourself**.
- Your PCP may refer you to a nonparticipating provider for covered services that are not available within the network. Services from nonparticipating providers require prior approval by Aetna in addition to a special nonparticipating referral from your PCP. When properly authorized, these services are covered after the applicable copayment.

REMEMBER: You cannot request referrals after you visit a specialist or hospital. Therefore, to receive maximum coverage, you need to contact your PCP and get authorization from Aetna (when applicable) before seeking specialty or hospital care.

Some PCPs are affiliated with integrated delivery systems (IDS) or other provider groups (such as Independent Practice Associations and Physician-Hospital Associations). If your PCP participates in such an arrangement, you will usually be referred to specialists and hospitals within that system or group. However, if your medical needs extend beyond the scope of the affiliated providers, you may ask to have services provided by non-affiliated physicians or facilities. Services provided by non-affiliated providers may require prior authorization from Aetna and/or the IDS or other provider group. Check with your PCP or call the Aetna One Advisor number that appears on your ID card to find out if prior authorization is necessary.

Copayment Schedule

All non-emergency specialty and hospital services require a prior referral from your PCP, unless noted below as a "direct access" benefit.

MAXIMUM BENEFIT	UNLIMITED PER PLAN PARTICIPANT PER LIFETIME
Primary and Preventive Care	
PCP Office Visits	$15 copay per visit
Telemedicine Service (virtual visit with a provider)	$15 copay per visit
Telemedicince (Teladoc Health)	$0 copay per visit
After Hours/Home Visits/Emergency Visits	$25 copay per visit
Adult Routine Physical Examination 1 visit per plan year	$0 copay per visit
Preventive Child and Well-Baby Care 3 exams in the 25th-36 months of life; 1 exam per plan year thereafter to age 21	$0 copay per visit
Immunizations	$0 copay per visit
Inpatient Visits	$100 copay per day $200 maximum per admission
Routine Gynecological Exams Direct access (no referral) to participating providers for 1 visit per plan year	$0 copay per visit
Routine Mammogram One annual mammogram age 40 and older One baseline mammogram age 35-39 (3D mammograms are covered)	$0 copay per visit
Prostate Screening One annual prostate screening age 40 and older	$0 copay per visit
Colorectal Cancer Screening Age 45 and older Includes Virtual Colonoscopies	$0 copay
Routine Eye Examinations 1 visit every 24 months Direct access (no referral) to participating eye doctor	$15 copay per visit
Voluntary Sterilization (women)	$0 copay

MAXIMUM BENEFIT	UNLIMITED PER PLAN PARTICIPANT PER LIFETIME
Voluntary Sterilization (men)	Payable in accordance with the type of expense incurred and the place where service is provided.
Contraceptive Devices and Injectables (provided and billed by a physician – including insertion/administration)	$0 copay
Contraceptive Counseling first 2 visits per plan year	$0 copay per visit
Subsequent visits	Payable in accordance with the type of expense incurred and the place where service is provided.
Lactation Support visits 1-6 in a 12-month period	$0 copay
Subsequent visits	Payable in accordance with the type of expense incurred and the place where service is provided.
Breast pumps and supplies 1 manual or electric breast pump per birth (coverage to rent or purchase is at the discretion of Aetna)	$0 copay
Hearing Exam by an Audiologist	$25 copay per visit
Hearing Aids for children to age 24	20% copay. 3 hearing aids within 36 months (initial allowance, plus 1 replacement; 1 additional hearing aid if needed due to growth).
Specialty and Outpatient Care	
Specialist Office Visits	$25 copay per visit
Telemedicine virtual visit with a provider & Teladoc Health Dermatology Services	$25 copay per visit
Prenatal Care for the first OB visit	$25 copay
Subsequent Prenatal Visits	$0 copay
Implantable Contraceptives	$0 copay
Basic Fertility Services	Copay based on place of service where rendered
Comprehensive Fertility & Advanced Reproductive Technology (ART) (Does not apply to out-of-pocket maximum)	Copay based on place of service where rendered $30,000 Lifetime Maximum for medical services

MAXIMUM BENEFIT	UNLIMITED PER PLAN PARTICIPANT PER LIFETIME
Allergy Testing	$25 copay per visit
Allergy Treatment	$5 copay per visit
Diagnostic Laboratory Tests (blood work) For list of Non-Hospital Affiliated preferred labs please visit **DE.gov/statewidebenefits**	$10 copay per visit when performed at Non-hospital affiliated preferred lab. Aetna's national preferred lab is Quest Diagnostics and Labcorp. $50 copay per visit when performed at Hospital-affiliated Outpatient Facility Lab services obtained at a non-participating lab may not be covered under your plan.
Basic Diagnostic Imaging (X-rays & ultrasound) For list of Freestanding Radiology Facilities please visit **DE.gov/statewidebenefits**	$0 copay per visit when performed at Non-Hospital Affiliated Freestanding Radiology Facility $50 copay per visit when performed at Hospital Outpatient Facility
High Tech Imaging Scans and Tests Services must be precertified except when rendered in the emergency room or if inpatient Complex Imaging Services, including but not limited to: Magnetic Resonance Imaging (MRI); Computerized Axial Tomography (CAT); and Positron Emission Tomography (PET) ; and other outpatient diagnostic imaging service. For list of Freestanding Radiology Facilities please visit **DE.gov/statewidebenefits**	$0 copay per visit when performed at Non-Hospital Affiliated Freestanding Radiology Facility $100 copay per visit when performed at Hospital Outpatient Facility
Occupational Therapy and Physical Therapy Occupational and Physical: Up to 45 visits per incident of illness or injury beginning with the first day of treatment. No visit maximum or review of medical necessity for the treatment of back pain and for the treatment of mental health and substance use disorder diagnoses.	20% (of the contracted rate) per visit $15 copay or 20% coinsurance (whichever amount is equal to or less than than 25% of the contracted rate) for the treatment of mental health and substance use disorder diagnoses.
Speech Therapy: A separate 45 visits per incident of illness or injury beginning with the first day of treatment based on medical necessity. Review of medical necessity is completed at 25 visits. No visit maximum or review of medical necessity for the treatment of back pain and for the treatment of mental health and substance use disorder diagnoses.	20% (of the contracted rate) per visit $15 copay or 20% coinsurance (whichever amount is equal to or less than than 25% of the contracted rate) for the treatment of mental health and substance use disorder diagnoses.

MAXIMUM BENEFIT	UNLIMITED PER PLAN PARTICIPANT PER LIFETIME
Physical Therapy For the treatment of back pain: No visit maximum. Review of medical necessity is completed at 25 visits, except for visits for the purpose of treating back pain.	20% (of the contracted rate) per visit $15 copay or 20% coinsurance (whichever amount is equal to or less than than 25% of the contracted rate) for the treatment of mental health and substance use disorder diagnoses.
Autism Spectrum Disorder	$15 copay per visit
Chiropractic Care	Lesser of either $15 copay or 25% of allowable charges. Review of medical necessity is completed at 25 visits, except for visits for the purpose of treating back pain & medically necessary maintenance care provided by license chiropractor.
Home Health Care PDN services rendered in the home covered whenmedically necessary, precert required.	$0 copay per visit
Hospice Care	$0 copay per visit
Durable Medical Equipment (DME)	20% (of the cost) per item
Diabetic equipment and supplies	The cost/deductible amount, if any, for the following diabetes equipment and supplies purchased through in network providers will not exceed $35.00 per month: covered blood glucose meters and strips, urine testing strips, syringes, continuous glucose monitors and supplies, and insulin pump supplies.
Medically necessary Insulin Pumps	$0 copay
Cooling Caps (Scalp Hypothermia) Covered for members undergoing chemotherapy treatment	20% (of the contracted rate) $1,000 maximum benefit per plan year.
DME Maximum Benefit	Unlimited
Prosthetic Devices	$0 copay- some prostheses must be approved in advance by Aetna
Mastecomy Bra Up to 6 bras in first 12 months following mastectomy, then up to 4 bras every 12 months	$0 copay
Wig/Hair Piece Covered for any illness or injury resulting in hair loss (1 piece covered up to $1,000 maximum per plan year)	$0 copay

MAXIMUM BENEFIT	UNLIMITED PER PLAN PARTICIPANT PER LIFETIME
Plan Payment Limit (Excludes precertification penalties)	
Individual	$4,500
Family	$9,000
*Unless otherwise indicated, any applicable deductible must be met before benefits are paid.	
Inpatient Services	
Hospital Room and Board and Other Inpatient Services	$100 copay per day $200 copay maximum per admission
Skilled Nursing Facilities	$0 copay admission
Hospice Facility	$0 copay per admission
Maternity	$100 copay per admission $200 copay maximum per admission
Surgery and Anesthesia	
Inpatient Surgery	Subject to inpatient copay shown above
Outpatient Surgery Performed at a Hospital Outpatient Facility	$150 copay per visit
Performed at a facility other than a Hospital Outpatient Facility	$50 copay per visit
Bariatric Surgery Covered through SurgeryPlus. Refer to SurgeryPlus plan document **DHR.Delaware.gov/benefits/surgery-plus/index.shtml** Outpatient Obesity Treatment (non surgical) Copay based on place of service where rendered	Not covered
Transplants Approved Aetna IOE Facility	100% subject to the applicable inpatient copayment

MAXIMUM BENEFIT	UNLIMITED PER PLAN PARTICIPANT PER LIFETIME
Non-Approved Participating Aetna Facility	Not Covered
Orthopedic (Knee & Hip) & Spine Surgery Approved Aetna IOQ Facility	100% subject to the applicable inpatient copayment
Non-Approved Participating Aetna Facility	$500 copay per admission. Pre-certification is required.
Mental and Nervous Conditions	
Inpatient Treatment	$100 copay per day $200 copay maximum per admission (See Inpatient visits)
Outpatient Treatment	$15 copay per visit
Telemedicine services (Teladoc Health)	$0 copay per visit
Telemedicine Service (virtual visit with a provider)	$15 copay per visit
Treatment of Alcohol and Drug Abuse	
Inpatient Detoxification	$100 copay per day $200 copay maximum per admission
Outpatient Detoxification	$15 copay per visit
Emergency Care	
Hospital Emergency Room or Outpatient Department In Case of Medical Emergency refer to page 32	$200 copay per visit. Waived if admitted
Urgent Care Facility Direct access (no referral) to participating urgent care providers	$15 copay per visit
Ambulance	$50 copay per trip
Walk-in Clinic	$15 copay per visit
Prescription Drugs	Outpatient prescription drug coverage is administered by CVS Caremark. Refer to your CVS Caremark booklet describing the coverage available.

Your Benefits

Although a specific service may be listed as a covered benefit, it may not be covered unless it is medically necessary for the prevention, diagnosis or treatment of your illness or condition. Refer to the "Glossary" section for the definition of "medically necessary."

Certain services must be precertified by Aetna. Your participating provider is responsible for obtaining this approval. If services are not precertified by Aetna, claims will not be paid.

HMO Medical Plan

Many preventive and routine medical expenses as well as expenses incurred for a serious illness or injury are covered. This section describes which expenses are covered expenses. Only expenses incurred for the services and supplies shown in this section are covered expenses. Limitations and exclusions apply.

Wellness

This section on Wellness describes the covered expenses for services and supplies provided when you are well. Refer to the Schedule of Benefits for the frequency limits that apply to these services, if not shown below.

Many preventive health services are covered at no cost to you when delivered by an in-network provider. For a complete list of covered no-cost preventive health services, see **Healthcare.gov/preventive-care-benefits**

Routine Physical Exams

Covered expenses include charges made by your physician for routine physical exams. A routine exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:

- Radiological services, X-rays, lab and other tests given in connection with the exam; and
- Immunizations for infectious diseases and the materials for administration of immunizations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services, Center for Disease Control; and
- Testing for Tuberculosis.

Covered expenses for children from birth to age 18 also include:

- *An initial hospital check up and well child visits in accordance with the prevailing clinical standards of the American Academy of Pediatric Physicians.*

Unless specified above, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this plan;
- Services which are for diagnosis or treatment of a suspected or identified illness or injury;
- Exams given during your stay for medical care;
- Services not given by a physician or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams.

Important Reminder:
Refer to the Schedule of Benefits for details about any applicable deductibles, payment percentage, benefit maximums and frequency and age limits for physical exams.

Diabetes Prevention Programs

YMCA Diabetes Prevention Program for members age 18 and older

In person program at participating YMCA locations is covered at 100%, no copayment, no referral required.

Covered expenses include 16 one-hour sessions followed by monthly meetings for up to one year.

Pre-Diabetes means that a person's blood sugar (glucose) level is higher than normal but not yet high enough to be type 2 diabetes. Diabetes has no cure, however pre-diabetes can be reversed. Factors that put you at risk:

- Obesity or overweight
- Inactive lifestyle
- Higher than normal blood glucose levels, but not high enough for diabetes
- Age 45 years and older
- Family history
- History of diabetes during pregnancy

To participate in the Diabetes Prevention Program, you need to meet the following eligibility criteria:

- 18 years or older;
- Not diagnosed with Type 1 or Type 2 diabetes or ESRD (End Stage Renal Disease);
- Overweight (BMI > 25; BMI > 23 for Asian individuals); and
- Have ONE of the following:
  - Diagnosed with pre-diabetes by qualifying blood test values;
  - Previous diagnosis of gestational diabetes; or
  - Qualifying Risk Score as determined by the online Risk Assessment

To determine if you are at risk, talk to your doctor or visit **YMCAde.org/preventdiabetes**

Solera Diabetes Prevention Program for members age 18 and older

Covered expenses include 16 weekly sessions followed by monthly sessions for up to one year at 100%, no copayment, no referral required.

The Diabetes Prevention Program helps participants:

- Lose weight
- Adopt healthy habits
- Significantly decrease their risk of developing Type 2 diabetes

Complete one-minute quiz at **GoSolera.com/stateofde** to determine if you are at-risk and qualify for the program.

Screening and Counseling Services

Covered expenses include charges made by your primary care physician in an individual or group setting for the following:

Obesity

Screening and counseling services to aid in weight reduction due to obesity.

Coverage includes:

- Preventive counseling visits and/or risk factor reduction intervention;
- Medical nutrition therapy;
- Nutrition counseling; and
- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

Benefits for the screening and counseling services above are subject to the visit maximums shown in your Schedule of Benefits. In figuring the visit maximums, each session of up to 60 minutes is equal to one visit.

Nutritional Counseling

Services are provided for the assessment and guidance of members at nutritional risk due to nutritional history, current dietary intake, medication use or chronic illness. Nutritional counseling is indicated for certain diagnoses, including diabetes, malnutrition, eating disorders and cardiovascular disease.

Nutritional counseling benefits are not provided for weight loss in the absence of co-morbid conditions, or for conditions that have not been shown to be nutritionally related, including, but not limited to, chronic fatigue syndrome and hyperactivity.

Misuse of Alcohol and/or Drugs

Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.

Benefits for the screening and counseling services above are subject to the visit maximums shown in your Schedule of Benefits. In figuring the visit maximums, each session of up to 60 minutes is equal to one visit.

Use of Tobacco Products

Screening and counseling services to aid in the cessation of the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including: cigarettes, cigars; smoking tobacco; snuff; smokeless tobacco and candy-like products that contain tobacco.

Coverage includes:

- preventive counseling visits;
- treatment visits; and
- class visits;

to aid in the cessation of the use of tobacco products.

Benefits for the screening and counseling services above are subject to the visit maximums shown in your Schedule of Benefits. In figuring the visit maximums, each session of up to 60 minutes is equal to one visit.

Limitations:

Unless specified above, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this plan;
- Services which are for diagnosis or treatment of a suspected or identified illness or injury;
- Exams given during your stay for medical care;
- Services not given by a physician or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams.

For Covered Females

Screening and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:

- Screening and counseling services for:
  - Interpersonal and domestic violence;
  - Sexually transmitted diseases; and
  - Human Immune Deficiency Virus (HIV) infections.
- Screening for gestational diabetes.
- High risk Human Papillomavirus (HPV) DNA testing age 30 to 65 limited to once every three years.

Routine Cancer Screenings

Covered expenses include charges incurred for routine cancer screening as follows:

- 1 mammogram every plan year age 40 and older (3D mammograms are covered as preventive);
- 1 baseline mammogram age 35-39
- 1 Pap smear every plan year;
- 1 gynecological exam every plan year;
- 1 fecal occult blood test every plan year; and
- 1 digital rectal exam and 1 prostate specific antigen (PSA) test every plan year as directed by your doctor.

The following tests are covered expenses if you are age 45 and older when recommended by your physician:

- 1 Sigmoidoscopy every 5 years for persons at average risk; or
- 1 Double contrast barium enema (DCBE) every 5 years for persons at average risk; or
- 1 Colonoscopy every 10 years for persons at average risk for colorectal cancer.

Family Planning Services

Covered expenses include charges for certain contraceptive and family planning services, even though not provided to treat an illness or injury. Refer to the Schedule of Benefits for any frequency limits that apply to these services, if not specified below.

Contraception Services

Covered expenses include charges for contraceptive services and supplies provided on an outpatient basis, including:

- Contraceptive drugs and contraceptive devices prescribed by a physician provided they have been approved by the Federal Drug Administration;
- Related outpatient services such as:
  - Consultations;
  - Exams;
  - Procedures; and
  - Other medical services and supplies.
- Office visit for the injection of injectable contraceptives;

Not covered are:

- Charges for services which are covered to any extent under any other part of the Plan or any other group plans sponsored by your employer; and
- Charges incurred for contraceptive services while confined as an inpatient.

Other Family Planning

Covered expenses include charges for family planning services, including:

- Voluntary sterilization.
- Voluntary termination of pregnancy.

The plan does not cover the reversal of voluntary sterilization procedures, including related follow-up care. Also see section on pregnancy and fertility related expenses on a later page.

Primary and Preventive Care

One of the Plan's goals is to help you maintain good health through preventive care. Routine exams, immunizations and well-child care contribute to good health and are covered by the Plan (after any applicable copayment) if provided by your PCP or on referral from your PCP:

- Office visits with your PCP during office hours and during non-office hours.
- Home visits by your PCP.
- Treatment for illness and injury.
- Routine physical examinations, as recommended by your PCP.
- Well-child care from birth, including immunizations and booster doses, as recommended by your PCP.
- Health education counseling and information.
- Annual prostate screening (PSA) and digital exam for males age 40 and over, and for males considered to be at high risk who are under age 40, as directed by physician.
- Sigmoidoscopy for members age 45 and older (considered medically necessary every 5 years for persons at average risk)
- Colonoscopy for members age 45 and older (considered medically necessary every 10 years for persons at average risk)
- Choice of virtual colonoscopies or traditional colonoscopies.
- Routine gynecological examinations and Pap smears performed by your PCP. You may also visit a participating gynecologist for a routine GYN exam and Pap smear without a referral.
- Annual mammography screening for asymptomatic women age 40 and older. Annual screening is covered for younger women who are judged to be at high risk by their PCP.

Note: Diagnostic mammography for women with signs or symptoms of breast disease is covered as medically necessary.

- Routine immunizations (except those required for travel or work).
- Periodic eye examinations
- Routine hearing screenings performed by your PCP as part of a routine physical examination.
- Lead screening test.
- There are circumstances in which a preventive exam could become diagnostic in nature. Examples of this are when a polyp is found during a colonoscopy, an abnormal growth/mass during a mammogram or well woman exam or a medical condition is discussed during a preventive checkup.
- The diagnosis code billed determines if the service is preventive or diagnostic.

Specialty and Outpatient Care

The Plan covers the following specialty and outpatient services. You must have a prior written or electronic referral from your PCP in order to receive coverage for any non-emergency services the specialist or facility provides.

- Participating specialist office visits.
- Participating specialist consultations, including second opinions.
- Outpatient surgery for a covered surgical procedure when furnished by a participating outpatient surgery center. All outpatient surgery must be approved in advance by Aetna.
- Preoperative and postoperative care.
- Casts and dressings.
- Radiation therapy.
- Cancer chemotherapy.
- Short-term speech, occupational (except vocational rehabilitation and employment counseling), and physical therapy for treatment of non-chronic conditions and acute illness or injury. Medical necessity review does not apply for physical therapy for the treatment of back pain.
- Cognitive therapy associated with physical rehabilitation for treatment of non-chronic conditions and acute illness or injury.
- Short-term cardiac rehabilitation provided on an outpatient basis following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Short-term pulmonary rehabilitation provided on an outpatient basis for the treatment of reversible pulmonary disease.

- Diagnostic, laboratory and X-Ray services provided to diagnose an illness or injury. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a physician. The charges must be made by a physician, hospital or licensed radiogical facility or lab. If multiple lab slips from one or more physicians are presented during the same lab visit, one copay will apply.
- If multiple labs are visited on the same day (i.e. Labcorp and Quest Diagnostics) or the member visits a lab for two separate encounters, then a copay would apply for each independent visit.
- Emergency care including ambulance service - 24 hours a day, 7 days a week (see "In Case of Emergency").
- Home health services provided by a participating home health care agency, including:
  - skilled nursing services provided or supervised by an RN.
  - services of a home health aide for skilled care.
  - medical social services provided or supervised by a qualified physician or social worker if your PCP certifies that the medical social services are necessary for the treatment of your medical condition.
- Outpatient hospice services for a member who is terminally ill, including:
  - counseling and emotional support.
  - home visits by nurses and social workers.
  - pain management and symptom control.
  - instruction and supervision of a family member.

NOTE: The Plan does not cover the following hospice services:

  - funeral arrangements, pastoral counseling, or financial or legal counseling.
  - homemaker or caretaker services and any service not solely related to the care of the terminally ill patient.

- Implantable contraceptives prescribed by a physician and approved by the Federal Drug Administration (FDA).
- Reconstructive breast surgery following a mastectomy, including:
  - reconstruction of the breast on which the mastectomy is performed, including areolar reconstruction and the insertion of a breast implant,
  - surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed, and
  - physical therapy to treat the complications of the mastectomy, including lymphedema.
- Chiropractic services. Subluxation services must be consistent with Aetna's guidelines for spinal manipulation to correct a muscular skeletal problem or subluxation that could be documented by diagnostic X-rays performed by a participating radiologist. Medical necessity review does not apply for the treatment of back pain and medically necessary maintenance care provided by license chiropractor.
- Phenylketonuria (PKU) and other inherited metabolic diseases - The plan covers medical formulas and foods and low protein modified formulas and modified food products when prescribed as medically necessary and administered under the directions of a physician.

Prosthetic Devices

Wig or hair piece

- Wig or hair piece ordered by a physician is a covered prosthetic device. One piece covered for the treatment of any illness or injury resulting in hair loss up to $1,000 maximum per plan year. Includes the costs of repairs/adjustments and replacements when all of the following applies:

For repairs/adjustments:

- It is 6 months or more after the initial purchase.
- Needed because of a change in physical condition, normal growth or wear and tear.
- The cost of repair is less expensive than the cost of replacement.

For replacements:

- Needed because of a change in physical condition, normal growth or wear and tear.
- Cost of new one is less than cost of repairs to existing one.
- The existing one is not fixable.
- Prosthetic appliances and orthopedic braces (including repair and replacement when due to normal growth). Certain prosthetics require preauthorization by Aetna. Contact Aetna prior to placing order or making purchase to determine if preauthorization is required. Lack of preauthorization, if required, will result in claim being denied.

Durable Medical and Surgical Equipment (DME)

- Durable medical equipment (DME), prescribed by a physician for the treatment of an illness or injury, and preauthorized by Aetna.

The Plan covers instruction and appropriate services required for the Plan participant to properly use the item, such as attachment or insertion, if approved by Aetna. Replacement, repair and maintenance are covered only if:

- they are needed due to a change in your physical condition, or
- it is likely to cost less to buy a replacement than to repair the existing equipment or rent like equipment.

The request for any type of DME must be made by your physician and coordinated through the Aetna Patient Management Department.

Cooling Caps (Scalp Hypothermia)

Covered durable medical equipment for members undergoing chemotherapy treatment up to $1,000 maximum per plan year. Includes the costs of repairs/adjustments and replacements when all of the following applies:

For repairs/adjustments:

- It is 6 months or more after the initial purchase.
- Needed because of a change in physical condition, normal growth or wear and tear.
- The cost of repair is less expensive than the cost of replacement.

For replacements:

- Needed because of a change in physical condition, normal growth or wear and tear.
- Cost of new one is less than cost of repairs to existing one.
- The existing one is not fixable.

Bariatric Surgery

- Bariatric surgery is covered through SurgeryPlus. Refer to SurgeryPlus plan document **DHR.Delaware.gov/benefits/surgery-plus/index.shtml**
- Covered expenses under the Aetna medical plan include charges made by a physician, licensed or certified dietician, nutritionist or hospital for the non-surgical treatment of obesity for the following outpatient weight management services:
- An initial medical history and physical exam; and,
- Diagnostic tests given or ordered during the first exam.

Vision Therapy

(orthoptics and/or pleoptic training)

- The maximum number of visits allowed for a specific diagnosis is determined by Aetna's Clinical Policy Bulletin (489).

Second Surgical Opinion

Charges of a physician for a second surgical opinion on the need or advisability of performing a surgical or oral surgical procedure:

- for which the charges are a Covered Medical Expense; and
- which is recommended by the first physician who proposed to perform the surgery; and
- which is not for an emergency condition.

A benefit is also paid for charges made for a third surgical opinion. This will be done when the second one does not confirm the recommendation of the first physician who proposed to perform the surgery.

A surgical opinion is:

- an exam of the person; and
- x-ray and lab work; and
- a written report by the physician who renders the opinion.

The surgical opinion must both:

- be performed by a physician who is certified by the American Board of Surgery or other specialty board; and
- take place before the date the proposed surgery is scheduled to be done.

Benefits are not paid for a surgical opinion if the physician who renders the surgical opinion is associated or in practice with the first physician who recommended and proposed to perform the surgery.

This plan complies with the 149th General Assembly House Bill 319 effective 6/13/2018, House Bill 386 effective 8/29/2018 and Senate Bill 225 effective 1/11/2019.

Diabetic Education

Diabetic education provides instruction on the care and treatment of diabetes, including foot care, eye exams for diabetic retinopathy, blood sugar monitoring, medication management and diabetic nutritional counseling. Diabetic education can be performed by either physicians or Certified Diabetic Educators, either on an individual basis or in a group setting.

Diabetes Program

Transform Diabetes Care® program is a 12-month program to help keep your diabetes in check. Covered at 100%, no copayment and no referral is required. You'll receive customized guidance based on your specific needs.

- Get reminders about refills, doctor appointments or preventive screenings and nutrition plans based on what you like and need.
- Access to Health Optimizer™ app to monitor your glucose and blood pressure; track and share readings; learn more about diabetes and maintaining a healthy lifestyle; make meals that align with your dietary restrictions; and more.
- You'll get personalized support from Certified Diabetes Care and Education Specialist nurses and support from your Aetna One™ Advisor team.
- If you're managing diabetes, you'll be enrolled automatically into the program.

Oral Surgery

Oral Surgery is only covered for:

- Extracting bony impacted teeth; and
- Correcting accidental injuries (to the jaws, cheeks, lips, tongue, roof and floor of mouth).

Oral Surgery is covered when done in a dentist's or an oral surgeon's office or in a hospital outpatient department or ambulatory surgical center.

Coverage is not provided for the extraction of normal, abscessed or diseased teeth or for the removal, repair or replacement of teeth damaged due to accidental injuries or disease, even if such services are necessary to correct other injuries suffered as a result of accident or disease.

When it is medically necessary, due to a member's physical, intellectual or other medically compromised condition, for dental services to be performed under general anesthesia outside of a dentist's or oral surgeon's office, the plan will cover the anesthesia and facility charges.

Some services may require medical necessity review.

Morbid Obesity Surgical Expenses

Covered through SurgeryPlus. Refer to SurgeryPlus plan document **DHR.Delaware.gov/benefits/surgery-plus/index.shtml**

Not covered:

- Cost of meals
  - Weight control services including surgincal procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions; except as provided in this Booklet.

Annual testing for exposure to hepatitis or tuberculosis, and immunizations for hepatitis, for at-risk employees.

Autism Spectrum Disorder

Covered expenses include charges made by a physician or behavioral health provider for services and supplies for diagnosis and treatment of Autism Spectrum Disorder, including behavioral therapy and Applied Behavioral Analysis. Services and supplies must be ordered by a physician as part of a treatment plan.

Applied Behavioral Analysis is an educational service that is the process of applying interventions that:

- Systematically change behavior; and
- Are responsible for the observable improvement in behavior.

Autism Spectrum Disorder means one of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

- Autistic Disorder;
- Rett's Disorder;
- Childhood Disintegrative Disorder;
- Asperger's Syndrome; and
- Pervasive Developmental Disorder – Not Otherwise Specified

High Tech Imaging Scans and Tests

- Scans and tests classified as High-Tech Imaging include Magnetic Resonance Imaging (MRI), Computed Axial Tomography (CT), Positron Emission Tomography (PET), and Nuclear Cardiac Imaging.
- Once your doctor prescribes a MRI, CT or PET scan and it's approved the Aetna One Advisor team will reach out to you to provide options on where to obtain the imaging service and that will result in the lowest out-of-pocket cost for you.

Requests for these tests, to be performed as an out-patient, may require pre-authorization through the member's health care provider to determine if the test is appropriate for the member's medical condition. It is the treating physician's responsibility to submit and receive approval for the high-tech imaging tests prior to the member receiving the test. When the physician receives approval the test may then be scheduled with the testing facility. Failure to receive approval prior to having the test performed may result in the claim being denied and the Provider held accountable for the entire cost of the test. Tests and scans performed during a member's hospitalization or Emergency Room visit are exempt from this program. The member is responsible for applicable copays.

Fertility Services

Infertility is defined as a condition (an interruption, cessation, or disorder of body functions, systems or organs) of the reproductive tract, which prevents the conception of a child or the ability to carry a pregnancy to delivery. Fertility services are covered under your plan to diagnose and treat the underlying medical cause of infertility. Fertility benefits are paid based on the provider and place of service identified in your "Schedule of Benefits".

You may obtain fertility services to diagnose and treat the underlying medical cause of infertility from a participating gynecologist or fertility specialist without a referral from your PCP.

- Initial evaluation, including history, physical exam and laboratory studies performed at an appropriate participating laboratory
- Evaluation of ovulatory function
- Ultrasound of ovaries at an appropriate participating radiology facility
- Postcoital test
- Hysterosalpingogram
- Endometrial biopsy
- Hysteroscopy.

Semen analysis at an appropriate participating laboratory is covered for male Plan participants; a referral from your PCP is necessary.

If you do not conceive after receiving the above fertility services, or if the diagnosis suggests that there is no reasonable chance of pregnancy as a result of the above services, you are eligible to receive the following services through a participating fertility specialist when preauthorized through and coordinated by the Aetna Infertility Unit:

Artificial Reproductive Technologies

This plan provides fertility care services and fertility preservation services for individuals diagnosed with infertility or at risk of infertility due to surgery, radiation, chemotherapy or other medical treatment. Covered services include artificial insemination, in vitro fertilization and related technologies, and cryopreservation of cells and tissue.

Artificial Insemination (AI, IUI, ICI)

Artificial Insemination is a procedure, also known as intrauterine insemination (IUI) or intracervical/intravaginal insemination (ICI), by which sperm is directly deposited into the vagina, cervix or uterus to achieve fertilization and pregnancy.

In Vitro Fertilization (IVF, GIFT, ZIFT)

IVF (or related technologies, including, but not limited to: gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT)) may be considered medically necessary when the following criteria are met:

- Individual has a congenital absence or anomaly of reproductive organ(s); or
- Individual fulfills one of the following definitions of infertility:
- Individual is less than the age of 35 years and has not achieved a successful pregnancy after at least twelve (12) months of appropriately timed unprotected vaginal intercourse or intrauterine insemination; or
- Individual is 35 years of age or older and has not achieved a successful pregnancy after at least six (6) months of appropriately timed unprotected vaginal intercourse or intrauterine insemination.

AND

- In the absence of known tubal disease and/or severe male factor problems (contraindications to insemination cycles), the individual has not achieved a successful pregnancy as described

above, which includes up to three (3) intrauterine insemination cycles; and

- Individual has at least one risk factor that includes, but is not limited to the following:
- Tubal disease that cannot be corrected surgically; or
- Diminished ovarian reserve; or
- Irreparable distortion of the uterine cavity or other uterine anomaly (when using a gestational carrier); or
- Male partner with sever male factor infertility; or
- Unexplained infertility; or
- Stage 4 endometriosis as defined by the American Society of Reproductive Medicine;

AND

- Individual does not have either of the following contraindications:
- Ovarian failure: premature (i.e., ovaries stop working before age 40) or
- menopause (i.e., absence of menstrual periods for 1 year); or
- Contraindication to pregnancy

For IVF services, retrievals must be completed before the individual is 45 years old and transfers must be completed before the individual is 50 years old.

The benefit is limited to six (6) completed egg retrievals per lifetime, with unlimited embryo transfers in accordance with the guidelines of the American Society for Reproductive Medicine, using single embryo transfer (SET) when recommended and medically appropriate.

Gestational Carrier/Surrogate

Medical services or supplies rendered to a gestational carrier or surrogate may be considered medically necessary if the member has ANY of the following indications:

- Congenital absence of a uterus; or
- Uterine anomalies that cannot be repaired; or
- A medical condition for which pregnancy may pose a life-threatening risk.

Benefit Limits

There's a $30,000 lifetime payment limit for services related to assisted reproductive surgical procedures. The $30,000 limit applies even when you switch to another State of Delaware plan. If pregnancy results, your maternity benefits are then applied.

Note: Drugs are covered under your prescription drug benefit and are subject to a separate $15,000 limit.

To receive coverage you must:

- obtain a referral from your PCP or participating gynecologist or contact an Infertility Unit case manager at the Aetna One Advisor number shown on your ID card,
- and obtain preauthorization through the Infertility Unit, either directly or through your ART specialist.

Exclusions and Limitations

The following related services to reproductive technologies/techniques are considered not medically necessary:

- Infertility that is a result of voluntary sterilization of either partner. (In situations where the female partner has a diagnosis of infertility and the male partner has had a voluntary sterilization, IVF coverage may still be reviewed and approved based on the female partner's infertility condition.): or,
- Reversal of voluntary sterilization (tuboplasty or vasoplasty); or
- Payment for surrogate service fees for purposes of child birth; or
- Living expenses; or
- Travel expenses

Inpatient Care in a Hospital, Skilled Nursing Facility or Hospice

If you are hospitalized by a participating PCP or specialist (with prior referral except in emergencies), you receive the benefits listed below. See "Behavioral Health" for inpatient mental health and substance abuse benefits.

- Confinement in semi-private accommodations (or private room when medically necessary and certified by your PCP) while confined to an acute care facility.
- Confinement in semi-private accommodations in an extended care/skilled nursing facility.
- Confinement in semi-private accommodations in a hospice care facility for a Plan participant who is diagnosed as terminally ill.
- Intensive or special care facilities.

- Visits by your PCP while you are confined.
- General nursing care.
- Surgical, medical and obstetrical services provided by the participating hospital.
- Use of operating rooms and related facilities.
- Medical and surgical dressings, supplies, casts and splints.
- Drugs and medications.
- Intravenous injections and solutions.
- Administration and processing of blood, processing fees and fees related to autologous blood donations. (The blood or blood product itself is not covered.)
- Nuclear medicine.
- Preoperative care and postoperative care.
- Anesthesia and anesthesia services.
- Oxygen and oxygen therapy.
- Inpatient physical and rehabilitation therapy, including:
  - cardiac rehabilitation, and
  - pulmonary rehabilitation.
- X-rays (other than dental X-rays), laboratory testing and diagnostic services.
- Magnetic resonance imaging.
- Transplant services are covered if the transplant is not experimental or investigational and has been approved in advance by Aetna. Transplants must be performed in hospitals specifically approved and designated by Aetna to perform the procedure. The Institutes of Excellence (IOE) network is Aetna's network of providers for transplants and transplant-related services, including evaluation and follow-up care. Each facility has been selected to perform only certain types of transplants, based on their quality of care and successful clinical outcomes. A transplant will be covered only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any facility that is not specified as an Institute of Excellence network facility is considered as an out-of-network facility for transplant-related services, even if the facility is considered as a participating facility for other types of services.
- Maximum of 365 days per calendar year for hospice services.

Institutes of Quality (IOQ) for Orthopedic (Knee & Hip) & Spine Surgery

Aetna Institutes provide access to a quality and efficient network for specific procedures. Facilities that have met extensive quality, as well as efficiency criteria have been selected by Aetna to participate in their Aetna Institutes network.

Orthopedic Care IOQs are health care facilities that are designated based on measures of clinical performance, access and efficiency for orthopedic care. Aetna Orthopedic IOQs provide a full range of orthopedic care services. These include:

- Spine (laminectomy, Primary Fusion, Fusion Revision, Discectomy (w/out decompression), decompression (w/out fusion)
- Total Joint Replacement (Knee/Hip)

The highest network level of benefits is paid only for treatment at a facility designated by the plan as an Orthopedic and Spine Institutes of Quality (IOQ) facility.

Services obtained from a facility that is a network facility but not designated as an Orthopedic and Spine Institutes of Quality (IOQ) facility will be covered at a lower network level of benefits. Precertification is required.

Travel and Lodging Reimbursement:

The plan covers:

For an Orthopedic IOQ facility 100 miles from the recipient's home reimbursement of $50 per night for lodging for each person, maximum of $100 per night.

Travel & Lodging reimbursement is limited to $10,000 per episode of care. The $10,000 is inclusive of expenses for the patient and one adult companion.

Coach class air fare, train or bus travel and ground transportation for personal vehicle are examples of covered services.

Personal vehicle includes reimbursement for mileage, parking and tolls. Mileage reimbursement is based on the current IRS medical mileage reimbursement.

Reimbursement period begins 1 day prior to surgery and ends 6 months after surgery.

Preauthorization is required.

Not covered:

- Cost for meals
- Alcohol/tobacco
- Car rental

- Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
- Expenses for persons other than the patient and his/her designated support person
- Gas
- Personal care items (e.g., shampoo, deodorant, etc.)
- Souvenirs (e.g., t-shirts, sweatshirts, toys, etc.)
- Telephone calls and hotel room service

Gene-based, cellular and other innovative therapies (GCIT)

Covered services include GCIT provided by a physician, hospital or other provider.

GCIT are defined as any services that are:

- Gene-based
- Cellular and innovative therapeutics

The services have a basis in genetic/molecular medicine and are not covered under the Institutes of Excellence™ (IOE) programs. We call these "GCIT services."

GCIT covered services include:

- Cellular immunotherapies.
- Genetically modified oncolytic viral therapy.
- Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain therapeutic conditions.
- All human gene-based therapy that seeks to change the usual function of a gene or alter the biologic properties of living cells for therapeutic use. **Examples include therapies using:**
  - Luxturna® (Voretigene neparvovec)
  - Zolgensma® (Onasemnogene abeparvovec-xioi)
  - Spinraza® (Nusinersen)
- Products derived from gene editing technologies, including CRISPR-Cas9.
- Oligonucleotide-based therapies. **Examples include:**
  - Antisense. An example is Spinraza.
  - siRNA.
  - mRNA.
  - microRNA therapies.

Facilities/provider for gene-based, cellular and other innovative therapies

We designate facilities to provide GCIT services or procedures. GCIT physicians, hospitals and other providers are GCIT-designated facilities/providers for Aetna.

IMPORTANT NOTE: You must get GCIT covered services from the GCIT-designated facility/provider. If there are no GCIT-designated facilities/providers assigned in your network, it's important that you contact us so we can help you determine if there are other facilities that may meet your needs. If you do not get your GCIT services at the facility/provider we designate, they will not be covered services.

- Travel and lodging expenses
  - If you are working with a GCIT-designated facility/provider that is 100 or more miles away from where you live, travel and lodging expenses are covered services for you and a companion, to travel between home and the GCIT-designated facility/provider.
  - Coach class air fare, train or bus travel and ground transportation for personal vehicle are examples of covered services.
  - Personal vehicle includes reimbursement for mileage, parking and tolls. Mileage reimbursement is based on the current IRS medical mileage reimbursement.
  - $50 per night for lodging per person for patient and one companion, $100 total per night.

The following are not **covered services** unless you receive prior written approval from us:

- GCIT services received at a facility or with a provider that is not a GCIT-designated facility/provider.
- All associated services when GCIT services are not covered. **Examples include** infusion, laboratory, radiology, anesthesia, and nursing services.

Travel & Lodging reimbursement is limited to $10,000 per episode of care. The $10,000 is inclusive of expenses for the patient and one adult companion.

Preauthorization is required.

Not covered:

- Cost for meals
- Alcohol/tobacco
- Car rental
- Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
- Expenses for persons other than the patient and his/her designated support person
- Gas
- Personal care items (e.g., shampoo, deodorant, etc.)
- Souvenirs (e.g., t-shirts, sweatshirts, toys, etc.)
- Telephone calls and hotel room service

Maternity

The Plan covers physician and hospital care for mother and baby, including prenatal care, delivery and postpartum care. In accordance with the Newborn and Mothers Healthcare Protection Act, you and your newly born child are covered for a minimum of 48 hours of inpatient care following a vaginal delivery (96 hours following a cesarean section). However, your provider may – after consulting with you – discharge you earlier than 48 hours after a vaginal delivery (96 hours following a cesarean section).

You do not need a referral from your PCP for visits to your participating obstetrician. A list of participating obstetricians can be found in your provider directory on **MyAetnaNetwork.com** (see "Provider Information").

NOTE: Your participating obstetrician is responsible for obtaining precertification from Aetna for all obstetrical care after your first visit. They must request approval (precertification) for any tests performed outside of their office and for visits to other specialists. Please verify that the necessary referral has been obtained before receiving such services.

If you are pregnant at the time you join the Plan, you receive coverage for authorized care from participating providers on and after your effective date. There is no waiting period. Coverage for services incurred prior to your effective date with the Plan are your responsibility or that of your previous plan.

Lactation Support, Counseling and Supplies

Covered expenses include charges made for comprehensive lactation support (assistance and training in breast feeding) and counseling services to females during pregnancy and in the post-partum period. Services must be provided by a certified lactation support provider in a group or individual setting.

Covered expenses also include the rental or purchase of breast feeding durable medical equipment for pumping and storage of breast milk and the purchase of the accessories and supplies needed to operate the equipment. Aetna reserves the right to limit the payment of charges to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of Aetna.

IMPORTANT REMINDER: Refer to the Schedule of Benefits for details about any deductible, payment percentage and limit that may apply to covered services.

Gender Affirming Surgery

Eligibility for this benefit is limited to you and your qualified dependents, having met Aetna's criteria for diagnosis of "true transsexualism, and documented completion of a recognized program at a specialized gender identity treatment center. Aetna's policies regarding the eligibility for Gender Reassignment Surgery (as described in Aetna's Clinical Policy Bulletin 0615) and other procedures and services are available in the Medical Clinical Policy Bulletins, accessible on the Aetna member website.

You and your qualified dependent must meet criteria for the diagnosis of "true" transsexualism, including:

- Life-long sense of belonging to the opposite sex and of having been born into the wrong sex, often since childhood; and
- A sense of estrangement from one's own body, so that any evidence of one's own biological sex is regarded as repugnant; and
- Wishes to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; and
- A stable transsexual orientation evidenced by a desire to be rid of one's genitals and to live in society as a member of the other sex for at least 2 years, that is, not limited to periods of stress; and
- Does not gain sexual arousal from cross-dressing; and
- Absence of physical inter-sex of genetic abnormality; and
- Not due to another biological, chromosomal or associated psychiatric disorder, such as schizophrenia.

Covered Expenses

Covered expenses include charges in connection with a medically necessary Gender Affirming Surgery as long as you or a covered dependent have obtained precertification from Aetna.

Covered expenses include:

Charges made by a physician for:

- Charges for psychotherapy for gender identity disorders;
- Performing the surgical procedure;
- Pre- and post-operative hospital and office visits; and
- Pre- and post-operative hormone replacement treatment.

Charges made by a hospital for inpatient and outpatient services (including outpatient surgery). Room and board charges in excess of the hospital's semi-private rate will not be covered unless a private room is ordered by your physician and precertification has been obtained.

- Charges made by a Skilled Nursing Facility for inpatient services and supplies.
- Daily room and board charges over the semi private rate will not be covered.
- Charges made for the administration of anesthetics.

Charges for outpatient diagnostic laboratory and x-rays.

Charges for blood transfusion and the cost of unreplaced blood and blood products. Also included are the charges for collecting, processing and storage of self-donated blood after the surgery has been scheduled.

Genital reconstruction surgery including, but not limited to, hysterectomy, oophorectomy and mastectomy. The Aetna Clinical Policy Bulletin 0615 will provide a comprehensive list of covered surgeries.

IMPORTANT REMINDERS: No payment will be made for any covered expenses under this benefit unless they have been precertified by Aetna.

Refer to the Schedule of Benefits for details about deductibles, coinsurance or benefit maximums.

Limitations:

- The plan does not cover expenses in excess of one surgical procedure per covered person per lifetime.

Transplant Expenses

Once it has been determined that you or one of your dependents may require an organ transplant, you, or your physician should call the Aetna precertification department to discuss coordination of your transplant care. Aetna will coordinate all transplant services. In addition, you must follow any precertification requirements found in the Certification for Admissions sections of this document. Organ means: Solid organ, Hematopoietic stem cell, Bone marrow, CAR-T and T-cell receptor therapy for FDA-approved treatments.

Benefits may vary if an Institute of Excellence (IOE) facility or non-IOE is used. In addition, some expenses listed below are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure you require. A transplant will be covered as preferred care only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any treatment or service related to transplants that is provided by a facility that is not specified as an IOE network facility, even if the facility is considered as a preferred facility for other types of services, will be covered at the non-preferred level. Please read each section carefully.

Covered Transplant Expenses

Covered transplant expenses include the following:

- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are your biological parent, sibling or child.
- Inpatient and outpatient expenses directly related to a transplant.
- Charges made by a physician or transplant team.
- Charges made by a hospital, outpatient facility or physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the IOE facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one Transplant Occurrence.

A Transplant Occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date you are discharged from the hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one Transplant Occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant Evaluation/Screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.
2. Pre-transplant/Candidacy Screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members.
3. Transplant Event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement.
4. Follow-up Care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

For the purposes of this section, the following will be considered to be one Transplant Occurrence:

- Heart
- Lung
- Heart/ Lung
- Simultaneous Pancreas Kidney (SPK)
- Pancreas
- Kidney
- Liver
- Intestine
- Bone Marrow/Stem Cell transplant
- Multiple organs replaced during one transplant surgery
- Tandem transplants (Stem Cell)
- Sequential transplants
- Re-transplant of same organ type within 189 days of the first transplant
- Any other single organ transplant, unless otherwise excluded under the Plan

The following will be considered to be more than one Transplant Occurrence:

- Autologous Blood/Bone Marrow transplant followed by Allogenice Blood/Bone Marrow transplant (when not part of a tandem transplant).
- Allogenic Blood/Bone Marrow transplant followed by an Autologous Blood/Bone Marrow transplant (when not part of a tandem transplant).
- Re-transplant after 180 days of the first transplant.
- Pancreas transplant following a kidney transplant.
- A transplant necessitated by an additional organ failure during the original transplant surgery/process.
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g. a liver transplant with subsequent heart transplant).

Limitations:

The transplant coverage does not include charges for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient Transplant Occurrence.
- Services and supplies furnished to a donor when the recipient is not a covered person under this plan.
- Home infusion therapy after the Transplant Occurrence.
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness.
- Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness.
- Cornea (Corneal Graft with Amniotic Membrane or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by Aetna

Transplant Travel and Lodging Reimbursement:

The plan covers:

For an IOE Transplant facility 50 miles from the recipient's home reimbursement of $50 per night for lodging for each person, maximum of $100 per night.

Travel & Lodging reimbursement is limited to $10,000 per transplant or procedure type. The $10,000 is inclusive of expenses for the patient and one adult companion.

Coach class air fare, train or bus travel and ground transportation for personal vehicle are examples of covered services.

Personal vehicle includes reimbursement for mileage, parking and tolls. Mileage reimbursement is based on the current IRS medical mileage reimbursement.

Reimbursement period ends 12 month post-transplant.

Preauthoritization is required.

Not covered:

- Cost for meals
- Alcohol/tobacco
- Car rental
- Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
- Expenses for persons other than the patient and his/her designated support person
- Gas
- Personal care items (e.g., shampoo, deodorant, etc.)
- Souvenirs (e.g., t-shirts, sweatshirts, toys, etc.)
- Telephone calls and hotel room service

Behavioral Health

Your mental health/substance abuse benefits will be provided by participating behavioral health providers. You do not need a referral from your PCP to obtain care from participating mental health and substance abuse providers. Instead, when you need mental health or substance abuse treatment, call the behavioral health telephone number shown on your ID card. A clinical care manager will assess your situation and refer you to participating providers, as needed.

Mental Health Treatment

The Plan covers the following services for mental health treatment:

- Inpatient medical, nursing, counseling and therapeutic services in a hospital or non-hospital residential facility, appropriately licensed by the Department of Health or its equivalent.
- Short-term evaluation and crisis intervention mental health services provided on an outpatient basis.

Treatment of Alcohol and Drug Abuse

The Plan covers the following services for treatment of alcohol and drug abuse:

- Inpatient care for detoxification, including medical treatment and referral services for substance abuse or addiction.
- Inpatient medical, nursing, counseling and therapeutic rehabilitation services for treatment of alcohol or drug abuse or dependency in an appropriately licensed facility.
- Outpatient visits for substance abuse detoxification. Benefits include diagnosis, medical treatment and medical referral services by your PCP.
- Outpatient visits to a participating behavioral health provider for diagnostic, medical or therapeutic rehabilitation services for substance abuse.

Outpatient treatment for substance abuse or dependency must be provided in accordance with an individualized treatment plan.

AbleTo, Inc

AbleTo, Inc., is a national outpatient provider group in behavioral health support. AbleTo provides behavioral health treatment to members identified with certain medical conditions or going through certain life change.

Health care conditions	Life changes
Cardiac	Resilience - Depression/anxiety
Diabetes	Momentum - Post-partem depression
Thrive - Breast cancer recovery	Anxiety & Panic
Thrive - Prostate cancer recovery	Bereavement
GI Health	Caregiver - For adults
Renew - Pain management	Caregiver - support for children
Respiratory	Caregiver - support for autism
Alcohol and Substance Abuse	Military Transitions - help veterans address emotional challenges that accompany return from service

AbleTo is a specific network of outpatient behavioral health providers that members can access through their Aetna Behavioral Health benefit plan. No precertification or referrals are required.

Members can be evaluated for services through outreach or by calling AbleTo directly. Regardless of the referral channel, members are screened to make sure the treatment option is right for them.

There are several ways we identify members to AbleTo support. These include:

- During support calls, our nurses may identify members who could benefit from an AbleTo forum. They will refer members via warm transfer or share the AbleTo phone number.
- Members with certain conditions (cardiac and diabetes) who may benefit from the treatment support are identified each week. We send a member list to AbleTo and their staff contacts members to introduce the services.
- Members may self-refer online at **AbleTo.com/enroll** or by calling AbleTo at 1-844-330-3648.
- HMS, your EAP provider, can refer directly by calling AbleTo at **1-855-773-2354**.

Prescription Drugs

The Plan covers only prescription drugs administered while you are an inpatient in a covered health care facility, administered in a doctor's office, or through home infusion. Prescription drugs, if your doctor writes you a prescription, are covered through the State of Delaware's prescription benefit manager.

Please refer to the separate booklet describing the outpatient prescription drug coverage available through the State of Delaware prescription drug benefit manager.

Exclusions and Limitations

Exclusions

The Plan does not cover the following services and supplies:

- Acupuncture and acupuncture therapy, except when performed by a participating physician as a form of anesthesia in connection with covered surgery.
- Ambulance services, when used as routine transportation to receive inpatient or outpatient services.
- Any service in connection with, or required by, a procedure or benefit not covered by the Plan.
- Any services or supplies that are not medically necessary, as determined by Aetna.
- Biofeedback, except as specifically approved by The Plan.
- Breast augmentation and otoplasties, including treatment of gynecomastia.
- Canceled office visits or missed appointments.
- Care for conditions that, by state or local law, must be treated in a public facility, including mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem. However, the Plan covers the following:
  - reconstructive surgery to correct the results of an injury.
  - surgery to treat congenital defects (such as cleft lip and cleft palate) to restore normal bodily function.
  - surgery to reconstruct a breast after a mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure.
- Court-ordered services and services required by court order as a condition of parole or probation, unless medically necessary and provided by participating providers upon referral from your PCP.
- Custodial care and rest cures.
- Dental care and treatment, except as specified under "Your Benefits". The Plan does not cover:
  - care, filling, removal or replacement of teeth,
  - dental services related to the gums,
  - apicoectomy (dental root resection),
  - orthodontics,
  - root canal treatment,
  - soft tissue impactions,
  - alveolectomy,

- augmentation and vestibuloplasty treatment of periodontal disease,
- prosthetic restoration of dental implants, and
- dental implants.

- Drugs and medicines which by law need a physician's prescription and for which no coverage is provided under the Prescription Drug Expense Coverage.
- EDUCATIONAL SERVICES:
- Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
- Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause; and
- Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.
- Expenses that are the legal responsibility of Medicare or a third party payor.
- Experimental and investigational services and procedures; ineffective surgical, medical, psychiatric, or dental treatments or procedures; research studies; or other experimental or investigational health care procedures or pharmacological regimes, as determined by Aetna, unless approved by Aetna in advance.

This exclusion will not apply to drugs:

- that have been granted treatment investigational new drug (IND) or Group c/ treatment IND status,
- that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute, or
- that Aetna has determined, based upon scientific evidence, demonstrate effectiveness or show promise of being effective for the disease.

Refer to the "Glossary" for a definition of "experimental or investigational."

- False teeth.
- Hair analysis.
- Health services, including those related to pregnancy, that are provided before your coverage is effective or after your coverage has been terminated.
- Hearing aids, eyeglasses, or contact lenses or the fitting thereof, except as specified in the "Copayment Schedule".
- Household equipment, including (but not limited to) the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, is not covered. Improvements to your home or place of work, including (but not limited to) ramps, elevators, handrails, stair glides and swimming pools, are not covered.
- Hypnotherapy, except when approved in advance by Aetna.
- Immunizations related to travel or work, except for high risk work related
- Implantable drugs
- Fertility services, except as described under "Your Benefits." The Plan does not cover:
  - Reversal of voluntary sterilization (tuboplasty or vasoplasty); or
  - Payment for surrogate service fees for purposes of child birth; or
  - Living expenses; or
  - Travel expenses.
- Orthotics.
- Disposable Outpatient Supplies: Any outpatient disposable supply or device including (but not limited to), sheaths, bags, elastic garments or stockings, support hose, bandages, incontinence pads, bedpans, syringes, blood or urine testing supplies such as reagent strips, and other home test kits, and splints, neck braces, compresses, and other devices not intended for reuse by another patient except when obtained in conjunction with a visit to a medical provider (e.g., excluded from coverage when purchased in a retail setting).
- Personal comfort or convenience items, including services and supplies that are not directly related to medical care, such as guest meals and accommodations, barber services, telephone

charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other similar items and services.

- Private duty while inpatient or special nursing care. Also, private duty nursing services provided outside of the home (e.g., while attending daycare, preschool or school) or while traveling.
- Radial keratotomy, including related procedures designed to surgically correct refractive errors.
- Recreational, educational and sleep therapy, including any related diagnostic testing.
- COUNSELING:
  - Services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counselor. Except marriage counseling, marital therapy, couples counseling covered when rendered by a licensed behavioral health provider when at least 1 party in the relationship has a diagnosed behavioral health disorder, such as:
    - Adjustment disorder
    - Alcoholism
    - Anxiety
    - Depression
- Reversal of voluntary sterilizations, including related follow-up care.
- Routine hand and foot care services, including routine reduction of nails, calluses and corns.
- Services not covered by the Plan, even when your PCP has issued a referral for those services.
- Services or supplies covered by any automobile insurance policy, up to the policy's amount of coverage limitation.
- Services provided by your close relative (your spouse, child, brother, sister, or the parent of you or your spouse) for which, in the absence of coverage, no charge would be made.
- EXAMINATIONS**:**
  - Any health examinations:
  - Any health examinations or treatment including laboratory and imaging testing to obtain or maintain employment or to attend a school, camp or sporting or other recreational events. Any special medical reports not directly related to treatment except when provided as part of a covered services.
  - Examples of non-covered services includes:
    - Screening examinations for infectious disease, including laboratory or x-ray tests
    - Drug testing
    - Hearing or vision examinations
    - Vocational rehabilitation
    - Employment counseling
- Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the What the Plan Covers section.
- Services and supplies that are not medically necessary.
- Services you are not legally obligated to pay for in the absence of this coverage.
- Special education, including lessons in sign language to instruct a Plan participant whose ability to speak has been lost or impaired to function without that ability.
- Special medical reports, including those not directly related to the medical treatment of a Plan participant (such as employment or insurance physicals) and reports prepared in connection with litigation.
- Specific injectable drugs, including:
  - experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the FDA and the National Institutes of Health, injectable drugs not considered medically necessary or used for cosmetic, performance, or enhancement purposes, or not specifically covered under this plan,
  - drugs related to treatments not covered by the Plan, and
  - drugs related to the treatment of infertility, contraception, and performance-enhancing steroids.
- Specific non-standard allergy services and supplies, including (but not limited to):
  - skin titration (rinkel method),
  - cytotoxicity testing (Bryan's Test),
  - treatment of non-specific candida sensitivity, and
  - urine autoinjections.

- Speech therapy for treatment of delays in speech development, unless resulting from disease, injury, or congenital defects.
- Surgical operations, procedures or treatment of obesity covered through SurgeryPlus except for non-surgical treatment outlined as covered under the Aetna medical plan.
- Therapy or rehabilitation, including (but not limited to):
  - primal therapy.
  - chelation therapy.
  - rolfing.
  - psychodrama.
  - megavitamin therapy.
  - purging.
  - bioenergetic therapy.
  - vision perception training.
  - carbon dioxide therapy.
- Thermograms and thermography.
- Treatment in a federal, state or governmental facility, including care and treatment provided in a nonparticipating hospital owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.
- Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ except when medically necessary.
  - Sex therapy, sex counseling, marriage counseling or other counseling or advisory services. Except marriage counseling, marital therapy, couples counseling covered when rendered by a licensed behavioral health provider when at least 1 party in the relationship has a diagnosed behavioral health disorder, such as:
  - Adjustment disorder
  - Alcoholism
  - Anxiety
  - Depression
- Treatment of diseases, injuries or disabilities related to military service for which you are entitled to receive treatment at government facilities that are reasonably available to you.
- Treatment of injuries sustained while committing a felony.
- Treatment of mental retardation, defects and deficiencies. This exclusion does not apply to mental health services or medical treatment of the retarded individual as described under "Your Benefits."
- Treatment of occupational injuries and occupational diseases, including injuries that arise out of (or in the course of) any work for pay or profit, or in any way result from a disease or injury which does. If you are covered under a Workers' Compensation law or similar law, and submit proof that you are not covered for a particular disease or injury under such law, that disease or injury will be considered "non-occupational," regardless of cause.
- Treatment of temporomandibular joint (TMJ) syndrome, including (but not limited to):
  - treatment performed by placing a prosthesis directly on the teeth,
  - surgical and non-surgical medical and dental services, and
  - diagnostic or therapeutic services related to TMJ.
- Weight reduction programs and dietary supplements.

Limitations

In the event there are two or more alternative medical services that, in the judgment of Aetna, are equivalent in quality of care, the Plan reserves the right to cover only the least costly service, as determined by Aetna, provided that Aetna approves coverage for the service or treatment in advance.

SurgeryPlus™ Overview

Enrollment in the SurgeryPlus™ benefit is included with participation in the State of Delaware's Aetna HMO medical plan. The SurgeryPlus™ benefit is a comprehensive surgical program that provides a personalized concierge experience from dedicated Care Advocates and access to quality-centric health care through a network of credentialed surgeons. Its mission is to simplify the surgical process from start to finish – from helping schedule appointments to eliminating medical bills related to your care. Credentialed SurgeryPlus surgeons undergo a rigorous evaluation process to

ensure that you receive high quality care from specialists who excel in the area related to your needs. By using the SurgeryPlus™ benefit, you may also save money through reduced financial responsibility.

How It Works

When you have a procedure through the SurgeryPlus™ benefit, a Care Advocate assists you with coordinating the medical care that is best for you. Care Advocates ensure you have access to the best information as you make decisions about your care, and they provide guidance throughout the process, answers to any questions that arise, and support in handling logistics throughout the course of treatment. Any related health care bills are handled by the SurgeryPlus™ benefit so you know your cost upfront and so there aren't any surprises you weren't planning on.

Refer to the SurgeryPlus plan document for more information **DHR.Delaware.gov/benefits/surgery-plus/index.shtml**

Emergency Services

Guidelines

You have coverage 24 hours a day, 7 days a week, anywhere inside or outside the plan's service area, for:

- An emergency medical condition; or
- An urgent condition.

Emergency services

When you experience an emergency medical condition, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance help.

Your coverage for emergency services will continue until your condition is stabilized and:

- Your attending physician determines that you are medically able to travel or to be transported, by non-medical or non-emergency medical transportation, to another provider if you need more care
- You are in a condition to be able to receive from the out-of-network provider delivering services the notice and consent criteria with respect to the services
- Your out-of-network provider delivering the services meets the notice and consent criteria with respect to the services

If your physician decides you need to stay in the hospital (emergency admission) or receive follow-up care, these are not emergency services. Different benefits and requirements apply. Please refer to the How your plan works – Medical necessity and precertification requirements section and the Coverage and exclusions section that fits your situation (for example, Hospital care or Physician services). You can also contact us or your network physician or primary care physician (PCP).

Non-emergency services

If you go to an emergency room for what is not an emergency medical condition, the plan may not cover your expenses. See the schedule of benefits for more information.

In the case of a surprise bill from an out-of-network provider, where you had no control of their participation in your covered services, you will pay the same cost share you would have if the covered services were received from a network provider. The cost share will be based on the median contracted rate. Contact us immediately if you receive such a bill.

Follow-Up Care After Emergencies

All follow-up care should be coordinated by your PCP. You must have a referral from your PCP and approval from Aetna to receive follow-up care from a nonparticipating provider. Whether you were treated inside or outside your Aetna service area, you must obtain a referral before any follow-up care can be covered. Suture removal, cast removal, X-rays, and clinic and emergency room revisits are some examples of follow-up care.

Urgent Care

Treatment that you obtain outside of your service area for an urgent medical condition is covered if:

- The service is a covered benefit;
- You could not reasonably have anticipated the need for the care prior to leaving the network service area; and
- A delay in receiving care until you could return and obtain care from a participating network provider would have caused serious deterioration in your health.

Urgent care from participating providers within your service area is covered if your PCP is not reasonably available to provide services to you. You

should first seek care through your PCP. Referrals to participating urgent care providers are not required, but the care must be urgent, non-preventive or non-routine.

Some examples of urgent medical conditions are:

- Severe vomiting
- Sore throat
- Earaches
- Fever

Follow-up care provided by your PCP is covered, subject to the office visit copayment. Other follow-up care by participating specialists is fully covered with a prior written or electronic referral from your PCP, subject to the specialist copay shown in the "Copayment Schedule."

Urgent Care – $15 copay vs. Emergency Room – $150 copay

Walk-in Clinic Visits

Covered expenses include charges made by network walk-in clinics for:

Unscheduled, non-emergency illnesses and injuries; and the administration of certain immunizations administered within the scope of the clinic's license.

Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.

What to Do Outside Your Aetna Service Area

Members who are traveling outside the service area, or students who are away at school, are covered for emergency care and treatment of urgent medical conditions. Urgent care may be obtained from a private practice physician, a walk-in clinic, or an urgent care center. An urgent medical condition that occurs outside your Aetna service area can be treated in any of the above settings. You should call your PCP before receiving treatment from a non-participating urgent care provider.

If, after reviewing information submitted to Aetna by the provider(s) who supplied your care, the nature of the urgent or emergency problem does not clearly qualify for coverage, it may be necessary to provide additional information. Aetna will send you an Emergency Room Notification Report or an Aetna One Advisor can take this information over the telephone.

Telemedicine Consultations

Covered Benefits include charges made by a Physician, PCP or Provider for a routine, non-emergency, medical consultation. You must make your Telemedicine appointment through an Aetna authorized internet service vendor. You may have to register with that internet service vendor. Information about providers who are signed up with an authorized vendor may be found in the provider Directory on **MyAetnaNetwork.com** or by calling the number on your Member identification card.

Specialist Physician Benefits

Covered Benefits include outpatient and inpatient services.

Member may request a second opinion regarding a proposed surgery or course of treatment recommended by Member's PCP or a Specialist. Second opinions must be obtained by a Participating Provider and are subject to precertification.

Covered Benefits also include Telemedicine consultations. Registration with a service vendor may be required. Information about Participating Providers who conduct Telemedicine consultations may be found in the provider Directory, online on **MyAetnaNetwork.com** or by calling the number on your Member identification card.

Important Reminder: For a description of the preventive care benefits covered under this Certificate Booklet, refer to the Preventive Care Benefits section in this Certificate Booklet.

Discount Programs

Discount Arrangements

Aetna offers discount arrangements or special rates from certain service providers to persons covered under the Plan such as:

- Gym memberships
- Fitness products
- Acupuncture
- Massage therapy
- Chiropractic
- Nutrition
- Lasik surgery
- Vision exams and materials
- Hearing exams and hearing aids
- Oral Health Care
- Weight management
- Tickets and travel deals for the whole family

Some of these arrangements may be made available through third parties who may make payments to Aetna in exchange for making these services available. The third party service providers are independent contractors and are solely responsible to covered persons for the provision of any such goods and/or services. Aetna reserves the right to modify or discontinue such arrangements at any time. These discount arrangements are not insurance. There are no benefits payable to covered persons nor does Aetna compensate providers for services they may render. You are responsible for paying for the discounted goods or services.

No referrals, claims or limits. Log into your Aetna member website at **Aetna.com** and look for the "Stay Healthy" tab.

For more information, call the Aetna One Advisor number on your ID card or visit the Aetna Book discount program page in Aetna member website by logging onto **Aetna.com**

Member Health Education Programs

The key to a long, healthy life is developing good health habits and sticking with them. Through the use of educational materials, Aetna's innovative Member Health Education Programs offer health education, preventive care and wellness programs to Plan participants. These programs provide materials that, in conjunction with care and advice from a physician, help promote a healthy lifestyle and good health.

To obtain information on Member Health Education Programs, call the toll-free number on your ID card or visit **Aetna.com/health-guide/living-healthy**

Childhood Immunization Program

Children need immunizations to protect them from a number of dangerous childhood diseases that could have very serious complications. Vaccines have been proven to be powerful tools for preventing certain diseases. It has been shown over time that the risks of serious illness from not vaccinating children far outweigh any risk of reaction to immunization. The common childhood diseases that vaccinations can guard against are:

- Measles
- Mumps
- Rubella
- Polio
- Pertussis (whooping cough)
- Diphtheria
- Tetanus
- Haemophilus influenzae type B
- Hepatitis B
- Varicella (chicken pox)

To promote good health through prevention, the Childhood Immunization Program sends immunization reminders to parents of children covered under this Plan.

An 18-month reminder is sent to families encouraging parents to schedule immunization visits with their pediatrician or family doctor if their child is not already fully immunized. This reminder contains a list of immunizations recommended at 18 months.* The objective of this reminder is to help promote timely childhood immunizations and to stress the importance of completing immunizations.

If you have questions about specific vaccinations, please call your pediatrician or your family doctor.

Adolescent Immunization

Adolescents need to see their doctors regularly for physical exams and screenings and to update immunizations. To reinforce the importance of protecting their children's health, parents of all 11- and 12-year-olds are sent a newsletter that includes examination and immunization schedule recommended for these age groups. This reminder is in the form of a newsletter provided by Merck & Co., Inc.

Preventive Reminders

Influenza, pneumococcal pneumonia and colorectal cancer are serious health threats. Each year, Aetna sends a preventive health care reminder to households with a member who is particularly vulnerable to one or more of these diseases – adults who are age 50 and older, children ages 6-23 months, and people over age 2 with a chronic condition such as asthma, congestive heart failure, or chronic renal failure.

The reminder stresses the importance of receiving vaccines to prevent influenza and pneumococcal pneumonia, as well as completing appropriate colorectal cancer screening.

Cancer Screening Programs

Early detection and treatment is important in helping our members lead longer, healthier lives. Member Health Education provides members with an important means of early detection.

Breast Cancer Screening

Beginning annually at age 40, each female Plan participant is sent information that stresses the importance of mammography, breast self-examination and annual gynecological exams. The mailer also includes information about menopause and heart disease. The mailer may also include information on participating mammography centers or information for women who have chosen a primary care physician with a capitated radiology office.

Cervical

Gynecological examinations and Pap smears are vital to women's health because they are often the first step in the detection and treatment of abnormalities. This program reminds female members, starting at 18 years of age, to get exams and Pap smears on a regular basis. Annually, female members are sent information stressing the importance of annual gynecological exams, direct access to care, as well as instructions on how to perform breast self-examination.

Colorectal

The colorectal cancer cure rate can exceed 80 percent when detected early. We encourage you to discuss questions about colorectal cancer screening with your physician. Together you and your physician can choose the most appropriate method of colorectal cancer screening. Aetna sends annual reminders stressing the importance of completing appropriate colorectal cancer screening.

Numbers-to-Know™ — Hypertension and Cholesterol Management

Aetna created Numbers To Know™ to promote blood pressure and cholesterol monitoring. The Numbers To Know mailer is sent to Plan participants who are targeted by selected diagnoses within specific age groups. The mailer includes helpful tips on blood pressure and cholesterol management; desirable goals for blood pressure and cholesterol; and a tri-fold wallet card to track blood pressure, total cholesterol, medication and dosage information.

Hypertension and high cholesterol are never "cured" but may be controlled with lifestyle changes and adherence to a treatment plan. You can help to stay "heart healthy" by monitoring your blood pressure and blood cholesterol numbers.

Numbers To Know can help encourage you to understand your illness, monitor your high blood pressure and high cholesterol and work with your physician to develop an appropriate treatment plan.

Women's Health Care

Aetna is focused on the unique health care needs of women. They have designed a variety of benefits and programs to promote good health throughout each distinct life stage, and are committed to educating female Plan participants about the lifelong benefits of preventive health care.

Support for Women with Breast Cancer

Aetna's Breast Health Education Center helps women make informed choices when they've been newly-diagnosed with breast cancer. A dedicated breast cancer nurse consultant provides the following services:

- Breast cancer information
- Second opinion options
- Information about community resources
- Benefit eligibility
- Help with accessing participating providers for:
  - Wigs
  - Lymphedema pums

Call **1-888-322-8742 (TTY: 711)** to reach Aetna's Breast Health Education Center.

Mastectomy bra

Covered prostheses up to 6 bras in the first 12 months following mastectomy, then up to 4 bras every 12 months afterwards.

Confidential Genetic Testing for Breast and Ovarian Cancers

Aetna covers confidential genetic testing for Plan participants who have never had breast or ovarian cancer, but have a strong familial history of the disease. Screening test results are reported directly to the provider who ordered the test.

Direct Access for OB/GYN Visits

This program allows a female Plan participant to visit any participating gynecologist for one routine well-woman exam (including a Pap smear) per year, without a referral from her PCP. The Plan also covers additional visits for treatment of gynecological problems and follow-up care, without a PCP referral. Participating general gynecologists may also refer a woman directly for appropriate gynecological services without the patient having to go back to her participating PCP.

If your gynecologist is affiliated with an IDS or provider group, such as an independent practice association (IPA), you may be required to coordinate your care through that IDS or provider group.

Fertility Case Management and Education

Fertility treatment can be an emotional experience for couples. Aetna's infertility case management unit provides Plan participants with educational materials and assistance with coordinating covered infertility care. A dedicated team of registered nurses and infertility coordinators staffs the unit.

Aetna Enhanced Maternity Program

The Aetna Enhanced Maternity Program provides you with maternity health care information, and guides you through pregnancy. This program provides:

- Educational materials on prenatal care, labor and delivery, postpartum depression and breastfeeding
- Specialized information for Dad or partner
- Web-based materials and access to program services through Women's Health Online
- Care coordination by trained obstetrical nurses
- Access to Smoke-free Moms-to-be® smoking cessation program for pregnant women
- Preterm labor education
- Access to breastfeeding support services

Under the program, all care during your pregnancy is coordinated by your participating obstetrical care provider and program case managers, so there is no need to return to your PCP for referrals. However, your obstetrician will need to request a referral from Aetna for any tests performed outside of the office. To ensure that you are covered, please make sure your obstetrician has obtained this referral before the tests are performed.

Another important feature, Pregnancy Risk Assessment, identifies women who may need more specialized prenatal and/or postnatal care due to medical history or present health status. If risk is identified, the program assists you and your physician in coordinating any specialty care that may be medically necessary.

Eligibility

Eligibility

Who Can Be Covered

Your plan may cover:

- You;
- Your spouse by marriage; or;
- Your children.

NOTE: The State of Delaware requires proof of dependency.

You Are Eligible To Be Covered If:

- You are a regular officer or employee of the State;
- You are a regular officer or employee of a State agency or school district;
- You are a pensioner already receiving a State pension;
- You are a per diem and contractual employee of the Delaware General Assembly and have been continuously employed for 5 or more years;
- You are regularly scheduled full-time employee of any Delaware authority or commission participating in the State's Group Health Insurance Program;
- You are a regularly scheduled full-time employee of the Delaware Stadium Corporation or the Delaware Riverfront Corporation;
- You are a paid employee of any volunteer fire or volunteer ambulance company participating in the State's Group Health Insurance Program;
- You are a regularly scheduled full-time employee of any county, soil and water conservation district or municipality participating in the Group Health Insurance program;
- You are receiving or eligible to receive retirement benefits in accordance with the Delaware County and Municipal Police/Firefighter Pension Plan with Chapter 88 of Title 11 of the Delaware Code or the county and municipal pension plan under Chapter 55A of Title 29 of the Delaware Code.
- You are a pensioner eligible to receive a State pension.

Coverage Administration for Spouses

You may enroll your spouse. A spouse is one of two persons united in marriage that is recognized by and valid under Delaware law.

Information on civil union or same-gender marriage, including Frequently Asked Questions (FAQ), tax dependent status, coverage codes, health plan rates and enrollment is available at **DE.gov/statewidebenefits**

The benefits for spouses enrolled under this contracted health plan are as follows:

- We pay normal plan benefits if your spouse isn't employed.
- We pay after your spouse's plan pays if your spouse:
  - is eligible for, and,
  - is enrolled in a health benefit plan sponsored by his/her employer or by an organization from which he or she is collecting a pension benefit or
  - is enrolled in an individual health plan through the Health Insurance Marketplace.
- We pay 20% of allowable covered charges if your spouse's employer provides a benefit plan or cash in lieu of a benefit plan, or an organization from which your spouse is collecting a pension provides a benefit plan or cash in lieu of a benefit plan, and your spouse:
  - is eligible for, and,
  - is not enrolled in that plan or
  - is not enrolled in an individual health plan through the Health Insurance Marketplace.

The combined payments can't be more than 100% of covered charges. Additional information can be found in the Coordination of Benefits section.

Children

To be covered, a child must be:

- under age 26; and,
- either:
  - born to you or your spouse;
  - adopted by you or your spouse; or,
  - placed in your home for adoption; or
- someone for whom health care coverage is your or your spouse's responsibility under the terms of a Qualified Medical Child Support Order. A copy of the order must be provided to your Human Resources/Benefits Office.

The State of Delaware requires proof of dependency when submitting application for coverage, such as a birth certificate or adoption papers.

Disabled Children

Disabled children can be covered after age 26. They may be covered if:

- They were continuously covered as a dependent by a parent's health plan before reaching age 26;
- They are not married;
- They cannot support themselves because of a disability;
- Their disability happened before age 26;
- They depend on you for at least 50% of support;
- Disability is expected to last more than 12 months or result in death; and
- They are not eligible for coverage under Medicare, unless federal or state law requires otherwise.

Other rules may apply in the case of divorced parents.

You must file a Request for Continuation of Coverage for Handicapped Child form with Aetna. A Handicapped Child Attending Physician Statement is also required. Forms are available at **DE.gov/statewidebenefits**. Aetna can also provide you with the forms if you request them from the Aetna One Advisor team.

You must print the form, complete it, obtain physician's information and signature, and mail the form to Aetna at the address provided on the form.

Coverage for Other Children

You may also cover a child who is not your or your spouse's natural or adoptive child if the child is:

- Unmarried; and
- Living with you in a regular parent-child relationship; and
- Dependent on you for support and qualifies as your dependent under Internal Revenue Code Sections 105 and 152; and
- Is under age 19; or
- Is a full-time student and under age 24.

For each child, you are required to show proof of dependency, such as a birth certificate, court order or federal tax return. The applicable documents must be provided to your Human Resources/ Benefits Office upon enrollment. You must request enrollment within 30 days of the date the child became eligible.

You must also submit a Statement of Support form to verify you provide at least 50 percent support for the child upon enrollment and any time there are changes to the support you provide. The Statement of Support form is available at **DE.gov/statewidebenefits.** Please print the form, complete it, and provide to your Human Resources/Benefits Office.

You must also submit a Full-Time Student Certification form for each child between the ages of 19 and under age 24, when the child is initially eligible as a full-time student, each time the child's student status changes, and for each school semester. The Full-Time Student Certification form is available at **DE.gov/statewidebenefits**. Please print the form, complete it, and provide to your Human Resources/Benefits Office.

Special Enrollment Period for Certain Individuals Who Lose Other Health Coverage

You or an eligible dependent may be enrolled during a special enrollment period, if requirements a, b, c, and d are met:

a. You or your eligible dependent was covered under another group health plan or other health insurance coverage when initially eligible for coverage under the Plan.

b. You or your eligible dependent previously declined coverage in writing under the Plan;

c. You or your eligible dependent loses coverage under the other group health plan or other health insurance coverage for one of the following reasons:

   i. the other group health coverage is COBRA continuation coverage under another plan, and the COBRA continuation coverage under that other plan has since been exhausted; or,

   ii. the other coverage is a group health plan or other health insurance coverage, and the other coverage has been terminated because you or your dependent lose eligibility for the coverage or employer contributions towards the other coverage have been terminated.

Loss of eligibility includes the following:

- a loss of coverage as a result of legal separation, divorce, or death;
- termination of employment;
- reduction in the number of hours of employment;

- any loss of eligibility after a period that is measured by reference to any of the foregoing;
- termination of Plan coverage due to you or your dependent moving outside of the Plan's service area; and also the termination of health coverage including Non-HMO, due to plan termination;
- plan ceases to offer coverage to a group of similarly situated individuals;
- cessation of a dependent's status as an eligible dependent;
- termination of benefit package;
- with respect to coverage under Medicaid or S-Chip Plan (State Children's Health Insurance Program), you or your dependents no longer qualify for such coverage.

d. You or your dependents become eligible for premium assistance, with respect to coverage under the Plan, under Medicaid or S-Chip Plan.

Loss of eligibility does not include a loss due to failure of you or your dependent to pay premiums on a timely basis or due to termination of coverage for cause as referenced in the Termination of Coverage section of this Plan Description.

You will need to enroll yourself or a dependent for coverage within:

- 30 days of the loss of coverage under the other group health plan or other health insurance coverage;
- 60 days of when coverage under Medicaid or S-Chip Plan ends; or
- 60 days of the date you or your dependents become eligible for Medicaid or S-Chip premium assistance.

Medicare Eligibility and Enrollment

You, and your spouse, are eligible to enroll in Medicare Parts A and B based on age when you turn 65 or sooner based on being disabled. In accordance with 29 Delaware Code § 5203(b) and the State of Delaware's Group Health Insurance Program's Eligibility and Enrollment Rule 4.08 you and your spouse must enroll in Medicare upon eligibility. Failure to enroll and maintain enrollment in Medicare Parts A and B when eligible may result in you, as the subscriber, being held financially responsible for the cost of claims incurred, including prescription costs, for you and your spouse. The following information is for you and your spouse.

Medicare Part A helps cover inpatient care in hospitals and is provided at no charge to you. Medicare Part B helps cover doctors' and other health care providers' services, outpatient care, durable medical equipment, and home health care and is provided to you at a monthly cost to you as determined by the Social Security Administration.

If you are a benefit eligible active employee, or the spouse of a benefit eligible active employee, about three months before turning 65:

- Visit your local Social Security Administration Office and apply for Medicare Part A;
- Advise your Human Resources/Benefits Office that you have applied;
- When you receive your Medicare Part A card, provide your Human Resources/Benefits Office with a copy of your card.

Active employees and their spouses who are age 65 or older have a right to decide which medical plan will be their primary insurer: either the employer health plan or Medicare. If you or your spouse selects Medicare as primary, the State cannot offer or subsidize a health plan to supplement Medicare's benefits. If you choose, BCBSD may remain your primary plan while you are an active employee.

- About three months before retirement, you must apply for Medicare Part B

If you are a State of Delaware pensioner, or the spouse of a State of Delaware pensioner, about three months before turning 65:

- Visit your local Social Security Administration Office and apply for Medicare Parts A and B;
- Advise the State's Office of Pensions that you have applied;
- When you receive your Medicare Parts A and B card, provide the State's Office of Pensions with a copy of your identification card. The Office of Pensions will enroll you in a Medicare Supplement, Special Medicfill, plan to cover costs not covered by Medicare Parts A and B.

If you are a State of Delaware pensioner, or the spouse of a State of Delaware pensioner, and are disabled or become disabled, regardless of age:

- Visit your local Social Security Administration Office and apply for Medicare Parts A and B;
- Advise the State's Office of Pensions that you have applied;

- When you receive your Medicare Parts A and B card, provide the State's Office of Pensions with a copy of your identification card. The Office of Pensions will enroll you in a Medicare Supplement, Special Medicfill, plan to cover costs not covered by Medicare Parts A and B.

If you are denied enrollment in Medicare Parts A and/or B, then you are required to appeal and provide a copy of the denial and your appeal to the State's Office of Pensions. Failure to enroll and maintain enrollment in Medicare Parts A and B when eligible may result in you, as the subscriber, being held financially responsible for the cost of the claims incurred, including prescription costs, for you and your spouse. Should Medicare deny your appeal and you provide a copy of the denial to the State's Office of Pensions, then you will continue to be covered under your Aetna plan with the State's Group Health Insurance Plan.

NOTE: The classification of being "disabled" by the State of Delaware as it relates to your ability to perform your job for the State of Delaware (or another employer for a spouse) may differ from the classification of being "disabled" by the Social Security Administration, it is always your responsibility to provide the State's Office of Pensions with your current classification by the Social Security Administration.

There are special Medicare requirements regarding some health conditions, such as End Stage Renal Disease (ESRD) and Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease). Upon receiving a diagnosis of either of these conditions, whether you are an active employee or pensioner or spouse, you should contact the Aetna One Advisor team at **1-877-542-3862 (TTY: 711)** and request information on the Medicare requirements.

Enrollment

Types of Enrollment

You may enroll in one of these coverage types:

- Employee for you only;
- Employee and Child (ren) for you and your family;
- Employee and Spouse for you and your spouse; or
- Family for you, your spouse and your children.

Enrollment Date

Your enrollment date is the later of:

- Your date of hire for Timely Enrollees (if you're in an employee class eligible for health coverage);
- The date you move to an employee class that is eligible for health coverage (such as going from part-time to full-time employee); or,
- The date coverage begins if you're a Special Enrollee or a Late Enrollee.

How to Enroll

You may enroll yourself and your dependents when you are first eligible or at open enrollment by completing an enrollment form/application and returning it to your Human Resources/Benefits Office (with any premium owed). If you want to cover your spouse, you'll need to complete the Spousal Coordination of Benefits Form. The Spousal Coordination of Benefits form is available at **DE.gov/statewidebenefits**

How to Decline Coverage

You may decline coverage if you don't want to enroll when you are first eligible. You will need to complete the enrollment process indicating that you are waiving coverage as designated by your Human Resources/Benefits Office.

Pre-existing Conditions

A pre-existing condition is an injury or illness (excluding pregnancy) for which medical advice, diagnosis, care or treatment was received during the three months before enrollment in this Plan. This Plan does not include any exclusions or limitations for expenses related to any pre-existing condition.

When Coverage Begins

When your coverage begins is determined by:

- When you are eligible for coverage; and,
- When you enroll for coverage.

There are three categories of enrollees based on when you enroll for coverage. You can be a:

- Timely Enrollee;
- Special Enrollee; or,
- Late Enrollee.

Timely Enrollees

You are a Timely Enrollee if you enroll within 30 days (31 days for newborns) of when you are first eligible to be covered.

Coverage for new employees (and their dependents) begins:

- on the date of hire; or
- on the first of the month of any month following date of hire up to the first of the month when eligible for State/Employer Share when an employee moves to a class that is eligible for health coverage.

Special Enrollees

You are a Special Enrollee if you request enrollment within the 30-day enrollment period. The enrollment period is within 30 days of:

- Losing other health coverage under certain conditions;
- Obtaining a new dependent because of marriage, birth (enrollment period is 31 days for newborns, see Changes in Enrollment / Newborns section), adoption, or placement in the home for adoption, or court ordered support.

Employees or dependents may qualify as Special Enrollees if the following requirements are met:

- Employees: if you're not already enrolled in this plan, you must:
  - be eligible to enroll in this plan; and,
  - enroll at the same time you enroll a dependent.
- Spouses and Children: you're a dependent of an employee:
  - who is already enrolled or is eligible to enroll in this plan; and,
  - who enrolls at the same time you enroll.

If you don't request enrollment within the 30-day enrollment period, you are a Late Enrollee.

Loss of Other Coverage

To qualify as a Special Enrollee because of loss of coverage, you (the employee or dependent) must meet all these conditions:

- You were covered under another group or individual health plan when coverage was previously offered under this plan (when first eligible or during open enrollment);
- When this plan was previously offered, you declined coverage under this plan because you had other coverage; and,
- The other coverage was either:
  - COBRA continuation coverage that is exhausted; or,
  - other (non-COBRA) coverage that was lost because:
  - you are no longer eligible;
  - the employer stopped contributing; and,
  - you request enrollment within 30 days of the date
  - COBRA continuation coverage that is exhausted; or,
  - the other (non-COBRA) coverage that was lost because:
  - you lost eligibility; or,
  - the employer stopped contributing, and,
- You can prove the loss of the other coverage by providing proof of coverage, such as a Certificate of Coverage.

New Dependents

You (employee or dependent) are a Special Enrollee if the employee gets a new dependent because of:

- Marriage;
- Birth;
- Adoption;
- Placement of a child in the home for adoption; or,
- Court ordered support.

When Coverage Begins

Coverage for Special Enrollees begins as follows if the Human Resources/Benefits Office was notified of a loss of coverage or new dependent within 30 days and your application and premium is subsequently submitted:

- Employees: the first day of the month after the loss of coverage.
- Spouses: either the date of the marriage or the first day of the month after the marriage.

- Children: either:
  - the date of birth, adoption or placement in the home for adoption;
  - the first day of the month after you request enrollment if:
  - you lost coverage under a prior plan; or,
  - you got married.

Remember, if you enroll after the 30-day enrollment period, you (and your dependents) will be Late Enrollees.

When you get married and add your spouse, you'll need to complete the Spousal Coordination of Benefits Form, available at **DE.gov/statewidebenefits**, and provide copy of your Marriage/Civil Union Certificate to your Human Resources/Benefits Office. The Spousal Coordination of Benefits Form must be completed and submitted online annually or when your spouse has a change of job status or health insurance status.

Late Enrollees

Who Can Be a Late Enrollee

If you did not enroll as a Timely or Special Enrollee, you are a Late Enrollee. Late Enrollees can enroll at an open enrollment period.

Children are Late Enrollees if enrollment was not requested within 30 days of:

- Birth (30 days);
- Adoption;
- Placement in the home for adoption; or
- Parents married.
- Coverage for Late Enrollees begins the first day of the new plan year.

Changes in Enrollment

You can change your enrollment because of one of the reasons described below. You must enroll yourself (and any dependents) within 30 days of the date of the event. You and your dependents will be late enrollees if you are not enrolled in the 30-day waiting period. Newborns must be enrolled within a 31-day period. See your Human Resources/Benefits Office. If added premium is due, you must pay when you enroll.

Marriage

You may add your spouse when you get married . You must request enrollment within 30 days after the marriage . If added premium is due, you must pay when you request enrollment. If you request enrollment within the 30-day period, your spouse will be a Special Enrollee. If you don't request enrollment within the 30-day period, your spouse will be a Late Enrollee.

Don't forget, when you get married you'll also need to complete the Spousal Coordination of Benefits Form and provide a copy of your marriage certificate to your Human Resources/Benefits Office. You may also add stepchildren you acquire when you marry. See section below describing coverage for other children.

Divorce

Former spouses are not eligible for coverage under this program. You must notify your Human Resources/Benefits Office of the divorce and provide them with a copy of your divorce decree. An enrollment form/application must be completed within 30 days of the divorce. You should state "divorce" as the reason for the change.

Coverage ends on the day after the date the divorce is granted. Failure to provide notice of your divorce to your Human Resources/Benefits Office will result in you being held financially responsible for the cost of the premium as well as health care and prescription services provided to your former spouse and his or her children.

Newborns

You may add your newborn child. Coverage for a child born to regular officer, employee, eligible pensioner or spouse will begin from the moment of birth to a maximum of thirty-one (31) day from the date of birth. To be covered as a dependent beyond the thirty-one (31) days period, you must:

- request enrollment of the newborn child within 31-days of the date of birth; and complete the necessary paperwork and provide a valid copy of the child's birth certificate to the Human Resource/Benefits Office within 31-days of the enrollment request; and
- if applicable, you must change your coverage to a type that includes children, and pay any additional premium.

Adopted Children

You may add a child because of adoption or placement in your home for adoption. A birth certificate or legal documentation needs to be supplied to your Human Resources/Benefits Office. You must request enrollment within 30 days of the date of adoption or placement in the home in order for the child to be a Special Enrollee. If you don't request enrollment within the 30-day period, the child will be a Late Enrollee.

Other Children

You may also cover a child who is not your or your spouse's natural or adoptive child if the child is:

- Unmarried; and
- Living with you in a regular parent-child relationship; and
- Dependent on you for support and qualifies as your dependent under Internal Revenue Code Sections 105 and 152; and
- Is under age 19; or
- A full-time student and under age 24.

For each child, you are required to show proof of dependency, such as a birth certificate, court order or federal tax return. The applicable documents must be provided to your Human Resources/Benefits Office upon enrollment. You must request enrollment within 30 days of the date the child became eligible.

You must also submit a Statement of Support form to verify you provide at least 50 percent support fo the child upon enrollment and any time there are changes to the support you provide. The Statement of Support form is available at **DE.gov/statewidebenefits**. Please print the form, complete it, and provide to your Human Resources/Benefits Office.

You must also submit a Full-Time Student Certification form for each child between the ages of 19 and under age 24, when the child is initially eligible as a full-time student, each time the child's student status changes, and for each school semester. The Full-Time Student Certification form is available at **DE.gov/statewidebenefits**. Please print the form, complete it, and provide to your Human Resources/Benefits Office.

When Continuation of Coverage Under COBRA Ends

You may have declined coverage under this plan when you were first eligible because you chose to keep COBRA coverage with another plan. If you enroll in this plan before your COBRA continuation coverage is exhausted, you will be a Late Enrollee.

When your COBRA continuation coverage is exhausted, you may request enrollment in this plan within 30 days. If you request enrollment within the 30-day period, you will be a Special Enrollee. If you don't request enrollment within the 30-day period, you will be a Late Enrollee.

When Coverage Ends

Coverage under your plan can end for a variety of reasons. In this section, you will find details on how and why coverage ends, and how you may still be able to continue coverage.

When Coverage Ends for Employees

Your Aetna health benefits coverage will end if:

- The Aetna health benefits plan is discontinued;
- You voluntarily stop your coverage;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your employer; or
- Your employer notifies Aetna that your employment is ended.
- The date of your death.

It is your employer's responsibility to let Aetna know when your employment ends.

Coverage terminates at the end of the month in which you leave your job.

Your Proof of Prior Medical Coverage

Under the Health Insurance Portability and Accountability Act of 1996, your employer is required to give you a certificate of creditable coverage when your employment ends. This certificate proves that you were covered under this plan when you were employed. Ask your employer about the certificate of creditable coverage.

When Coverage Ends for Dependents

- You are no longer eligible for dependents' coverage;
- You do not make the required contribution toward the cost of dependents' coverage;
- Your own coverage ends for any of the reasons listed under When Coverage Ends for Employees;
- Your dependent is no longer eligible for coverage. In this case, coverage ends at the end of the calendar month when your dependent no longer meets the plan's definition of a dependent; or
- Your dependent becomes eligible for comparable benefits under this or any other group plan offered by your employer.
- Unless covered as a disabled child, your child's coverage ends at the end of the month in which he or she reaches:
  - age 26 if your natural or adopted child;
  - age 19 if eligible under the terms described in coverage for other children;
  - age 24 if similarly eligible and a full-time student.

- The plan is canceled. (Coverage ends the day the State of Delaware's contract ends with Aetna.)

Coverage for dependents may continue for a period after your death. Coverage for handicapped dependents may continue after your dependent reaches any limiting age. See Continuation of Coverage for more information.

Divorce

Former spouses are not eligible for coverage under this program. You must notify your Human Resources/Benefits Office of the divorce and provide them with a copy of your divorce decree. An enrollment form/application must be completed within 30 days of the divorce. You should state "divorce" as the reason for the change.

Coverage ends on the day after the date the divorce is granted. Failure to provide notice of your divorce to your Human Resources/Benefits Office will result in you being held financially responsible for the cost of the premium as well as health care and prescription services provided to your former spouse and his or her children.

Continuation of Coverage

Continuing Health Care Benefits

Continuing Coverage for Dependent Students on Medical Leave of Absence

If your dependent child who is eligible for coverage and enrolled in this plan by reason of his or her status as a full-time student at a postsecondary educational institution ceases to be eligible due to:

- a medically necessary leave of absence from school; or
- a change in his or her status as a full-time student,

resulting from a serious illness or injury, such child's coverage under this plan may continue.

Coverage under this continuation provision will end when the first of the following occurs:

- The end of the 12 month period following the first day of your dependent child's leave of absence from school, or a change in his or her status as a full-time student;
- Your dependent child's coverage would otherwise end under the terms of this plan;
- Dependent coverage is discontinued under this plan; or
- You fail to make any required contribution toward the cost of this coverage.

To be eligible for this continuation, the dependent child must have been enrolled in this plan and attending school on a full-time basis immediately before the first day of the leave of absence.

To continue your dependent child's coverage under this provision you should notify your employer as soon as possible after your child's leave of absence begins or the change in his or her status as a full-time student. Aetna may require a written certification from the treating physician which states that the child is suffering from a serious illness or injury and that the resulting leave of absence (or change in full-time student status) is medically necessary.

IMPORTANT NOTE: If at the end of this 12 month continuation period, your dependent child's leave of absence from school (or change in full-time student status) continues, such child may qualify for a further continuation of coverage under the Handicapped Dependent Children provision of this plan. Please see the section, Handicapped Dependent Children, for more information.

Handicapped Dependent Children

Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child. However, such coverage may not be continued if the child has been issued an individual medical conversion policy.

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to Aetna no later than 30 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

Aetna will have the right to require proof of the continuation of the handicap. Aetna also has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age under your plan.

Continuing Your Coverage Under COBRA

You may continue your coverage after you lose coverage under this plan. This right is provided under a law called the Consolidated Omnibus Budget Reconciliation Act (COBRA). If you decide to continue your coverage, you will have to pay up to 102% of the cost of coverage.

The following is a brief explanation of the law:

Employee

You (and your dependents) can continue coverage for up to 18 months if you lose group coverage because:

- your hours at work are reduced; or,
- your job ends (for reasons other than gross misconduct).

You, the employee, can continue coverage beyond 18 months if you:

- are disabled when you become eligible for COBRA coverage; and,
- are considered disabled under Social Security.

You are then entitled to an additional 11 months (totaling 29 months). Your cost would be 150% of the plan cost for months 19 through 29.

Spouse of Employee

Your spouse can continue coverage for up to 36 months if coverage ends because:

- you die;
- you divorce from your spouse; or,
- you become eligible for Medicare.

Dependent Child of Employee

A child can continue coverage for up to 36 months if coverage ends because:

- you die;
- you and your spouse are divorced or legally separated;
- you become eligible for Medicare; or,
- the child is no longer considered a dependent under this plan.

Notifying the State

You need to let your Human Resources/Benefits Office know within 30 days of:

- a divorce;
- a child losing dependent status; or,
- disability determination by Social Security

Notify your Human Resources/Benefits Office within 30 days if Social Security determines you are no longer disabled.

After you notify your Human Resources/Benefits Office, you will be sent information about COBRA and how much it costs. You can choose to continue coverage under COBRA. If you do, then you have the right to the same coverage as the active employees. If you don't, your coverage under this plan ends.

You should contact State of Delaware's COBRA Administrator if you have any questions.

When Your Coverage Under COBRA Ends

You can lose the coverage you continued under COBRA if:

- the State of Delaware no longer has any group health coverage;
- you don't pay the premium on time;
- you become eligible for Medicare or,
- you get coverage under another group plan. An exception may apply if the other plan:
  - has a preexisting condition waiting period; and,
  - provides credit for prior creditable coverage to offset the preexisting condition waiting period.

In such cases, you can be covered under both plans.

You are eligible to receive a standard Certificate of Coverage after you lose coverage under COBRA.

Termination for Cause

A Plan participant's coverage may be terminated for cause. "For cause" is defined as:

- Failure to make copayments: You or a member of your family fails to make any required copayment or any other payment that you are obligated to pay.
- Furnishing incorrect or incomplete information: You or a member of your family willfully furnishes incorrect or incomplete information in a statement made for the purpose of enrolling in, or obtaining benefits from, the Plan. Termination will be effective immediately.
- Fraud against the Plan: This may include, but is not limited to, allowing a person who is not a participant of the Plan to use your Aetna ID card. Termination will be effective immediately.
- Misconduct: You or a covered member of your family abuses the system, including (but not limited to) theft, damage to the property of a participating provider, or forgery of drug prescriptions. Termination will be effective immediately.

No benefits will be provided to you and your family members once coverage is terminated.

Any termination for cause is subject to review in accordance with the Plan's grievance process. You may request that Aetna conduct a grievance hearing within 15 working days after receiving notice that coverage has been or will be terminated. Coverage will be continued until a final decision on the grievance is rendered, provided you continue to make required contributions. Termination may be retroactive to the original date of termination if the final decision is in favor of Aetna.

Family and Medical Leave

If your employer grants you an approved family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA), you may continue coverage for yourself and your eligible dependents during your approved leave. You must agree to make any required contributions.

The continued coverage will cease when:

- You fail to make any required contribution;
- Your approved leave is determined by your employer to be terminated; or
- The Plan is discontinued.

In addition, any coverage for a dependent will not be continued beyond the date it would otherwise terminate.

If you do not return to work at the end of the approved leave, your employer may recover from you the cost of maintaining your benefits coverage during the entire period of the leave, unless the failure to return to work was for reasons beyond your control.

If coverage under the Plan terminates because your approved FMLA leave is deemed terminated, you may, on the date of termination, be eligible to continue coverage under COBRA on the same terms as though your employment terminated on that date. If, however, your employment is terminated because of your gross misconduct, you will not be eligible for COBRA continued coverage.

Claim Procedures

A claim occurs whenever a Plan participant requests:

- An authorization or referral from a participating provider or Aetna; or
- Payment for items or services received.

Because you are a participant in an HMO-type plan, you do not need to submit a claim for most of your covered healthcare expenses. However, if you receive a bill for covered services, the bill must be submitted promptly to Aetna for payment. Send the itemized bill for payment with your identification number clearly marked to the address shown on your ID card.

Aetna will make a decision on your claim. For concurrent care claims, Aetna will send you written notification of an affirmative benefit determination. For other types of claims, you may only receive written notice if Aetna makes an adverse benefit determination.

Adverse benefit determinations are decisions Aetna makes that result in denial, reduction, or termination of a benefit or the amount paid for it. It also means a decision not to provide a benefit or service. Adverse benefit determinations can be made for one or more of the following reasons:

- The individual is not eligible to participate in the Plan; or
- Aetna determines that a benefit or service is not covered by the Plan because:

- it is not included in the list of covered benefits,
- it is specifically excluded,
- a Plan limitation has been reached, or
- it is not medically necessary.

Aetna will provide you with written notices of adverse benefit determinations within the time frames shown below. These time frames may be extended under certain limited circumstances. The notice you receive from Aetna will provide important information that will assist you in making an appeal of the adverse benefit determination, if you wish to do so. Please see "Complaints and Appeals" for more information about appeals.

Aetna Appeal Process

For State of Delaware's Aetna Health Plans Department of Human Resources, Statewide Benefits Office

You may supply additional information that you would like us to consider. In addition, you may request copies of documents relevant to your claim (free of charge) by contacting us at the number on your member identification card. You are not responsible for the cost of the review or any filing fees.

Initial Service

1. Employee receives service and a claim is filed by the employee (or by provider on employee's behalf) with the carrier.

IF DENIED,

Level I Appeal – Administered By Aetna

2. Employee must file an appeal with Aetna within 180 calendar days from receipt of the notice of denial to request a second review of the claim.
3. Aetna approves or denies the appeal with written notice to the employee
   a. Within 15 calendar days for Pre-Service,
   b. Within 30 calendar days for Post-Service requests, or
   c. Within 36 hours for expedited appeals under certain conditions. In the event that the denial of an expedited appeal is upheld, the employee will have the option to skip the Level II Appeal and move directly to a Level III Appeal to the Statewide Benefits Office or External Review.

IF DENIAL IS UPHELD,

Level II Appeal – Administered By Aetna

4. Employee must file a Level II appeal within 60 calendar days from receipt of the notice of denial of the Level I appeal.
5. Aetna approves or denies the appeal with written notice to the employee
   a. Within 15 calendar days for Pre-Service requests,
   b. Within 30 calendar days for Post-Service requests, or
   c. Within 36 hours for expedited appeals under certain conditions.

IF DENIAL IS UPHELD,

Level III Appeal – Administered By The State Of Delaware Statewide Benefits Office (SBO) And/Or Aetna

For medical judgment or necessity, including care that is cosmetic or experimental, the employee may choose to file a Level III voluntary appeal to the SBO and/or an appeal administered by Aetna.

VOLUNTARY APPEAL TO THE STATEWIDE BENEFITS OFFICE

a. Employee may file an appeal of the denial in writing to the Statewide Benefits Office within 20 days of the postmark date of the notice of denial of the Level II appeal (or within 20 days of the postmark date of the notice of denial of an expedited Level I appeal).

Appeals Administrator
RE: APPEAL
Statewide Benefits Office
841 Silver Lake Boulevard
Suite 100
Dover, DE 19904

Appeal must contain how the employee may be contacted (mailing address, telephone number, etc.), a written summary of events, applicable Explanation of Benefits (EOBs), and any additional documentation employee desires to provide to support his/her position. Additionally, employee must sign and submit with the appeal, the State of Delaware's Authorization for Release of Protected Health Information Form to provide authorization to the Statewide Benefits Office to obtain applicable information from Aetna and the SBO's Health Plan Appeal Form and Checklist, both of which are available at **DE.gov/statewidebenefits**

Employees submitting an appeal without a signed Authorization Form and/or completed Health Plan Appeal Form and Checklist will be requested, in writing, to submit the forms. Statewide Benefits Office will not begin to review the appeal until the Authorization Form and the Appeal Form and Checklist are received.

The Appeals Administrator from the Statewide Benefits Office (or his/her designee) will conduct an internal review of the appeal and provide a written notice of the decision to the employee and the carrier within 30 days of receiving the appeal.

NOTE: The one hundred twenty day timeframe for requesting an external appeal begins upon receipt of the Level II denial or if the appeal is an expedited appeal and the Level II is skipped, the 120 day time frame should begin upon receipt of the Level I denial, regardless of whether or not a Level III appeal is requested. By choosing to request a Level III appeal with the Statewide Benefits Office, the time may expire for you to request an External Appeal review with Aetna.

EXTERNAL REVIEW PROVIDED VIA AETNA

b. Employee may request an external review for decisions involving medical judgment or necessity, including care considered to be cosmetic or experimental care by contacting Aetna and requesting a Request for External Review form. An external review is performed by independent physicians with expertise in the medical service or supply at issue. Upon completion of the external review, Aetna accepts the decision of the external reviewer, however, you may file an appeal denial to the Statewide Benefits Office and/or the State Employee Benefits Committee. Your request for an External Review must be returned to Aetna within 120 calendar days from receipt of the notice of denial of the Level II appeal or if the appeal is an expedited appeal and the Level II is skipped, the 120 day time frame should begin upon receipt of the Level I denial (or receipt of the notice of denial of the Level III appeal by the Statewide Benefits Office, if applicable) to the address appearing on the form.

IF DENIAL IS UPHELD BY EITHER THE STATEWIDE BENEFITS OFFICE OR AETNA'S EXTERNAL REVIEW CARRIER

Level IV (Final) Appeal – Administered By The State Of Delaware – State Employee Benefits Committee

6. Employee may file a written appeal to the State Employee Benefits Committee (SEBC) within 20 days of the postmark date of the notice of denial from the Level III appeal.

Co-Chair, State Employee Benefits Committee (SEBC)

RE: APPEAL
Department of Human Resources
841 Silver Lake Boulevard
Suite 100
Dover, DE 19904

7. The SEBC receives the appeal and:
   a. Identifies a Hearing Officer (Division Director, Statewide Benefits Office). The Hearing Officer conducts a hearing and submits a report to the SEBC within 60 days of the date of the hearing. The SEBC accepts or modifies the report, and notice of the decision is postmarked to the employee within 60 days; OR
   b. Hears the appeal, and notice of the decision is postmarked to the employee within 60 days of the hearing.

If you have questions about your appeal rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at **1-866-444-EBSA (3272).**

Bariatric Surgery appeals

Appeals related to Bariatric Surgery denials should be directed to SurgeryPlus™.

• Refer to SurgeryPlus plan document **DHR.Delaware.gov/benefits/surgery-plus/index.shtml**

Coordination of Benefits

Coordination of Benefits

Spouse's Benefits

You may add your spouse when you get married . You must request enrollment within 30 days after the marriage . A copy of your marriage certificate is required by your Human Resources/Benefits Office. If added premium is due, you must pay when you request enrollment.

Don't forget, when you cover a spouse, you'll also need to complete the Spousal Coordination of Benefits form available at **DE.gov/statewidebenefits.** The form must be completed and submitted online.

The benefits for spouses enrolled under this contracted health plan are as follows:

- We pay normal plan benefits if your spouse isn't employed.
- We pay after your spouse's plan pays if your spouse:
  - is eligible for, and,
  - is enrolled in a health benefit plan sponsored by his/her employer or by an organization from which he or she is collecting a pension benefit, or
  - is enrolled in an individual health plan through the Health Insurance Marketplace.
- We pay 20% of allowable covered charges if your spouse's employer provides a benefit plan or cash in lieu of a benefit plan, or an organization from which your spouse is collecting a pension provides a benefit plan or cash in lieu of a benefit plan, and your spouse:
  - is eligible for, and,
  - is not enrolled in that plan or
  - is not enrolled in an individual health plan through the Health Insurance Marketplace.

The combined payments can't be more than 100% of covered charges.

The above will not apply if your spouse is not enrolled in his/her employer's plan because your spouse:

- doesn't work full time;
- isn't eligible because he/she doesn't work enough hours to be eligible;
- isn't eligible because he/she hasn't completed a waiting period;
- has to pay more than 50% of the plan's cost (including flexible credits);
- doesn't meet the underwriting requirements of the sponsored plans; or
- is not offered health coverage at work.

You may also add any stepchildren you acquire when you marry . A birth certificate or legal documentation must be supplied to your Human Resources/Benefits Office. You must request enrollment within 30 days of the date the child becomes eligible.

Dependent Children

You are responsible for completing a Dependent Coordination of Benefits form for each enrolled dependent regardless of age, any time the dependent is enrolled in other health coverage or upon request by the Statewide Benefits Office or Aetna. The Dependent Coordination of Benefits form is available at **DE.gov/statewidebenefits**

Terms

These terms are used to explain the rules for Coordination of Benefits (COB):

- Allowable Expense is a necessary, reasonable and usual health care expense. The expense must be covered at least in part by a plan that covers you.
- COB Provision sets the order in which plans pay when you're covered by two or more plans.
- Other Plans is any arrangement you have that covers your health care.
- Primary Plan is the plan applied before any other plan. Benefits under this plan are set without considering the other plan's benefits.
- Secondary Plan is the plan applied after the other plan. Benefits under this plan may be cut because of the other plan's benefits.

Order of Benefits Determination

The primary and secondary plan payments are set by these rules:

- A plan with no COB rules is primary over a plan with such rules.
- A plan that covers you as an employee is primary over a plan that covers you as a dependent.

- A plan that covers you as an active employee is primary over a plan that covers you as a non-active employee. Non-active means a laid-off or retired employee.
- For dependents, a plan for which you are a subscriber (active or retired) will be primary over a plan for which you are a dependent.
- For a child covered by plans under both parents, these rules apply:
  - The plan of the parent whose birthday comes first is primary.
  - If both parents have the same birthday, the plan that covered one parent longer is primary.
  - If the other plan does not have the parent birthday rule, the other plan's COB rules apply.
- If the parents are divorced or separated, this order applies:
  - First, the plan of the parent with custody;
  - Then, the plan of the spouse of the parent with custody; and,
  - Last, the plan of the parent not having custody.

This order can change by court decree. A court decree may make one parent responsible for the child's health care costs. If so, that parent's plan is primary.

- If these rules don't decide the primary plan, then the plan covering you longest is the primary.
- There may be two or more secondary plans. If so, these rules repeat until this plan's obligation for benefits is set.

Effect of Benefits

- When this plan is primary, we pay without regard to any secondary plan.
- When this plan is secondary, we account for payments made by other plans. We'll coordinate with the other plans. We'll make sure payments by all plans don't exceed the Allowable Expenses. Our payment will never be more than if we were primary.
- If the other plan is primary and reduces or does not cover benefits because there is coverage under this plan, then we'll calculate the benefit as if:
  - the State's plan is secondary; and,
  - the other plan has paid the normal payment.

Important Reminder: Keep in mind that you cannot receive coverage under this plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.

COB Examples

Other Carrier Allowed:

Submitted Expense:	$60.00
Other Carrier's Allowed:	$53.00
Other Carrier Paid:	$42.40
Aetna Copay:	**$15.00**

Other Carrier Allowed:	$53.00
Minus Other Carrier Paid:	$42.40
Balance due per Primary:	**$10.60**
Equals Other Carrier Allowed:	$53.00
Minus Aetna Copay:	$15.00
Equals Aetna Normal Benefit:	$38.00
Paid by Aetna:	**$10.60** (Lesser of $10.60 vs. $38)
Member Owes:	$0.00

Other Carrier Denied:

Submitted Expense:	$60.00
Other Carrier's Allowed:	$0.00
Other Carrier Paid:	$0.00
Aetna Copay:	**$15.00**

Other Carrier Allowed:	$0.00
Minus Other Carrier Paid:	$0.00
Balance due per Primary:	**$60.00**
Aetna Allowed amount:	$38.00
Minus Aetna Copay:	$15.00
Aetna pays:	$23.00
Member Owes:	$15.00

How COB Works with Managed Care

The rules below will apply to you, your spouse and your dependent children.

COB When This Plan is Primary

The State's managed care rules must be followed. If you don't, benefits are coordinated by applying the penalties of this plan.

COB When This Plan is Secondary

Your health care plan coverage through the state will never pay more than what we would pay if this plan were primary.

You don't have to follow the State's managed care rules when this plan is secondary. However, you should follow the primary plan's managed care rules.

- If you do, both plans will pay up to the maximum.
- If you don't, we'll apply the other plan's penalties when calculating your benefit payment.

We will coordinate benefits if the primary plan:

- Has a preferred Provider Network; or.
- Is a Point of Service Plan.

You will have to follow the primary plan's In-Network or Out-of-Network managed care guidelines to get the maximum payment.

Exceptions are:

- This plan may cover benefits that the other plan doesn't cover. If this happens, we'll pay benefits as if this plan were primary. You must follow the State's managed care rules to receive maximum payment.
- The other plan may have a day or dollar maximum on a particular benefit. This plan will pay benefits if:
  - you've met the maximum for that benefits; and,
  - this plan covers the particular benefit.

The State's plan will pay until you are again eligible for that benefit under the other plan.

To file a secondary claim, you'll need to send a completed claim form to Aetna (or a detailed receipt from the provider indicating both the procedure and diagnosis code) and a copy of your Notice of Benefits from the other carrier if applicable. That way we'll be able to see what the primary plan paid and what the managed care penalties were, if any.

Right to Receive and Release Needed Information

We have the right to decide when to apply COB rules. To do this, we may obtain information as needed. We may also release information to any organization or person as needed for payment purposes.

You must give us the information we need to apply COB rules. This includes information about you and your dependents. If you do not cooperate, we may deny payment.

Facility of Payment

If your contracted health care plan through the state is primary, but the other plan paid a claim, we have the right to pay the other plan. Our payment will be the amount we decide is our share under COB rules. Such payment will meet our obligation under this plan.

Right of Recovery

If we paid more than our share under COB rules, we'll recover the excess from:

- you or any person to or for whom such payments were made;
- any insurance plan;
- other organizations.

Subrogation

Subrogation and Right of Recovery Provision

Terms

These terms are used to explain the Subrogation and Right of Recovery provisions:

- Responsible Party means any party actually, possible, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness or condition. The term "Responsible Party" includes the liability insurer of such party or any insurance coverage.
- Insurance Coverage refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.
- Covered Person includes anyone on whose behalf the Plan pays or provides any benefits including, but not limited to, the minor child or dependent of any Plan member or person entitled to receive any benefits from the Plan.

Subrogation

Immediately upon paying or providing any benefit under this health care Plan, the Plan shall be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person's injury, illness, or condition to the full extent of benefits provided or to be provided by the Plan.

Reimbursement

In addition, if a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an injury, illness, or condition, the Plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts this Plan has paid and will pay as a result of that injury, illness, or condition, up to and including the full amount the Covered Person receives from any Responsible Party.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that if he or she receives any payment from any Responsible Party as a result of an injury, illness, or condition, he or she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the Plan.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for treatment of the illness, injury, or condition for which the Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise related to treatment for any illness, injury, or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the Covered Person, the Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan.

First Priority Claims

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person acknowledges that this Plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the Plan before any other claim for the Covered Person's damages. This Plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the Plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for

payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only.

Cooperation

The Covered Person shall fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness, or condition sustained by the Covered Person. The Covered Person and his or her agents shall provide all information requested by the Plan, including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. Failure to provide this information may result in the termination of health benefits for the Covered Person or the institution of court proceedings against the Covered Person.

The Covered Person shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

The Covered Person acknowledges that the Plan has the right to conduct an investigation regarding the injury, illness, or condition to identify any Responsible Party. The Plan reserves the right to notify the Responsible Party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

Exclusion

This Plan does not cover services and supplies, in the opinion of the Claims Administrator or its authorized representative, that are associated with injuries, illness, or conditions suffered due to the acts or omissions of a third party.

Recovery of Overpayments

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. The Plan has the right to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a Participant in the Plan. Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by the Plan's third-party administrator -- Aetna. Under this process, Aetna reduces future payments to providers by the amount of the overpayments they received, and then credits the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan are subject to this same process when Aetna recovers overpayments for other plans administered by Aetna.

This right does not affect any other right of recovery the Plan may have with respect to overpayments.

Federal Notices

Reporting of Claims

A claim must be submitted to Aetna in writing. It must give proof of the nature and extent of the loss. Your employer has claim forms.

All claims should be reported promptly. The deadline for filing a claim is 90 days after the date of the loss.

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims for health benefits will not be covered if they are filed more than 2 years after the deadline.

The Newborns' and Mothers' Health Protection Plan Act

Federal law generally prohibits restricting benefits for hospital lengths of stay to less than 48 hours following a vaginal delivery and less than 96 hours following a caesarean section. However, the plan may pay for a shorter stay if the attending provider (physician, nurse midwife or physician assistant) discharges the mother or newborn earlier, after consulting with the mother.

Also, federal law states that plan benefits may not, for the purpose of benefits or out-of-pocket costs, treat the later portion of a hospital stay in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Finally, federal law states that a plan may not require a physician or other health care provider to obtain authorization of a length of stay up to 48 hours or 96 hours, as described above. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification.

The Women's Health and Cancer Rights Act

In accordance with the Women's Health and Cancer Rights Act, this Plan covers the follow procedures for a person receiving benefits for an appropriate mastectomy:

- Reconstruction of the breast on which a mastectomy has been preformed;
- Surgery and reconstruction of the breast to create a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply to the mastectomy.

For answers to questions about the plan's coverage of mastectomies and reconstructive surgery, call the Aetna One Advisor team at the number shown on your ID card.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or you're treated by an out-of-network provider at an in- network hospital, or ambulatory surgical center or by an air ambulance provider, you are protected from surprise billing or balance billing.

What types of plans do these rights and protections apply to?

- Self-funded health benefit plans, including state government and municipal health benefit plans
- Fully insured health benefit plans
- Federal Employees Health Benefit Plan (FEHBP)
- Grandfathered Health Plans
- If you are not sure what type of plan you have, contact us, we're here to help you!

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance and/or a deductible. You may have other costs or must pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

- "Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be allowed to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called **"balance billing."** This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.
- "Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care. Examples are when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of- network provider.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost, such as the copayments, coinsurance, and deductibles, that you would pay if the provider or facility was in- network. Your health plan will pay out-of-network providers and facilities directly.
- You're never required to give up your protections from balance billing. You also don't have to get care out-of-network. You can choose a provider or facility in your plan's network.

You are protected from balance billing for:

- **Emergency services**
  If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount. This includes copayments, deductibles and coinsurance. You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition. The exception is if you give written consent and give up your protections not to be balanced billed for these post- stabilization services.
- **Certain services performed by an out of network provider at an in-network hospital or ambulatory surgical cente**r
  When you get services from certain out-of-network providers at an in-network hospital or ambulatory surgical center, those out-of-network providers may not balance bill you or ask you to sign a written notice and consent form that allows balance billing. You pay only your plan's in-network cost sharing amount. This applies to anesthesia, assistant surgeon, emergency medicine, hospitalist, intensivist service, laboratory, neonatology, pathology, or radiology.

  If you get **other services from any other out-of-network providers** at in an in-network hospital or ambulatory surgical center, these out-of-network providers **can't** balance bill you, unless you sign a written notice and consent form that allows balance billing and are provided with a good faith estimate of your costs from the hospital or ambulatory surgical center before services are given. If you sign the notice and consent form, you can be balance billed for out-of-network services. **You are not required to sign the notice and consent form. You may seek care from an available in-network provider**.
- **Air Ambulance**
  When you receive medically necessary air ambulance services from an out-of-network provider, your cost share will be the same amount that you would pay if the service was provided by an in-network provider. Any coinsurance or deductible will be based on rates that would apply if the services were supplied by an in-network provider.

Some states have surprise bill/balance billing laws. These laws apply to fully insured plans and may have impact to some self-funded plans, including state government or municipal plans and church plans. Check with your plan administrator and/or booklet to find if state law applies to your coverage.

Your health plan generally must:

- Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may send complaints about potential violations of federal law or state law to:

- The U.S. Department of Health & Human Services at:
  - Phone: **1-800-985-3059**
  - Website: **https://www.cms.gov/nosurprises/consumers**
- Your state agency, which can be located **State Contacts** for Fed NSA; scroll down to the state information

How to handle services supplied based on inaccurate provider directory information?

If you relied on inaccurate information from our provider directories or website or that we verbally provided, we hold you harmless. For example, if you received services from a provider that you believed was in-network based on inaccurate information showing that the provider was in-network, but your claim was paid as out-of-network. In these situations, contact us and we will review the claim. After review, you may be responsible only for your in-network cost share.

Your Rights and Responsibilities

Your Rights and Responsibilities

As a Plan participant, you have a right to:

- Get up-to-date information about the doctors and hospitals participating in the Plan.
- Obtain primary and preventive care from the PCP you chose from the Plan's network.
- Change your PCP to another available PCP who participates in the Aetna network.
- Obtain covered care from participating specialists, hospitals and other providers.
- Be referred to participating specialists who are experienced in treating your chronic illness.
- Be told by your doctors how to make appointments and get health care during and after office hours.
- Be told how to get in touch with your PCP or a back-up doctor 24 hours a day, every day.
- Call 911 (or any available area emergency response service) or go to the nearest emergency facility in a situation that might be life-threatening.
- Be treated with respect for your privacy and dignity.
- Have your medical records kept private, except when required by law or contract, or with your approval.
- Help your doctor make decisions about your health care.
- Discuss with your doctor your condition and all care alternatives, including potential risks and benefits, even if a care option is not covered.
- Know that your doctor cannot be penalized for filing a complaint or appeal.
- Know how the Plan decides what services are covered.
- Know how your doctors are compensated for the services they provide. If you would like more information about Aetna's physician compensation arrangements, visit their website at **Aetna.com**. Select Find a doctor. If already a member login to secure site and select find a provider and under other useful resources select Quality and Care Information.If not a member select plan from an employer, under other useful resources select Quality and Cost Information
- Get up-to-date information about the services covered by the Plan — for instance, what is and is not covered, and any applicable limitations or exclusions.
- Get information about copayments and fees you must pay.
- Be told how to file a complaint, grievance or appeal with the Plan.
- Receive a prompt reply when you ask the Plan questions or request information.
- Obtain your doctor's help in decisions about the need for services and in the grievance process.
- Suggest changes in the Plan's policies and services.

As a Plan participant, you have the responsibility to:

- Choose a PCP from the Plan's network and form an ongoing patient-doctor relationship.
- Help your doctor make decisions about your health care.
- Tell your PCP if you do not understand the treatment you receive and ask if you do not understand how to care for your illness.
- Follow the directions and advice you and your doctors have agreed upon.
- Tell your doctor promptly when you have unexpected problems or symptoms.
- Consult with your PCP for non-emergency referrals to specialist or hospital care.
- See the specialists your PCP refers you to.
- Make sure you have the appropriate authorization for certain services, including inpatient hospitalization and out-of-network treatment.
- Call your PCP before getting care at an emergency facility, unless a delay would be detrimental to your health.
- Understand that participating doctors and other health care providers who care for you are not employees of Aetna and that Aetna does not control them.
- Show your ID card to providers before getting care from them.
- Pay the copayments and coinsurance required by the Plan.
- Call the Aetna One Advisor team if you do not understand how to use your benefits.

- Promptly follow the Plan's grievance procedures if you believe you need to submit a grievance.
- Give correct and complete information to doctors and other health care providers who care for you.
- Treat doctors and all providers, their staff, and the staff of the Plan with respect.
- Advise Aetna about other medical coverage you or your family members may have.
- Not be involved in dishonest activity directed to the Plan or any provider.
- Read and understand your Plan and benefits. Know the copayments and what services are covered and what services are not covered.

Patient Self-Determination Act (Advance Directives)

There may be occasions when you are not able to make decisions about your medical care. An Advance Directive can help you and your family members in such a situation.

What Is an Advance Directive?

An Advance Directive is generally a written statement that you complete in advance of serious illness that outlines how you want medical decisions made.

If you can't make treatment decisions, your physician will ask your closest available relative or friend to help you decide what is best for you. But there are times when everyone doesn't agree about what to do. That's why it is helpful if you specify in advance what you want to happen if you can't speak for yourself. There are several kinds of Advance Directives that you can use to say what you want and whom you want to speak for you.
The two most common forms of an Advance Directive are:

- A Living Will; and
- A Durable Power of Attorney for Health Care.

What Is a Living Will?

A Living Will states the kind of medical care you want, or do not want, if you become unable to make your own decisions. It is called a Living Will because it takes effect while you are still living.

The Living Will is a document that is limited to the withholding or withdrawal of life-sustaining procedures and/or treatment in the event of a terminal condition. If you write a living will, give a copy to your PCP.

What Is a Durable Power of Attorney for Health Care?

A Durable Power of Attorney for Health Care is a document giving authority to make medical decisions regarding your health care to a person that you choose. The Durable Power of Attorney is planned to take effect when you can no longer make your own medical decisions.

A Durable Power of Attorney can be specific to a particular treatment or medical condition, or it can be very broad. If you write a Durable Power of Attorney for Health Care, give a copy to your PCP.

Who Decides About My Treatment?

Your physicians will give you information and advice about treatment. You have the right to choose. You can say "Yes" to treatments you want. You can say "No" to any treatment you don't want — even if the treatment might keep you alive longer.

How Do I Know What I Want?

Your physician must tell you about your medical condition and about what different treatments can do for you. Many treatments have side effects, and your doctor must offer you information about serious problems that medical treatment is likely to cause you. Often, more than one treatment might help you — and people have different ideas about which is best. Your physician can tell you which treatments are available to you, but they can't choose for you. That choice depends on what is important to you.

How Does the Person Named in My Advance Directive Know What I Would Want?

Make sure that the person you name knows that you have an Advance Directive and knows where it is located. You might consider the following:

- If you have a Durable Power of Attorney, give a copy of the original to your "agent" or "proxy." Your agent or proxy is the person you choose to make your medical decisions when you are no longer able.
- Ask your PCP to make your Advance Directive part of your permanent medical record.
- Keep a second copy of your Advance Directive in a safe place where it can be found easily, if it is needed.
- Keep a small card in your purse or wallet that states that you have an Advance Directive and where it is located, and who your agent or proxy is, if you have named one.

Who Can Fill Out the Living Will or Advance Directive Form?

If you are 18 years or older and of sound mind, you can fill out this form. You do not need a lawyer to fill it out.

Whom Can I Name to Make Medical Treatment Decisions When I'm Unable to Do So?

You can choose an adult relative or friend you trust to be your agent or proxy, and to speak for you when you're too sick to make your own decisions.

There are a variety of living will forms available, or you can write your wishes on a piece of paper. If necessary, your doctor and family can use what you write to help make decisions about your treatment.

Do I Have to Execute an Advance Directive?

No. It is entirely up to you.

Will I Be Treated If I Don't Execute an Advance Directive?

Absolutely. We just want you to know that if you become too ill to make decisions, someone else will have to make them for you. With an Advance Directive, you can instruct others about your wishes before becoming unable to do so.

Can I Change My Mind After Writing an Advance Directive?

Yes. You may change your mind or cancel these documents at any time as long as you are competent and can communicate your wishes to your physician, your family and others who may need to know.

What Is the Plan's Policy Regarding Advance Directives?

We share your interest in preventive care and maintaining good health. Eventually, however, every family may face the possibility of serious illness in which important decisions must be made. We believe it is never too early to think about decisions that may be very important in the future and urge you to discuss these topics with your PCP, family, friends, and other trusted, interested people.

You are not required to execute an Advance Directive. If you choose to complete an Advance Directive, it is your responsibility to provide a copy to your physician and to take a copy with you when you check into a hospital or other health facility so that it can be kept with your medical records.

How Can I Get More Information About Advance Directives?

Call the Aetna One Advisor toll-free number on your ID card.

General Information About the Plan

Amendment or Termination of the Plan

The State of Delaware has the right to amend or terminate the Plan, in whole or in part, at any time. If a change is made, you will be notified.

The establishment of an employee benefit plan does not imply that employment is guaranteed for any period of time or that any employee receives any nonforfeitable right to continued participation in any benefits plan.

Plan Documents

This Plan Description covers the major features of the HMO Plan administered by Aetna Life Insurance Company, effective July 1, 2016 or the State of Delaware. This Plan Description has been designed to provide a clear and understandable summary of the Plan.

Glossary

Glossary

B

Body Mass Index - means a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

C

Capitation – a system by which Members' access to certain providers are assigned by the Plan based on primary care provider selection and provider reimbursement. Under the Plan's HMO plan design, Members are required to choose a primary care provider who will issue referrals to specialists. In New Castle County, the choice in primary care providers will also automatically assign specific Podiatrists, Radiologists, and Physical Therapists. These specialists were carefully selected by the primary care provider. Members who choose New Castle County PCP's must receive services from those specifically assigned providers for coverage under the Plan. If the Member receives Podiatry, Radiology, and Physical Therapy services from any other provider, whether or not in the Aetna provider network, there will be no coverage under the Plan except for emergencies. Members in the Plan's HMO plan design outside of New Castle County must still choose a primary care provider and obtain referrals to see specialists but they are not required to see specifically assigned Podiatrists, Radiologists, and Physical Therapists.

Claims Administrator - means the person designated as such by the instrument under which the plan is operated. (If the administrator is not so designated, administrator then means the plan sponsor.) The administrator's responsibilities include but are not limited to:

- Act solely in the interest of the plan participants and beneficiaries, and for the exclusive purposes of providing benefits and defraying reasonable administrative expenses.
- Manage the Plan's assets to minimize the risk of large losses.
- Act in accordance with the documents governing the Plan.

Coinsurance - means the sharing of certain covered expenses by the Plan and the Plan participant. For example, if the Plan covers an expense at 80% (the Plan's coinsurance), your coinsurance share is 20%.

Companion - means a person whose presence as a companion or caregiver is necessary to enable a National Medical Excellence (NME) patient to:

- Receive services from an NME Program provider on an inpatient or outpatient basis; or
- Travel to and from an NME Program provider to receive covered services.

Copayment (copay) - means the fee that must be paid by a Plan participant to a participating provider at the time of service for certain covered expenses and benefits, as described in the "Copayment Schedule."

Cosmetic surgery - means any surgery or procedure that is not medically necessary and whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem, but which does not:

- Restore bodily function;
- Correct a diseased state, physical appearance or disfigurement caused by an accident or birth defect; or
- Correct or naturally improve a physiological function.

Covered services and supplies (covered expenses) - means the types of medically necessary services and supplies described in "Your Benefits."

Creditable Coverage - Coverage of the Plan participant under a group health plan (including a governmental or church plan), a health insurance coverage (either group or individual insurance), Medicare, Medicaid, a military-sponsored health care (CHAMPUS), a program of the Indian Health Service, a State health benefits risk pool, the Federal Employees Health Benefits Program (FEHBP), a public health plan, including coverage received under a plan established or maintained by a foreign country or political subdivision as well as one established and maintained by the government of the United States, any health benefit plan under section 5(e) of the Peace Corps Act and the State Children's Health Insurance Program (S-Chip). Creditable Coverage does not include coverage only for accident; Workers' Compensation or similar insurance; automobile medical payment insurance; coverage for on-site

medical clinics; or limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits that is provided in a separate policy.

Custodial care - means any service or supply, including room and board, which:

- Is furnished mainly to help you meet your routine daily needs;
- Can be furnished by someone who has no professional health care training or skills; or,
- Is at a level such that you have reached the maximum level of physical or mental function and are not likely to make further significant progress.

D

Detoxification - means the process whereby an alcohol-intoxicated, alcohol-dependent or drug-dependent person is assisted in a facility licensed by the state in which it operates, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factor, or alcohol in combination with drugs as determined by a licensed physician, while keeping physiological risk to the patient at a minimum.

Diabetic Equipment and Supplies - Blood glucose meters and strips, urine testing strips, syringes, continuous glucose monitors and supplies, and insulin pump supplies..

Durable medical equipment (DME) - means equipment determined to be:

- Designed and able to withstand repeated use;
- Made for and used primarily in the treatment of a disease or injury;
- Generally not useful in the absence of an illness or injury;
- Suitable for use while not confined in a hospital;
- Not for use in altering air quality ortemperature; and
- Not for exercise or training.

E

Emergency - means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

With respect to emergency services furnished in a hospital emergency department, the Plan does not require prior authorization for such services if you arrive at the emergency medical department with symptoms that reasonably suggest an emergency condition, based on the judgment of a prudent layperson, regardless of whether the hospital is a participating provider. All medically necessary procedures performed during the evaluation (triage and treatment of an emergency medical condition) are covered by the Plan.

Experimental or investigational - means services or supplies that are determined by Aetna to be experimental. A drug, device, procedure or treatment will be determined to be experimental if:

- There are not sufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved;
- Required FDA approval has not been granted for marketing;
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes;
- The written protocol(s) used by the treating facility or the protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes;
- It is not of proven benefit for the specific diagnosis or treatment of your particular condition;

- It is not generally recognized by the medical community as effective or appropriate for the specific diagnosis or treatment of your particular condition; or,
- It is provided or performed in special settings for research purposes.

G

Gene-based, cellular and other innovative therapies (GCIT) -

Gene

- A gene is a unit of heredity which is transferred from a parent to child and is thought to determine some feature of the child.

Molecular

- Molecular means relating to or consisting of molecules. A molecule is a group of atoms bonded together, making the smallest vital unit of a chemical compound that can take part in a chemical reaction.

Therapeutic

- Therapeutic means a treatment, therapy, or drug meant to have a good effect on the body or mind; adding to a sense of well-being.

H

Home health services - means those items and services provided by participating providers as an alternative to hospitalization, and approved and coordinated in advance by Aetna.

Hospice care - means a program of care that is:

- Provided by a hospital, skilled nursing facility, hospice or duly licensed hospice care agency;
- Approved by Aetna; and
- Focused on palliative rather than curative treatment for a Plan participant who has a medical condition and a prognosis of less than 12 months to live.

Hospital - means an institution rendering inpatient and outpatient services, accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by Aetna as meeting reasonable standards. A hospital may be a general, acute care, rehabilitation or specialty institution.

I

Infertility - means:

- Infertility is defined as a condition (an interruption, cessation, or disorder of body functions, systems or organs) of the reproductive tract, which prevents the conception of a child or the ability to carry a pregnancy to delivery.

Institute of Excellence (IOE)- This is a facility that is contracted with Aetna to furnish particular services and supplies to you and your covered dependents in connection with one or more highly specialized medical procedures. The maximum charge made by the IOE for such services and supplies will be the amount agreed to between Aetna and the IOE.

M

Medical services - means those professional services of physicians or other health professionals, including medical, surgical, diagnostic, therapeutic and preventive services authorized by Aetna.

Medically necessary - means services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards, as described in the "Your Benefits" section of this Plan Description. To be medically necessary, the service or supply must:

- Be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, as to both the disease or injury involved and your overall health condition;
- Be care or services related to diagnosis or treatment of an existing illness or injury, except for covered periodic health evaluations and preventive and well-baby care, as determined by Aetna;
- Be a diagnostic procedure, indicated by the health status of the Plan participant, and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any

alternative service or supply, as to both the disease or injury involved and your overall health condition;

- Include only those services and supplies that cannot be safely and satisfactorily provided at home, in a physician's office, on an outpatient basis, or in any facility other than a hospital, when used in relation to inpatient hospital services; and
- As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests.
- In determining whether a service or supply is medically necessary, Aetna will consider:
- Information provided on your health status;
- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;
- The opinion of health professionals in the generally recognized health specialty involved;
- The opinion of the attending physicians, which has credence but does not overrule contrary opinions; and
- Any other relevant information brought to Aetna's attention.
- In no event will the following services or supplies be considered medically necessary:
- Services or supplies that do not require the technical skills of a medical, mental health or dental professional;
- Custodial care, supportive care or rest cures;
- Services or supplies furnished mainly for the personal comfort or convenience of the patient, any person caring for the patient, any person who is part of the patient's family or any health care provider;
- Services or supplies furnished solely because the Plan participant is an inpatient on any day when their disease or injury could be diagnosed or treated safely and adequately on an outpatient basis;
- Services furnished solely because of the setting if the service or supply could be furnished safely and adequately in a physician's or dentist's office or other less costly setting; or
- Experimental services and supplies, as determined by Aetna.

Member - means an employee, pensioner, and their dependents covered under the Aetna HMO plan.

Mental Disorders - means an illness commonly understood to be a mental disorder, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a behavioral health provider such as a psychiatric physician, a psychologist or a psychiatric social worker.

The following conditions are considered a mental disorder under this plan:

- Anorexia/Bulimia Nervosa.
- Bipolar disorder.
- Major depressive disorder.
- Obsessive-compulsive disorder.
- Panic disorder.
- Pervasive Mental Developmental Disorder (including Autism).
- Psychotic Disorders/Delusional Disorder.
- Schizo-affective Disorder.
- Schizophrenia.

Morbid Obesity - means a Body Mass Index that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including: hypertension; a cardiopulmonary condition; sleep apnea; or diabetes.

O

Outpatient - means:

- A Plan participant who is registered at a practitioner's office or recognized health care facility, but not as an inpatient; or
- Services and supplies provided in such a setting.

P

Partial hospitalization - means medical, nursing, counseling and therapeutic services provided on a regular basis to a Plan participant who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care. Services must be provided in a hospital or non-hospital facility that is licensed as an alcohol, drug abuse or mental illness treatment program by the appropriate regulatory authority.

Participating provider - means a provider that has entered into a contractual agreement with Aetna to provide services to Plan participants.

Physician - means a duly licensed member of a medical profession, who is properly licensed or certified to provide medical care under the laws of the state where they practice, and who provides medical services which are within the scope of their license or certificate.

Plan - means your Health Maintenance Organization (HMO) benefit program that is sponsored and self-funded by the State of Delaware (State) and administered by Aetna.

Plan administrator - means the third party administrator the State of Delaware has ontracted with to administrator its health care plan/s.

Plan benefits - means the medical services, hospital services, and other services and care to which a Plan participant is entitled, as described in this Plan Description.

Plan Description - means the written and distributed highlights of a specific type of health care plan for reference by a plan participant.

Primary Care Physician (PCP) - means a participating physician who supervises, coordinates, and provides initial care and basic medical services as a general or family care practitioner or, in some cases, as an internist or a pediatrician, to Plan participants; initiates their referral for specialist care; and maintains continuity of patient care.

Provider - means a physician, health professional, hospital, skilled nursing facility, home health agency, or other recognized entity or person licensed to provide hospital or medical services to Plan participants.

R

Referral - means specific written or electronic direction or instruction from a Plan participant's PCP, in conformance with Aetna's policies and procedures, which directs the Plan participant to a participating provider for medically necessary care.

Residential Treatment Facility (Mental Disorders)

This is an institution that meets all of the following requirements:

- On-site licensed Behavioral Health Provider 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a Physician.
- Has access to necessary medical services 24 hours per day/7 days a week.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a Psychiatrist or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed Behavioral Health Provider who, while not needing to be

individually contracted, needs to (1) meet the Aetna credentialing criteria as an individual practitioner, and (2) function under the direction/ supervision of a licensed psychiatrist (Medical Director).

- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

Residential Treatment Facility (Substance Abuse)

This is an institution that meets all of the following requirements:

- On-site licensed Behavioral Health Provider 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a Physician.
- Has access to necessary medical services 24 hours per day/7 days a week.
- If the member requires detoxification services, must have the availability of on-site medical treatment 24 hours per day/7days a week, which must be actively supervised by an attending Physician.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a Psychiatrist or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed Behavioral Health Provider who, while not needing to be individually contracted, needs to (1) meet the Aetna credentialing criteria as an individual practitioner, and (2) function
- under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.
- Ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally.
- 24-hours per day/7 days a week supervision by a physician with evidence of close and frequent observation.
- On-site, licensed Behavioral Health Provider, medical or substance abuse professionals 24 hours per day/7 days a week.

S

Service area - means the geographic area, established by Aetna and approved by the appropriate regulatory authority, in which a Plan participant must live or work or otherwise meet the eligibility requirements in order to be eligible as a participant in the Plan.

Skilled nursing facility - means an institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing skilled nursing care and related services as a skilled nursing facility, extended care facility, or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by Aetna to meet the reasonable standards applied by any of the aforesaid authorities.

Specialist - means a physician who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

Substance abuse - means any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal.

T

Telemedicine - The mode of delivering health care services via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telemedicine facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

As used in this definition, a provider is a healthcare practitioner who is:

- acting within the scope of their practice;
- licensed (in Delaware or the State in which the provider is located if exempted under Delaware State law to provide telemedicine services without a Delaware license) to provide the service for which they bill; and
- located in the United States.

Terminal illness - means an illness of a Plan participant, which has been diagnosed by a physician and for which they have a prognosis of six (6) months or less to live.

U

Urgent Care Provider

This is:

- A freestanding medical facility that meets all of the following requirements.
  - Provides unscheduled medical services to treat an urgent condition if the person's physician is not reasonably available.
  - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
  - Makes charges.
  - Is licensed and certified as required by any state or federal law or regulation.
  - Keeps a medical record on each patient.
  - Provides an ongoing quality assurance program. This includes reviews by physicians other than those who own or direct the facility.
  - Is run by a staff of physicians. At least one physician must be on call at all times.
  - Has a full-time administrator who is a licensed physician.
- A physician's office, but only one that:
  - Has contracted with Aetna to provide urgent care; and
  - Is, with Aetna's consent, included in the directory as a network urgent care provider.
- It is not the emergency room or outpatient department of a hospital.

Urgent medical condition - means a medical condition for which care is medically necessary and immediately required because of unforeseen illness, injury or condition, and it is not reasonable, given the circumstances, to delay care in order to obtain the services through your home service area or from your PCP.

W

Walk-in Clinic - Walk-in Clinics are free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.

Assistive Technology

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call **1-800-370-4526**.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

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

Aetna:

- 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 our Civil Rights Coordinator.

If you believe that Aetna 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 with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, **1-800-648-7817, TTY 711**, Fax **859-425-3379**, **CRCoordinator@aetna.com**. California HMO/HNO Members: Civil Rights Coordinator, PO Box 24030 Fresno CA, 93779, **1-800-648-7817 (TTY 711)**, Fax 860-262-7705, **CRCoordinator@aetna.com**. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator 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 **OCR.portal.hhs.gov/ocr/portal/lobby.jsf**, 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, 1-800-537-7697 (TDD)**

Complaint forms are available at **HHS.gov/ocr/office/file/index.html**

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.

Language Assistance

TTY: 711

For language assistance in English call 1-800-370-4526 at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526. (Spanish)

欲取得繁體中文語言協助, 請撥打 1-800-370-4526, 無需付費。(Chinese)

Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad. (Tagalog)

Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an. (German)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-370-4526. (Arabic)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-370-4526 gratis. (French Creole)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526. (Italian)

日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。(Japanese)

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526 번으로 전화해 주십시오. (Korean)

برای راهنمایی به زبان فارسی با شماره 1-877-459-6604 بدون هیچ هزینه ای تماس بگیرید. انگلیسی (Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526. (Polish)

Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente. (Portuguese)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526. (Russian)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-800-370-4526. (Vietnamese)

All services, plans and benefits are subject to and governed by the terms (including exclusions and limitations) of the agreement between Aetna Life Insurance Company and the State of Delaware. The information herein is believed accurate as of the date of publication and is subject to change without notice.

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STATE-DE-00023 (07/24)

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