



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered healthcare services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, you can visit www.HealthReformPlanSBC.com or call 1-877-542-3862. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.HealthReformPlanSBC.com or call 1-877-542-3862 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	<u>Network provider</u> : \$1,500 individual/ \$3,000 family; <u>Out-of-Network provider</u> : \$1,500 individual/ \$3,000 family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. In- <u>network preventive care</u> services, certain annual cancer <u>screening</u> services, female voluntary sterilization, contraceptive counseling, contraceptive devices and injectables, breast pump (one per 36 months), lactation support, and routine prenatal visits are covered before you meet your <u>network deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount, but a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive</u> services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . A State-funded Health Reimbursement Account (HRA) is available to help offset a large part of the <u>deductible</u> . The State funds the HRA, \$1,250 for individual and \$2,500 for dependent coverage levels, upon subscriber's enrollment in the Aetna CDH Gold plan at the beginning of the plan year, July 1, 2023 HRA funds are prorated in accordance with subscriber's effective date of enrollment or change in coverage tier level.
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	For <u>Network provider</u> Medical: \$4,500 individual/ \$9,000 family; <u>Network provider</u> Prescription Drug: \$2,100 individual/ \$4,200 family. <u>Out-of-Network provider</u> Medical: \$7,500 individual/ \$15,000 family; <u>Out-of-Network provider</u> Prescription Drug: Not Applicable	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.

State of Delaware: Aetna CDH Gold

Coverage for: Individual + Family | Plan Type: PPO

<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p>Premiums, <u>balance billing</u> charges, health care this <u>plan</u> does not cover, <u>coinsurance</u> on certain services and penalties for failure to obtain <u>preauthorization</u>.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
<p>Will you pay less if you use a <u>network provider</u>?</p>	<p>Yes. See www.aetna.com or call 1-877-542-3862 for a list of <u>network providers</u>.</p>	<p>This <u>plan</u> uses a <u>provider network</u>. You will pay less if you use a <u>provider</u> in the <u>plan's network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</p>
<p>Do you need a <u>referral</u> to see a <u>specialist</u>?</p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>



All coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What Will You Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you visit a <u>healthcare provider's office or clinic</u>	Primary care visit to treat an injury or illness	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge <u>Deductible</u> does not apply	30% <u>coinsurance</u>	Age and frequency schedules may apply. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.

Common Medical Event	Services You May Need	What Will You Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u> Your cost will be lower at preferred freestanding labs.	30% <u>coinsurance</u>	Preferred freestanding laboratories: Quest Diagnostics and LabCorp in Delaware.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u> Your cost will be lower at non-hospital affiliated freestanding facilities.	30% <u>coinsurance</u>	<u>Preauthorization</u> is required, except when rendered in emergency room or inpatient facility. If you don't get <u>preauthorization</u> , benefits will be denied.
If you need drugs to treat your illness or condition	Generic drugs	\$10 <u>copay</u> /prescription for 30-day supply (retail or mail order); \$20 <u>copay</u> /prescription for 90-day supply (participating retail or mail order)	Reimbursement limited to in- <u>network</u> allowable amount minus applicable <u>copay</u>	Up to 30-day fills at retail or mail order for non-maintenance drugs; 90-day fills for maintenance drugs available at participating pharmacies or mail order only, maintenance drugs filled as 30-day supply incur penalty at fourth fill; under Choice Program, you pay applicable copay plus difference between generic and brand when preferred generic equivalent is available. Erectile dysfunction (ED) drugs are not covered unless medically necessary for conditions other than ED. Prescription drugs with an over-the-counter equivalent are not covered, except for emergency contraception. Qualified members ages 40 - 75 receive generic low to moderate dose statins at no cost. No charge for diabetic supplies purchased through the prescription plan. One copay applies for multiple diabetic medications filled at a 90-day participating retail pharmacy or mail order pharmacy, if purchased at the same time.
	Preferred brand drugs	\$32 <u>copay</u> /prescription for 30-day supply (retail or mail order); \$64 <u>copay</u> /prescription for 90-day supply (participating retail or mail order)	Reimbursement limited to in- <u>network</u> allowable amount minus applicable <u>copay</u>	
	Non-preferred brand drugs	\$60 <u>copay</u> /prescription for 30-day supply (retail or mail order); \$120 <u>copay</u> /prescription for 90-day supply (participating retail or mail order)	Reimbursement limited to in- <u>network</u> allowable amount minus applicable <u>copay</u>	
	<u>Specialty drugs</u>	No charge if enrolled in the PrudentRx program; 30% <u>coinsurance</u> if not enrolled in the PrudentRx program	Not covered	

Common Medical Event	Services You May Need	What Will You Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required for certain outpatient surgical procedures and other outpatient services. If you don't get <u>preauthorization</u> , benefits will be denied. Additional benefits for non-emergency, planned surgeries are available through Lantern.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required for certain outpatient surgical procedures and other outpatient services. If you don't get <u>preauthorization</u> , benefits will be denied.
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	No coverage for non-emergency use.
	<u>Urgent care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Telemedicine is covered at 10% <u>coinsurance</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u> ; no charge for bariatric surgery through Lantern	30% <u>coinsurance</u>	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied. Additional benefits for non-emergency, planned surgeries are available through Lantern. Bariatric surgeries are only covered through Lantern.
	Physician/surgeon fee	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
If you are pregnant	Office visits	No charge <u>Deductible</u> does not apply	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may

Common Medical Event	Services You May Need	What Will You Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 240 visits per year, combined with Private Duty Nursing benefit. <u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Coverage for Outpatient Physical, Occupational, and Speech Therapy subject to medical necessity review at 25 visits. <u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied. No visit maximum or medical necessity review for Physical, Occupational and Speech Therapy for mental health/substance abuse disorder diagnosis.
	<u>Habilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Coverage is limited to 120 days per year. <u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Hospice services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	If your child needs dental or eye care	Children's eye exam	Not covered	Not covered
Children's glasses		Not covered	Not covered	

Common Medical Event	Services You May Need	What Will You Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
	Children's dental check-up	No charge under Delta Dental or Dominion Dental	20% <u>coinsurance</u> under Delta Dental; not covered under Dominion Dental	Delta Dental: \$1,500 maximum per person per <u>plan</u> year; Dominion Dental: no maximum.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)	
<ul style="list-style-type: none"> • Cosmetic surgery • Glasses • Long-term care 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U. S. • Routine eye care (Adult) • Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> • Acupuncture (in lieu of anesthesia) • Bariatric surgery (only covered through Lantern) • Dental care (bone fractures, removal of bony impacted teeth, tumors and odontogenic cysts; limited accidental injuries) • Employee assistance services through Health Advocate 	<ul style="list-style-type: none"> • Chiropractic care (up to 30 visits per <u>plan</u> year, except for treatment of back pain) • Hearing aids (1 hearing aid per ear every 3 years for children to age 24) • Infertility treatment (lifetime maximum: \$30,000 medical and \$15,000 prescription drug) 	<ul style="list-style-type: none"> • Private-duty nursing (240 visits per year, combined with home health care; 8 hours equals one shift; <u>preauthorization</u> required) • Weight loss programs (nutritional counseling)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov. You can also contact the plan at 1-877-542-3862. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Aetna by calling the toll free number on your Medical ID Card. Additionally, a consumer assistance program can help you file your appeal. Contact information is at <https://www.aetna.com/individuals-families/member-rights-resources/complaints-grievances-appeals.html>.

Does this Coverage Provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the premium tax credit.

Does this Coverage Meet the Minimum Value Standard? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Arabic (العربية): إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-489-8933

Chinese (繁體中文): 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-489-8933。

French (Français): Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-489-8933.

French Creole (Kreyòl Ayisyen): Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-489-8933.

German (Deutsch): Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer 1-800-489-8933.

Italian (Italiano): In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-489-8933.

Japanese (日本語): 日本語を話される場合、無料の言語支援をご利用いただけます。1-800-489-8933 まで、お電話にてご連絡ください。

Korean (한국어): 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-489-8933 번으로 전화해 주십시오.

Persian-Farsi (فارسی): اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-489-8933 تماس بگیرید (فارسی)

Polish (Polski): Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-489-8933.

Portuguese (Português): Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-489-8933.

Russian (Русский): Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-489-8933.

Spanish (Español): Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-489-8933.

Tagalog (Tagalog): Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-489-8933.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible:	\$1,500
■ Specialist coinsurance:	10%
■ Hospital (facility) coinsurance:	10%
■ Obstetric care coinsurance:	10%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$10
Coinsurance	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,670

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible:	\$1,500
■ Specialist coinsurance:	10%
■ Hospital (facility) coinsurance:	10%
■ Diagnostic test (blood work) coinsurance:	10%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$500
Coinsurance	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,060

Mia's Simple Fracture

(in-network emergency room visit and follow-up care)

■ The plan's overall deductible:	\$1,500
■ Specialist coinsurance:	10%
■ Hospital (facility) coinsurance:	10%
■ Diagnostic test (x-ray) coinsurance:	10%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$10
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,610

Note: A State-funded Health Reimbursement Account (HRA) is available to help offset a large part of the deductible. The State funds the HRA upon subscriber's enrollment at the beginning of the plan year. HRA funds are prorated in accordance with subscriber's effective date of enrollment or change in coverage tier level.