

Summary of Benefits: This Summary of Benefits highlights the health plans available. Summary Plan Description Booklets are available at www.ben.omb.delaware.gov/medical. Existing contracts and law supersede any discrepancies in this brief benefits overview.

FIRST STATE BASIC PLAN (BCBSDE)		
Description of Benefit	In-Network Benefits Deductible: \$500/\$1000* Out-of-Pocket Max: \$2,000/\$4,000** including deductible	Out-of-Network Benefits Deductible: \$1,000/\$2,000* Out-of-Pocket Max: \$4,000/\$8,000** including deductible
Inpatient Room & Board	90% after deductible	70% after deductible
Inpatient Physicians'/Surgeons' Services	90% after deductible	70% after deductible
Outpatient Services	90% after deductible	70% after deductible
Prenatal and Postnatal Care	90% after deductible	70% after deductible
Delivery Fee	90% after deductible	70% after deductible
Hospice	90% after deductible for up to 365 days	70% after deductible for up to 365 days
Home Care Services	90% after deductible for up to 240 days per plan year	70% after deductible for up to 240 days per plan year
Urgent Care	100% after \$25 copay	100% after \$25 copay
Emergency Services	90% after deductible	90% after deductible
MENTAL HEALTH CARE/SUBSTANCE ABUSE CARE		
Inpatient Acute/ Partial Hospitalization	90% after deductible (subject to authorization)	70% after deductible (subject to authorization)
Outpatient	90% after deductible	70% after deductible
OTHER SERVICES		
Durable Medical Equipment	90% after deductible	70% after deductible
Skilled Nursing Facility	90% for up to 120 days per confinement	70% for up to 120 days per confinement
Emergency Ambulance	90% after deductible	70% after deductible
Physician Home/Office Visits (sick)	90% after deductible	70% after deductible
Specialist Care	90% after deductible	70% after deductible
Chiropractic Care	90% after deductible for up to 30 visits per plan year	75% after deductible, for up to 30 visits per plan year
Allergy Testing/Allergy Treatment	90% after deductible	70% after deductible
X-Ray, MRI's, CT Scans, Lab & other Diagnostic Services ***	90% after deductible	70% after deductible
Short-Term Therapies: Physical, Speech, Occupational	90% after deductible	70% after deductible
Annual Gyn Exam/Pap Smear	100% covered, no deductible	70% covered, no deductible
Periodic Physical Exams, Immunizations, Diabetes Education	100% covered, no deductible	70% covered, no deductible
Vision Care	Not covered	Not covered
Hearing Tests	100% covered, no deductible	70% covered, no deductible
Hearing Aids	90% after deductible, under age 24	70% after deductible, under age 24
All Infertility Services	75% after deductible; \$10,000 lifetime maximum for medical services 75% after deductible, \$15,000 lifetime maximum for prescription services	55% after deductible; \$10,000 lifetime maximum for medical services 55% after deductible; \$15,000 lifetime maximum for prescription services
Bariatric Surgery	90% after deductible if "Blue Distinction Center for Bariatric Surgery" is used; 75% after deductible if an authorized hospital/surgical center is used	55% after deductible

* Two individuals must meet the deductible each plan year in order for the family deductible to be met.

** Out-of-pocket maximums apply to each plan year and include your deductible but do not include your prescription costs.

*** MRI, MRA, CT and PET scans require a prior authorization

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AETNA CDH GOLD PLAN		
Description of Benefits	In-Network Benefits Deductible: \$1,500/\$3,000* Out-of-Pocket Max: \$3,000/\$6,000**	Out-of-Network Benefits Deductible: \$1,500/\$3,000* Out-of-Pocket Max: \$6,000/\$12,000**
Health Reimbursement Account	\$1,250 Employee/\$2,500 Family	
	IN-NETWORK	OUT-OF-NETWORK
Inpatient Room & Board	90% after deductible	70% after deductible
Inpatient Physicians' and Surgeons' Services	90% after deductible	70% after deductible
Outpatient Services	90% after deductible	70% after deductible
Prenatal and Postnatal Care	90% after deductible	70% after deductible
Delivery Fee	90% after deductible	70% after deductible
Hospice	90% after deductible	70% after deductible
Home Care Services	90% after deductible for up to 240 days per plan per plan year	70% after deductible for up to 240 days per plan per plan year
Urgent Care	90% after deductible	70% after deductible
Emergency Services	90% after deductible	90% after deductible
MENTAL HEALTH & SUBSTANCE ABUSE		
Inpatient Acute/Partial Hospitalization	90% after deductible	70% after deductible
Outpatient	90% after deductible	70% after deductible
OTHER COVERED SERVICES		
Durable Medical Equipment	90% after deductible	70% after deductible
Skilled Nursing Facility	90% after deductible for up to 120 days per confinement	70% after deductible for up to 120 days per confinement
Emergency Ambulance	90% after deductible	70% after deductible
Physician Home/Office Visits (non-routine)	90% after deductible	70% after deductible
Specialist Care	90% after deductible	70% after deductible
Chiropractic Care	90% after deductible for up to 30 visits per plan year	75% after deductible for up to 30 visits per plan year
Allergy Testing/Allergy Treatment	90% after deductible	70% after deductible
X-ray, MRI's, CT Scans, PET Scans, Lab & Other Diagnostic Services***	90% after deductible	70% after deductible
Short-term Therapies: Physical, Speech, Occupational	90% after deductible	70% after deductible
Annual Gyn Exam/Pap Smear	100%, no deductible	70% covered, after deductible
Routine Physical Exam & Immunizations	100%, no deductible	70% after deductible
Vision Care	Not covered	Not covered
Hearing Tests - 1 exam every 12 months	100%, no deductible	70% after deductible
Hearing Aids – Children to age 24	90% after deductible, under age 24	70% after deductible, under age 24
All Infertility Services	75% covered; \$10,000 lifetime maximum for medical services 75% covered; \$15,000 lifetime maximum for prescription services	55% covered; \$10,000 lifetime maximum for medical services 55% covered; \$15,000 lifetime maximum for prescription services
Bariatric Surgery	90% after deductible if "Institute of Excellence for Bariatric Surgery" is used; 75% after deductible if an authorized hospital/surgical center is used.	55% after deductible.

* Once the Family Deductible Limit is met, all family members will be considered as having met their deductible.

** Out of pocket maximums apply to each benefit year and DO NOT include your deductible.

*** MRI, MRA, CT and PET scans require a prior authorization

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BLUE CROSS BLUE SHIELD OF DELAWARE CDH GOLD PLAN		
Description of Benefits	In-Network Benefits Deductible: \$1,500/\$3,000* Out-of-Pocket Max: \$3,000/\$6,000**	Out-of-Network Benefits Deductible: \$1,500/\$3,000* Out-of-Pocket Max: \$6,000/\$12,000**
Health Reimbursement Account	\$1,250 Employee/\$2,500 Family	
	IN-NETWORK	OUT-OF-NETWORK
Inpatient Room & Board	90% after deductible	70% after deductible
Inpatient Physicians' and Surgeons' Services	90% after deductible	70% after deductible
Outpatient Services	90% after deductible	70% after deductible
Prenatal and Postnatal Care	90% after deductible	70% after deductible
Delivery Fee	90% after deductible	70% after deductible
Hospice	90% after deductible	70% after deductible
Home Care Services	90% after deductible for up to 240 days per plan year	70% after deductible for up to 240 days per plan year
Urgent Care	90% after deductible	70% after deductible
Emergency Services	90% after deductible	90% after deductible
MENTAL HEALTH & SUBSTANCE ABUSE CARE		
Inpatient Acute/Partial Hospitalization	90% after deductible	70% after deductible
Outpatient	90% after deductible	70% after deductible
OTHER COVERED SERVICES		
Durable Medical Equipment	90% after deductible	70% after deductible
Skilled Nursing Facility	90% after deductible for up to 120 days per confinement	70% after deductible for up to 120 days per confinement
Emergency Ambulance	90% after deductible	70% after deductible
Physician Home/Office Visits (non-routine)	90% after deductible	70% after deductible
Specialist Care	90% after deductible	70% after deductible
Chiropractic Care	90% after deductible for up to 30 visits per plan year	75% after deductible for up to 30 visits per plan year
Allergy Testing/Allergy Treatment	90% after deductible	70% after deductible
X-ray, MRI's, CT Scans, PET Scans, Lab & Other Diagnostic Services***	90% after deductible	70% after deductible
Short-term Therapies: Physical, Speech, Occupational	90% after deductible	70% after deductible
Annual Gyn Exam/Pap Smear	100%, no deductible	70% covered, after deductible
Routine Physical Exam & Immunizations	100%, no deductible	70% after deductible
Vision Care	Not covered	Not covered
Hearing Tests - 1 exam every 12 months	100%, no deductible	70% after deductible
Hearing Aids – Children to age 24	90% after deductible	70% after deductible
All Infertility Services	75% covered; \$10,000 lifetime maximum for medical services 75% covered; \$15,000 lifetime maximum for prescription services	55% covered; \$10,000 lifetime maximum for medical services 55% covered; \$15,000 lifetime maximum for prescription services
Bariatric Surgery	90% after deductible if "Blue Distinction Center for Bariatric Surgery" is used; 75% after deductible if an authorized hospital/surgical center is used	55% after deductible

* Once the Family Deductible Limit is met, all family members will be considered as having met their deductible.

** Out of pocket maximums apply to each benefit year and DO NOT include your deductible.

*** MRI, MRA, CT and PET scans require a prior authorization

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DESCRIPTION OF BENEFITS	AETNA HMO	BLUE CARE® HMO
Inpatient Room & Board	\$100 copay/day with max of \$200 per admission	\$100 copay/day with max of \$200 per admission
Inpatient Physicians' and Surgeons' Services	100%	100%
Outpatient Surgery– Ambulatory Center	\$30 copay	\$30 copay
Outpatient Surgery–Doctors Office Visit	\$20 copay	\$20 copay
Outpatient Surgery–Hospital	\$75 copay	\$75 copay
Prenatal and Postnatal Care	100% after \$20 initial copay (inpatient room and board copays do apply to hospital deliveries/ birthing centers)	100% after \$20 initial copay (inpatient room and board copays do apply to hospital deliveries/ birthing centers)
Delivery Fee	100%	100%
Hospice	100%	100% up to 365 days
Home Care Services	100% for up to 240 visits per plan year	100% for up to 240 visits per plan year
Urgent Care	\$20 copay	\$20 copay
Emergency Services	\$135 copay (waived if admitted)	\$135 copay (waived if admitted)
MENTAL HEALTH CARE/SUBSTANCE ABUSE CARE		
Inpatient Acute/Partial Hospitalization	\$100 copay/day with max. of \$200/hospitalization (subject to authorization)	\$100 copay/day with max. of \$200/hospitalization (subject to authorization)
Outpatient	\$20 copay per visit	\$10 copay per visit
OTHER SERVICES		
Durable Medical Equipment	80%, limit of \$5,000 per member per plan year	80%
Skilled Nursing Facility	100%	100%
Emergency Ambulance	\$50 copay	\$50 copay
Physician Home/Office Visits (sick)	\$10 copay per office visit \$25 copay per home or after hours visit	\$10 copay per office visit/ \$25 copay per home or after hours visit
Specialist Care	\$20 copay per visit	\$20 copay per visit
Chiropractic Care	80% of the allowable charges	80% of the allowable charges; limited to one visit per day and 60 consecutive days per acute condition
Allergy Testing/Allergy Treatment	\$20 copay per visit (allergy testing)/ \$5 copay per visit (allergy treatment)	\$20 copay per visit (allergy testing)/ \$5 copay per visit (allergy treatment)
X-Ray, Lab & other Diagnostic Services	Lab: \$5 copay per visit/X-Ray:\$15 copay per visit	Lab: \$5 copay per visit/ X-Ray: \$15 copay per visit
MRI's, CT Scans and PET Scans*	\$25 copay per visit	\$25 copay per visit
Short-Term Therapies: Physical, Speech, Occupational	80%, 45 visits per condition for physical and occupational therapy combined/ 80%, 45 visits per condition for speech therapy	80%, 60 consecutive days/except for physical therapy. Physical therapy/45 visits per condition
Annual Gyn Exam/Pap Smear	Exam: \$10 copay/Pap Smear: \$5 copay	Exam: \$10 copay/Pap Smear: \$5 copay
Periodic Physical Exams, Immunizations, Diabetes Education	\$10 copay per visit/ 100% Diabetes education	\$10 copay per visit/ 100% Diabetes education
Vision Care	100% after office visit copay (one exam every 24 months)	100% after office visit copay (one exam every 24 months)
Hearing Tests	100% after office visit copay	100% after office visit copay
All Infertility Services	75% covered \$10,000 lifetime maximum for medical services; 75% covered; \$15,000 lifetime maximum for prescription services	75% covered; \$10,000 lifetime maximum for medical services. 75% covered; \$15,000 lifetime maximum for prescription services
Bariatric Surgery	100% if "Institute Excellence for Bariatric Surgery" is used; 75% if an authorized hospital/surgical center is used	100% if "Blue Distinction Center for Bariatric Surgery" is used; 75% if an authorized hospital/ surgical center is used

* MRI, MRA, CT and PET scans require a prior authorization

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COMPREHENSIVE PREFERRED PROVIDER ORGANIZATION (BCBSDE)

DESCRIPTION OF BENEFIT	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS DEDUCTIBLE: \$300/\$600* OUT-OF-POCKET MAX: \$1,800/\$3,600 INCLUDING DEDUCTIBLE**
Inpatient Room & Board	\$100 copay/day with max. of \$200/admission	80% after deductible
Inpatient Physicians' and Surgeons' Services	100%	80% after deductible
Outpatient Services	100%	80% after deductible
Prenatal and Postnatal Care	100% (inpatient room and board copays do apply to hospital deliveries/birthing centers)	80% after deductible
Delivery Fee	100%	80% after deductible
Hospice	100% up to 365 days	80% after deductible up to 365 days
Home Care Services	100%	80% after deductible for up to 240 visits per plan year
Urgent Care	\$25 copay	80% after deductible
Emergency Services	\$125 copay (waived if admitted) Physician: 100%	\$125 copay (waived if admitted) Physician: 100% after deductible
MENTAL HEALTH CARE/SUBSTANCE ABUSE CARE		
Inpatient Acute/Partial Hospitalization	\$100 copay/day with max of \$200/adm. (subject to authorization)	80% after deductible (subject to authorization)
Outpatient	100% after \$15 copay	80% after deductible
OTHER SERVICES		
Durable Medical Equipment	100%	80% after deductible
Skilled Nursing Facility	100% up to 120 days per confinement	80% after deductible up to 120 days per confinement
Emergency Ambulance	100%	100% no deductible
Physician Home/Office Visits (sick)	\$15 copay	80% after deductible
Specialist Care	\$25 copay	80% after deductible
Chiropractic Care	85% covered; 30 visits per plan year	80% after deductible; 30 visits per plan year
Allergy Testing/Allergy Treatment	Testing: \$25 copay/Treatment:\$5 copay	80% after deductible
X-Ray, MRI's, CT Scans, PET Scans, Lab & other Diagnostic Services ***	Lab: \$5 copay per visit X-ray: \$15 copay per visit	80% after deductible
Short-Term Therapies: Physical, Speech, Occupational Therapies	85%	80% after deductible
Annual Gyn Exam/Pap Smear	Exam: \$15 copay/Pap Smear: \$5 copay	80% after deductible
Periodic Physical Exams, Immunizations, Diabetes Education	100% after \$15 copay	80% after deductible
Vision Care	Not covered	Not covered
Hearing Tests	100% after office visit copay	80% after deductible
Hearing Aids	100%, under age 24	80% after deductible, under age 24
All Infertility Services	75% covered, \$10,000 lifetime maximum for medical services 75% covered, \$15,000 lifetime maximum for prescription services	55% after deductible; \$10,000 lifetime maximum for medical services 55% after deductible; \$15,000 lifetime maximum for prescription services
Bariatric Surgery	100% covered if "Blue Distinction Center for Bariatric Surgery" is used;75% covered if an authorized hospital/surgical center is used.	55% after deductible

* Two individuals must meet the deductible each plan year in order for the family deductible to be met.

** Out-of-pocket maximums apply to each plan year and include your deductible but do not include your prescription costs.

*** MRI, MRA, CT and PET scans require a prior authorization