### Important Questions

<table>
<thead>
<tr>
<th><strong>What is the overall deductible?</strong></th>
<th><strong>Answers</strong></th>
<th><strong>Why this Matters:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Network provider: $1,500 individual/ $3,000 family; Out-of-Network provider: $1,500 individual/ $3,000 family.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Are there services covered before you meet your deductible?</strong></th>
<th><strong>Answers</strong></th>
<th><strong>Why this Matters:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes. In-network preventive care services, certain annual cancer screening 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 network deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Are there other deductibles for specific services?</strong></th>
<th><strong>Answers</strong></th>
<th><strong>Why this Matters:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>What is the out–of–pocket limit for this plan?</strong></th>
<th><strong>Answers</strong></th>
<th><strong>Why this Matters:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>For Network provider Medical: $4,500 individual/ $9,000 family; Network provider Prescription Drug: $2,100 individual/ $4,200 family. Out-of-Network provider Medical: $7,500 individual/ $15,000 family; Out-of-Network provider Prescription Drug: Not Applicable</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>In-network Provider (You will pay the least)</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge Deductible does not apply</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
</tr>
</tbody>
</table>

For more information about limitations and exceptions, see the plan or policy document at www.HealthReformPlanSBC.com or by calling 1-877-542-3862.
### Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

**State of Delaware: Aetna CDH Gold**

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Pay</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>In-network Provider</strong>&lt;br&gt;(You will pay the least)</td>
<td><strong>Out-of-network Provider</strong>&lt;br&gt;(You will pay the most)</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$8 copay/prescription for 30-day supply (retail or mail order); $16 copay/prescription for 90-day supply (participating retail or mail order)</td>
<td>Reimbursement limited to in-network allowable amount minus applicable copay</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$28 copay/prescription for 30-day supply (retail or mail order); $56 copay/prescription for 90-day supply (participating retail or mail order)</td>
<td>Reimbursement limited to in-network allowable amount minus applicable copay</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$50 copay/prescription for 30-day supply (retail or mail order); $100 copay/prescription for 90-day supply (participating retail or mail order)</td>
<td>Reimbursement limited to in-network allowable amount minus applicable copay</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>Copay based on whether drug is generic, preferred, or non-preferred</td>
<td>Not covered</td>
<td>First fill can be at retail; future fills must be through specialty pharmacy.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
</tbody>
</table>

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### Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

**State of Delaware: Aetna CDH Gold**

#### Coverage Period: 07/01/2018 - 06/30/2019

**Coverage for:** Individual + Family | **Plan Type:** PPO

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What Will You Pay</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-network Provider (You will pay the least)</td>
<td>Out-of-network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Emergency room care</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge Deductible does not apply</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
</tbody>
</table>

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Summary of Benefits and Coverage:  What this Plan Covers & What You Pay for Covered Services

State of Delaware:  Aetna CDH Gold

Coverage Period: 07/01/2018 - 06/30/2019
Coverage for: Individual + Family | Plan Type: PPO

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-network Provider (You will pay the least)</th>
<th>Out-of-network Provider (You will pay the most)</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>Coverage for Outpatient Physical, Occupational, and Speech Therapy subject to medical necessity review at 25 visits. Preauthorization is required. If you don’t get preauthorization, benefits will be denied.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>Coverage is limited to 120 days per year. Preauthorization is required. If you don’t get preauthorization, benefits will be denied.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
</tbody>
</table>

If your child needs dental or eye care

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-network Provider (You will pay the least)</th>
<th>Out-of-network Provider (You will pay the most)</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Children’s eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
<td>You must pay 100% of these expenses.</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>You must pay 100% of these expenses.</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>No charge under Delta Dental or Dominion Dental</td>
<td>20% coinsurance under Delta Dental; not covered under Dominion Dental</td>
<td>Delta Dental: $1,500 maximum per person per plan year; Dominion Dental: no maximum.</td>
</tr>
</tbody>
</table>

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Glasses
- Long-term care
- Non-emergency care when traveling outside the U. S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

- Acupuncture (in lieu of anesthesia)
- Bariatric surgery
- Chiropractic care (up to 30 visits per plan year)
- Dental care (bone fractures, removal of bony impacted teeth, tumors and orthodontogenic cysts)
- Hearing aids (1 hearing aid per ear every 3 years for children to age 24)
- Infertility treatment (lifetime maximum: $10,000 medical and $15,000 prescription drug)
- Private-duty nursing (240 visits per year, combined with home health care; 8 hours equals one shift; preauthorization required)

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-EBJA (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-EBJA (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
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 (العربي): إذا كنت تتحدث اللغة، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل برقم 8933-489-800.
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 sévis éd pou lang ki disponib gratis pou ou. Rele 1-800-489-8933.
German (Deutsch): Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfstdienstleistungen zur Verfügung. Rufnummer 1-800-489-8933.

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Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
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Coverage for:
- Individual + Family
- Plan Type: PPO

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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.

<table>
<thead>
<tr>
<th><strong>Peg is Having a Baby</strong> (9 months of in-network pre-natal care and a hospital delivery)</th>
<th><strong>Managing Joe’s Type 2 Diabetes</strong> (a year of routine in-network care of a well-controlled condition)</th>
<th><strong>Mia’s Simple Fracture</strong> (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan’s overall deductible:</strong> $1,500</td>
<td><strong>The plan’s overall deductible:</strong> $1,500</td>
<td><strong>The plan’s overall deductible:</strong> $1,500</td>
</tr>
<tr>
<td><strong>Specialist coinsurance:</strong> 10%</td>
<td><strong>Specialist coinsurance:</strong> 10%</td>
<td><strong>Hospital (facility) coinsurance:</strong> 10%</td>
</tr>
<tr>
<td><strong>Hospital (facility) coinsurance:</strong> 10%</td>
<td><strong>Hospital (facility) coinsurance:</strong> 10%</td>
<td><strong>Diagnostic test (blood work) coinsurance:</strong> 10%</td>
</tr>
<tr>
<td><strong>Obstetric care coinsurance:</strong> 10%</td>
<td><strong>Diagnostic test (blood work) coinsurance:</strong> 10%</td>
<td><strong>Diagnostic test (x-ray) coinsurance:</strong> 10%</td>
</tr>
</tbody>
</table>

**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)*

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)*

**What isn’t covered**
- Limits or exclusions $60

**Total Example Cost** $12,800

**In this example, Peg would pay:**

<table>
<thead>
<tr>
<th><strong>Cost Sharing</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$30</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,110</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
</tr>
</tbody>
</table>

The total Peg would pay is $2,690

**Total Example Cost** $7,400

**In this example, Joe would pay:**

<table>
<thead>
<tr>
<th><strong>Cost Sharing</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$600</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$100</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
</tr>
</tbody>
</table>

The total Joe would pay is $2,260

**Total Example Cost** $1,900

**In this example, Mia would pay:**

<table>
<thead>
<tr>
<th><strong>Cost Sharing</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$40</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
</tr>
</tbody>
</table>

The total Mia would pay is $1,540

Note: A State-funded Health Reimbursement Arrangement (HRA) is available to help offset a large part of the deductible.

The plan would be responsible for the other costs of these EXAMPLE covered services.