OPEN ENROLLMENT
MAY 8 – 26, 2017

TO: ACTIVE FULL-TIME & ELIGIBLE PART-TIME EMPLOYEES

It's your once-a-year opportunity to enroll or make changes to your health, dental and vision benefits. Open Enrollment will begin on **May 8, 2017** and will end on **May 26, 2017**. This Open Enrollment period also includes the opportunity to enroll or change coverage with AFLAC and Supplemental Life Insurance Programs, administered by UNUM & TransAmerica.

WHAT YOU NEED TO KNOW

- Aetna will be the only health plan administrator for the HMO Plan and the CDH Gold Plan as of July 1, 2017.
- The IPA/HMO and CDH Gold Plan offered through Highmark Delaware will no longer be available effective July 1, 2017. Highmark Delaware will continue to administer the First State Basic Plan and Comp PPO Plan.
- If you are currently enrolled in either the Highmark Delaware IPA/HMO or Highmark Delaware CDH Gold Plan and you take **no action during this Open Enrollment period, you will be automatically defaulted into the corresponding Aetna HMO Plan or CDH Gold Plan for the plan year that begins July 1, 2017.**
- **IMPORTANT:** HMO members are required to select a Primary Care Provider (PCP). Employees who default or enroll in the Aetna HMO and do not select a PCP during Open Enrollment will have one assigned to them by Aetna (based on location/proximity of the member to the provider).
- Step-by-step instructions on how to find an Aenta PCP on the Aetna DocFind website can be found at http://ben.omb.delaware.gov/medical/aetna/docfind-instructions.shtml

A Health Plan Comparison Chart is included with this memo. This chart will provide you coverage options and plan features for each of the four health plans available. A copy of the City of Dover Health Premiums for 15% and 20% employee cost sharing is also included. Summaries of benefits and coverages for each of the four health plans available and enrollment forms are included as well.

Premiums for Fiscal Year beginning July 1, 2017 will not change for health, dental & vision plans.

Please take the time to read the information provided so that you are an active participant in this year's Open Enrollment process. If you are not making any changes and wish to continue your current level of coverage, no action is needed, unless you insure a spouse on your plan.

PLEASE NOTE: ALL EMPLOYEES WHO COVER THEIR SPOUSE UNDER THE GROUP HEALTH PLAN PROVIDED BY THE CITY OF DOVER/STATE OF DELAWARE MUST COMPLETE A SPOUSAL COORDINATION OF BENEFIT FORM DURING OPEN ENROLLMENT BETWEEN MAY 8 – 26, 2017.

YOU MUST COMPLETE THIS FORM ONLINE EVEN IF YOU ARE NOT MAKING ANY CHANGES TO YOUR BENEFITS. IT IS IMPORTANT THAT YOU COMPLETE THE ONLINE FORM BY MAY 26, 2017.

The electronic Spousal Coordination of Benefits form can be found on the Statewide Benefits website at https://cob.ben.omb.delaware.gov/. After completing the form online, click on "Printable Summary" to print a copy for your records. Please note that completing the spousal coordination of benefits form **DOES NOT** enroll your spouse or discontinue coverage for your spouse. You must complete and submit an enrollment application. If concerns arise regarding your spouse's coverage, Human Resources will request a copy of the Printable Summary mentioned above.

If you are enrolling, changing or canceling coverage during this open enrollment period, please complete the appropriate forms and return them **directly** to Human Resources **prior** to the close of Open Enrollment on May 26, 2017. **Changes made during Open Enrollment will become effective on July 1, 2017.** At the conclusion of open enrollment, employees will receive an email or written notification from Human Resources of all the changes that have been received.

If you have any questions or concerns, please contact a member of the Human Resources Department via phone at (302) 736-7073 or email at humanresources@dover.de.us.

State of Delaware Health Plan Comparison Chart
(Effective July 1, 2017)

Plan Options	Highmark Delaware First State Basic PPO Plan		Aetna CDH Gold Plan		Aetna HMO Plan		Highmark Delaware Comprehensive PPO Plan	
Plan Type	Preferred Provider Organization (PPO)		Consumer Directed Health (CDH)		Health Maintenance Organization (HMO)		Preferred Provider Organization (PPO)	
Primary Care Provider (PCP) Selection	Recommended		Recommended		Required		Recommended	
Plan Feature	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Preventive Care/ Screening/Immunization (age, gender and risk parameters may apply)	100% covered, not subject to deductible	70% covered, not subject to deductible	100% covered, not subject to deductible	70% covered after deductible	100% covered	Not covered	100% covered	80% covered after deductible
Deductible (Per plan year)	$500 per individual/ $1,000 per family	$1,000 per individual/ $2,000 per family	$1,500 per individual/ $3,000 per family	$1,500 per individual/ $3,000 per family	N/A	N/A	N/A	$300 per individual/ $600 per family
Health Reimbursement Account (HRA)	N/A	N/A	$1,250 per individual/ $2,500 family	$1,250 per individual/ $2,500 family	N/A	N/A	N/A	N/A
Out-of-Pocket Maximum (including copays and deductibles)	$2,000 per individual/ $4,000 per family	$4,000 per individual/ $8,000 per family	$4,500 per individual/ $9,000 per family	$7,500 per individual/ $15,000 per family	$4,500 per individual/ $9,000 per family	N/A	$4,500 per individual/ $9,000 per family	$7,500 per individual/ $15,000 per family
Prenatal and Postnatal Care	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	100% after $25 initial copay (inpatient room and board copays do apply to hospital deliveries/ birthing centers)	Not covered	100% (inpatient room and board copays do apply to hospital deliveries/birthing centers)	80% covered after deductible

Plan Options	Highmark Delaware First State Basic PPO Plan		Aetna CDH Gold Plan		Aetna HMO Plan		Highmark Delaware Comprehensive PPO Plan	
Plan Feature	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
24/7 Nurse Line	Yes, no cost		Yes, no cost		Yes, no cost		Yes, no cost	
Primary Care Visit to treat an injury or illness	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	$15 copay per visit	Not covered	$20 copay per visit	80% covered after deductible
Telemedicine (Virtual Doctor Visits)	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	$15 copay per visit	Not covered	$20 copay per visit	80% covered after deductible
Urgent Care Visit	100% covered after $25 copay	100% covered after $25 copay	90% covered after deductible	70% covered after deductible	$15 copay per visit	Not covered	$20 copay per visit	80% covered after deductible
Emergency Room	90% covered after deductible	90% covered after deductible	90% covered after deductible	90% covered after deductible	$150 copay per visit (waived if admitted)	$150 copay per visit	$150 copay per visit (waived if admitted)	$150 copay per visit (waived if admitted)
Chiropractic Care* **	90% covered after deductible for up to 30 visits per plan year	75% covered after deductible for up to 30 visits per plan year	90% covered after deductible for up to 30 visits per plan year	75% covered after deductible for up to 30 visits per plan year	Lesser of $15 copay or 20% coinsurance (Referrals required through PCP)	Not covered	85% covered for up to 30 visits per plan year	80% covered after deductible for up to 30 visits per plan year
Specialist Visit	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	$25 copay per visit (Referrals required for certain services through PCP)	Not covered	$30 copay per visit	80% covered after deductible
Diagnostic Test (X-Ray, Ultrasound, Blood (Lab) Work, etc.)	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	Lab: $10 copay per visit; X-Ray or Ultrasound: $20 copay per visit	Not covered	Lab: $10 copay per visit; X-Ray or Ultrasound: $20 copay per visit	80% covered after deductible
High-Tech Imaging (MRI, CT Scan, PET Scan)**	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	Non-Hospital Affiliated Freestanding Facility: $0 copay per visit _____ Hospital Facility: $35 copay per visit	Not covered	Non-Hospital Affiliated Freestanding Facility: $0 copay per visit _____ Hospital Facility: $35 copay per visit	80% covered after deductible
Outpatient Surgery	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	Ambulatory Center: $50 copay per visit _____ Hospital Facility: $100 copay per visit	Not covered	Ambulatory Center: $50 copay per visit _____ Hospital Facility: $100 copay per visit	80% covered after deductible
Hospital Admission	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	$100 copay per day with max of $200 per admission	Not covered	$100 copay per day with max of $200 per admission	80% covered after deductible

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

***Chiropractic coverage requires medical necessity and excludes preventive/maintenance care.

Please note: The specific premiums (rates) referenced in this document apply to State of Delaware employees. Flex credits offered to school district or charter school employees to reduce their employee premiums for health care are not reflected in this information. Please see your HR/Benefits Office for information about your flex credits. Employees who are eligible for and receiving reduced premiums due to double state share eligibility are not reflected in this information. State share and pensioner contributions depend on years of service and the date of hire/retirement. Non-State Participating Group Employees should contact their HR/Benefits Office within their organization for premium information.

Health Premiums
Effective: July 1, 2017
15% Employee Cost Sharing

Plan Name	Coverage Type	Employee Pays per Month	Biweekly Payroll Deduction	City Pays	Total Cost Monthly
Highmark Delaware First State Basic	Employee Only	$ 109.92	$ 54.96	$ 622.92	$ 732.84
	Employee & Child(ren)	$ 166.88	$ 83.44	$ 945.70	$ 1,112.58
	Employee & Spouse	$ 227.00	$ 113.50	$ 1,286.32	$ 1,513.32
	Family	$ 283.66	$ 141.83	$ 1,607.38	$ 1,891.04
Highmark Delaware Comprehensive PPO	Employee Only	$ 125.44	$ 62.72	$ 710.82	$ 836.26
	Employee & Child(ren)	$ 193.10	$ 96.55	$ 1,094.25	$ 1,287.34
	Employee & Spouse	$ 259.86	$ 129.93	$ 1,472.57	$ 1,732.42
	Family	$ 324.76	$ 162.38	$ 1,840.33	$ 2,165.08
Aetna HMO	Employee Only	$ 114.74	$ 57.37	$ 650.20	$ 764.94
	Employee & Child(ren)	$ 175.30	$ 87.65	$ 993.46	$ 1,168.76
	Employee & Spouse	$ 241.46	$ 120.73	$ 1,368.36	$ 1,609.82
	Family	$ 301.20	$ 150.60	$ 1,706.82	$ 2,008.02
Aetna CDH Gold	Employee Only	$ 113.74	$ 56.88	$ 644.61	$ 758.36
	Employee & Child(ren)	$ 173.58	$ 86.79	$ 983.65	$ 1,157.24
	Employee & Spouse	$ 235.44	$ 117.72	$ 1,334.12	$ 1,569.54
	Family	$ 298.98	$ 149.49	$ 1,694.26	$ 1,993.24

Health Premiums
Effective: July 1, 2017
20% Employee Cost Sharing

Plan Name	Coverage Type	Employee Pays per Month	Biweekly Payroll Deduction	City Pays	Total Cost Monthly
Highmark Delaware First State Basic	Employee Only	$146.56	$ 73.28	$ 586.28	$ 732.84
	Employee & Child(ren)	$222.52	$ 111.26	$ 890.06	$ 1,112.58
	Employee & Spouse	$302.66	$ 151.33	$ 1,210.66	$ 1,513.32
	Family	$378.20	$ 189.10	$ 1,512.84	$ 1,891.04
Highmark Delaware Comprehensive PPO	Employee Only	$167.24	$ 83.62	$ 669.02	$ 836.26
	Employee & Child(ren)	$257.46	$ 128.73	$ 1,029.88	$ 1,287.34
	Employee & Spouse	$346.48	$ 173.24	$ 1,385.94	$ 1,732.42
	Family	$433.02	$ 216.51	$ 1,732.06	$ 2,165.08
Aetna HMO	Employee Only	$152.98	$ 76.49	$ 611.96	$ 764.94
	Employee & Child(ren)	$233.74	$ 116.87	$ 935.02	$ 1,168.76
	Employee & Spouse	$321.96	$ 160.98	$ 1,287.86	$ 1,609.82
	Family	$401.60	$ 200.80	$ 1,606.42	$ 2,008.02
Aetna CDH Gold	Employee Only	$151.68	$ 75.84	$ 606.68	$ 758.36
	Employee & Child(ren)	$231.44	$ 115.72	$ 925.80	$ 1,157.24
	Employee & Spouse	$313.90	$ 156.95	$ 1,255.64	$ 1,569.54
	Family	$398.64	$ 199.32	$ 1,594.60	$ 1,993.24

20% Employee Cost Sharing

AFSCME Union Employees hired on or after May 20, 2015

DOE Union Employees hired on or after December 22, 2015

FOP Union Employees hired on or after October 9, 2015

IBEW Union Employees hired on or after July 1, 2014

State of Delaware: Aetna HMO

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/2017 - 06/30/2018

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

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 health care 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?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive care services	This plan covers preventive care services, even if you have not met the deductible amount. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit for this plan?	Yes. In-Network Medical: **$4,500** person/**$9,000** family; In-Network Prescription Drug: **$2,100** person/**$4,200** family. Out-of-Network: No out-of-pocket limit.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billing, health care this plan does not cover, bariatric surgery expenses and infertility expenses.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. For a list of in-network providers, see **www.aetna.com** or call **1-877-542-3862**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Do you need a referral to see a specialist?	Yes. You need a written referral from your primary care physician (PCP) to see a **specialist**.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.

All copayment and 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 health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay per visit	Not covered	-- None --
	Specialist visit	$25 copay per visit	Not covered	-- None --
	Preventive care/screening/ immunization	No charge	Not covered	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	Laboratory: $10 copay per visit; X-ray: $20; Diagnostic Testing: $20 copay per visit	Not covered	You must use in-network laboratory providers.
	Imaging (CT/PET scans, MRIs)	No charge at freestanding facilities; $35 copay per visit at hospital-based facilities	Not covered	Prior authorization required. Failure to pre-authorize will result in a denial.

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com.	Generic drugs	$8 copay for 30-day supply retail or mail order; $16 copay for 90-day supply participating retail or mail order	Reimbursement limited to in-network allowable amount minus applicable copay	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 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.
	Preferred brand drugs	$28 copay for 30-day supply retail or mail order; $56 copay for 90-day supply participating retail or mail order	Reimbursement limited to in-network allowable amount minus applicable copay	
	Non-preferred brand drugs	$50 copay for 30-day supply retail or mail order; $100 copay for 90-day supply participating retail or mail order	Reimbursement limited to in-network allowable amount minus applicable copay	
	Specialty drugs	Copay based on whether drug is generic, preferred, or non-preferred	Not covered	First fill can be at retail; future fills must be through specialty pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Outpatient Hospital: $100 copay per visit; Ambulatory Surgery Center: $50 copay per visit	Not covered	-- None --
	Physician/surgeon fees	No charge	Not covered	-- None --
If you need immediate medical attention	Emergency room care	$150 copay per visit (waived if admitted)	$150 copay per visit	No coverage for non-emergency use
	Emergency medical transportation	$50 copay per visit	$50 copay per visit	No coverage for non-emergency use
	Urgent care	$15 copay per visit	Not covered	No coverage for non-urgent use

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 hospital stay	Facility fee (e.g., hospital room)	$100 copay per day with maximum of $200 per admission	Not covered	Pre-authorization required. Failure to preauthorize will result in a denial.
	Physician/surgeon fee	No charge	Not covered	-- None --
If you have mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay per visit	Not covered	-- None --
	Inpatient services	$100 copay per day with maximum of $200 per admission	Not covered	Pre-authorization required. Failure to preauthorize will result in a denial.
If you are pregnant	Office visits	$25 copay; initial visit only, thereafter no charge	Not covered	-- None --
	Childbirth/delivery professional services	No charge	Not covered	-- None --
	Childbirth/delivery facility services	$100 copay per day with maximum of $200 per admission	Not covered	-- None --
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Pre-authorization required. Failure to preauthorize will result in a denial.
	Rehabilitation services	20% coinsurance	Not covered	Limited to 45 visits per condition for physical and occupational therapy combined. Coverage is limited to 45 visits per condition for speech therapy.
	Habilitation services	Covered same as any other expense based on the type of service performed	Not covered	Coverage is limited to $36,000 per plan year for applied behavioral analysis (ABA).
	Skilled nursing care	No charge	Not covered	Pre-authorization required. Failure to preauthorize will result in a denial.
	Durable medical equipment	20% coinsurance	Not covered	-- None --
	Hospice services	No charge	Not covered	-- None --
If your child needs dental or eye care	Children's eye exam	$15 copay per visit	Not covered	Limited to 1 exam per 24 months.

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 glasses	Not covered	Not covered	You must pay 100% of these expenses.
	Children's dental check-up	No charge under Delta Dental or Dominion Dental	20% coinsurance under Delta Dental; not covered under Dominion Dental	Delta Dental: $1,500 maximum per person per plan year; Dominion Dental: no maximum.

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic surgery
- Glasses
- Long-term care
- Non-emergency care when traveling outside the U. S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Dental care (Adult)
- Hearing aids (up to age 24)
- Infertility treatment (coverage limited to $10,000 lifetime maximum)
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-542-3862. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact us by calling the toll free number on your Medical ID Card. Additionally, a consumer assistance program can help you file an 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.

Notice of Nondiscrimination

Discrimination is Against the Law

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

The State of Delaware Group Health Insurance Plan:

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

If you need these services, contact Brenda Lakeman.

If you believe that The State of Delaware Group Health Insurance Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Brenda Lakeman, Director of Statewide Benefits and Insurance Coverage, at Office of Management and Budget (OMB), Statewide Benefits, 97 Commerce Way, Suite 201, Dover, DE 19904, phone: 1-800-489-8933, fax: 1-302-739-8339, and email: benefits@state.de.us. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Brenda Lakeman, Director of Statewide Benefits and Insurance Coverage 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 https://ocrportal.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, 800-537-7697 (TDD)

For more information about limitations and exceptions, see the plan or policy document at www.HealthReformPlanSBC.com or by calling 1-877-542-3862.

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

Language Access Services:

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

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

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:** $0
- **Specialist copayment:** $25
- **Hospital (facility) copayment:** $100 per day, Maximum $200 per admission
- **Other:** Based on type of service

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	**$13,200**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$860**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible:** $0
- **Specialist copayment:** $25
- **Hospital (facility) copayment:** $100 per day, Maximum $200 per admission
- **Other:** Based on type of service

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,260**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible:** $0
- **Specialist copayment:** $25
- **Hospital (facility) copayment:** $100 per day, Maximum $200 per admission
- **Other:** Based on type of service

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	**$2,000**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$450**

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

State of Delaware: Aetna CDH Gold

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/2017 - 06/30/2018

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

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 health care 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?	In-Network: **$1,500** person/ **$3,000** family; Out-of-Network: **$1,500** person/ **$3,000** family. Doesn't apply to prescription drugs or in-network preventive care. Balance billing and excluded services do not count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. 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
Are there services covered before you meet your deductible?	Yes. Preventive care services	This plan covers preventive care services, even if you have not met the deductible amount. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit for this plan?	Yes. In-Network Medical: **$4,500** person/ **$9,000** family; In-Network Prescription Drug: **$2,100** person/**$4,200** family. Out-of-Network Medical: **$7,500** person/**$15,000** family; Out-of-Network Prescription Drug: No out-of-pocket limit.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billing, health care this plan does not cover,	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

	bariatric surgery expenses and infertility expenses.	
Will you pay less if you use a network provider?	Yes. For a list of in-network **providers**, see **www.aetna.com** or call **1-877-542-3862**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.

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 health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	30% coinsurance	-- None --
	Specialist visit	10% coinsurance	30% coinsurance	-- None --
	Preventive care/screening/ immunization	No charge; deductible waived	30% coinsurance	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	You must use in-network laboratory providers.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Prior authorization required. Failure to pre-authorize will result in a denial.

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com.	Generic drugs	$8 copay for 30-day supply retail or mail order; $16 copay for 90-day supply participating retail or mail order	Reimbursement limited to in-network allowable amount minus applicable copay	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 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.
	Preferred brand drugs	$28 copay for 30-day supply retail or mail order; $56 copay for 90-day supply participating retail or mail order	Reimbursement limited to in-network allowable amount minus applicable copay	
	Non-preferred brand drugs	$50 copay for 30-day supply retail or mail order; $100 copay for 90-day supply participating retail or mail order	Reimbursement limited to in-network allowable amount minus applicable copay	
	Specialty drugs	Copay based on whether drug is generic, preferred, or non-preferred	Not covered	First fill can be at retail; future fills must be through specialty pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	-- None --
	Physician/surgeon fees	10% coinsurance	30% coinsurance	-- None --
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	No coverage for non-emergency use
	Emergency medical transportation	10% coinsurance	30% coinsurance	No coverage for non-emergency use
	Urgent care	10% coinsurance	30% coinsurance	-- None --

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 hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Pre-authorization required. Failure to preauthorize will result in a denial.
	Physician/surgeon fee	10% coinsurance	30% coinsurance	-- None --
If you have mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	-- None --
	Inpatient services	10% coinsurance	30% coinsurance	Pre-authorization required. Failure to preauthorize will result in a denial.
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	No charge for in-network preventive prenatal care.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	-- None --
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	-- None --
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Limited to 240 visits per year, combined with Private Duty Nursing benefit. Preauthorization required. Failure to preauthorize will result in a denial.
	Rehabilitation services	10% coinsurance	30% coinsurance	Coverage includes Speech, Occupational and Physical Therapy.
	Habilitation services	Covered same as any other expense based on the type of service performed	Covered same as any other expense based on the type of service performed	Coverage is limited to $36,000 per plan year for applied behavioral analysis (ABA).
	Skilled nursing care	10% coinsurance	30% coinsurance	Limited to 120 days per year. Preauthorization required. Failure to preauthorize will result in a denial.
	Durable medical equipment	10% coinsurance	30% coinsurance	-- None --
	Hospice services	10% coinsurance	30% coinsurance	-- None --
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	You must pay 100% of these expenses.
	Children's glasses	Not covered	Not covered	You must pay 100% of these expenses.

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% coinsurance under Delta Dental; not covered under Dominion Dental	Delta Dental: $1,500 maximum per person per plan year; Dominion Dental: no maximum.

Excluded Services & Other Covered Services:

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

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

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

- Bariatric surgery
- Chiropractic care
- Dental care (Adult)
- Hearing aids (coverage for children to age 24)
- Infertility treatment (coverage limited to $10,000 lifetime maximum)
- Private-duty nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-542-3862. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact us by calling the toll free number on your Medical ID Card. Additionally, a consumer assistance program can help you file an 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.

Notice of Nondiscrimination

Discrimination is Against the Law

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

The State of Delaware Group Health Insurance Plan:

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

If you need these services, contact Brenda Lakeman.

If you believe that The State of Delaware Group Health Insurance Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Brenda Lakeman, Director of Statewide Benefits and Insurance Coverage, at Office of Management and Budget (OMB), Statewide Benefits, 97 Commerce Way, Suite 201, Dover, DE 19904, phone: 1-800-489-8933, fax: 1-302-739-8339, and email: benefits@state.de.us. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Brenda Lakeman, Director of Statewide Benefits and Insurance Coverage 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 https://ocrportal.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, 800-537-7697 (TDD)

For more information about limitations and exceptions, see the plan or policy document at www.HealthReformPlanSBC.com or by calling 1-877-542-3862.

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

Language Access Services:

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

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

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%
- **Other:** Based on type of service

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$30
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,830**

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%
- **Other:** Based on type of service

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$600
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,400**

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%
- **Other:** Based on type of service

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

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.

12.6.2011

STATE OF DELAWARE — OFFICE OF MANAGEMENT AND BUDGET — STATEWIDE BENEFITS OFFICE

AETNA — Enrollment/Change Request Form

A. REASON FOR APPLICATION

☐ New coverage
☐ Change coverage
☐ Information change
☐ Waive coverage
Date of event checked: _____

ADD DEPENDENTS DUE TO:
☐ Marriage/Civil Union ☐ Non-voluntary coverage loss
☐ Birth ☐ Other
☐ Adoption/Guardianship
Date of event checked: _____

TERM DEPENDENTS DUE TO:
☐ Divorce ☐ Death
☐ Over age ☐ Other
☐ No longer dependent
Date of event checked: _____

REINSTATE COVERAGE DUE TO:
☐ Administrative error
☐ Other
Date of event checked: _____

B. PERSONAL INFORMATION

☐ Male ☐ Female	Social Security Number	**Employer**	Employer Group Number:

Last Name	First Name	M.I.	Date of Birth (month, day, year)	Home Phone (include area code)	Business Phone (include area code)

Street Address	City	State	Zip Code

C. HEALTH CARE COVERAGE CHOICES

COVERAGE IS FOR: ☐ Employee ☐ Employee & Spouse ☐ Employee & child (ren) ☐ Family

CHOOSE ONE: ☐ Aetna HMO ☐ Aetna CDH Gold ☐ Aetna HMO COBRA ☐ Aetna CDH Gold COBRA

D. ELIGIBLE DEPENDENTS TO BE C OVERED / PRIMARY CARE PHYSICIAN SELECTION

If you select Aetna HMO complete all of the below information. If you Select Aetna CDH Gold you do not need to provide Primary Care Physician information.

If more space is needed to list dependents, please use a separate sheet of paper and attach it to this application.

Name of Your Primary Care Physician	Physician's ID Number	Is this your current physician? ☐YES ☐NO

☐Add ☐Change ☐Remove	Spouse's First Name	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Spouse's Social Security Number	Spouse's Primary Care Physician	Physician's ID Number	Spouse's current physician? ☐Y ☐N
☐Add ☐Change ☐Remove	Dependent's First Name ☐ Fulltime student ☐Male ☐ Handicapped ☐Female	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? ☐Y ☐N
☐Add ☐Change ☐Remove	Dependent's First Name ☐ Fulltime student ☐Male ☐ Handicapped ☐Female	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? ☐Y ☐N

E. OTHER COVERAGE INFORMATION

Anyone covered by other health insurance? ☐I am ☐My spouse ☐ My dependent child(ren)	If YES, and the coverage is through an employer, list name of employer below: If covering a spouse you must go online at www.ben.omb.delaware.gov/documents/cob and complete a Coordination of Benefits form.	Name and Location of Other Insurance Company

F. CONDITIONS OF ENROLLMENT Applicant Acknowledgments and Agreements

On behalf of myself and dependents listed, I agree to or with the following: 1) I acknowledge that by enrolling in the following plans, coverage is underwritten or administered by the following entities (collectively referred to as "Aetna"):

- HMO
- HMO COBRA
- CDH Gold Plan
- CDH Gold COBRA

2) I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage. 3) I understand and agree that this Enrollment/Change Request may be transmitted to Aetna or its agent by my employer or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers") to give Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this Enrollment/Change Request form, including those involving mental health, substance abuse and HIV/AIDS. I further authorize Aetna to use such information and to disclose such information to affiliates, providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse and competent adult dependents and I have obtained their consent to those terms. I understand that this authorization is provided under state law and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand that I am entitled to receive a copy of this authorization upon request and that a copy is as valid as the original. 4) The plan documents (Schedule of Benefits, Group Agreement, Certificate of Coverage, Group Policy, Group Insurance Certificate) will determine the rights and responsibilities or other description of the plan. 5) I understand and agree that, with certain exceptions described in the plan documents, HMO plans only provide coverage for referred benefits, and that, in order to be covered, services must be performed either by a participating primary care physician, or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by a referral from a participating primary care physician.

Misrepresentation: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I ELECT to participate in the State Plan and do agree to the above terms.

Signature: _____ Date: _____

I elect **NOT** to participate in the State Plan.

Signature: _____ Date: _____

State of Delaware: Highmark First State Basic

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/2016 - 06/30/2017

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

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.highmarkbcbsde.com** or by calling **1-844-459-6452.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: **$500** person/ **$1,000** family; Out-of-Network: **$1,000** person/ **$2,000** family. Doesn't apply to preventive care, prescription drugs or any service with a copay.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-Network Medical: **$2,000** person/**$4,000** family; In-Network Prescription Drug: **$2,100** person/**$4,200** family. Out-of-Network Medical: **$4,000** person/**$8,000** family; Out-of-Network Prescription Drug: No out-of-pocket limit.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billing, health care this plan does not cover, bariatric surgery expenses and infertility expenses.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.

Does this plan use a network of providers?	Yes. For a list of in-network **providers**, see **www.highmarkbcbsde.com, call 1-844-459-6452**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	30% coinsurance	-- None --
	Specialist visit	10% coinsurance	30% coinsurance	-- None --
	Other practitioner office visit	10% coinsurance for Chiropractic Care	25% coinsurance for Chiropractic Care	Coverage is limited to 30 visits per plan year for chiropractic care.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Preventive care/screening/immunization	No charge	30% coinsurance	Coverage is limited by age, gender and risk parameters as identified in Highmark Delaware's Preventive Health Guidelines. Refer to **www.highmarkbcbsde.com** or call **1-800-633-2563** for specific information.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	-- None --
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Prior authorization required. Failure to pre-authorize will result in a denial.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com.	Generic drugs	$8 copay for 30-day supply retail or mail order; $16 copay for 90-day supply participating retail or mail order	Reimbursement limited to in-network allowable amount minus applicable copay	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 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.
	Preferred brand drugs	$28 copay for 30-day supply retail or mail order; $56 copay for 90-day supply participating retail or mail order	Reimbursement limited to in-network allowable amount minus applicable copay	
	Non-preferred brand drugs	$50 copay for 30-day supply retail or mail order; $100 copay for 90-day supply participating retail or mail order	Reimbursement limited to in-network allowable amount minus applicable copay	
	Specialty drugs	Copay based on whether drug is generic, preferred, or non-preferred	Not covered	First fill can be at retail; future fills must be through specialty pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	-- None --

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Physician/surgeon fees	10% coinsurance	30% coinsurance	-- None --
If you need immediate medical attention	Emergency room services	10% coinsurance	10% coinsurance	Care must be rendered within 48 hours of onset of symptoms.
	Emergency medical transportation	10% coinsurance	30% coinsurance	-- None --
	Urgent care	$25 copay	$25 copay	-- None --
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Pre-authorization required. Failure to preauthorize will result in a denial.
	Physician/surgeon fee	10% coinsurance	30% coinsurance	Pre-authorization required. Failure to preauthorize will result in a denial.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	30% coinsurance	-- None --
	Mental/Behavioral health inpatient services	10% coinsurance	30% coinsurance	Pre-authorization required. Failure to preauthorize will result in a denial.
	Substance use disorder outpatient services	10% coinsurance	30% coinsurance	-- None --
	Substance use disorder inpatient services	10% coinsurance	30% coinsurance	Pre-authorization required. Failure to preauthorize will result in a denial.
If you are pregnant	Prenatal and postnatal care	10% coinsurance	30% coinsurance	-- None --
	Delivery and all inpatient services	10% coinsurance	30% coinsurance	-- None --
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Limited to 240 visits per plan year. Preauthorization required. Failure to preauthorize will result in a denial.
	Rehabilitation services	10% coinsurance	30% coinsurance	Applied behavioral analysis (ABA) limited to $36,000 per person per plan year to age 21.
	Habilitation services	Not covered	Not covered	You must pay 100% of these expenses, even in-network.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Skilled nursing care	10% coinsurance	30% coinsurance	Limited to 120 days per benefit period. Benefits renew after 180 days without care. Pre-authorization required. Failure to pre-authorize will result in a denial.
	Durable medical equipment	10% coinsurance	30% coinsurance	-- None --
	Hospice service	10% coinsurance	30% coinsurance	Coverage is limited to 365 days.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	You must pay 100% of these expenses.
	Glasses	Not covered	Not covered	You must pay 100% of these expenses.
	Dental check-up	No charge under Delta Dental or Dominion Dental	20% coinsurance under Delta Dental; not covered under Dominion Dental	Delta Dental: $1,500 maximum per person per plan year; Dominion Dental: no maximum.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Eye exam
- Glasses
- Habilitation services
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Dental care (Adult)
- Hearing aids (up to age 24)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-844-459-6452. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Highmark Blue Cross Blue Shield Delaware at 1-844-459-6452 or www.highmarkbcbsde.com. Additionally, a consumer assistance program can help you file an appeal. Contact The Delaware Department of Insurance/Consumer Assistance Program, 841 Silver Lake Blvd., Dover, DE 19904 or 302-674-7300 (local), 1-800-282-8611 (toll free) or consumer@state.de.us.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-844-459-6452.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-459-6452.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-844-459-6452.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-459-6452.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,220
- **Patient pays** $1,320

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$10
Coinsurance	$660
Limits or exclusions	$150
Total	**$1,320**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,350
- **Patient pays** $1,050

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Copays	$320
Coinsurance	$190
Limits or exclusions	$40
Total	**$1,050**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

State of Delaware: Highmark Comprehensive PPO

Coverage Period: 07/01/2017 - 06/30/2018

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

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

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 health care 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.highmarkbcbsde.com** or by calling **1-844-459-6452**. 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.highmarkbcbsde.com** or by calling **1-844-459-6452** to request a copy

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: **$0**; Out-of- Network: **$300** person/**$600** family. Doesn't apply to preventive care, copayments or prescription drugs. Balance billing and excluded services do not count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. 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.
Are there services covered before you meet your deductible?	Yes. Preventive care services	This plan covers preventive care services, even if you have not met the deductible amount. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit for this plan?	Yes. In-Network Medical: **$4,500** person/**$9,000** family; In-Network Prescription Drug: **$2,100** person/**$4,200** family. Out-of-Network Medical: **$7,500** person/**$15,000** family; Out-of-Network Prescription Drug: No out-of-pocket limit.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billing, health care this plan does not cover, bariatric surgery expenses and infertility expenses.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

Will you pay less if you use a network provider?	Yes. For a list of in-network **providers**, see **www.highmarkbcbsde.com, call 1-844-459-6452**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.

All **copayment** and **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 health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay	20% coinsurance	-- None --
	Specialist visit	$30 copay	20% coinsurance	-- None --
	Preventive care/screening/ immunization	No charge	20% coinsurance	Coverage is limited by age, gender and risk parameters as identified in Highmark Delaware's Preventive Health Guidelines. Refer to **www.highmarkbcbsde.com** or call **1-844-459-6452** for specific information.
If you have a test	Diagnostic test (x-ray, blood work)	Lab: $10 copay; X-Ray: $20 copay; Machine Testing: No Charge	20% coinsurance	-- None --
	Imaging (CT/PET scans, MRIs)	No charge at freestanding facilities; $35 copay at hospital-based facilities	20% coinsurance	Prior authorization required. Failure to pre-authorize will result in a denial.

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com.	Generic drugs	$8 copay for 30-day supply retail or mail order; $16 copay for 90-day supply participating retail or mail order	Reimbursement limited to in-network allowable amount minus applicable copay	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 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.
	Preferred brand drugs	$28 copay for 30-day supply retail or mail order; $56 copay for 90-day supply participating retail or mail order	Reimbursement limited to in-network allowable amount minus applicable copay	
	Non-preferred brand drugs	$50 copay for 30-day supply retail or mail order; $100 copay for 90-day supply participating retail or mail order	Reimbursement limited to in-network allowable amount minus applicable copay	
	Specialty drugs	Copay based on whether drug is generic, preferred, or non-preferred	Not covered	First fill can be at retail; future fills must be through specialty pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Outpatient Hospital: $100 copay per visit; Ambulatory Surgery Center: $50 copay per visit	20% coinsurance	-- None --
	Physician/surgeon fees	No charge	20% coinsurance	-- None --
If you need immediate medical attention	Emergency room care	$150 copay (waived if admitted)	$150 copay (waived if admitted)	Care must be rendered within 48 hours of onset of symptoms.
	Emergency medical transportation	No charge	No charge	-- None --
	Urgent care	$20 copay per day	20% coinsurance	-- None --

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 hospital stay	Facility fee (e.g., hospital room)	$100 copay per day with $200 maximum per admission	20% coinsurance	Pre-authorization required. Failure to preauthorize will result in a denial.
	Physician/surgeon fees	No charge	20% coinsurance	Pre-authorization required. Failure to preauthorize will result in a denial.
If you have mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay	20% coinsurance	-- None --
	Inpatient services	$100 copay per day with $200 maximum per admission	20% coinsurance	Pre-authorization required. Failure to preauthorize will result in a denial.
If you are pregnant	Office visits	No charge	20% coinsurance	-- None --
	Childbirth/delivery professional services	No charge	20% coinsurance	-- None --
	Childbirth/delivery facility services	$100 copay per day with $200 maximum per admission	20% coinsurance	-- None --
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Coverage is limited to 240 visits per plan year. Pre-authorization required. Failure to pre-authorize will result in a denial.
	Rehabilitation services	15% coinsurance; No charge for applied behavioral analysis (ABA)	20% coinsurance	ABA limited to $36,000 per person per plan year to age 21.
	Habilitation services	Not covered	Not covered	You must pay 100% of these expenses, even in-network.
	Skilled nursing care	No charge	20% coinsurance	Coverage is limited to 120 days per benefit period. Benefits renew after 180 days without care. Pre-authorization required. Failure to pre-authorize will result in a denial.

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)	
	Durable medical equipment	No charge	20% coinsurance	-- None --
	Hospice services	No charge	20% coinsurance	Coverage is limited to 365 days.
If your child needs [redacted] eye care	Children's eye exam	Not covered	Not covered	You must pay 100% of these expenses, even in-network.
	Children's glasses	Not covered	Not covered	You must pay 100% of these expenses, even in-network.
	[redacted]	[redacted]	[redacted]	[redacted]

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic surgery
- Eye exam
- Glasses
- Habilitation services
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Dental care (Adult)
- Hearing aids (up to age 24)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-844-459-6452. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Highmark Blue Cross Blue Shield Delaware at 1-844-459-6452 or www.highmarkbcbsde.com. Additionally, a consumer assistance program can help you file an appeal. Contact The Delaware Department of Insurance/Consumer Assistance Program, 841 Silver Lake Blvd., Dover, DE 19904 or 302-674-7300 (local), 1-800-282-8611 (toll free) or consumer@state.de.us.

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.

Notice of Nondiscrimination

Discrimination is Against the Law

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

The State of Delaware Group Health Insurance Plan:

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

If you need these services, contact Brenda Lakeman.

If you believe that The State of Delaware Group Health Insurance Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Brenda Lakeman, Director of Statewide Benefits and Insurance Coverage, at Office of Management and Budget (OMB), Statewide Benefits, 97 Commerce Way, Suite 201, Dover, DE 19904, phone: 1-800-489-8933, fax: 1-302-739-8339, and email: benefits@state.de.us. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Brenda Lakeman, Director of Statewide Benefits and Insurance Coverage 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 https://ocrportal.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, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Access Services:

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

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

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:** $0
- **Specialist copayment:** $30
- **Hospital (facility) copayment:** $100 per day, Maximum $200 per admission
- **Other:** Based on type of service

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$460**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible:** $0
- **Specialist copayment:** $30
- **Hospital (facility) copayment:** $100 per day, Maximum $200 per admission
- **Other:** Based on type of service

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,060**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible:** $0
- **Specialist copayment:** $30
- **Hospital (facility) copayment:** $100 per day, Maximum $200 per admission
- **Other:** Based on type of service

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	**$2,000**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$30
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$230**

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

HIGHMARK Delaware

STATE OF DELAWARE APPLICATION FOR COVERAGE

FOR STATE OF DELAWARE USE ONLY

Name	Phone	Date	Group Number	Contact	Dept./Agency

A. REASON FOR APPLICATION (CHECK ALL THAT APPLY). PLEASE PRINT LEGIBLY.

☐ New coverage
☐ Change coverage
☐ Information change
☐ Refuse coverage *(see Section E)*

ADD DEPENDENTS DUE TO:
☐ Marriage/Civil Union ☐ Non-voluntary coverage loss
☐ Birth ☐ Other
☐ Adoption/Guardianship Date of event checked:

CANCEL DEPENDENTS DUE TO:
☐ Divorce/Dissolution ☐ Death
☐ Over age ☐ Other
☐ No longer dependent Date of event checked:

REINSTATE COVERAGE DUE TO:
☐ Rehire ☐ Administrative error
☐ Return from leave ☐ Other
☐ Return from layoff Date of event checked:

B. PERSONAL INFORMATION

☐ Male ☐ Retiree ☐ Non-employee ☐ Female ☐ Surviving spouse	Date of Hire/Retirement (month, day, year)	Social Security Number	Agency or School District

Last Name	First Name	M.I.	Date of Birth (month, day, year)	Home Phone (include area code)	Business Phone (include area code)

Street Address	City	State	Zip Code

C. HEALTH CARE COVERAGE CHOICES

COVERAGE IS FOR: ☐ Employee ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family
PLEASE MAKE ONE HEALTHCARE COVERAGE CHOICE: ☐ First State Basic ☐ Blue Care (IPA) *(see Section D)*
☐ Comprehensive PPO ☐ CDH Gold Plan ☐ Special Medicfill ☐ Special Medicfill without prescription
☐ **I AM 65 OR OLDER.** ☐ **MY SPOUSE IS 65 OR OVER; I AM A FULLTIME EMPLOYEE.**

MEDICARE INFORMATION:
Applicant's Medicare #: ______________________
Part A Effective Date: ______________________
Part B Effective Date: ______________________

D. ELIGIBLE DEPENDENTS TO BE COVERED / PRIMARY CARE PHYSICIAN SELECTION

If you choose Blue Care (IPA) coverage, you MUST select a primary care physician (PCP) for yourself, spouse and all eligible dependents.
If more space is needed to list dependents, please use a separate sheet of paper and attach it to this application.

Name of Your Primary Care Physician	Physician's ID Number	Is this your current physician? ☐ YES ☐ NO

☐ Add ☐ Cancel	Spouse's First Name	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Spouse's Social Security Number	Spouse's Primary Care Physician	Physician's ID Number	Spouse's current physician? ☐ Y ☐ N
☐ Add ☐ Cancel	Dependent's First Name ☐ Fulltime student ☐ Male ☐ Handicapped ☐ Female	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? ☐ Y ☐ N
☐ Add ☐ Cancel	Dependent's First Name ☐ Fulltime student ☐ Male ☐ Handicapped ☐ Female	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? ☐ Y ☐ N
☐ Add ☐ Cancel	Dependent's First Name ☐ Fulltime student ☐ Male ☐ Handicapped ☐ Female	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? ☐ Y ☐ N

ENR-196 (R4-13)

E. OTHER COVERAGE INFORMATION

Anyone covered by other health insurance? ☐ I am ☐ My spouse ☐ My dependent child(ren)	If YES, and the coverage is through an employer, list name of employer below:	Name and Location of Other Insurance Company	Transferring your coverage from another Highmark DE contract? ☐ Y ☐ N

F. TERMS OF AGREEMENT

I understand that: 1) Rights to service are subject to acceptance of this application and to the terms and conditions specified in the present contract and any future contract between my employer, association and Highmark Blue Cross Blue Shield Delaware (Highmark DE). 2) I certify that all representations and information supplied by me are true. My coverage shall be void if any or part of this application is false or incomplete. 3) I authorize my employer, as my agent, if applicable to collect the premiums by payroll deduction or otherwise, for remittance to Highmark DE, with the understanding that payment will not be complete until actually received. 4) I, on behalf of myself and my covered dependents, authorize any physician, hospital or any other health care provider to release information available to them concerning any diagnosis, treatment or other health care services they render to me or my covered dependents to Highmark DE or its designee for purposes reasonably related to this contract. 5) I, on behalf of myself and my covered dependents, authorize Highmark DE to release appropriate demographic information, diagnostic and medical conditions to other persons, entities or organizations for audits, claims processing, coordination of benefits, disease management programs, member satisfaction surveys, other party liability, utilization review, case management, quality improvement and assurance and other reasonably related purposes for the administration of this contract or as required by law. 6) If covering a spouse, you must go online at and complete a Coordination of Benefits form.

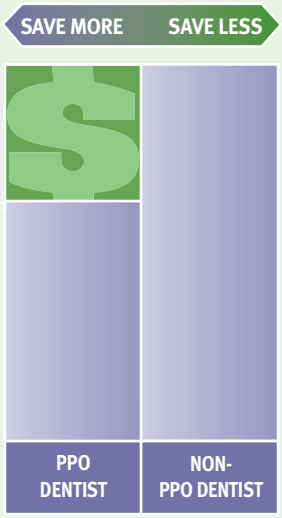
I elect not to participate in the State Health Insurance Program. Signature:	I have read and do agree to the above terms. Signature:	Date

Delta Dental PPO℠ – Easy, Friendly, Accessible

We'll do **whatever it takes and then some.**

Save with a PPO dentist

YOUR COSTS



AMOUNT YOU **SAVE**

AMOUNT YOU **PAY**

Illustration showing sample enrollee share of cost for information purposes only. Actual dentist fees and contract allowances will vary by region, procedure and group contract.

We're pleased to be your partner in maintaining great oral health. The Delta Dental PPO† plan makes it easy for you to find a dentist and control your costs when you visit a network dentist. Here are some of the great things you'll need to know about enrolling with Delta Dental:

- **Save with a PPO dentist.** Our PPO network dentists accept reduced fees for covered services, so you'll usually pay the least when you visit a PPO network dentist. Non-Delta Dental dentists may balance bill you the difference between the contracted fee and their usual fee.
- **Large dentist network.** Since Delta Dental offers access to some of the largest dentist networks in the U.S.,‡ chances are there's a wide choice of PPO dentists near your home or office. Use your desktop or mobile device to search for a dentist at deltadentalins.com.
- **Visit the dentist of your choice.** Want to visit a non-Delta Dental dentist? No problem. You can visit any licensed dentist, but your costs are usually lowest with a PPO dentist.
- **Log in to Online Services.** Check benefits, eligibility and claims status, view or print an ID card and use our "Fee Finder" tool to check average costs in your area. You can also change your Profile preference to go paperless. Use your mobile device to access many of these tools on the go; show the dental office your ID card information instead of carrying a printed card.

Visit the *SmileWay*® Wellness section of our site for dental health articles, videos, quizzes and a risk assessment tool. You can also subscribe to our free dental health e-newsletter.

† In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.
‡ Netminder Dental Network Trend Report, March 2013.

DELTA DENTAL®

A REGISTERED MARK OF DELTA DENTAL PLANS ASSOCIATION

Socialize with us: deltadentalins.com/enrollees

HL_PPO_2col #72828 (rev. 7/13)

Plan Benefit Highlights for: City of Dover

Group No: 15426 – Low Plan

DELTA DENTAL PPO℠

BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse and eligible dependent children to the end of the month that dependent turns age 19 or to age 23 if dependent is full-time student		
Deductibles	$50 per person / $150 per family each plan year		
Deductibles waived for D & P?	Yes		
Maximums	$1,000 per person each plan year		
D & P counts toward maximum?	Yes		
Waiting Period(s)	Basic Benefits None	Major Benefits N/A	Prosthodontics N/A

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays and sealants	100 %	100 %
Basic Services Fillings and simple tooth extractions	80 %	80 %
Endodontics (root canals)	0 %	0 %
Periodontics (gum treatment)	0 %	0 %
Oral Surgery	0 %	0 %
Major Services Crowns, inlays, onlays and cast restorations	0 %	0 %
Prosthodontics Bridges and dentures	0 %	0 %

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and 90th percentile for non-Delta Dental dentists.

Delta Dental of Delaware
One Delta Drive
Mechanicsburg, PA 17055

Customer Service
800-932-0783

Claims Address
P.O. Box 2105
Mechanicsburg, PA 17055-6999

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

Plan Benefit Highlights for: City of Dover

Group No: 15426 – High Plan

DELTA DENTAL PPO℠

BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse and eligible dependent children to the end of the month that dependent turns age 19 or to age 23 if dependent is full-time student		
Deductibles	$50 per person / $150 per family each plan year		
Deductibles waived for D & P?	Yes		
Maximums	$1,250 per person each plan year		
D & P counts toward maximum?	Yes		
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays and sealants	100 %	100 %
Basic Services Fillings and simple tooth extractions	80 %	80 %
Endodontics (root canals) Covered Under Major Services	50 %	50 %
Periodontics (gum treatment) Covered Under Major Services	50 %	50 %
Oral Surgery Covered Under Major Services	50 %	50 %
Major Services Crowns, inlays, onlays and cast restorations	50 %	50 %
Prosthodontics Bridges, dentures and implants	50 %	50 %

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and 90th percentile for non-Delta Dental dentists.

Delta Dental of Delaware
One Delta Drive
Mechanicsburg, PA 17055

Customer Service
800-932-0783

Claims Address
P.O. Box 2105
Mechanicsburg, PA 17055-6999

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

Monthly Premiums

Effective: July 1, 2017

Plan Name	Coverage Type	Employee Pays per Month
Delta Dental High Plan	Employee Only	$ 40.35
	Employee & One Dependent	$ 75.70
	Family	$ 119.65
Delta Dental Low Plan	Employee Only	$ 27.24
	Employee & One Dependent	$ 52.33
	Family	$ 98.07

Premiums for dental coverage are deducted from second paycheck of the month.

Eligible dependent children are covered to the end of the month that dependent turns age 19 or to age 23 if dependent is full-time student. Child/Student Status Form along with a copy of college transcript is required to verify student status.

Enrollment/ Change Form

DELTA DENTAL

One Delta Drive, Mechanicsburg, PA 17055
(800) 932-0783
TTY/TDD (888) 373-3582
deltadentalins.com

Please check the applicable box or boxes.

- ☐ New enrollment
- ☐ COBRA
- ☐ Coverage change
- ☐ Name change
- ☐ Address change
- ☐ Change of dependents
- ☐ Termination
- ☐ Decline Coverage

Please check the applicable box or boxes.

- ■ Delta Dental PPO Plus Premier
  - ☐ High Plan
  - ☐ Low Plan

Please check the Delta Dental plan that administers your dental benefits.

- ☐ Delta Dental of Pennsylvania
- ☐ Delta Dental of New York
- ☐ Delta Dental Insurance Company
- ■ Delta Dental of Delaware
- ☐ Delta Dental of West Virginia

Primary Enrollee Social Security Number	Last Name	First Name	MI	Date of Birth	Gender
					☐ Male ☐ Female

Alternate Identification Number *(if applicable)*

Address (Is this a change of address? ☐ Yes ☐ No)
Street City State Zip Code

Group Number	Sublocation	Group Name
15426		CITY OF DOVER

Change of Coverage

New Coverage: Former Coverage:

Name Change

From: To:

Dependent Change

Please check one of the boxes: ☐ Add dependent(s) listed below ☐ Delete dependent(s) listed below

Do you or your dependents have other dental coverage?

☐ Yes ☐ No *If yes, please complete the following:*

Carrier Name and Address: _____

Group Number: _____

Last name (if different)	First Name	MI	Gender	Date of Birth	Social Security Number
Spouse			M F		
Children			M F		
			M F		
			M F		
			M F		
			M F		

Date of Hire:

Effective Date:

Primary Enrollee Signature _____

SUBMIT

Any person who knowingly and with intent to defraud any insurance company or any other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. Enrollees whose company is headquartered in the state of New York and who commit a fraudulent insurance crime shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

VBA Vision makes using your benefits simple and easy.

Step 1

Go to **www.vbaplans.com**, log in to your account then click on “Am I Eligible.”

Step 2

If you are eligible, click on “Find A Doctor” at the top of the page. From there you can fill in your zip code and find a doctor close to you.

Step 3

Go to your appointment and let your doctor know that you have a VBA Vision plan. During your appointment, your doctor will give you an exam, order your materials, make sure your lenses are made correctly, and dispense your prescription.

Step 4

Relax—we’ve got you covered! VBA Vision will pay your doctor for covered exams, lenses, and frames.

If your doctor is not within the VBA network, requesting reimbursement is simple.

To request reimbursement for services provided by an out-of-network provider, go to **www.vbaplans.com**, download and complete a reimbursement form, attach all receipts and mail or fax to the address below.

This sheet is for information only and does not guarantee benefits.

300 Weyman Road, Suite 400
Pittsburgh, PA 15236
1-800-432-4966
Fax: 412-881-4898
www.vbaplans.com

vba

Expert Solutions.
Exceptional Service.

Monthly Premiums as of July 1, 2017

Premiums for vision coverage are deducted from the first paycheck of the month.

Employee Only	$0.00
Employee & Child(ren)*	$4.09
Employee & Spouse	$3.97
Family	$8.21

** Children between the ages of 19 -25 are considered eligible dependents provided they are enrolled as a full-time student in an accredited school, college or university and are soley dependent upon the employee for support.*

Child/Student Status Form along with a copy of college transcript is required to verify student status.

VISION BENEFITS OF AMERICA **City of Dover**

ENROLLMENT FORM **VBA # 087**

COVERAGE EFFECTIVE DATE _____ _____ _____

INSTRUCTIONS FOR EMPLOYEE:

1. COMPLETE SECTION BELOW AND SIGN.
2. RETURN COMPLETED FORM TO YOUR BENEFITS OFFICE.

EMPLOYEE SOCIAL SECURITY NUMBER _____

EMPLOYEE NAME _____ BIRTHDATE ____/____/____

ADDRESS _____

CITY _____ STATE_____ZIP CODE _____ _____

PLEASE LIST ALL FAMILY MEMBERS TO BE COVERED:

FIRST NAME MIDDLE INITIAL LAST NAME BIRTHDATE

SPOUSE _____

CHILD _____

CHILD _____

CHILD_____

CHILD_____

STUDENT INFORMATION (COMPLETE FOR DEPENDENTS WHO ARE ENROLLED **AS FULL-TIME COLLEGE STUDENTS**.)

STUDENTS NAME NAME OF SCHOOL OR UNIVERSITY

_____

_____

ANY HANDICAPPED CHILD COVERED ON MEDICAL?

CHILD NAME

_____

EMPLOYEE SIGNATURE _____ DATE _____ _____ _____

Submit

Child/Student Overage Status Form
Vision & Dental Coverage

Employee/Retiree Name: _____

Last Four Digits of Social Security #: _____ **Date of Birth:** _____

Dependent Name: _____

Last Four Digits of Social Security _____ **Date of Birth:** _____

Are you currently a student: If no, please sign at the bottom & return form to address noted at the bottom of the page. ☐ **Yes** ☐ **No**

Name of School: _____ **Date Began Attending:** _____

Please provide a copy of one of the following documents as proof of student status.

Registration Form (*for current enrollment period)* ☐ **Transcript** ☐

By signing this form you acknowledge all of the information provided above is true and accurate.

Employee/Retiree Name _____ **Dependent Name** _____

Employee/Retiree Signature _____ **Dependent Signature** _____

Please return completed form to:
City of Dover
ATTN: Human Resources Department
P.O. Box 475,
Dover, DE 19903-0475
Fax: (302) 736-7093

Voluntary Life Insurance Options

This is your open enrollment period for Voluntary Permanent Life Insurance and Voluntary Term Insurance!

Transamerica Universal Life Insurance (Permanent Life Insurance)

Universal Life rates are projected to stay the same throughout the life of your policy. Other insurance plans (such as term life) increase in price on a regular basis.

- Guaranteed insurance benefits among the highest in the industry
- Benefit Flexibility – select what fits your budget
- Cash Value Accumulation account enables policy flexibility
- Portability – Keep the plan if you leave your employer with no change in the rate
- Ability to purchase insurance on dependents
- Includes Accidental Death and Dismemberment, which doubles your insurance in the event of an accidental death*

Guaranteed Acceptance

No Medical Questions for Newly Eligible Employees!**

Employee - $150,000

Spouse - $15,000

Child - $25,000

** hired since 6/1/2016

Example Rates:

Age	Non-Tobacco			Tobacco		
	Weekly Expense	Benefit Amount	Projected Cash Value @ Age 65*	Weekly Expense	Benefit Amount	Projected Cash Value @ Age 65*
30	$6.00	51,460	$8,421	$6.00	$35,788	$8,285
40	$6.00	$35,649	$5,031	$6.00	$23,481	$4,583
50	$6.00	$22,435	$2,247	$6.00	$14,270	$1,859

*Accidental Death and Dismemberment is available to employees under age 70

[redacted]

TRANSAMERICA LIFE INSURANCE COMPANY

Transamerica Life Insurance Company *("Insurer")*
Home Office: Cedar Rapids, IA
Administrative Office: P.O. Box 8063
Little Rock, AR 72203-8063

TransElite Universal Life Application

☐ First Application ☐ Add Dependents – Contract # _____ ☐ Increase Coverage – Contract # _____

Group Name | Group Number | Location

Applicant Information

Name *(Last, First, M.I.)*	☐ Male ☐ Female	Social Security No.	Date of birth	Cell or home phone
Home address		City	State	Zip code
Email address	Do you agree to receive correspondence about your coverage electronically? ☐ Yes ☐ No		Tobacco user in the last year? ☐ No ☐ Yes *Answer if rates are tobacco distinct.*	
Date of hire / Weekly hours worked	Annual salary	Occupation	Applicant ID	Work phone/ext.

Protection against unintended lapse: I understand I have the right to designate at least one person other than myself to receive notice of lapse or termination of this coverage for nonpayment of premium. I understand notice will not be given until thirty days after premium is due and unpaid.
☐ I elect **NOT** to designate any person to receive such notice.

Secondary Addressee Name	Home Address	City	State	Zip code

Dependent Information

Name *(Last, First, M.I.)*	Gender	Relationship to applicant	Date of birth	Social Security No.	Tobacco user in the last year? *Answer for Spouse or Civil Union/Domestic Partner**
	☐ M ☐ F				☐ No ☐ Yes
	☐ M ☐ F				
	☐ M ☐ F				
	☐ M ☐ F				
	☐ M ☐ F				

Beneficiary

Name *(Last, First, M.I.)*	Address	Relationship	Phone #	Social Security No.
Primary				
Contingent				

Applicant will be the beneficiary for any dependent coverage

Benefit Selections

Premium Mode: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other _____

Universal Life

☐ **TransElite Universal Life** Option: ☐ A (level) ☐ B (increasing)	Universal Life Face Amount	Automatic Increase Option Rider	Premium
☐ Applicant	$	☐ Yes ☐ No	$
☐ Spouse or Civil Union/Domestic Partner	$	☐ Yes ☐ No	$
☐ Children	$		$
			$

*Attach Child Term Rider to ☐ Applicant ☐ Spouse or Civil Union/Domestic Partner

Term Rider* Face Amount	Premium
$	$
$	$
$	$
	$

Dependents can be covered under UL or Term Rider, but not both

Total Premium $

Life Insurance Owner (if different than Applicant)	Address	Relationship	Social Security No.

**The terms "Civil Union" or "Domestic Partner" are not recognized in all states.*

Eligibility Questions

1. *Employer Groups:* Are you actively at work on a full-time basis and able to perform the duties of your occupation? *Member Groups:* Are you a member in good standing and able to perform the normal activities of someone of like age? If "no", you and your dependents are not eligible for coverage.	☐ No ☐ Yes
2. If applying for dependent coverage, is any proposed insured currently disabled? If "yes", list names _____, who are not eligible for coverage.	☐ No ☐ Yes

If you answer "no" to question #1, no coverage will be issued. Anyone named as being ineligible on question 2 will be automatically excluded from coverage.*
**Residents of MD and NH cannot be automatically excluded - You must sign an endorsement form acknowledging these exclusions before coverage can be issued.*

Evidence of Insurability Questions Part 1: Please answer the following questions to the best of your knowledge and belief.	
3. In the past six months, has any proposed insured been hospitalized (inpatient or outpatient) or missed more than five consecutive days of work due to any accident or sickness, except for normal pregnancy? If "yes", list names _____, who do not qualify for coverage.	☐ No ☐ Yes
4. In the past five years, has any proposed insured had an actual diagnosis or treatment by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ***(Residents of CA: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.)*** ***(Residents of FL:*** In the past five years, has any proposed insured been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? If "yes", list names _____, who do not qualify for coverage.	☐ No ☐ Yes

Anyone named as not qualifying for coverage will have coverage reduced to the Guaranteed Issue amount, or, if Guaranteed Issue is not available, will be excluded from coverage.*
**Residents of MD cannot be automatically excluded – You must sign an endorsement form acknowledging these exclusions before coverage can be issued.*

Evidence of Insurability Questions Part 2: Please answer the following questions to the best of your knowledge and belief.	
5. Indicate Height and Weight: Applicant	/
Spouse or Civil Union/Domestic Partner	/
6. In the past five years, has any proposed insured been diagnosed or treated by a member of the medical profession for any heart (including heart attack), circulatory, vascular (including stroke), blood, brain, digestive, kidney, liver, lung, musculoskeletal, respiratory, rheumatoid, neurological, pancreas, reproductive, or other major organ disorders, cancer or malignancy in any form (except non-melanoma skin cancer), diabetes, Optic Neuritis, blood transfusion, chronic fatigue syndrome, fibromyalgia, high blood pressure requiring more than two medications to control, or been treated or counseled in the past two years for alcohol or drug abuse? ***(Residents of FL:*** *diagnosed or treated by a licensed physician)* ***(Residents of ME:*** *exclude HIV related diseases)* If "yes", list names _____, who do not qualify for coverage.	☐ No ☐ Yes

Anyone named as not qualifying for coverage will have coverage reduced to the Guaranteed Issue amount, or, if Guaranteed Issue is not available, will be excluded from coverage.*
**Residents of MD cannot be automatically excluded - You must sign an endorsement form acknowledging these exclusions before coverage can be issued.*

For further consideration for anyone who fails to qualify for coverage above, provide details of all "yes" answers to questions 2, 3, 4, & 6.
(Residents of FL: *Do NOT provide details regarding "yes" answers to question 4)*
Anyone found to be acceptable will be added to your coverage via an endorsement.

Question #	Name	Please list: Illness, Injury, Condition, Medication, Date of last Treatment, Date Condition Diagnosed, Duration, Result, Current Health Status, Prognosis, Name & Address of Doctor or Hospital. For High Blood Pressure, please indicate most recent blood pressure reading, name of any medications and dosage.

Life Replacement

Residents of AL, AK, AZ, CO, HI, IA, LA, MD, ME, MS, MT, NC, NE, NH, NJ, NM, OH, OR, RI, SC, SD, TX, UT, VA, VT, WI, or WV:
Answer question L1. If "yes", complete a life replacement form for your state and return with this application.

Residents of AR: Answer questions L1 and L2. If "yes" to question L2, complete a life replacement form for your state and return with this application.

Residents of all other states: Answer question L2. If "yes", complete a life replacement form for your state and return with this application.

L1. Do you currently have any other existing life insurance policies or contracts? ☐ No ☐ Yes

L2. Is the insurance being applied for intended to replace or change any existing life insurance coverage? ☐ No ☐ Yes (provide details)

Which product(s)	Name of existing insurance company	Policy/certificate #

Universal Life and Whole Life Illustration Acknowledgement

I certify that a life insurance illustration showing non-guaranteed values was not used during the sale of the insurance coverage I am applying for on this application. I understand that if my application is approved, an illustration conforming to the policy/certificate as issued will be delivered to me no later than when I receive my policy/certificate. I understand that any non-guaranteed elements contained in any illustration are subject to change and could be either higher or lower and that they are not guaranteed. I will review the illustration, sign the acknowledgment, and will return a copy of the signed illustration to the Insurer.

Life Accelerated Death Benefit Disclosure Acknowledgement

If applying for an Accelerated Death Benefit Rider, did you receive the applicable Disclosure, if required in your state?
ADB for Chronic Condition Rider ☐ Yes ☐ No ADB for Critical Condition Rider ☐ Yes ☐ No ADB for Terminal Condition Rider ☐ Yes ☐ No

Applicant Statement and Agreement

I **have** read or had read to me the completed application. **I represent** ***(Residents of MN and VA: I certify)*** that all statements and answers made on or attached to this application are true to the best of my knowledge and belief. I **realize** that any false statements herein which materially affect the acceptance of the risk or the hazard assumed may result in loss of coverage under the policy/certificate to which this application is attached.

AL, DC, LA, & RI: **Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

CA: **I understand that any false statement made with actual intent to deceive or which materially affects either the acceptance of the risk or the hazard assumed could bar the right to receive benefits under the policy to which this application is attached.**

FL: **I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.**

KS: **Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud as determined by a court of law.**

KY: **Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, any information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.**

MA, NC & OR: **I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, any information concerning any fact material thereto, commits a fraudulent insurance act which may be a crime and may subject such person to criminal and civil penalties.**

MD: **Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

NJ: **I understand that any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.**

OK: **Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.**

TN & WA: **It is a crime to knowingly present false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.**

VA: **I understand that any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.**

VT: **I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, any information concerning any fact material thereto, may be committing a fraudulent insurance act which may be a crime subject to criminal and civil penalties.**

***ME* and all other states**: **Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

I understand that completion of this application in no way implies that I will be accepted for insurance coverage. **I understand** that coverage will take effect only if this application is approved by the Insurer and the first month's premium has been received by the Insurer, provided that I meet any eligibility or coverage effective date requirements listed in the policy/certificate to which this application is attached.

Signed in (City/State) _____ Date: _____

Signatures _____ _____

Applicant Adult Dependents (where required)

Licensed Agent/Representative Statement and Agreement

I **certify** that I have accurately recorded on this application all of the information supplied by the applicant. The applicant has read or had read to him/her the completed application.

I **certify** that this insurance does not replace or change any existing life insurance coverage, except as noted under Life Replacement.

***(For applications written in North Carolina** – To the best of your knowledge, does any applicant currently have any other existing life insurance policies or contracts? ☐ No ☐ Yes If yes, be sure the applicant completes a life replacement form for your state and return with this application.*

***(For applications written in Utah – I certify** that I am not aware of any existing life insurance coverage, except as noted under Life Replacement.)*

I **certify** that a life insurance illustration **was not** used in connection with this application (but a company-provided rate sheet may have been used and no non-guaranteed values were shown to the applicant)

I **certify** that I have provided any applicable outline of coverage and life accelerated death benefit disclosure forms.

Name _____ Signature _____ Agent # _____ License # _____

Authorization to Release Information

I **hereby authorize** any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, the Medical Information Bureau*, or other organization, institution or person, that has any records or knowledge of me or my health, to give to Insurer, or its reinsurers, any such information.

***Residents of MN**: This authorization excludes the release of information about HIV (AIDS Virus) tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. Emergency medical personnel includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards (including security guards at the Minnesota security hospital) who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency or while an injured person is being transported to receive medical care and who would qualify for immunity under the good Samaritan Law.*

I **hereby authorize** Transamerica Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to the Medical Information Bureau*. **I understand** the information obtained by use of this Authorization will be used by Insurer to determine eligibility for insurance. Any information obtained will not be released by Insurer to any person or organization except to reinsuring companies, the Medical Information Bureau*, or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I authorize. I **know** that I, or any person authorized by me, may request to receive a copy of this Authorization. I **agree** that a photographic copy of this Authorization shall be as valid as the original. I **agree** that this Authorization shall be valid for 24 months from the date shown below. *(**Residents of MN: I agree** that this Authorization shall be valid as long as any proposed insured is continually insured with Transamerica Life Insurance Company.)* I understand that I may revoke this authorization at any time by sending written notice to Transamerica Life Insurance Company.

Signed in (City/State) _____ Date: _____ Signatures _____ _____
Applicant Adult Dependents

*Information regarding your insurability will be treated as confidential. The Insurer, or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642 for hearing impaired). Insurer, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

UNUM Voluntary Group Term Life Insurance

- An affordable option for an untimely death
- Portability and Conversion
- Ability to purchase insurance on dependents
- Accelerated Benefit Amount: 50% to $750,000

A Closer Look at Guarantee Issue Coverage

Guarantee Issue Amounts:

- **Employee:** $150,000
- **Spouse:** $25,000
- **Child(ren):** $10,000

How Guarantee Issue Works:

- **If you or your eligible dependents *are currently enrolled* in coverage:** now is your chance to increase your life coverage up to the GI amounts above ***without answering any medical questions***. Any life insurance coverage over the guaranteed amount(s) will be subject to medical questions.
- **If you or your eligible dependents *are not currently enrolled* in coverage:** you may apply for coverage during the annual enrollment and will be required to answer health questions for ***any*** amount of coverage.
- [redacted]

Need a packet? Please contact your Human Resources Department.

Have questions? Please contact Jan Marie Dysart –

800-724-6369 extension 115

unum

GROUP INSURANCE ENROLLMENT FORM
Unum Life Insurance Company of America
2211 Congress Street, Portland, ME 04122

Please print legibly and complete this form in its entirety. Blank fields will cause significant delays in processing.

Policyholder Name | **Policy No.** | **Division No.**

Employee Social Security Number | **Gender** M F | **Date of Birth** (mm/dd/yyyy) | **Hours Worked Per Week**

Employee First Name | **M.I.** | **Last Name**

Employee Street Address | **City** | **State** | **Zip Code**

Original Date of Hire | **Annual Salary** $ | **Occupation**

Exempt Non-Exempt

Date entered into an eligible class ***(ex: part time to full time)*** **or**
Rehire Date or
Date of promotion to an eligible class

Spouse First Name (if coverage is selected) | **Spouse Date of Birth** (mm/dd/yyyy)

COVERAGE ELECTIONS: Your employer will inform you of available coverage. Check yes to enroll; check no if you decline or coverage is not available.

Life/AD&D Yes No **Dependent Life** Yes No **LTD** Yes No **STD** Yes No

AMOUNT OF COVERAGE SELECTED FOR:

LIFE/AD&D You: $ Spouse: $ Child: $

Note: If you have chosen coverage over the Guarantee Issue amount for you or your spouse, you will also need to complete an Evidence of Insurability form. The amount of coverage over your Guarantee Issue amount will be subject to medical underwriting and will become effective on the first of the month coincident with or next following the date Unum approves your Evidence of Insurability form. If you **DO NOT APPLY FOR** coverage for you or your dependent (s) during your or their initial enrollment period, you will need to complete an Evidence of Insurability form for all amounts of coverage. You may complete and electronically submit an Evidence of Insurability form—please see your Plan Administrator.

Beneficiary Information:

Name (last name, first, middle initial):	**Relation to You:**	**Benefit %:**
If the beneficiary(ies) named above are not living, then pay:		

Request for Signature and Certification: I understand that my coverage may be subject to exclusions, limitations, delayed effective dates and benefit offsets, as described in the enrollment materials or employee booklet(s) that have been provided to me by my employer. I certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available to me at my request. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change.

Employee Signature | *Date* | *Work Phone* | *Home Phone*

Fred Wilson
AFLAC Insurance Agent
Phone: (302) 858-8719
frederick_wilsoniii@us.aflac.com

Now More Than Ever

Aflac®

INDIVIDUAL POLICIES

1-in-8
people seek medical attention for an injury each year.[1]

Short-Term Disability

Provides you with a source of income if you're disabled due to an accident or illness.

In Idaho, Short-Term Disability policy A57600IDR. In Oklahoma, Short-Term Disability policies A57600OK and A57600LBOK. In Idaho and Oklahoma, Life policies ICC1368100 through ICC1368400.

$17,553
was the average facility price for a hospital stay in 2013[2]

Hospital Confinement Indemnity

Eases the financial burden of hospital stays due to an accident or illness by providing cash benefit.

In Idaho, Hospital Confinement Indemnity policies A49100ID—A49400ID, A4910HID. In Oklahoma, Hospital Confinement Indemnity policies A49100OK—A49400OK, and A4910HOK. In Idaho, Dental policies A82100RID—A82400RID. In Oklahoma Dental, policies A82100ROK—A82400ROK. In Idaho, Vision policy VSN100ID. In Oklahoma, Vision policy VSN100OKR.

1-in-2
The lifetime risk of U.S. men for developing cancer. For women the risk is a little more than one-in-three.[3]

Accident

Reduces the financial impact of an accident by providing cash benefits.

Cancer/Specified-Disease

Helps with the costs of cancer treatment.

Critical Illness (Specified Health Event)

Helps with the costs of treatment if you experience a covered health event, such as a heart attack, stroke, or paralysis.

Aflac Plus Rider

Pays a lump sum benefit amount along with additional benefits when you are diagnosed with a covered health event.

Contact Fred Wilson by May 20th to discuss obtaining the Aflac products of your choice!

AFLAC CANCELLATION NOTICE

Date: _____

I, _____, do hereby request cancellation
(printed name of insured)

of my _____ Policy _____.
(type of policy) (policy number)

I, _____, do hereby request cancellation
(printed name of insured)

of only my _____ rider on my
(type of rider)

_____ policy, Policy No. _____.
(type of policy) (policy number)

Please make this cancellation effective _____.
(date)

Insured's signature: _____

Insured's SSN: _____

Associate/Agent: _____
(name and writing number)

American Family Life Assurance Company of Columbus (Aflac)
Worldwide Headquarters • Columbus, Georgia 31999
1.800.992.3522 telephone • 1.800.448.8922 fax • aflac.com