State of Delaware Health Plan Comparison Chart
(Effective July 1, 2021)

Plan Options	Highmark Delaware First State Basic Plan		Aetna CDH Gold Plan		Aetna HMO Plan		Highmark Delaware Comprehensive PPO Plan	
Plan Type	Preferred Provider Organization (PPO)		Preferred Provider Organization (PPO)		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	30% coinsurance, not subject to deductible	100% covered, not subject to deductible	30% coinsurance after deductible	100% covered	Not covered	100% covered	20% coinsurance 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	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	100% covered after $25 initial copay (inpatient room and board copays do apply to hospital deliveries/ birthing centers)	Not covered	100% covered (inpatient room and board copays do apply to hospital deliveries/birthing centers)	20% coinsurance after deductible
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 (in-person or virtual)	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	$15 copay per visit	Not covered	$20 copay per visit	20% coinsurance after deductible
Telemedicine (Virtual Doctor Visits)	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	$0 copay per visit for acute issues or behavioral health visits using a Teladoc provider $25 copay per visit for Dermatology using a Teladoc provider	Not covered	$0 copay per visit for acute issues using a Doctor on Demand or Amwell provider $0 copay per visit for behavioral health visits using an Amwell provider	20% coinsurance after deductible

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Plan Feature	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Urgent Care Visit	100% covered after $25 copay per visit	100% covered after $25 copay per visit	10% coinsurance after deductible	30% coinsurance after deductible	$15 copay per visit	Not covered	$20 copay per visit	20% coinsurance after deductible
Emergency Room	10% coinsurance after deductible	10% coinsurance after deductible	10% coinsurance after deductible	10% coinsurance after deductible	$200 copay per visit (waived if admitted)	$200 copay per visit (waived if admitted)	$200 copay per visit (waived if admitted)	$200 copay per visit (waived if admitted)
Chiropractic Care (Requires medical necessity and excludes preventive/maintenance care) Note: No visit maximum for treatment of back pain	10% coinsurance after deductible for up to 30 visits per plan year	25% coinsurance after deductible for up to 30 visits per plan year	10% coinsurance after deductible for up to 30 visits per plan year	25% coinsurance after deductible for up to 30 visits per plan year	Lesser of $15 copay or 20% coinsurance (Referrals required through PCP)	Not covered	15% coinsurance for up to 30 visits per plan year	20% coinsurance after deductible for up to 30 visits per plan year
Physical Therapy (Requires medical necessity) Note: No visit maximum for treatment of back pain	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance for up to 45 visits per illness/injury (Referrals required through PCP)	Not covered	15% coinsurance	20% coinsurance after deductible
Specialist Visit (In-person or virtual)	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	$25 copay per visit (Referrals required for certain services through PCP)	Not covered	$30 copay per visit	20% coinsurance after deductible
Lab Work (Blood Work) Note: Lab Work at a non-preferred non-hospital affiliated lab may not be covered	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	LabCorp and Quest Diagnostics Lab (Preferred): $10 copay per visit Hospital/Other Lab Facility: $50 copay per visit	Not covered	In-Network Non-Hospital Affiliated Lab (Preferred): $10 copay per visit Hospital/Other Lab Facility: $50 copay per visit	20% coinsurance after deductible
Basic Imaging/Radiology (i.e., X-Ray, Ultrasound)	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	Non-Hospital Affiliated Freestanding Facility (Preferred): $0 copay per visit (Referrals required through PCP) Hospital Affiliated Facility: $50 copay per visit (Referrals required through PCP)	Not covered	Non-Hospital Affiliated Freestanding Facility (Preferred): $0 copay per visit Hospital Affiliated Facility: $50 copay per visit	20% coinsurance after deductible
High-Tech Imaging/Radiology (i.e., MRI, CT Scan) Note: Requires a prior authorization	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	Non-Hospital Affiliated Freestanding Facility (Preferred): $0 copay per visit Hospital Affiliated Facility: $75 copay per visit	Not covered	Non-Hospital Affiliated Freestanding Facility (Preferred): $0 copay per visit Hospital Affiliated Facility: $75 copay per visit	20% coinsurance after deductible

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Plan Feature		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health, Behavioral Health, and Substance Abuse	**Outpatient Services**	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	$15 copay per visit	Not covered	$20 copay per visit Intensive Outpatient Care 100% covered	20% coinsurance after deductible
	Inpatient Services	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	$100 copay per day with max of $200 per admission	Not covered	$100 copay per day with max of $200 per admission	20% coinsurance after deductible
Outpatient Surgery		10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance 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	20% coinsurance after deductible
Hospital Admission		10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	$100 copay per day with max of $200 per admission	Not covered	$100 copay per day with max of $200 per admission	20% coinsurance after deductible
Center of Excellence (COE)*: Costs noted are for an inpatient stay. Note: Highmark refers to COE facilities as Blue Distinction Centers and Aetna refers to COE facilities as Institutes of Quality and Institutes of Excellence.									
Plan Feature		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Orthopedic (hip replacement/ knee replacement) **Note: Requires a prior authorization**		10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	COE Facility* (Preferred): $100 copay per day; $200 copay max per admission Non-COE Facility: $500 copay per admission	Not covered	COE Facility* (Preferred): $100 copay per day; $200 copay max per admission Non-COE Facility: $500 copay per admission	20% coinsurance after deductible
Spine (i.e., Cervical and lumbar fusion, cervical laminectomy, and lumbar laminectomy/ discectomy procedures) **Note: Requires a prior authorization**		10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	COE Facility* (Preferred): $100 copay per day; $200 copay max per admission Non-COE Facility: $500 copay per admission	Not covered	COE Facility* (Preferred): $100 copay per day; $200 copay max per admission Non-COE Facility: $500 copay per admission	20% coinsurance after deductible

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Plan Feature	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Bariatric **Note: Requires a prior authorization**	COE Facility* (Preferred): 10% coinsurance after deductible Non-COE Facility: 25% coinsurance after deductible	45% coinsurance after deductible	COE Facility* (Preferred): 10% coinsurance after deductible Non-COE Facility: 25% coinsurance after deductible	45% coinsurance after deductible	COE Facility* (Preferred): $100 copay per day; $200 copay max per admission Non-COE Facility: 25% coinsurance	Not covered	COE Facility* (Preferred): $100 copay per day; $200 copay max per admission Non-COE Facility: 25% coinsurance	45% coinsurance after deductible
Transplants** **(For Highmark plans, does not apply to kidney and bone marrow/stem cell)** **Note: Requires a prior authorization**	COE Facility* (Preferred): 10% coinsurance after deductible	30% coinsurance after deductible	COE Facility* (Preferred): 10% coinsurance after deductible	30% coinsurance after deductible	COE Facility* (Preferred): $100 copay per day; $200 copay max per admission	Not covered	COE Facility* (Preferred): $100 copay per day; $200 copay max per admission	20% coinsurance after deductible

*Aetna and Highmark Delaware have designated certain healthcare facilities within their provider network as Centers of Excellence, or simply COE Facilities. COE Facilities have been identified as delivering high-quality services and superior outcomes for specific procedures or conditions. This means improved outcomes and reduced cost, which includes delivering surgery and post-operative care more efficiently and with lower risk of complications and readmissions.

**Members are encouraged to review the Highmark or Aetna plan documents for details regarding coverage.

Important Note on Allowable Charge and Coinsurance:

- **Allowable Charge is the price your health carrier (Highmark or Aetna) determines is reasonable for care or supplies. The amount the plan pays for covered services received in or out-of-network is based on the allowable charge and this may be different than the billed amount shown on your Explanation of Benefits (EOB). If an out-of-network provider bills more than the allowable charge, you may have to pay the difference.**

- **Coinsurance is the part of the allowable charge that you pay after you satisfy your deductible and is typically a percentage of the allowable charge for a service. For example, if the health plan covers 90% of the allowable charge for a specific service, you may be required to pay the remaining 10% as coinsurance. If your in-network allowable charge for covered medical services is $100 and your coinsurance is 10%, you would pay $10. The health plan would pay the remaining $90.**

Additional benefits automatically included with your Health Plan enrollment:				
SurgeryPlus (Surgeons of Excellence) Alternative benefits for non-emergency, planned procedures **(Joint Replacement & Revision, Spine, Cardiac, GYN, Bariatric, Hernia, Gallbladder, Thyroid, Orthopedics, ENT, Gastroenterology (i.e., Colonoscopy, Endoscopy), Pain Management, Other Minor/Misc. Procedures (i.e., Biopsy, Excision of Mass))**	All out-of-pocket costs (deductible, coinsurance, copay) are waived; Concierge service (Care Advocate) included; Eligible travel expenses covered; Financial incentives offered (receive a check for $500 up to $4,000 depending upon procedure)	All out-of-pocket costs (deductible, coinsurance, copay) are waived; Concierge service (Care Advocate) included; Eligible travel expenses covered; Financial incentives offered (receive a check for $500 up to $4,000 depending upon procedure)	All out-of-pocket costs (deductible, coinsurance, copay) are waived; Concierge service (Care Advocate) included; Eligible travel expenses covered; Financial incentives offered (receive a check for $500 up to $4,000 depending upon procedure)	All out-of-pocket costs (deductible, coinsurance, copay) are waived; Concierge service (Care Advocate) included; Eligible travel expenses covered; Financial incentives offered (receive a check for $500 up to $4,000 depending upon procedure)
Prescription Coverage **(Administered by CVS Caremark)**	Included	Included	Included	Included
Employee Assistance Program **(Administered by ComPsych® GuidanceResources®)** **Note: Members can obtain a maximum of 5 one-on-one professional counseling sessions annually**	Included	Included	Included	Included
Wellness and Condition Care Coordination **(Provided through your health plan)**	Included	Included	Included	Included

For more information, visit the Statewide Benefits Office (SBO) website at de.gov/statewidebenefits.