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FIRST STATE BASIC PLAN (HIGHMARK DELAWARE)

Description of Benefit	In-Network Benefits Deductible: $500/$1000* Out-of-Pocket Max: $2,000/$4,000** including deductible	Out-of-Network Benefits Deductible: $1,000/$2,000* Out-of-Pocket Max: $4,000/$8,000** including deductible
Inpatient Room & Board	90% after deductible	70% after deductible
Inpatient Physicians'/Surgeons' Services	90% after deductible	70% after deductible
Outpatient Services	90% after deductible	70% after deductible
Prenatal and Postnatal Care	90% after deductible	70% after deductible
Delivery Fee	90% after deductible	70% after deductible
Hospice	90% after deductible for up to 365 days	70% after deductible for up to 365 days
Home Care Services	90% after deductible for up to 240 days per plan year	70% after deductible for up to 240 days per plan year
Urgent Care	100% after $25 copay per visit	100% after $25 copay
Emergency Services	90% after deductible	90% after deductible
MENTAL HEALTH CARE/SUBSTANCE ABUSE CARE		
Inpatient Acute/ Partial Hospitalization	90% after deductible (subject to authorization)	70% after deductible (subject to authorization)
Outpatient	90% after deductible	70% after deductible
OTHER SERVICES		
Durable Medical Equipment	90% after deductible	70% after deductible
Skilled Nursing Facility	120 days per benefit period Benefits renew after 180 days without care	120 days per benefit period Benefits renew after 180 days without care
Emergency Ambulance	90% after deductible	70% after deductible
Physician Home/Office Visits (sick)	90% after deductible	70% after deductible
Specialist Care	90% after deductible	70% after deductible
Chiropractic Care	90% after deductible for up to 30 visits per plan year	75% after deductible, for up to 30 visits per plan year
Allergy Testing/Allergy Treatment	90% after deductible	70% after deductible
X-Ray, MRI's, CT Scans, Lab & other Diagnostic Services ***	90% after deductible	70% after deductible
Short-Term Therapies: Physical, Speech, Occupational	90% after deductible	70% after deductible
Annual Gyn Exam/Pap Smear	100% covered, no deductible	70% covered, no deductible
Periodic Physical Exams, Immunizations, Diabetes Education	100% covered, no deductible	70% covered, no deductible
Vision Care	Not covered	Not covered
Hearing Tests	100% covered, no deductible	70% covered, no deductible
Hearing Aids	90% after deductible, under age 24	70% after deductible, under age 24
All Infertility Services	75% after deductible; $10,000 lifetime maximum for medical services 75% after deductible, $15,000 lifetime max. for prescription services	55% after deductible; $10,000 lifetime maximum for medical services 55% after deductible; $15,000 lifetime max. for prescription services
Bariatric Surgery	90% after deductible if "Blue Distinction Center for Bariatric Surgery" is used; 75% after deductible if an authorized hospital/surgical center is used	55% after deductible

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

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

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

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AETNA CDH GOLD PLAN		
Description of Benefits	In-Network Benefits Deductible: $1,500/$3,000* Out-of-Pocket Max: $4,500/$9,000** including deductible	Out-of-Network Benefits Deductible: $1,500/$3,000* Out-of-Pocket Max: $7,500/$15,000** including deductible
Health Reimbursement Account	$1,250 Employee/$2,500 Family	
	IN-NETWORK	**OUT-OF-NETWORK**
Inpatient Room & Board	90% after deductible	70% after deductible
Inpatient Physicians' and Surgeons' Services	90% after deductible	70% after deductible
Outpatient Services	90% after deductible	70% after deductible
Prenatal and Postnatal Care	90% after deductible	70% after deductible
Delivery Fee	90% after deductible	70% after deductible
Hospice	90% after deductible	70% after deductible
Home Care Services	90% after deductible for up to 240 days per plan per plan year	70% after deductible for up to 240 days per plan per plan year
Urgent Care	90% after deductible	100% after $25 copay
Emergency Services	90% after deductible	90% after deductible
MENTAL HEALTH & SUBSTANCE ABUSE		
Inpatient Acute/Partial Hospitalization	90% after deductible	70% after deductible
Outpatient	90% after deductible	70% after deductible
OTHER COVERED SERVICES		
Durable Medical Equipment	90% after deductible	70% after deductible
Skilled Nursing Facility	90% after deductible for up to 120 days per confinement	70% after deductible for up to 120 days per confinement
Emergency Ambulance	90% after deductible	70% after deductible
Physician Home/Office Visits (non-routine)	90% after deductible	70% after deductible
Specialist Care	90% after deductible	70% after deductible
Chiropractic Care	90% after deductible for up to 30 visits per plan year	75% after deductible for up to 30 visits per plan year
Allergy Testing/Allergy Treatment	90% after deductible	70% after deductible
X-ray, MRI's, CT Scans, PET Scans, Lab & Other Diagnostic Services***	90% after deductible	70% after deductible
Short-term Therapies: Physical, Speech, Occupational	90% after deductible	70% after deductible
Annual Gyn Exam/Pap Smear	100%, no deductible	70% covered, after deductible
Routine Physical Exam & Immunizations	100%, no deductible	70% after deductible
Vision Care	Not covered	Not covered
Hearing Tests - 1 exam every 12 months	100%, no deductible	70% after deductible
Hearing Aids – Children to age 24	90% after deductible, under age 24	70% after deductible, under age 24
All Infertility Services	75% covered; $10,000 lifetime maximum for medical services 75% covered; $15,000 lifetime maximum for prescription services	55% covered; $10,000 lifetime maximum for medical services 55% covered; $15,000 lifetime maximum for prescription services
Bariatric Surgery	90% after deductible if "Institute of Excellence for Bariatric Surgery" is used; 75% after deductible if other center is used.	55% after deductible.

* Once the Family Deductible Limit is met, all family members will be considered as having met their deductible.
** Out-of-pocket maximums apply to each plan year and include your deductible. There are separate out-of-pocket maximums for prescription drugs.
*** MRI, MRA, CT and PET scans require a prior authorization

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DESCRIPTION OF BENEFITS	AETNA HMO
	Out-of-Pocket Max: $4,500/$9,000**
Inpatient Room & Board	$100 copay/day with max of $200 per admission
Inpatient Physicians' and Surgeons' Services	100%
Outpatient Surgery– Ambulatory Center	$50 copay
Outpatient Surgery–Doctors Office Visit	$20 copay
Outpatient Surgery–Hospital	$100 copay
Prenatal and Postnatal Care	100% after $25 initial copay (inpatient copays do apply to hospital deliveries/birthing centers)
Delivery Fee	100%
Hospice	100% upto 365 days
Home Care Services	100% for up to 240 visits per plan year
Urgent Care	$15 copay
Emergency Services	$150 copay (waived if admitted)
MENTAL HEALTH CARE/SUBSTANCE ABUSE CARE	
Inpatient Acute/Partial Hospitalization	$100 copay/day with max. of $200/hospitalization (subject to authorization)
Outpatient	$25 copay per visit
OTHER SERVICES	
Durable Medical Equipment	80%
Skilled Nursing Facility	100%
Emergency Ambulance	$50 copay
Physician Home/Office Visits (sick)	$15 copay per office visit $25 copay per home or after hours visit
Specialist Care	$25 copay per visit
Chiropractic Care	Lesser of either a $15 copay or 20% of the allowable charges
Allergy Testing/Allergy Treatment	$25 copay per visit (allergy testing)/ $5 copay per visit (allergy treatment)
X-Ray, Lab & other Diagnostic Services	Lab: $10 copay per visit/ X-Ray:$20 copay per visit
MRI's, CT Scans and PET Scans*	Hospital affiliation: $35 copay per visit Non-hospital free standing facility $0 copay per visit
Short-Term Therapies: Physical, Speech, Occupational	80%, 45 visits per condition for physical and occupational therapy combined/ 80%, 45 visits per condition for speech therapy
Annual Gyn Exam/Pap Smear	100%
Periodic Physical Exams, Immunizations, Diabetes Education	100%
Vision Care	100% after office visit copay (one exam every 24 months)
Hearing Tests	100% after office visit copay
All Infertility Services	75% covered $10,000 lifetime maximum for medical services; 75% covered; $15,000 lifetime maximum for prescription services
Bariatric Surgery	100% if "Institute Excellence for Bariatric Surgery" is used; 75% if an authorized hospital/ surgical center is used

** Out-of-pocket maximums apply to each plan year. There are separate out-of-pocket maximums for prescription drugs.

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

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HIGHMARK DELAWARE COMPREHENSIVE PREFERRED PROVIDER ORGANIZATION

Description of Benefit	In-Network Benefits Out-of-Pocket Max: $4,500/$9,000	Out-of-Network Benefits Deductible: $300/$600* Out-of-Pocket Max: $7,500/$15,000 including deductible**
Inpatient Room & Board	$100 copay/day with max. of $200/admission	80% after deductible
Inpatient Physicians' and Surgeon	100%	80% after deductible
Outpatient Surgery-Ambulatory Center	$50 copay	80% after deductible
Outpatient Surgery-Hospital Surgery Cntr.	$100 copay	80% after deductible
Prenatal and Postnatal Care	100% (inpatient room and board copays do apply to hospital deliveries/birthing centers)	80% after deductible
Delivery Fee	100%	80% after deductible
Hospice	100% up to 365 days	80% after deductible up to 365 days
Home Care Services	100%	80% after deductible for up to 240 visits per plan year
Urgent Care	$20 copay	80% after deductible
Emergency Services	$150 copay (waived if admitted) Physician: 100%	$150 copay (waived if admitted) Physician: 100% after deductible
MENTAL HEALTH CARE/SUBSTANCE ABUSE CARE		
Inpatient Acute/Partial Hospitalization	$100 copay/day with max of $200/admission (subject to authorization)	80% after deductible (subject to authorization)
Outpatient	100% after $15 copay	80% after deductible
OTHER SERVICES		
Durable Medical Equipment	100%	80% after deductible
Skilled Nursing Facility	120 days per benefit period Benefits renew after 180 without care	120 days per benefit period Benefits renew after 180 without care
Emergency Ambulance	100%	100% no deductible
Physician Home/Office Visits (sick)	$20 copay	80% after deductible
Specialist Care	$30 copay	80% after deductible
Chiropractic Care	85% covered; 30 visits per plan year	80% after deductible; 30 visits per plan year
Allergy Testing/Allergy Treatment	Testing: $30 copay/Treatment :$5 copay	80% after deductible
X-Ray, Lab & other Diagnostic Services	Lab: $10 copay per visit; X-ray: $20 copay per visit	80% after deductible
MRI's, CT Scans, PET Scans***	Hospital affiliation: $35 copay per visit Non-hospital free standing facility $0 copay per visit	80% after deductible
Short-Term Therapies: Physical, Speech, Occupational Therapies	85%	80% after deductible
Annual Gyn Exam/Pap Smear	100%	80% after deductible
Periodic Physical Exams, Immunizations, Diabetes Education	100%	80% after deductible
Vision Care	Not covered	Not covered
Hearing Tests	100% after office visit copay	80% after deductible
Hearing Aids	100%, under age 24	80% after deductible, under age 24
All Infertility Services	75% covered, $10,000 lifetime maximum for medical services 75% covered, $15,000 lifetime maximum for prescription services	55% after deductible; $10,000 lifetime maximum for medical services 55% after deductible; $15,000 lifetime maximum for prescription services
Bariatric Surgery	100% covered if "Blue Distinction Center for Bariatric Surgery " is used;75% covered if an authorized hospital/ surgical center is used.	55% after deductible

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

** Out-of-pocket maximums apply to each plan year and include your deductible. There are separate out-of-pocket maximums for prescription drugs.

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

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