# HEALTH PLAN COMPARISON CHART

## EFFECTIVE JULY 1, 2021

| Plan Type | Highmark Delaware First State Basic Plan | | Aetna CDH Gold Plan | | Aetna HMO Plan | | Highmark Delaware Comprehensive PPO Plan | |
|---|---|---|---|---|---|---|---|---|
| Plan Options | 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 | 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 |
| 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 | $0 copay per visit | Not covered | $0 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 | $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) | 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 |
| Physical Therapy (Requires medical necessity) | 90% covered after deductible | 70% covered after deductible | 90% covered after deductible | 70% covered after deductible | 80% covered for up to 45 visits per illness/injury (Referrals required) | Not covered | 85% covered | 80% covered after deductible |
| 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 |
| Lab Work (Blood Work) Note: Lab Work at a non-preferred non-hospital affiliated lab may not be covered | 90% covered after deductible | 70% covered after deductible | 90% covered after deductible | 70% covered after deductible | LabCorp and Quest Diagnostics: $10 copay per visit | Not covered | In-Network Non-Hospital Affiliated Preferred Lab: $10 copay per visit | 80% covered after deductible |
| | | | | | Hospital/Other Lab Facility: $50 copay per visit | | Hospital/Other Lab Facility: $50 copay per visit | |
| Basic Imaging/X-Ray/ Radiology/Ultrasound | 90% covered after deductible | 70% covered after deductible | 90% covered after deductible | 70% covered after deductible | Non-Hospital Affiliated Freestanding Facility Preferred: $0 copay per visit (Referrals required through PCP) | Not covered | Non-Hospital Affiliated Freestanding Facility Preferred: $0 copay per visit | 80% covered after deductible |
| | | | | | Hospital Affiliated Facility: $50 copay per visit (Referrals required through PCP) | | Hospital Affiliated Facility: $50 copay per visit | |

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|---|---|---|---|---|---|---|---|---|---|
| | | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **High-Tech Imaging/ Radiology** (i.e., MRI, CT Scan) Note: Requires a prior authorization | | 90% covered after deductible | 70% covered after deductible | 90% covered after deductible | 70% covered after deductible | Non-Hospital Affiliated Freestanding Facility Preferred: $0 copay per visit<br>Hospital Affiliated Facility: $75 copay per visit | Not covered | Non-Hospital Affiliated Freestanding Facility Preferred: $0 copay per visit<br>Hospital Affiliated Facility: $75 copay per visit | 80% covered after deductible |
| **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 | $25 copay per visit | Not covered | $20 copay per visit<br>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** | | 90% covered after deductible | 70% covered after deductible | 90% covered after deductible | 70% covered after deductible | Ambulatory Center: $50 copay per visit<br>Hospital Facility: $100 copay per visit | Not covered | Ambulatory Center: $50 copay per visit<br>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 |
| **Orthopedic** (hip replacement/knee replacement) Note: Requires a prior authorization | | 90% covered after deductible | 70% covered after deductible | 90% covered after deductible | 70% covered after deductible | COE Facility* Preferred: $100 copay per day; $200 copay max per admission<br>Non-COE Facility: $500 copay per admission | Not covered | COE Facility* Preferred: $100 copay per day; $200 copay max per admission<br>Non-COE Facility: $500 copay per admission | 80% covered after deductible |
| **Spine** (i.e., Cervical and lumbar fusion, cervical laminectomy, and lumbar laminectomy/ discectomy procedures) Note: Requires a prior authorization | | 90% covered after deductible | 70% covered after deductible | 90% covered after deductible | 70% covered after deductible | COE Facility* (Preferred): $100 copay per day; $200 copay max per admission<br>Non-COE Facility: $500 copay per admission | Not covered | COE Facility* Preferred: $100 copay per day; $200 copay max per admission<br>Non-COE Facility: $500 copay per admission | 80% covered after deductible |
| **Bariatric** Note: Requires a prior authorization | | COE Facility* Preferred: 90% covered after deductible<br>Non-COE Facility: 75% covered after deductible | 55% covered after deductible | COE Facility* Preferred: 90% covered after deductible<br>Non-COE Facility: 75% covered after deductible | 55% covered after deductible | COE Facility* (Preferred): $100 copay per day; $200 copay max per admission<br>Non-COE Facility: 75% covered after deductible | Not covered | COE Facility* (Preferred: $100 copay per day; $200 copay max per admission<br>Non-COE Facility: 75% covered after deductible | 55% covered after deductible |
| **Transplants**** (For Highmark plans, does not apply to kidney and bone marrow/stem cell) Note: Requires a prior authorization | | COE Facility* Preferred: 90% covered after deductible<br>Non-COE Facility: 70% covered after deductible | 70% covered after deductible | COE Facility* Preferred: 90% covered after deductible<br>Non-COE Facility: 70% covered after deductible | 70% covered after deductible | COE Facility* Preferred: $100 copay per day; $200 copay max per admission<br>Non-COE Facility: Not covered | Not covered | COE Facility* Preferred: $100 copay per day; $200 copay max per admission<br>Non-COE Facility: 80% covered | 80% covered after deductible |

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

For more information, including plan documents and listings of eligible Urgent Care Centers, COE Facilities and Non-Hospital Affiliated Freestanding Locations for Lab Work and Imaging/Radiology Services, visit the Statewide Benefits Office (SBO) website at de.gov/statewidebenefits.

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