

HEALTH PLAN COMPARISON CHART

EFFECTIVE JULY 1, 2023

| Plan Type | Highmark Delaware First State Basic | | Aetna CDH Gold | | Aetna HMO | | Highmark Delaware Comprehensive PPO | |
|--|--|--|--|---|--|--|---|--|
| 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 | 30% coinsurance, not subject to deductible | 100% covered, not subject to deductible | 30% coinsurance after deductible | 100% covered | Not covered | 100% covered | 20% 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 | 10% coinsurance after deductible | 30% coinsurance after deductible | 10% coinsurance after deductible | 30% coinsurance 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) | 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 | Not covered | \$0 copay per visit | 20% coinsurance after deductible |
| Urgent Care Visit | 100% covered after \$25 copay | 100% covered after \$25 copay | 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 | 30% 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 | 30% 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 (Preferred): \$10 copay per visit | Not covered | In-Network Non-Hospital Affiliated Preferred Lab: \$10 copay per visit | 20% coinsurance after deductible |
| | | | | Hospital/Other Lab Facility: \$50 copay per visit | Hospital/Other Lab Facility: \$50 copay per visit | | | |
| Basic Imaging/X-Ray/Radiology/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) | Not covered | Non-Hospital Affiliated Freestanding Facility Preferred: \$0 copay per visit | 20% coinsurance after deductible |
| | | | | Hospital Affiliated Facility: \$50 copay per visit (Referrals required through PCP) | Hospital Affiliated Facility: \$50 copay per visit | | | |

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| Plan Options | | Highmark Delaware First State Basic Plan | | Aetna CDH Gold Plan | | Aetna HMO Plan | | Highmark Delaware Comprehensive PPO Plan | |
|---|----------------------------|--|--|---|---|---|---|--|--|
| | | 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 | | 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 | Not covered | Non-Hospital Affiliated Freestanding Facility Preferred: \$0 copay per visit | 20% coinsurance after deductible |
| | | | | | | Hospital Affiliated Facility: \$100 copay per visit | | Hospital Affiliated Facility: \$100 copay per visit | |
| 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 | Non-Hospital Affiliated Ambulatory Center (Preferred): \$50 copay per visit | Not covered | Non-Hospital Affiliated Ambulatory Surgery Center (Preferred) \$50 copay per visit | 20% coinsurance after deductible |
| | | | | | | Hospital Facility: \$150 copay per visit | | Hospital Facility: \$150 copay per visit | |
| 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 |
| 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 | Not covered | COE Facility* Preferred: \$100 copay per day; \$200 copay max per admission | 20% coinsurance after deductible |
| | | | | | | Non-COE Facility: \$500 copay per admission | | Non-COE Facility: \$500 copay per admission | |
| Spine (i.e., Cervical and lumbar fusion, cervical laminectomy, and lumbar laminectomy/discectomy procedures) Note: Requires a prior authorization | | 10% coinsurance after deductible | 10% coinsurance after deductible | 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% covered after deductible |
| | | | | | | Non-COE Facility: \$500 copay per admission | | Non-COE Facility: \$500 copay per admission | |
| Bariatric Note: Requires a prior authorization | | Not covered under Highmark Required through SurgeryPlus benefit | Not covered under Highmark Required through SurgeryPlus benefit | Not covered under Aetna Required through SurgeryPlus benefit | Not covered under Aetna Required through SurgeryPlus benefit | Not covered under Aetna Required through SurgeryPlus benefit | Not covered under Aetna Required through SurgeryPlus benefit | Not covered under Highmark Required through SurgeryPlus benefit | Not covered under Highmark Required through SurgeryPlus benefit |
| 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% covered after deductible |
| | | Non-COE Facility: 30% coinsurance after deductible | | Non-COE Facility: 30% coinsurance after deductible | | Non-COE Facility: Not covered | | Non-COE Facility: 20% coinsurance | |

**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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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 dhr.delaware.gov/benefits/.