



## State of Delaware Health Plan Comparison Chart (Effective July 1, 2022)

**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.

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	
Coverage Options/ Premiums (Rates)	Total Monthly Premium (Rate)*	You Pay Monthly (Bi-Weekly) <i>*State pays difference</i>	Total Monthly Premium (Rate)*	You Pay Monthly (Bi-Weekly) <i>*State pays difference</i>	Total Monthly Premium (Rate)*	You Pay Monthly (Bi-Weekly) <i>*State pays difference</i>	Total Monthly Premium (Rate)*	You Pay Monthly (Bi-Weekly) <i>*State pays difference</i>
<b>Employee</b>	\$755.64	\$30.22 (\$15.11)	\$782.08	\$39.10 (\$19.55)	\$788.88	\$51.28 (\$25.64)	\$862.68	\$114.30 (\$57.15)
<b>Employee &amp; Spouse</b>	\$1,563.42	\$62.54 (\$31.27)	\$1,621.60	\$81.08 (\$40.54)	\$1,663.28	\$108.12 (\$54.06)	\$1,790.16	\$237.20 (\$118.60)
<b>Employee &amp; Child(ren)</b>	\$1,148.66	\$45.94 (\$22.97)	\$1,194.90	\$59.74 (\$29.87)	\$1,206.80	\$78.44 (\$39.22)	\$1,329.54	\$176.16 (\$88.08)
<b>Family</b>	\$1,954.34	\$78.18 (\$39.09)	\$2,060.10	\$103.00 (\$51.50)	\$2,075.40	\$134.90 (\$67.45)	\$2,237.94	\$296.52 (\$148.26)
Plan Feature	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Preventive Care/ Screening/Immunization (age, gender and risk parameters may apply)</b>	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
<b>Deductible (per plan year)</b>	\$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
<b>Health Reimbursement Account (HRA)</b>	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
<b>Out-of-Pocket Maximum (including copays and deductibles)</b>	\$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
<b>Prenatal and Postnatal Care</b>	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

Plan Options	Highmark Delaware First State Basic 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
<b>24/7 Nurse Line</b>	Yes, no cost		Yes, no cost		Yes, no cost		Yes, no cost	
<b>Primary Care Visit to treat an injury or illness (In-person or virtual)</b>	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
<b>Telemedicine (Virtual Doctor Visits)</b>	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
<b>Urgent Care Visit</b>	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
<b>Emergency Room</b>	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)
<b>Chiropractic Care (Requires medical necessity and excludes preventive/maintenance care)</b> <b>Note: No visit maximum for treatment of back pain</b>	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
<b>Physical Therapy (Requires medical necessity)</b> <b>Note: No visit maximum for treatment of back pain</b>	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
<b>Specialist Visit (In-person or virtual)</b>	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
<b>Lab Work (Blood Work)</b> <b>Note: Lab Work at a non-preferred non-hospital affiliated lab may not be covered</b>	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

Plan Options		Highmark Delaware First State Basic 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
<b>Basic Imaging/Radiology (i.e., X-Ray, Ultrasound)</b>		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	
<b>High-Tech Imaging/Radiology (i.e., MRI, CT Scan)</b> <b>Note: Requires a prior authorization</b>		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: \$75 copay per visit		Hospital Affiliated Facility: \$75 copay per visit	
<b>Mental Health, Behavioral Health, and Substance Abuse</b>	<b>Outpatient Services</b>	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
	<b>Inpatient Services</b>	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
<b>Outpatient Surgery</b>		10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	Ambulatory Center: \$50 copay per visit	Not covered	Ambulatory Center: \$50 copay per visit	20% coinsurance after deductible
						Hospital Facility: \$100 copay per visit		Hospital Facility: \$100 copay per visit	
<b>Hospital Admission</b>		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

Plan Options	Highmark Delaware First State Basic Plan		Aetna CDH Gold Plan		Aetna HMO Plan		Highmark Delaware Comprehensive PPO Plan	
<b>Center of Excellence (COE)*: Costs noted are for an inpatient stay.</b>								
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
<b>Orthopedic</b> <b>(hip replacement/  knee replacement)</b>  <b>Note: Requires a prior  authorization</b>	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	
<b>Spine</b> <b>(i.e., Cervical and lumbar  fusion, cervical laminectomy, and lumbar laminectomy/  discectomy procedures)</b>  <b>Note: Requires a prior  authorization</b>	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	
<b>Bariatric</b>  <b>Note: Requires a prior  authorization</b>	COE Facility* (Preferred): 10% coinsurance after deductible	45% coinsurance after deductible	COE Facility* (Preferred): 10% coinsurance after deductible	45% 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	45% coinsurance after deductible
	Non-COE Facility: 25% coinsurance after deductible		Non-COE Facility: 25% coinsurance after deductible		Non-COE Facility: 25% coinsurance		Non-COE Facility: 25% coinsurance	
<b>Transplants**</b> <b>(For Highmark plans, does  not apply to kidney and  bone marrow/stem cell)</b>  <b>Note: Requires a prior  authorization</b>	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
	Non-COE Facility: 30% coinsurance after deductible		Non-COE Facility: 30% coinsurance after deductible		Non-COE Facility: Not covered		Non-COE Facility: 20% coinsurance	

\*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.

**Additional benefits automatically included with your Health Plan enrollment.**

<p><b>SurgeryPlus (Surgeons of Excellence)</b></p> <p>Alternative benefits for non-emergency, planned procedures</p> <p>(Joint Replacement &amp; 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))</p>	<p>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)</p>	<p>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)</p>	<p>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)</p>	<p>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)</p>
<p><b>Prescription Coverage</b> (Administered by CVS Caremark)</p>	<p>Included</p>	<p>Included</p>	<p>Included</p>	<p>Included</p>
<p><b>Employee Assistance Program</b> (Administered by ComPsych® GuidanceResources® )</p> <p>Note: Members can obtain a maximum of 5 one-on-one professional counseling sessions annually</p>	<p>Included</p>	<p>Included</p>	<p>Included</p>	<p>Included</p>
<p><b>Wellness and Condition Care Coordination</b> (Provided through your health plan)</p>	<p>Included</p>	<p>Included</p>	<p>Included</p>	<p>Included</p>

**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.

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