HEALTH PLAN COMPARISON CHART

EFFECTIVE JULY 1, 2024

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 for acute issues and behavioral health visits $25 for dermatology visit	Not covered	$0 copay per visit for acute issues behavioral health visits	20% coinsurance after deductible
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) 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 0% coinsurance for behavioral health and substance abuse disorder diagnosis	20% coinsurance after deductible for up to 30 visits per plan year
Physical/Occupational Speech 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 No visit limit or medical necessity review for behavior health and substance abuse disorder diagnosis	30% coinsurance after deductible No visit limit or medical necessity review for behavior health and substance abuse disorder diagnosis	20% coinsurance for up to 45 visits per illness/injury (Referrals required by PCP) No visit limit and lesser of $15 copay or 20% coinsurance for behavioral health and substance abuse disorder diagnosis	Not covered	15% coinsurance 0% coinsurance for behavioral health and substance abuse disorder diagnosis	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 Hospital/Other Lab Facility: $50 copay per visit	Not covered	In-Network Non-Hospital Affiliated Preferred Lab: $10 copay per visit Hospital/Other Lab Facility: $50 copay per visit 0% copay per visit for behavioral health and substance abuse disorder diagnosis	20% coinsurance after deductible

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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
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	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: $100 copay per visit	Not covered	Non-Hospital Affiliated Freestanding Facility Preferred: $0 copay per visit Hospital Affiliated Facility: $100 copay per visit***	20% coinsurance 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	$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 Hospital Facility: $150 copay per visit	Not covered	Non-Hospital Affiliated Ambulatory Surgery Center (Preferred) $50 copay per visit Hospital Facility: $150 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
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 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 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% covered after deductible
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 Non-COE Facility: 30% coinsurance after deductible	30% coinsurance after deductible	COE Facility* Preferred: 10% coinsurance after deductible Non-COE Facility: 30% coinsurance after deductible	30% coinsurance after deductible	COE Facility* Preferred: $100 copay per day; $200 copay max per admission Non-COE Facility: Not covered	Not covered	COE Facility* Preferred: $100 copay per day; $200 copay max per admission Non-COE Facility: 20% coinsurance	20% covered 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

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

*** 0% copay per visit for behavioral health and substance abuse disorder diagnosis