



State of Delaware Health Plan Comparison Chart (Effective July 1, 2017)

Plan Options	Highmark Delaware First State Basic PPO Plan		Aetna CDH Gold Plan		Aetna HMO Plan		Highmark Delaware Comprehensive PPO Plan	
Plan Type	Preferred Provider Organization (PPO)		Consumer Directed Health (CDH)		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>
Employee	\$695.36	\$27.84 (\$13.92)	\$719.68	\$35.98 (\$17.99)	\$725.94	\$47.16 (\$23.58)	\$793.86	\$105.18 (\$52.59)
Employee & Spouse	\$1,438.68	\$57.52 (\$28.76)	\$1,492.22	\$74.58 (\$37.29)	\$1,530.58	\$99.50 (\$49.75)	\$1,647.34	\$218.26 (\$109.13)
Employee & Child(ren)	\$1,057.02	\$42.26 (\$21.13)	\$1,099.56	\$54.96 (\$27.48)	\$1,110.52	\$72.18 (\$36.09)	\$1,223.46	\$162.08 (\$81.04)
Family	\$1,798.42	\$71.92 (\$35.96)	\$1,895.74	\$94.78 (\$47.39)	\$1,909.82	\$124.12 (\$62.06)	\$2,059.40	\$272.86 (\$136.43)
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

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Plan Feature	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
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	\$15 copay per visit	Not covered	\$20 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	\$150 copay per visit (waived if admitted)	\$150 copay per visit	\$150 copay per visit (waived if admitted)	\$150 copay per visit (waived if admitted)
Chiropractic 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
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
Diagnostic Test (X-Ray, Ultrasound, Blood (Lab) Work, etc.)	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	Lab: \$10 copay per visit; X-Ray or Ultrasound: \$20 copay per visit	Not covered	Lab: \$10 copay per visit; X-Ray or Ultrasound: \$20 copay per visit	80% covered after deductible
High-Tech Imaging (MRI, CT Scan, PET Scan**)	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	Non-Hospital Affiliated Freestanding Facility: \$0 copay per visit Hospital Facility: \$35 copay per visit	Not covered	Non-Hospital Affiliated Freestanding Facility: \$0 copay per visit Hospital Facility: \$35 copay per visit	80% covered 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 Hospital Facility: \$100 copay per visit	Not covered	Ambulatory Center: \$50 copay per visit 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

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

***Chiropractic coverage requires medical necessity and excludes preventive/maintenance care.

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. Non-State Participating Group Employees should contact their HR/Benefits Office within their organization for premium information.