



## State of Delaware Health Plan Comparison Chart

(Effective July 1, 2026)

**Please note:** Employees who are eligible for and receiving reduced premiums due to Double State Share eligibility are not reflected in this information.

**District Medical Flex Credits are applied to the bi-weekly amounts listed below.**

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 Bi-Weekly <i>*State pays difference</i>	Total Monthly Premium (Rate)*	You Pay Bi-Weekly <i>*State pays difference</i>	Total Monthly Premium (Rate)*	You Pay Bi-Weekly <i>*State pays difference</i>	Total Monthly Premium (Rate)*	You Pay Bi-Weekly <i>*State pays difference</i>
<b>Employee</b>	\$1,117.52	\$0.00	\$1,156.82	\$0.19	\$1,166.88	\$9.20	\$1,276.06	\$55.80
<b>Employee &amp; Spouse</b>	\$2,312.52	\$2.20	\$2,398.60	\$15.90	\$2,460.26	\$35.90	\$2,647.92	\$131.37
<b>Employee &amp; Child(ren)</b>	\$1,699.06	\$0.00	\$1,767.46	\$2.04	\$1,785.04	\$15.87	\$1,966.60	\$88.14
<b>Family</b>	\$2,890.78	\$0.00	\$3,047.20	\$9.76	\$3,069.84	\$33.36	\$3,310.26	\$152.88
Plan Feature	In-Network <sup>1,2,3</sup>	Out-of-Network <sup>1,2,3</sup>	In-Network <sup>1,2,3</sup>	Out-of-Network <sup>1,2,3</sup>	In-Network <sup>1,2,3</sup>	Out-of-Network <sup>1,2,3</sup>	In-Network <sup>1,2,3</sup>	Out-of-Network <sup>1,2,3</sup>
<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 <sup>1,2,3</sup>	Out-of-Network <sup>1,2,3</sup>	In-Network <sup>1,2,3</sup>	Out-of-Network <sup>1,2,3</sup>	In-Network <sup>1,2,3</sup>	Out-of-Network <sup>1,2,3</sup>	In-Network <sup>1,2,3</sup>	Out-of-Network <sup>1,2,3</sup>
<b>24/7 Nurse Line</b>	Yes, no cost	Yes, no cost	Yes, no cost	Yes, no cost	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 with Teladoc (Aetna) or Amwell (Highmark))</b>	10% coinsurance after deductible	Not covered	10% coinsurance after deductible	Not covered	\$0 copay per visit for acute issues and behavioral health visits \$25 for dermatology visits	Not covered	\$0 copay per visit for acute issues and behavioral health visits	Not covered
<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)</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  0% coinsurance for behavioral health and substance abuse disorder diagnosis	20% coinsurance after deductible for up to 30 visits per plan year
<b>Physical Therapy/ Occupational Therapy/ Speech Therapy (Requires medical necessity)</b> <b>Note: No visit maximum for physical therapy for treatment of back pain</b>	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible  No visit limit or medical necessity review for behavioral health and substance abuse disorder diagnosis	30% coinsurance after deductible  No visit limit or medical necessity review for behavioral health and substance abuse disorder diagnosis	20% coinsurance for up to 45 visits per illness/injury (Referrals required through 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
<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

Plan Options	Highmark Delaware First State Basic Plan		Aetna CDH Gold Plan		Aetna HMO Plan		Highmark Delaware Comprehensive PPO Plan	
Plan Feature	In-Network <sup>1,2,3</sup>	Out-of-Network <sup>1,2,3</sup>	In-Network <sup>1,2,3</sup>	Out-of-Network <sup>1,2,3</sup>	In-Network <sup>1,2,3</sup>	Out-of-Network <sup>1,2,3</sup>	In-Network <sup>1,2,3</sup>	Out-of-Network <sup>1,2,3</sup>
<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  Hospital/Other Lab Facility for behavioral health and substance abuse disorder diagnosis: \$0 copay per visit	20% coinsurance after deductible
<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)  Hospital Affiliated Facility: \$50 copay per visit (Referrals required through PCP)	Not covered	Non-Hospital Affiliated Freestanding Facility (Preferred): \$0 copay per visit  Hospital Affiliated Facility: \$50 copay per visit  \$0 copay at any facility for behavioral health and substance abuse disorder diagnosis	20% coinsurance after deductible
<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  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  \$0 copay at any facility for behavioral health and substance abuse disorder diagnosis	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 <sup>1,2,3</sup>	Out-of-Network <sup>1,2,3</sup>	In-Network <sup>1,2,3</sup>	Out-of-Network <sup>1,2,3</sup>	In-Network <sup>1,2,3</sup>	Out-of-Network <sup>1,2,3</sup>	In-Network <sup>1,2,3</sup>	Out-of-Network <sup>1,2,3</sup>
<b>Mental Health, Behavioral Health, and Substance Abuse: Outpatient Services (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 Intensive Outpatient Care 100% covered	20% coinsurance after deductible
<b>Mental Health, Behavioral Health, and Substance Abuse: 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	Non-Hospital Affiliated Ambulatory Surgery Center (Preferred): \$50 copay per visit  Hospital Affiliated Facility: \$150 copay per visit	Not covered	Non-Hospital Affiliated Ambulatory Surgery Center (Preferred): \$50 copay per visit  Hospital Affiliated Facility: \$150 copay per visit	20% coinsurance after deductible
<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)*:</b> Costs noted are for an inpatient stay. 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 <sup>1,2,3</sup>	Out-of-Network <sup>1,2,3</sup>	In-Network <sup>1,2,3</sup>	Out-of-Network <sup>1,2,3</sup>	In-Network <sup>1,2,3</sup>	Out-of-Network <sup>1,2,3</sup>	In-Network <sup>1,2,3</sup>	Out-of-Network <sup>1,2,3</sup>
<b>Orthopedic</b> (hip replacement/ knee replacement)  <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  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
<b>Spine</b> (i.e., Cervical and lumbar fusion, cervical laminectomy, and lumbar laminectomy/discectomy procedures)  <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  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
<b>Bariatric</b>  <b>Note: Requires a prior authorization</b>	Not covered under Highmark  Required through Lantern benefit	Not covered under Highmark  Required through Lantern benefit	Not covered under Aetna  Required through Lantern benefit	Not covered under Aetna  Required through Lantern benefit	Not covered under Aetna  Required through Lantern benefit	Not covered under Aetna  Required through Lantern benefit	Not covered under Highmark  Required through Lantern benefit	Not covered under Highmark  Required through Lantern benefit
<b>Transplants**</b> (For Highmark plans, does not apply to kidney and bone marrow/stem cell)  <b>Note: Requires a prior authorization</b>	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% coinsurance 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 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>Lantern (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 \$3,000 depending upon procedure)</p> <p>Bariatric surgery required under Lantern and not eligible for a financial incentive</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 \$3,000 depending upon procedure)</p> <p>Bariatric surgery required under Lantern and not eligible for a financial incentive</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 \$3,000 depending upon procedure)</p> <p>Bariatric surgery required under Lantern and not eligible for a financial incentive</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 \$3,000 depending upon procedure)</p> <p>Bariatric surgery required under Lantern and not eligible for a financial incentive</p>
<p><b>Prescription Coverage (Administered by CVS Caremark)</b></p>	<p align="center">Included</p>	<p align="center">Included</p>	<p align="center">Included</p>	<p align="center">Included</p>
<p><b>Employee Assistance Program (Administered by Health Advocate)</b></p> <p>Note: Members can obtain a maximum of 5 one-on-one professional counseling sessions annually</p>	<p align="center">Included</p>	<p align="center">Included</p>	<p align="center">Included</p>	<p align="center">Included</p>
<p><b>Wellness and Condition Care Coordination (Provided through your health plan)</b></p>	<p align="center">Included</p>	<p align="center">Included</p>	<p align="center">Included</p>	<p align="center">Included</p>

**Important Notes:**

<sup>1</sup>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.

<sup>2</sup>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.

<sup>3</sup>This document is available to provide a quick glance at commonly utilized services and is not intended to be inclusive of all coverage available. Please refer to each plan booklet for a full list of coverage.

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