Highmark Delaware
Customer Service
1.800.633.2563

NEW CASTLE COUNTY COMPARISON OF BENEFITS
Active Employees

Aetna Select
Customer Service
1-855-281-8858

BENEFITS	BLUE CHOICE PPO		EPO		Aetna Select Open Access HMO		COMPREHENSIVE 80	
Coverage Options								
Plan Feature	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Deductible Per Calendar Year (Individual/Family)	$200 Individual $400 Family (DME, Prosthetics and Hearing Aids only)	$200 per Individual $400 per Family	N/A	N/A	N/A	N/A	$200 per Individual $400 per Family	N/A
Plan Pays	80% after deductible for DME, Prosthetics and Hearing Aids	80% after deductible	N/A	N/A	N/A	N/A	80%	N/A
Co-Insurance Maximum:	$2,000 per Individual/ $4,000 family for DME, Prosthetics and Hearing Aids	$2,000 per Individual $4,000 per Family						
Total Maximum Out of Pocket: Includes In-network medical deductible, coinsurance and copays. Once met, the plan pays 100% of covered services for the remainder of the calendar year. [1, 3]	$7, 350 Individual $14,700 Family	N/A	$7,350 Individual $14,700 Family	N/A	$7,350 Individual $14,700 Family	N/A	$7,350 Individual $14,700 Family	N/A
PREVENTIVE MEDICAL SERVICES[2]								

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Periodic Physical Exams	100% Covered	Not Covered	100% Covered	N/A	100% Covered	N/A	100% Covered	N/A
Routine Gynecological Care, Pap Smears	100% Covered	Not Covered (except PAP @ 100%)	100% Covered	N/A	100% Covered	N/A	100% Covered	N/A
Routine Mammogram	100% Covered	100%Covered	100% Covered	N/A	100% Covered	N/A	100% Covered	N/A
Routine Well Child Care	100% Covered	Not Covered	100% Covered	N/A	100% Covered	N/A	100% Covered	N/A
Routine Immunizations	100% Covered	Not Covered	100% Covered	N/A	100% Covered	N/A	100% Covered	N/A
Routine Sigmoidoscopy & Colonoscopy	100% Covered	Not Covered	100% Covered	N/A	100% Covered	N/A	100% Covered	N/A
Routine Blood Antigen Test (PSA)	100% Covered	Not Covered	100% Covered	N/A	100% Covered	N/A	100% Covered	N/A
TREATMENT OF ILLNESS OR INJURY								
Diagnosis and Treatment in the Primary Care Physician office	$15 Co-pay; then 100%	80% after deductible	$10 Co-pay then 100%	N/A	$10 Co-pay then 100%	N/A	80% after deductible	N/A
TREATMENT OF ILLNESS OR INJURY (Cont'd)								
Specialist Care	$25 Co-pay then 100%	80% after deductible.	$20 Co-pay then 100%	N/A	$20 Co-pay then 100%	N/A	80% after deductible	N/A
Outpatient Surgery	100% Covered	80% after deductible	100% Covered	N/A	100% Covered	N/A	80% Covered	N/A

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Allergy Testing & Treatment PCP Specialist	$15 Co-pay then 100% $25 Co-pay then 100%	80% after deductible 80% after deductible	$10 Co-pay then 100%	N/A	$10 Co-pay then 100%	N/A	80% after deductible; treatment only	N/A
Lab Services	100% covered	80% after deductible	100% Covered	N/A	100% Covered	N/A	100% Covered	N/A
X-Ray	$10 Co-pay then 100%	80% after deductible	$10 Co-pay then 100%	N/A	$10 Co-pay then 100%	N/A	100% Covered	N/A
Machine Tests	100% Covered	80% after deductible	100% Covered	N/A	100% Covered	N/A	100% Covered	N/A
Physical Therapy	100% Covered	80% after deductible	80% Covered	N/A	80% Covered	N/A	100% Covered	N/A
Speech and Occupational Therapy	100% Covered	80% after deductible	80% Covered	N/A	80% Covered	N/A	100% Covered	N/A
Radiation Therapy & Chemotherapy	100% Covered	80% after deductible	100% Covered	N/A	100% Covered	N/A	100% Covered	N/A
Nursing Home Visits	100% Covered	80% after deductible	$25 Co-pay then 100%	N/A	$25 Co-pay then 100%	N/A	80% covered after deductible	N/A
Chiropractic- 30 visit calendar year maximum	80% Covered	80% after deductible	80% Covered	N/A	80% Covered	N/A	80% Covered	N/A
IN THE HOSPITAL Room and Board *(Semi-private; includes intensive care, if medically appropriate and maternity)*	100% Covered	80% after deductible	100% Covered	N/A	100% Covered	N/A	100% Covered	N/A N/A

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Physician's and Surgeon's Services	100% Covered	80% after deductible	100% Covered except $25 Co-pay per procedure for Family Planning Services	N/A	100% Covered except $25 Co-pay per procedure for Family Planning Services	N/A	80% Covered	N/A
Other Medically Necessary Services	100% Covered	80% after deductible	100% Covered	N/A	100% Covered	N/A	100% Covered	N/A
MATERNITY (PHYSICIAN'S SERVICES) Prenatal/Postnatal Care	100% Covered	80% after deductible	100% Covered	N/A	100% Covered	N/A	80% Covered	N/A
Delivery	100% Covered	80% after deductible	100% Covered	N/A	100% Covered	N/A	80% Covered	N/A
EMERGENCY SERVICES Emergency Facility	$50 Co-pay per visit (waived if admitted) then 100%	$50 Co-pay per visit (waived if admitted) then 100%	$50 Co-pay then 100% (waived if admitted)	$50 Co-pay then 100% (waived if admitted)	$50 Co-pay then 100% (waived if admitted)	$50 Co-pay then 100% (waived if admitted)	100% Covered	100% Covered
Medical Emergency Care in facility	100% Covered	100% Covered	100 % Covered	N/A	100 % Covered	N/A	100% Covered	N/A
EMERGENCY SERVICES (Cont'd) Medical Emergency Care in PCP Office	$15 Co-pay; then 100%	80% after deductible	$10 Co-pay then 100%	N/A	$10 Co-pay then 100%	N/A	100% Covered after deductible	N/A

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AMBULANCE	100% Covered	100% Covered	$25 Co-pay then 100%	N/A	100% Covered	N/A	100% Covered	N/A
MENTAL HEALTH AND SUBSTANCE ABUSE Inpatient &/or Partial Hospital Care	100% Covered.	80% after deductible.	100% Covered.	N/A	100% Covered.	N/A	100% Covered.	N/A
Office Visit (Out Patient)	100% Covered	80% after deductible.	100% Covered	N/A	100% Covered	N/A	80% after deductible	N/A
OTHER SERVICES Private Duty Nursing	100% Covered; up to 240 hours per 12-month period (inpatient)	80% after deductible; up to 240 hours per 12-month period (inpatient)	100% Covered for 240 hours in a 12-month period (inpatient)	N/A	Outpatient coverage only. 100% Covered	N/A	80% Covered for 240 hours in a 12-month period (inpatient)	N/A
Hospice	100% Covered	100% Covered	100% Covered up to 240 days	N/A	100% Covered	N/A	100% Covered up to 240 days	N/A
Home Health Care	100% Covered up to 240 visits per calendar year.	100% Covered up to 240 visits per calendar year	100% Covered for up to 100 visits per calendar year	N/A	100% Covered for up to 100 visits per calendar year	N/A	100 % Covered up to 240 visits	N/A
Prosthetic Devices	80% after deductible.	80% after deductible	80% Covered for the initial fitting and purchase only	N/A	80% Covered for the initial fitting and purchase only	N/A	80% after deductible	N/A

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Durable Medical Equipment, Hearing Aids[4]	80% after deductible	80% after deductible	80% Covered	N/A	80% Covered	N/A	80% Covered	N/A
Skilled Nursing Facility	100% Covered; up to 120 days (in lieu of hospitalization)	100% Covered; up to 120 days per calendar year (in lieu of hospitalization)	100% Covered for 120 days (in lieu of hospitalization)	N/A	100% Covered for 120 days (in lieu of hospitalization)	N/A	100% Covered for 120 days (in lieu of hospitalizati on)	N/A
Vision Exam	100%. Covered one every 24 months	Not Covered	100%. Covered one every 24 months	N/A	100%. Covered One every 24 months	N/A	100%. Covered One every 24 months	N/A
Hearing Screening With the PCP	100% Covered	Not Covered	$10 Co-pay then 100%	N/A	$10 Co-pay then 100%	N/A	100% covered	N/A
Health Education Programs	Not Covered	Not Covered	$10 Co-pay then 100%	N/A	$10 Co-pay then 100%	N/A	Not Covered	N/A

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PRESCRIPTION DRUGS	Express Scripts **Generic** $5 copay (1-30 day supply) $10 (31-90 day supply) **Preferred Brand** $15 copay (1-30 day supply) $30 (31 -90 day supply **Non-Preferred $30** (1-30 day supply) $60 (31-90 day supply)	Not Covered	Express Scripts **Generic** $5 copay (1-30 day supply) $10 (31-90 day supply) **Preferred Brand** $15 copay (1-30 day supply) $30 (31 -90 day supply **Non-Preferred $30** (1-30 day supply) $60 (31-90 day supply)	N/A	Express Scripts **Generic** $5 copay (1-30 day supply) $10 (31-90 day supply) **Preferred Brand** $15 copay (1-30 day supply) $30 (31 -90 day supply **Non-Preferred $30** (1-30 day supply) $60 (31-90 day supply)	N/A	80% Covered after deductible (member submitted to Highmark)	
DEPENDENT CHILDREN	Covered until the end of the month in which they turn 26. COBRA option available.	Covered until the end of the month in which they turn 26. COBRA option available.	Covered until the end of the month in which they turn 26. COBRA option available.	N/A	Covered until the end of the month in which they turn 26. COBRA option available.	N/A	Covered until the end of the month in which they turn 26. COBRA option available.	N/A

NOTES:

1. **When calculating deductible, coinsurance, copays and out of pocket maximums, only the allowable charges are considered.**
2. **Preventive Care services are limited to those listed on the Highmark Delaware Preventive Schedule. Gender, age, and frequency limits may apply.**
3. **Member cost share is based on the type of service performed and the place where it is rendered.**
4. **Hearing Aids are limited to one per impaired ear every 36 months.**

This is not a contract. This benefit comparison is intended to provide you with a general overview of Highmark Blue Cross Blue Shield Delaware's Comprehensive 80, Blue Choice PPO and EPO programs. The services, benefits, terms and conditions under which they are provided are contained in the group contract between the Corporations and New Castle County.