Customer Service
(800) 633-2563

NEW CASTLE COUNTY COMPARISON OF ACTIVE EMPLOYEES BENEFITS PLAN YEAR 2022

Aetna Customer Select Service
(855) 281-8858

BENEFITS	HIGHMARK BLUE CHOICE PPO		HIGHMARK EPO	HIGHMARK COMPREHENSIVE 80	AETNA SELECT OPEN ACCESS HMO
	IN-NETWORK	OUT OF NETWORK			
	ACTIVE AND RETIRED GROUP: 10006173		ACTIVE GROUP: 10055812	ACTIVE GROUP: 10006183	ACTIVE GROUP: 834912-01000001
Deductible Per Calendar Year (Individual/Family)	$200 Individual $400 Family (DME, Prosthetics & Hearing Aids only)	$200 per Individual $400 per Family	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	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:	$8,700 Individual $17,400 Family	N/A	$8,700 Individual $17,400 Family	$8,700 Individual $17,400 Family	$8,700 Individual $17,400 Family
PREVENTIVE MEDICAL SERVICES[2]					
Periodic Physical Exams	100% Covered	Not Covered	100% Covered	100% Covered	100% Covered
Routine Gynecological Care, Pap Smears	100% Covered	Not Covered (except PAP @ 100%)	100% Covered	100% Covered	100% Covered
Routine Mammogram	100% Covered	Not Covered	100% Covered	100% Covered	100% Covered
Routine Well Child Care	100% Covered	Not Covered	100% Covered	100% Covered	100% Covered
Routine Immunizations	100% Covered	Not Covered	100% Covered	100% Covered	100% Covered
Routine Sigmoidoscopy & Colonoscopy	100% Covered	Not Covered	100% Covered	100% Covered	100% Covered
Routine Blood Antigen Test (PSA)	100% Covered	Not Covered	100% Covered	100% Covered	100% Covered

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	IN-NETWORK	OUT OF NETWORK			
TREATMENT OF ILLNESS OR INJURY					
Diagnosis and Treatment in the Primary Care Physician office	$25 Co-pay; then 100%	80% after deductible	$25 Co-pay then 100%	80% after deductible	$25 Co-pay then 100%
Specialist Care	$35 Co-pay then 100%	80% after deductible.	$35 Co-pay then 100%	80% after deductible	$35 Co-pay then 100%
Outpatient Surgery (Professional Fees)	100% Covered	80% after deductible	100% Covered	80% Covered	100% Covered
Allergy Testing & Treatment PCP Specialist	$25 Co-pay then 100% $35 Co-pay then 100%	80% after deductible 80% after deductible	$25 Co-pay then 100%	80% after deductible; treatment only	$25 Co-pay then 100%
Lab Services	100% covered	80% after deductible	100% Covered	100% Covered	100% Covered
X-Ray	100% Covered	80% after deductible	100% Covered	100% Covered	100% Covered
Machine Tests	100% Covered	80% after deductible	100% Covered	100% Covered	100% Covered
Physical Therapy	100% Covered	80% after deductible	80% Covered	100% Covered	80% Covered
Speech and Occupational Therapy	100% Covered	80% after deductible	80% Covered	100% Covered	80% Covered
Radiation Therapy & Chemotherapy	100% Covered	80% after deductible	100% Covered	100% Covered	100% Covered
Nursing Home Visits	100% Covered	80% after deductible	$25 Co-pay then 100%	80% covered after deductible	$25 Co-pay then 100%
Chiropractic- 30 visit calendar year maximum	80% Covered	80% after deductible	80% Covered	80% Covered	80% Covered
IN THE HOSPITAL					
Room and Board *(Semi-private; includes intensive care, if medically appropriate and maternity)*	100% Covered	80% after deductible	100% Covered	100% Covered	100% Covered
Medical/Surgical Expenses (except office visits)	100% Covered	80% after deductible	100% Covered	80% Covered	100% Covered
Other Medically Necessary Services	100% Covered	80% after deductible	100% Covered	100% Covered	100% Covered

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	IN-NETWORK	OUT OF NETWORK			
MATERNITY (PHYSICIAN'S SERVICES)					
Prenatal/Postnatal Care			100% Covered	80% after deductible	100% Covered
Delivery			100% Covered	80% after deductible	100% Covered
EMERGENCY SERVICES					
Emergency Facility	$100 Co-pay per visit (waived if admitted) then 100%	$100 Co-pay per visit (waived if admitted) then 100%	$100 Co-pay then 100% (waived if admitted)	100% Covered	$100 Co-pay then 100% (waived if admitted)
Medical Emergency Care in facility	100% Covered	100% Covered	100 % Covered	100 % Covered	100 % Covered
Medical Emergency Care in PCP Office	$25 Co-pay; then 100%	80% after deductible	$25Co-pay then 100%	100% Covered after deductible	$25 Co-pay then 100%
AMBULANCE	100% Covered	100% Covered	$25 Co-pay then 100%	100% Covered	100% Covered
MENTAL HEALTH AND SUBSTANCE ABUSE					
Inpatient &/or Partial Hospital Care	100% Covered.	80% after deductible.	100% Covered.	100% Covered.	100% Covered.
Office Visit (Out Patient)	100% Covered	80% after deductible.	100% Covered	80% Covered after deductible	100% Covered
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)	Covered 80% Covered for 240 hours in a 12-month period (inpatient)	Outpatient coverage only. 100% Covered
Hospice	100% Covered	100% Covered	100% Covered up to 240 days	100% Covered up to 240 days	100% Covered up to 240 days
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	100 % Covered up to 240 visits	100% Covered for up to 100 visits per calendar year

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Prosthetic Devices	80% after deductible.	80% after deductible	80% Covered for the initial fitting and purchase only	80% after deductible	80% Covered for the initial fitting and purchase only
Durable Medical Equipment, Hearing Aids[4]	80% after deductible	80% after deductible	80% Covered	80% Covered	80% Covered
Skilled Nursing Facility	100% Covered; up to 120 days per calendar year	100% Covered; up to 120 days per calendar year	100% Covered for 120 days (in lieu of hospitalization)	100% Covered for 120 days	100% Covered for 120 days (in lieu of hospitalization)
Vision Exam	100% Covered. One adult routine eye exam covered every 24 months; one pediatric routine eye exam covered every 12 months.	Not Covered	100% Covered. One adult routine eye exam covered every 24 months; one pediatric routine eye exam covered every 12 months.	100% Covered. One adult routine eye exam covered every 24 months; one pediatric routine eye exam covered every 12 months.	100% Covered. One adult routine eye exam covered every 24 months; one pediatric routine eye exam covered every 12 months.
OTHER SERVICES (Cont'd)					
Hearing Screening With the PCP	100% Covered	Not Covered	$10 Co-pay then 100%	100% Covered	$10 Co-pay then 100%
Health Education Programs	Not Covered	Not Covered	$10 Co-pay then 100%	Not Covered	$10 Co-pay then 100%
Infertility Services	Covered at applicable service's benefit/$40,000 Lifetime Maximum	Covered at applicable service's benefit/$40,000 Lifetime Maximum	Covered at applicable service's benefit/$40,000 Lifetime Maximum	Covered at applicable service's benefit/$40,000 Lifetime Maximum	Covered at applicable service's benefit/$40,000 Lifetime Maximum

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PRESCRIPTION DRUGS	The Prescription Drug Program is administered by Express Scripts directly, not Highmark. **Generic** $8 copay **Preferred** $30 copay **Non-Preferred** $50 copay $20,000 Lifetime Maximum for Infertility Drugs	Not Covered	The Prescription Drug Program is administered by Express Scripts directly, not Highmark. **Generic** $8 copay **Preferred** $30 copay **Non-Preferred** $50 copay $20,000 Lifetime Maximum for Infertility Drugs	80% Covered after deductible $20,000 Lifetime Maximum for Infertility Drugs	The Prescription Drug Program is administered by Express Scripts directly, not Aetna. **Generic** $8 copay **Preferred** $30 copay **Non-Preferred** $50 copay $20,000 Lifetime Maximum for Infertility Drugs
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.	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.

NOTES:

A. When calculating deductible, coinsurance, copays and out of pocket maximums, only the allowable charges are considered.

B. 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]

1. **Preventive Care services are limited to those listed on the Aetna or Highmark Delaware Preventive Schedule. Gender, age, and frequency y limits may apply.**
2. **Member cost share is based on the type of service performed and the place where it is rendered.**
3. **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 Aetna Select HMO, 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.