



City of Milford

DVHT PPO \$20/\$30 Rx \$10/\$32/\$60

Benefits	In Network	Out-of-Network
Deductible	None	\$300 single / \$600 family****
Out of Pocket Maximum	\$4,500 single / \$9,000 family	\$7,500 single / \$15,000 family
Primary Care Physician Office Visit	\$20 copay	80%, after deductible
Specialist Office Visit	\$30 copay	80%, after deductible
Teladoc (Virtual Physician, Specialist, Behavioral Health)	100%	N/A
Preventive Care*	100%	80%, after deductible
Routine GYN Exam/PAP*	100%	80%, after deductible
Pediatric Immunizations*	100%	80%, after deductible
Mammography*	100%	80%, after deductible
Hospitalization	\$100 copay per day (\$200 maximum per admission)	80%, after deductible
Maternity	Prenatal/Postnatal 100%. Inpatient hospitalization \$100 copay per day (\$200 maximum per admission).	80%, after deductible
Ambulance	100%	100%, no deductible
Emergency Room**	Facility: \$200 copay per visit, waived if admitted	Facility: \$200 copay per visit, waived if admitted
Urgent Care Facility***	\$20 copay	80%, after deductible
Walk-In Clinic	\$20 copay, except 100% at CVS Minute Clinic	80%, after deductible
Outpatient Surgery	Ambulatory Center: \$50 copay; Outpatient Dept Hospital: \$150 copay	80%, after deductible
Outpatient Routine Radiology/Diagnostic Lab	Labs: \$10 copay at Non-Hospital Affiliated Freestanding Facility/\$50 copay at Hospital Affiliated Facility; X-Ray: 100% at Non-Hospital Affiliated Freestanding Facility/\$50 copay at Hospital Affiliated Facility	80%, after deductible
Complex Imaging (MRI/MRA, CT/CTA Scan, PET Scan)	100% at Non-Hospital Affiliated Freestanding Facility/\$100 copay at Hospital Affiliated Facility	80%, after deductible
Physical/Speech/Occupational Therapy	85% covered, maximum number of visits allowed for a specific diagnosis is determined by medical necessity.	80%, after deductible, maximum number of visits allowed for a specific diagnosis is determined by medical necessity.



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Chiropractic Care	85% covered, maximum number of visits allowed for a specific diagnosis is determined by medical necessity.	80%, after deductible
Home Health Care	100%, up to 240 visits per plan year	80%, after deductible, up to 240 visits per plan year
Hospice Care	100%	80%, after deductible
Skilled Nursing Facility	100%	80%, after deductible
Mental Health Services	Inpatient \$100 copay per day (\$200 maximum per admission); Outpatient \$20 copay per office visit	80%, after deductible
Substance Abuse Treatment	Inpatient \$100 copay per day (\$200 maximum per admission); Outpatient \$20 copay per office visit	80%, after deductible
Durable Medical Equipment	100%	80%, after deductible
Orthotics	100%	80%, after deductible
Hearing Aids	Limited to one hearing aid per ear every 3 years for children less than 24 years of age	
Prescription Drug Out of Pocket Maximum	\$2,100 per Employee, \$4,200 per Family	N/A
Prescription Drug Retail	\$10 Generic/\$32 Preferred Brand/\$60 Non-Preferred Brand, up to a 30 day supply (Preventive Drugs \$0)	Reimbursement limited to in-network allowable amount minus applicable copay
Prescription Drug Mail Order	\$20 Generic/\$64 Preferred Brand/\$120 Non-Preferred Brand, up to a 90 day supply	Not covered
Specialty Drugs	No charge if enrolled in PrudentRx program; 30% coinsurance if not enrolled in PrudentRx. Specialty drugs must be filled by CVS Specialty Pharmacy.	Not covered

*Preventive services as defined by Federal Mandate and procedure code

**Copay will not be waived if claim is coded as "Observation stay"

***Non-urgent services (such as follow-up visits, suture removal, etc.) rendered at urgent care facility are not covered

****Two individuals must meet the deductible for the family deductible to be met