



City of Milford

DVHT PPO \$500/\$1,000 Rx \$10/\$32/\$60

Benefits	In Network	Out-of-Network
Deductible	\$500 single / \$1,000 family****	\$1,000 single / \$2,000 family****
Out of Pocket Maximum	\$2,000 single / \$4,000 family	\$4,000 single / \$8,000 family
Primary Care Physician Office Visit	90%, after deductible	70%, after deductible
Specialist Office Visit	90%, after deductible	70%, after deductible
Teladoc (Virtual Physician, Specialist, Behavioral Health)	90%, after deductible	N/A
Preventive Care*	100%, no deductible	70%, no deductible
Routine GYN Exam/PAP*	100%, no deductible	70%, no deductible
Pediatric Immunizations*	100%, no deductible	70%, no deductible
Mammography*	100%, no deductible	70%, no deductible
Hospitalization	90%, after deductible	70%, after deductible
Maternity	Prenatal/Postnatal 90%, after deductible; Inpatient hospitalization 90%, after deductible	Prenatal/Postnatal 70%, after deductible; Inpatient hospitalization 70%, after deductible
Ambulance	90%, after deductible	70%, after deductible
Emergency Room**	90%, after deductible	90%, after in-network deductible
Urgent Care Facility***	\$25 copay, no deductible	\$25 copay, no deductible
Walk-In Clinic	90%, after deductible. Except 100%, after deductible at CVS Minute Clinic.	70%, after deductible
Outpatient Surgery	90%, after deductible	70%, after deductible
Outpatient Routine Radiology/Diagnostic Lab	90%, after deductible	70%, after deductible
Complex Imaging (MRI/MRA, CT/CTA Scan, PET Scan)	90%, after deductible	70%, after deductible
Physical/Speech/Occupational Therapy	90%, after deductible, maximum number of visits is determined by medical necessity	70%, after deductible, maximum number of visits is determined by medical necessity



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Benefits	In Network	Out-of-Network
Chiropractic Care	90%, after deductible, limited to 30 visits per plan year	75%, after deductible, limited to 30 visits per plan year
Home Health Care	90%, after deductible, limited to 240 visits per plan year	75%, after deductible, limited to 240 visits per plan year
Hospice Care	90%, after deductible	70%, after deductible
Skilled Nursing Facility	90%, after deductible	70%, after deductible
Mental Health Services	Inpatient 90%, after deductible; Outpatient 90%, after deductible	Inpatient 70%, after deductible; Outpatient 70%, after deductible
Substance Abuse Treatment	Inpatient 90%, after deductible; Outpatient 90%, after deductible	Inpatient 70%, after deductible; Outpatient 70%, after deductible
Durable Medical Equipment	90%, after deductible	70%, after deductible
Orthotics	90%, after deductible	70%, 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	Specialty: 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