DELAWARE VALLEY HEALTH TRUST

City of Milford

DVHT PPO HRA-AHF $1,500/$3,000 Rx $10/$32/$60		
Benefits	**In Network**	**Out-of-Network**
Deductible	$1,500 single / $3,000 family****	$1,500 single / $3,000 family****
Employer Deductible Funding	$1,250 single / $2,500 family	$1,250 single / $2,500 family
Out of Pocket Maximum	$4,500 single / $9,000 family	$7,500 single / $15,000 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	Not covered
Preventive Care*	100%, no deductible	70%, after deductible
Routine GYN Exam/PAP*	100%, no deductible	70%, after deductible
Pediatric Immunizations*	100%, no deductible	70%, after deductible
Mammography*	100%, no deductible	70%, after deductible
Hospitalization	90%, after deductible	70%, after deductible
Maternity	100% per exam, no deductible; Inpatient hospitalization 90%, after deductible	70%, after deductible
Ambulance	90%, after deductible	70%, after deductible
Emergency Room*	Emergency 90%, after deductible. Non-emergency not covered.	Emergency 90%, after deductible. Non-emergency not covered.
Urgent Care Facility**	90%, after deductible	70%, after 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% per visit, after deductible, subject to medical necessity review at 25 visits	70% per visit, after deductible, subject to medical necessity review at 25 visits

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Chiropractic Care	Lesser of 90% per visit after Plan Year deductible or 25% of allowable charges. Up to 30 visits.	Lesser of 75% per visit after Plan Year deductible or 25% of allowable charges. Up to 30 visits.
Home Health Care	90%, after deductible, up to 240 visits	70%, after deductible, up to 240 visits
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% per visit, after deductible.	Inpatient 70%, after deductible. Outpatient 70% per visit, after deductible.
Substance Abuse Treatment	Inpatient 90%, after deductible. Outpatient 90% per visit, after deductible.	Inpatient 70%, after deductible. Outpatient 70% per visit, after deductible.
Durable Medical Equipment	90% per item, after deductible	70% per item, after deductible
Orthotics	Not covered	Not covered
Hearing Aids	90%, after deductible. Covers 1 hearing aid per ear every 3 years for child to age 24	70%, after deductible. Covers 1 hearing aid per ear every 3 years for child to age 24
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***
******Once the family deductible limit is met, all family members will be considered as having met their deductible***