Delaware Valley Health Trust

Kent County Levy Court

Aetna Open Choice PPO HIGH Plan – 100%/80% (July 1, 2018 – June 30, 2019)	DVHT HRA HDHP PPO 100, $5,000/$10,000, 80% out of network, with a $10 generic/$25 brand/$75 non-preferred pharmacy	
Benefits Summary	**In network**	**Out of network**
Deductible (Kent County Levy Court funds 100% of the deductible)	$5,000 individual/$10,000 family	$5,000 individual/$10,000 family
Out of Pocket Maximum	$7,150 individual/$14,300 family	$10,000 individual/$20,000 family
Primary Care Physician	$10 copay, no deductible	80%, after deductible
Specialist Office Visit	$20 copay, no deductible	80%, after deductible
Preventive Care/Screening/Immunization (includes physical exams, adult immunizations, colorectal cancer screening, routine gynecological exams, routine mammograms, PSA tests, routine pediatric physical exams and immunizations)	100%, no copay, no deductible	80%, after deductible
Hospitalization Inpatient	100%, after deductible	80%, after deductible
Hospitalization Outpatient	100%, after deductible	80%, after deductible
Maternity (non-preventive facility & professional services)	100%, after deductible	80%, after deductible
Medical/Surgical (except office visits)	100%, after deductible	
Ambulatory Surgery	100%, after deductible	80%, after deductible
Anesthesia	100%, after deductible	
Emergency Room	$150 copay per visit (waived if admitted), no deductible	
Ambulance	100%, after deductible	
Urgent Care Facility	$50 copay, no deductible	80%, after deductible
Chiropractic Care	100%, after deductible. Up to 30 visits per benefit period. Visits combined in and out of network.	80%, after deductible. Visits combined in and out of network.
Cardiac Rehabilitation	$20 copay, no deductible. Limit: 3 sessions a week and 3 months of treatment. Visits combined in and out of network.	80%, after deductible. Visits combined in and out of network.

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Benefits Summary	**In network**	**Out of network**
Chemotherapy and Radiation Therapy	100%, after deductible	80%, after deductible
Physical/Speech/Occupational Therapy	$20 copay, no deductible. Up to 30 visits per plan year for physical and occupational therapy. 30 visits per plan year for speech therapy. Visits combined in and out of network.	80%, after deductible. Visits combined in and out of network.
Mental Health Services	Inpatient 100%, after deductible. Outpatient $10 copay per visit.	80%, after deductible
Substance Abuse	Inpatient 100%, after deductible. Outpatient $10 copay per visit.	80%, after deductible
Diagnostic Testing (x-ray/bloodwork)	100%, after deductible	80%, after deductible
Complex Imaging (MRI's, CT/PET Scans)	100%, after deductible	80%, after deductible
Durable Medical Equipment (includes orthotics and prosthetics)	100%, after deductible	80%, after deductible
Home Health Care	100%, after deductible. Up to 100 visits/benefit period. Visits combined in and out of network.	80%, after deductible. Visits combined in and out of network.
Hospice	100%, after deductible	80%, after deductible
Private Duty Nursing	100%, after deductible. Up to 240 hours/benefit period, inpatient only. Combined in and out of network.	80%, after deductible. Combined in and out of network.
Skilled Nursing Facility	100%, after deductible. Up to 120 days per benefit period. Days combined in and out of network.	80%, after deductible. Days combined in and out of network.
Transplant Services	100%, after deductible	80%, after deductible

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HIGH Plan – 100%/80%
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Benefits Summary	In network	Out of network
Vision Exam Benefit	Adult routine vision exam 100%, no copay, no deductible. One routine eye exam every 24 months. Pediatric routine vision exam 100%, no copay, no deductible. One routine eye exam every 12 months. Performed at time of physical by PCP.	80%, after deductible
Prescription Drug Retail	Generic $10 copay, Preferred Brand $25 copay, Non-preferred brand $75 copay. Up to a 34 day supply. Note - a 90-day supply is available at a charge of 2 copays.	Not covered
Prescription Drug Mail Order	Generic $20 copay, Preferred Brand $50 copay, Non-preferred brand $150 copay.	Not covered
Mandatory Generic	Unless the prescribing physician indicates Dispense as Written, if an individual chooses a preferred or non-preferred brand drug when a generic drug is available, he or she will have to pay the difference between the charge for the preferred or non-preferred brand drug and the generic drug, plus the copay for the brand drug.	