

Delaware Valley Health Trust

Kent County Levy Court – Retirees

**Aetna Open Choice PPO
Medicare supplement - Age 65+
(July 1, 2018 – June 30, 2019)**

DVHT PPO \$0 with a \$10 generic/\$25 brand/\$75 non-preferred pharmacy

Benefits Summary	In network	Out of network
Deductible	N/A	N/A
Out of Pocket Maximum	\$6,350 individual/\$12,700 family	\$6,350 individual/\$12,700 family
Primary Care Physician	100%, no copay	100%, no copay
Specialist Office Visit	100%, no copay	100%, no copay
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	100%, no copay
Hospitalization Inpatient	100%, no copay	100%, no copay
Outpatient Surgery	100%, no copay	100%, no copay
Maternity	100%, no copay	100%, no copay
Emergency Room	100%, no copay. Waived if admitted.	
Ambulance	Emergency 100%, no copay. Non-emergency 100%, no copay.	Emergency 100%, no copay. Non-emergency 100%, no copay.
Urgent Care Facility	100%, no copay	100%, no copay
Walk-in Clinic	100%, no copay	100%, no copay
Chiropractic Care	100%, no copay	100%, no copay
Cardiac Rehabilitation	100%, no copay	100%, no copay
Chemotherapy and Radiation Therapy	100%, no copay	100%, no copay
Physical/Speech/Occupational Therapy	100%, no copay	100%, no copay

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Mental Health Services	100%, no copay	100%, no copay
Substance Abuse	100%, no copay	100%, no copay
Diagnostic testing (x-ray/bloodwork)	100%, no copay	100%, no copay
Complex imaging (MRI's, CT/PET Scans)	100%, no copay	100%, no copay
Durable Medical Equipment	100%, no copay	100%, no copay
Home Health Care	100%, no copay	100%, no copay
Hospice	100%, no copay	100%, no copay
Skilled Nursing Facility	100%, no copay	100%, no copay
Vision Exam Benefit	100%, no copay	100%, no copay
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 3 copays.	Not covered
Prescription Drug Mail Order	Generic \$20 copay, Preferred Brand \$50 copay, Non-preferred brand \$150 copay. Up to a 90 day supply.	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.	

Note – this plan is secondary to Medicare Part A and/or Part B