DELAWARE VALLEY HEALTH TRUST

Pennsbury School District

PPO $10/$20 RX $15/$30/$50		
Benefits	**In Network**	**Out-of-Network**
Deductible	N/A	$300 single / $600 family
Out of Pocket Maximum	$1,500 single / $3,000 family	$2,000 single / $4,000 family
Primary Care Physician Office Visit	$10 copay	70%, after deductible
Specialist Office Visit	$20 copay	70%, after deductible
Primary Care Services at DVHT Health Center	100%, no copay	N/A
Teladoc (Virtual Physician, Specialist, Behavioral Health)	$10 copay general medicine, $20 copay mental/behavioral health and dermatology	N/A
Preventive Care*	100%, no copay	70%, no deductible
Routine GYN Exam/PAP*	100%, no copay	70%, no deductible
Pediatric Immunizations*	100%, no copay	70%, no deductible
Mammography*	100%, no copay	70%, no deductible
Hospitalization	$75 copay per day, maximum of 5 copays per admission	70%, after deductible
Maternity	Initial visit based on place of service, Inpatient hospitalization $75 copay per day, maximum of 5 copays per admission	70%, after deductible
Ambulance	100%, no copay	Emergency use 100%, no copay Non-emergency use 70%, after deductible
Emergency Room*	$40 copay, copay waived if admitted	
Urgent Care Facility**	$20 copay	70%, after deductible
Walk-In Clinic	$20 copay, Except 100%, no copay, at CVS MinuteClinic	70%, after deductible
Outpatient Surgery	$75 copay	70%, after deductible
Outpatient Routine Radiology/Diagnostic Lab	Radiology $20 copay/ Diagnostic Lab 100%, no copay	70%, after deductible
Complex Imaging (MRI/MRA, CT/CTA Scan, PET Scan)	$20 copay	70%, after deductible
Physical/Speech/Occupational Therapy	$15 copay, up to 60 visits per calendar year, combined in and out of network	70%, after deductible, up to 60 visits per calendar year, combined in and out of network
Autism Therapies	Covered, including Autism physical therapy, Autism speech therapy, Autism occupational therapy, and applied behavioral analysis, combined in and out-of-network	Covered, including Autism physical therapy, Autism speech therapy, Autism occupational therapy, and applied behavioral analysis, combined in and out-of-network

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PPO $10/$20 RX $15/$30/$50		
Benefits	**In Network**	**Out-of-Network**
Chiropractic Care	$20 copay, up to 30 visits per calendar year, combined in and out of network	70%, after deductible, up to 30 visits per calendar year, combined in and out of network
Home Health Care	100%, no copay	70%, after deductible
Hospice Care	100%, no copay	70%, after deductible
Skilled Nursing Facility	100%, no copay, up to 120 days per calendar year, combined in and out of network	70%, after deductible, up to 120 days per calendar year, combined in and out of network
Mental Health Services	Inpatient hospitalization $75 copay per day, maximum of 5 copays per admission, Outpatient $20 copay	70%, after deductible
Substance Abuse Treatment	Inpatient hospitalization $75 copay per day, maximum of 5 copays per admission, Outpatient $20 copay	70%, after deductible
Durable Medical Equipment	$20 copay	70%, after deductible
Vision Exam Benefit****	100%, no copay, 1 routine eye exam and contact lens fitting every calendar year	$60 reimbursement 1 routine eye exam every calendar year $60 reimbursement 1 contact lens fitting every calendar year
Prescription Drug Retail	$0 select generics at DVHT Health Center. $15 generic/$30 preferred brand/$50 non-preferred brand, up to a 30 day supply	70% of recognized charges, after deductible and applicable copay
Prescription Drug Mail Order	$30 generic/$60 preferred brand/$100 non-preferred brand, up to a 90 day supply	Not Covered
Erectile Dysfunction Medications	6 pills per month	

Embedded Deductible Style. Embedded Out-of-Pocket Maximum Style.
****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***
*******The vision benefit is available through Aenta Vision Preferred***