DELAWARE VALLEY HEALTH TRUST

Pennsbury School District

QPOS $30/$40 RX $15/$40/$70/$75		
Benefits	**In Network**	**Out-of-Network**
Deductible	N/A	$1,000 single / $3,000 family
Out of Pocket Maximum	$5,000 single / $10,000 family	$10,000 single / $30,000 family
Primary Care Physician Office Visit	$30 copay	50%, after deductible
Specialist Office Visit	$40 copay	50%, after deductible
Primary Care Services at DVHT Health Center	100%, no copay	N/A
Teladoc (Virtual Physician, Specialist, Behavioral Health)	$30 copay general medicine, $40 copay mental/behavioral health and dermatology	N/A
Preventive Care*	100%, no copay	50%, no deductible
Routine GYN Exam/PAP*	100%, no copay	50%, no deductible
Pediatric Immunizations*	100%, no copay	50%, no deductible
Mammography*	100%, no copay	50%, no deductible
Hospitalization	$500 copay per admission	50%, after deductible
Maternity	Initial visit based on place of service, Inpatient hospitalization $500 copay per admission	50%, after deductible
Ambulance	100%, no copay	Emergency use 100%, no copay Non-emergency use 50%, after deductible
Emergency Room*	$125 copay, copay waived if admitted	
Urgent Care Facility**	$40 copay	50%, after deductible
Walk-In Clinic	$30 copay. Except 100%, no copay at CVS MinuteClinic	50%, after deductible
Outpatient Surgery	$300 copay	50%, after deductible
Outpatient Routine Radiology/Diagnostic Lab	100%, no copay	50%, after deductible
Complex Imaging (MRI/MRA, CT/CTA Scan, PET Scan)	100%, no copay	50%, after deductible
Physical/Speech/Occupational Therapy	$40 copay	50%, after deductible
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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Chiropractic Care	$40 copay	50%, after deductible
Home Health Care	100%, no copay	50%, after deductible
Hospice Care	100%, no copay	50%, after deductible
Skilled Nursing Facility	100%, no copay, up to 180 days per calendar year, combined in and out of network	50%, after deductible, up to 180 days per calendar year, combined in and out of network
Mental Health Services	Inpatient hospitalization $500 copay per admission, Outpatient $40 copay	50%, after deductible
Substance Abuse Treatment	Inpatient hospitalization $500 copay per admission, Outpatient $40 copay	50%, after deductible
Durable Medical Equipment	100%, no copay	50%, 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
Infertility	$40 copay. Basic services covered, includes artificial insemination and ovulation induction, 6 attempts per lifetime combined in and out-of-network	50%, after deductible. Basic services covered, includes artificial insemination and ovulation induction, 6 attempts per lifetime combined in and out-of-network
Prescription Drug Retail	$0 select generics at DVHT Health Center. $15 generic/$40 preferred brand/$70 non-preferred brand, up to a 30 day supply	50% of recognized charges, after deductible and applicable copay
Prescription Drug Mail Order	$30 generic/$80 preferred brand/$140 non-preferred brand, up to a 90 day supply	Not Covered
Specialty Drugs	$75 copay, up to a 30 day supply. Mandatory fill at Aetna specialty pharmacy	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***