

Town of Ocean View, DE

Employee Orientation
December 2025

Presented by:

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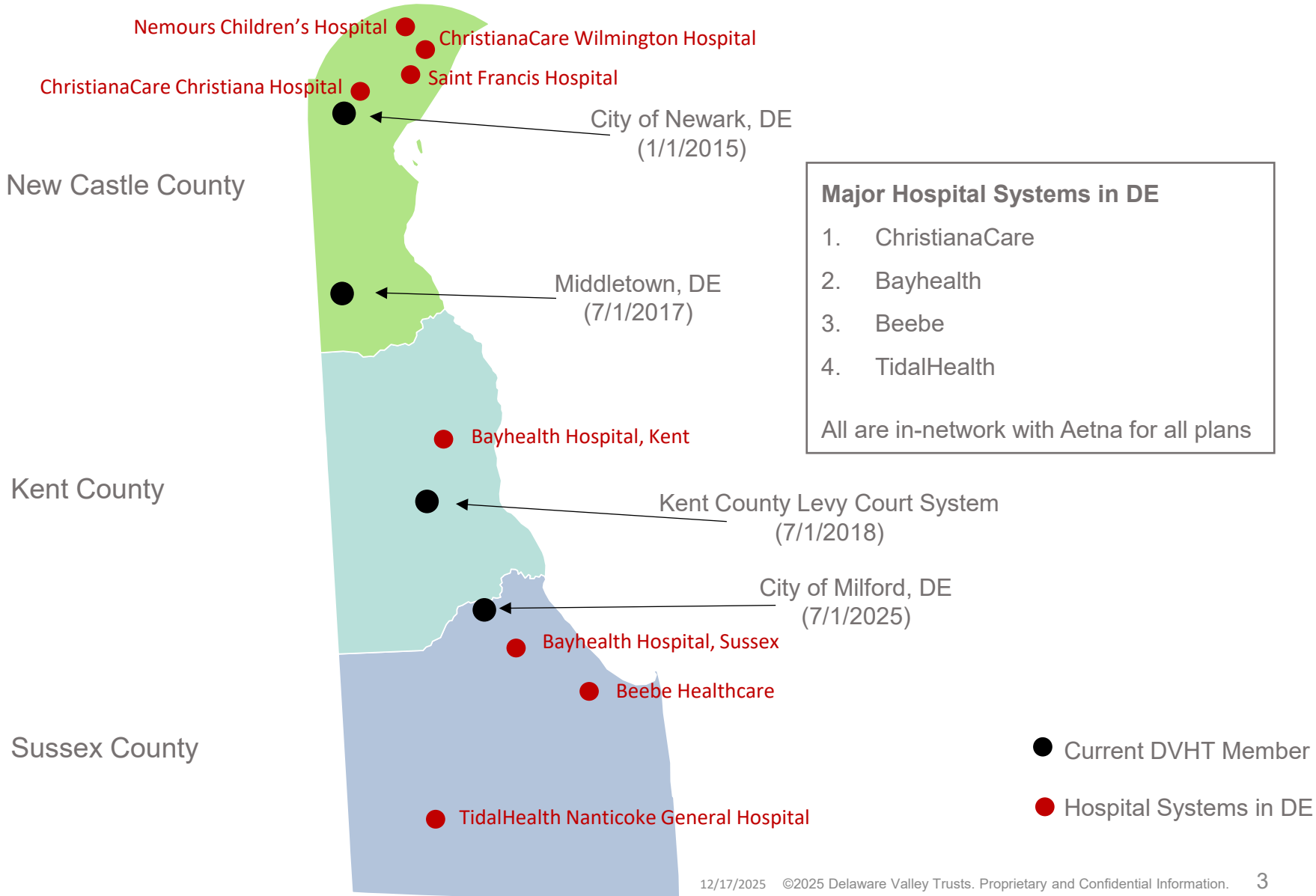




DELAWARE VALLEY
HEALTH
TRUST

- **Formed by local government for local government. Not a broker.**
- Self-insured intergovernmental risk pool serving Municipalities, School Districts, Counties, and Authorities in Pennsylvania and Delaware
- Non-Profit, Tax Exempt
- Now covers over 165 public entities and over 9,700 employee lives (over 25,000 member lives)
- Greater than 95% group retention rate since inception
- Strong Financial Position – Surplus Levels Meet Prudent Industry Standards

DVHT's Delaware Footprint

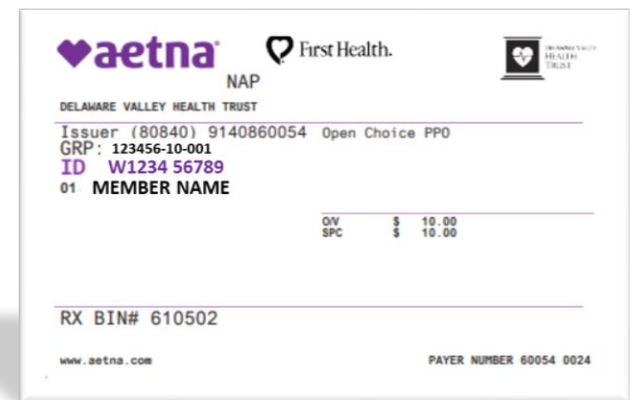




Plan Overview

Key Reminders

- Plans effective July 1, 2026
- Plan accumulators reset July 1
- Open Enrollment:
 - Opportunity to enroll in a Medical/Dental/Vision plan
 - Add/Remove dependents from plan
- No pre-existing condition exclusions
- Transition of Care Process



Town of Ocean View Plan Options

Current Plan Name	Highmark Delaware First State Basic Plan	Aetna CDH Gold Plan	Aetna HMO Plan	Highmark Delaware Comprehensive PPO Plan
DVHT Plan Options	DVHT PPO \$500/\$1,000	DVHT PPO \$1,500/\$3,000	DVHT HMO \$15/\$25	DVHT PPO \$20/\$30
Plan Type	Preferred Provider Organization (PPO)	Preferred Provider Organization (PPO)	Health Maintenance Organization (HMO)	Preferred Provider Organization (PPO)
Primary Care Provider (PCP) Selection	Recommended	Recommended	Required	Recommended



Town of Ocean View Plan Summary

PPO \$500 / \$1,000 Rx \$10 / \$32 / \$60

Benefits	In Network	Out-of-Network
<i>Deductible</i>	\$500 single / \$1,000 family****	\$1,000 single / \$2,000 family****
<i>Out of Pocket Maximum</i>	\$2,000 single / \$4,000 family	\$4,000 single / \$8,000 family
<i>Primary Care Physician Office Visit</i>	90%, after deductible	70%, after deductible
<i>Specialist Office Visit</i>	90%, after deductible	70%, after deductible
<i>Teladoc (Virtual Physician, Specialist, Behavioral Health)</i>	90%, after deductible	N/A
<i>Preventive Care*</i>	100%, no deductible	70%, no deductible
<i>Routine GYN Exam/PAP*</i>	100%, no deductible	70%, no deductible
<i>Pediatric Immunizations*</i>	100%, no deductible	70%, no deductible
<i>Mammography*</i>	100%, no deductible	70%, no deductible
<i>Hospitalization</i>	90%, after deductible	70%, after deductible
<i>Maternity</i>	Prenatal/Postnatal 90%, after deductible; Inpatient hospitalization 90%, after deductible	Prenatal/Postnatal 70%, after deductible; Inpatient hospitalization 70%, after deductible
<i>Ambulance</i>	90%, after deductible	70%, after deductible
<i>Emergency Room**</i>	90%, after deductible	90%, after in-network deductible
<i>Urgent Care Facility***</i>	\$25 copay, no deductible	\$25 copay, no deductible
<i>Walk-In Clinic</i>	90%, after deductible	70%, after deductible
<i>Outpatient Surgery</i>	90%, after deductible	70%, after deductible



Town of Ocean View Plan Summary

PPO \$500 / \$1,000 Rx \$10 / \$32 / \$60

Benefits	In Network	Out-of-Network
<i>Outpatient Routine Radiology/Diagnostic Lab</i>	90%, after deductible	70%, after deductible
<i>Complex Imaging (MRI/MRA, CT/CTA Scan, PET Scan)</i>	90%, after deductible	70%, after deductible
<i>Physical/Speech/Occupational Therapy</i>	90%, after deductible, maximum number of visits is determined by medical necessity	70%, after deductible, maximum number of visits is determined by medical necessity
<i>Chiropractic Care</i>	90%, after deductible, limited to 30 visits per plan year	75%, after deductible, limited to 30 visits per plan year
<i>Home Health Care</i>	90%, after deductible, limited to 240 visits per plan year	75%, after deductible, limited to 240 visits per plan year
<i>Hospice Care</i>	90%, after deductible	70%, after deductible
<i>Skilled Nursing Facility</i>	90%, after deductible	70%, after deductible
<i>Mental Health Services</i>	Inpatient 90%, after deductible; Outpatient 90%, after deductible	Inpatient 70%, after deductible; Outpatient 70%, after deductible
<i>Substance Abuse Treatment</i>	Inpatient 90%, after deductible; Outpatient 90%, after deductible	Inpatient 70%, after deductible; Outpatient 70%, after deductible
<i>Durable Medical Equipment</i>	90%, after deductible	70%, after deductible
<i>Orthotics</i>	90%, after deductible	70%, after deductible
<i>Hearing Aids</i>	Limited to one hearing aid per ear every 3 years for children less than 24 years of age	
<i>Prescription Drug Out of Pocket Maximum</i>	\$2,100 per Employee, \$4,200 per Family	N/A
<i>Prescription Drug Retail</i>	\$10 Generic / \$32 Preferred Brand / \$60 Non-Preferred Brand, up to a 30-day supply (Preventive Drugs \$0). \$20 Generic / \$64 Preferred Brand / \$120 Non-Preferred Brand, up to a 90-day supply for maintenance drugs at all retail pharmacies.	Reimbursement limited to in-network allowable amount minus applicable copay



Town of Ocean View Plan Summary

PPO \$500 / \$1,000 Rx \$10 / \$32 / \$60

Benefits	In Network	Out-of-Network
<i>Prescription Drug Mail Order</i>	\$20 Generic / \$64 Preferred Brand / \$120 Non-Preferred Brand, up to a 90-day supply	Not covered
<i>Specialty Drugs</i>	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*

*****Two individuals must meet the deductible for the family deductible to be met*



Town of Ocean View Plan Summary

PPO \$20 / \$30 Rx \$10 / \$32 / \$60		
Benefits	In Network	Out-of-Network
<i>Deductible</i>	None	\$300 single / \$600 family****
<i>Out of Pocket Maximum</i>	\$4,500 single / \$9,000 family	\$7,500 single / \$15,000 family
<i>Primary Care Physician Office Visit</i>	\$20 copay	80%, after deductible
<i>Specialist Office Visit</i>	\$30 copay	80%, after deductible
<i>Teladoc (Virtual Physician, Specialist, Behavioral Health)</i>	\$20 copay general medicine, \$20 copay mental/behavioral health and dermatology	N/A
<i>Preventive Care*</i>	100%	80%, after deductible
<i>Routine GYN Exam/PAP*</i>	100%	80%, after deductible
<i>Pediatric Immunizations*</i>	100%	80%, after deductible
<i>Mammography*</i>	100%	80%, after deductible
<i>Hospitalization</i>	\$100 copay per day (\$200 maximum per admission)	80%, after deductible
<i>Maternity</i>	Prenatal/Postnatal 100%. Inpatient hospitalization \$100 copay per day (\$200 maximum per admission).	80%, after deductible
<i>Ambulance</i>	100%	100%, no deductible
<i>Emergency Room**</i>	Facility: \$200 copay per visit, waived if admitted	Facility: \$200 copay per visit, waived if admitted
<i>Urgent Care Facility***</i>	\$20 copay	80%, after deductible
<i>Walk-In Clinic</i>	\$20 copay	80%, after deductible



Town of Ocean View Plan Summary

PPO \$20 / \$30 Rx \$10 / \$32 / \$60		
Benefits	In Network	Out-of-Network
<i>Outpatient Surgery</i>	Ambulatory Center: \$50 copay; Outpatient Dept Hospital: \$150 copay	80%, after deductible
<i>Outpatient Routine Radiology/Diagnostic Lab</i>	Labs: \$10 copay at Non-Hospital Affiliated Freestanding Facility/\$50 copay at Hospital Affiliated Facility; X-Ray: 100% at Non-Hospital Affiliated Freestanding Facility/\$50 copay at Hospital Affiliated Facility	80%, after deductible
<i>Complex Imaging (MRI/MRA, CT/CTA Scan, PET Scan)</i>	100% at Non-Hospital Affiliated Freestanding Facility/\$100 copay at Hospital Affiliated Facility	80%, after deductible
<i>Physical/Speech/Occupational Therapy</i>	85% covered, maximum number of visits allowed for a specific diagnosis is Determined by medical necessity.	80%, after deductible, maximum number of visits allowed for a specific diagnosis is Determined by medical necessity.
<i>Chiropractic Care</i>	85% covered, maximum number of visits allowed for a specific diagnosis is determined by medical necessity.	80%, after deductible
<i>Home Health Care</i>	100%, up to 240 visits per plan year	80%, after deductible, up to 240 visits per plan year
<i>Hospice Care</i>	100%	80%, after deductible
<i>Skilled Nursing Facility</i>	100%	80%, after deductible
<i>Mental Health Services</i>	Inpatient \$100 copay per day (\$200 maximum per admission); Outpatient \$20 copay per office visit	80%, after deductible
<i>Substance Abuse Treatment</i>	Inpatient \$100 copay per day (\$200 maximum per admission); Outpatient \$20 copay per office visit	80%, after deductible
<i>Durable Medical Equipment</i>	100%	80%, after deductible
<i>Orthotics</i>	100%	80%, after deductible



Town of Ocean View Plan Summary

PPO \$20 / \$30 Rx \$10 / \$32 / \$60		
Benefits	In Network	Out-of-Network
<i>Hearing Aids</i>	Limited to one hearing aid per ear every 3 years for children less than 24 years of age	
<i>Prescription Drug Out of Pocket Maximum</i>	\$2,100 per Employee / \$4,200 per Family	N/A
<i>Prescription Drug Retail</i>	\$10 Generic / \$32 Preferred Brand / \$60 Non-Preferred Brand, up to a 30-day supply (Preventive Drugs \$0). \$20 Generic / \$64 Preferred Brand / \$120 Non-Preferred Brand, up to a 90-day supply for maintenance drugs at all retail pharmacies.	Reimbursement limited to in-network allowable amount minus applicable copay
<i>Prescription Drug Mail Order</i>	\$20 Generic/\$64 Preferred Brand/\$120 Non-Preferred Brand, up to a 90-day supply	Not covered
<i>Specialty Drugs</i>	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**

******Two individuals must meet the deductible for the family deductible to be met**

*******Telemedicine Services (acute care for minor illnesses available on-demand 24/7) must be performed by a Highmark Designated Telemedicine Provider. Additional services provided by a Designated Telemedicine Provider are paid according to the benefit category that they fall under (e.g. PCP is eligible under the PCP Office Visit benefit, Behavioral Health is eligible under the Outpatient Mental Health Services benefit).**



Town of Ocean View Plan Summary

PPO \$1,500 / \$3,000 Rx \$10 / \$32 / \$60

Benefits	In Network	Out-of-Network
<i>Deductible</i>	\$1,500 single / \$3,000 family****	\$1,500 single / \$3,000 family****
<i>Employer Deductible Funding</i>	\$1,250 single / \$2,500 family	\$1,250 single / \$2,500 family
<i>Out of Pocket Maximum</i>	\$4,500 single / \$9,000 family	\$7,500 single / \$15,000 family
<i>Primary Care Physician Office Visit</i>	90%, after deductible	70%, after deductible
<i>Specialist Office Visit</i>	90%, after deductible	70%, after deductible
<i>Teladoc (Virtual Physician, Specialist, Behavioral Health)</i>	90%, after deductible	Not covered
<i>Preventive Care*</i>	100%, no deductible	70%, after deductible
<i>Routine GYN Exam/PAP*</i>	100%, no deductible	70%, after deductible
<i>Pediatric Immunizations*</i>	100%, no deductible	70%, after deductible
<i>Mammography*</i>	100%, no deductible	70%, after deductible
<i>Hospitalization</i>	90%, after deductible	70%, after deductible
<i>Maternity</i>	100% per exam, no deductible; Inpatient hospitalization 90%, after deductible	70%, after deductible
<i>Ambulance</i>	90%, after deductible	70%, after deductible
<i>Emergency Room**</i>	Emergency 90%, after deductible. Non-emergency not covered.	Emergency 90%, after deductible Non-emergency not covered.
<i>Urgent Care Facility***</i>	90%, after deductible	70%, after deductible
<i>Walk-In Clinic</i>	90%, after deductible	70%, after deductible



Town of Ocean View Plan Summary

PPO \$1,500 / \$3,000 Rx \$10 / \$32 / \$60

Benefits	In Network	Out-of-Network
<i>Outpatient Surgery</i>	90%, after deductible	70%, after deductible
<i>Outpatient Routine Radiology/Diagnostic Lab</i>	90%, after deductible	70%, after deductible
<i>Complex Imaging (MRI/MRA, CT/CTA Scan, PET Scan)</i>	90%, after deductible	70%, after deductible
<i>Physical/Speech/Occupational Therapy</i>	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
<i>Chiropractic Care</i>	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.
<i>Home Health Care</i>	90%, after deductible, up to 240 visits	70%, after deductible, up to 240 visits
<i>Hospice Care</i>	90%, after deductible	70%, after deductible
<i>Skilled Nursing Facility</i>	90%, after deductible	70%, after deductible
<i>Mental Health Services</i>	Inpatient 90%, after deductible. Outpatient 90% per visit, after deductible.	Inpatient 70%, after deductible. Outpatient 70% per visit, after deductible.
<i>Substance Abuse Treatment</i>	Inpatient 90%, after deductible. Outpatient 90% per visit, after deductible.	Inpatient 70%, after deductible. Outpatient 70% per visit, after deductible.
<i>Durable Medical Equipment</i>	90% per item, after deductible	70% per item, after deductible
<i>Orthotics</i>	Not covered	Not covered
<i>Hearing Aids</i>	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
<i>Prescription Drug Out of Pocket Maximum</i>	\$2,100 per Employee, \$4,200 per Family	N/A



Town of Ocean View Plan Summary

PPO \$1,500 / \$3,000 Rx \$10 / \$32 / \$60		
Benefits	In Network	Out-of-Network
<i>Prescription Drug Retail</i>	\$10 Generic / \$32 Preferred Brand / \$60 Non-Preferred Brand, up to a 30-day supply (Preventive Drugs \$0). \$20 Generic / \$64 Preferred Brand / \$120 Non-Preferred Brand, up to a 90-day supply for maintenance drugs at all retail pharmacies.	Reimbursement limited to in-network allowable amount minus applicable copay
<i>Prescription Drug Mail Order</i>	\$20 Generic / \$64 Preferred Brand / \$120 Non-Preferred Brand, up to a 90-day supply	Not covered
<i>Specialty Drugs</i>	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***



Town of Ocean View Plan Summary

PPO \$15 / \$25 Rx \$10 / \$32 / \$60	
Benefits	In Network
<i>Deductible</i>	N/A
<i>Out of Pocket Maximum</i>	\$4,500 single / \$9,000 family
<i>Primary Care Physician Office Visit</i>	\$15 copay
<i>Specialist Office Visit</i>	\$25 copay
<i>Teladoc (Virtual Physician, Specialist, Behavioral Health)</i>	\$0 copay
<i>Preventive Care*</i>	\$0 copay
<i>Routine GYN Exam/PAP*</i>	\$0 copay
<i>Pediatric Immunizations*</i>	\$0 copay
<i>Mammography*</i>	\$0 copay
<i>Hospitalization</i>	\$100 copay per day with max of \$200 copay per admission
<i>Maternity</i>	\$25 copay first visit only; Inpatient hospitalization \$100 copay per day with max of \$200 copay per admission
<i>Ambulance</i>	\$50 copay
<i>Emergency Room**</i>	\$200 copay, waived if admitted
<i>Urgent Care Facility***</i>	\$15 copay
<i>Walk-In Clinic</i>	\$15 copay
<i>Outpatient Surgery</i>	Ambulatory Center: \$50 copay; Hospital Facility: \$150 copay



Town of Ocean View Plan Summary

PPO \$15 / \$25 Rx \$10 / \$32 / \$60	
Benefits	In Network
<i>Outpatient Routine Radiology/Diagnostic Lab</i>	Radiology: Non-Hospital Affiliated Freestanding Facility (Preferred): \$0 copay; Hospital Affiliated Facility: \$50 copay Lab: Labcorp and Quest Diagnostics (Preferred): \$10 copay; Hospital/Other Lab Facility: \$50 copay
<i>Complex Imaging (MRI/MRA, CT/CTA Scan, PET Scan)</i>	Non-Hospital Affiliated Freestanding Facility (Preferred): \$0 copay; Hospital Affiliated Facility: \$100 copay
<i>Physical/Speech/Occupational Therapy</i>	20% of the contracted rate, per visit, up to 45 visits per incident or illness. \$15 copay or 20% coinsurance (whichever amount is equal to or less than 25% of the contracted rate) for the treatment of mental health and substance use disorder diagnoses.
<i>Chiropractic Care</i>	Lesser of \$15 copay or 25% of allowable charges
<i>Home Health Care</i>	\$0 copay
<i>Hospice Care</i>	\$0 copay
<i>Skilled Nursing Facility</i>	\$0 copay
<i>Mental Health Services</i>	Inpatient hospitalization \$100 copay per day with max of \$200 copay per admission; Outpatient \$15 copay per visit
<i>Substance Abuse Treatment</i>	Inpatient hospitalization \$100 copay per day with max of \$200 copay per admission; Outpatient \$15 copay per visit
<i>Durable Medical Equipment</i>	20% of the cost per item
<i>Orthotics</i>	Not covered
<i>Hearing Aids</i>	20% copay, 3 hearing aids within 36 months, for children to age 24
<i>Prescription Drug Out of Pocket Maximum</i>	\$2,100 per Employee, \$4,200 per Family



Town of Ocean View Plan Summary

HMO \$15 / \$25 Rx \$10 / \$32 / \$60	
Benefits	In Network
<i>Prescription Drug Retail</i>	\$10 Generic/\$32 Preferred Brand/\$60 Non-Preferred Brand, up to a 30-day supply (Preventive Drugs \$0). \$20 Generic/\$64 Preferred Brand/\$120 Non-Preferred Brand, up to a 90-day supply for maintenance drugs at all retail pharmacies.
<i>Prescription Drug Mail Order</i>	\$20 Generic/\$64 Preferred Brand/\$120 Non-Preferred Brand, up to a 90-day supply
<i>Specialty Drugs</i>	Specialty: No charge if enrolled in PrudentRx program;30% coinsurance if not enrolled in PrudentRx. Specialty drugs must be filled by CVS Specialty Pharmacy.

****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***



Benefit Summary Comparison

Plan Options	DVHT PPO \$500/\$1,000		DVHT PPO \$1,500/\$3,000		DVHT HMO \$15/\$25		DVHT PPO \$20/\$30	
Plan Type	Preferred Provider Organization (PPO)		Preferred Provider Organization (PPO)		Health Maintenance Organization (HMO)		Preferred Provider Organization (PPO)	
Primary Care Provider (PCP) Selection	Recommended		Recommended		Required		Recommended	
Plan Feature	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Preventive Care/ Screening/Immunization* (age, gender and risk parameters may apply)	100% covered, not subject to deductible	30% coinsurance, not subject to deductible	100% covered, not subject to deductible	30% coinsurance after deductible	100% covered	Not covered	100% covered	20% coinsurance after deductible
Deductible (per plan year)	\$500 per individual/ \$1,000 per family	\$1,000 per individual/ \$2,000 per family	\$1,500 per individual/ \$3,000 per family	\$1,500 per individual/ \$3,000 per family	N/A	N/A	N/A	\$300 per individual/ \$600 per family
Out-of-Pocket Maximum (including copays and deductibles)	\$2,000 per individual/ \$4,000 per family	\$4,000 per individual/ \$8,000 per family	\$4,500 per individual/ \$9,000 per family	\$7,500 per individual/ \$15,000 per family	\$4,500 per individual/ \$9,000 per family	N/A	\$4,500 per individual/ \$9,000 per family	\$7,500 per individual/ \$15,000 per family
Prenatal and Postnatal Care	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	100% covered after \$25 initial copay (inpatient room and board copays do apply to hospital deliveries/ birthing centers)	Not covered	100% covered (inpatient room and board copays do apply to hospital deliveries/birthing centers)	20% coinsurance after deductible
24/7 Nurse Line	Yes, no cost		Yes, no cost		Yes, no cost		Yes, no cost	
Primary Care Visit to treat an injury or illness (in-person or virtual)	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	\$15 copay per visit	Not covered	\$20 copay per visit	20% coinsurance after deductible
Telemedicine (Virtual Doctor Visits)	100% covered, not subject to deductible	30% coinsurance after deductible	100% covered, not subject to deductible	30% coinsurance after deductible	\$0 copay per visit	Not covered	\$0 copay per visit	20% coinsurance after deductible
Urgent Care Visit***	100% covered after \$25 copay per visit	100% covered after \$25 copay per visit	10% coinsurance after deductible	30% coinsurance after deductible	\$15 copay per visit	Not covered	\$20 copay per visit	20% coinsurance after deductible
Emergency Room**	10% coinsurance after deductible	10% coinsurance after deductible	10% coinsurance after deductible	10% coinsurance after deductible	\$200 copay per visit (waived if admitted)	\$200 copay per visit (waived if admitted)	\$200 copay per visit (waived if admitted)	\$200 copay per visit (waived if admitted)
Chiropractic Care (Requires medical necessity and excludes preventive/maintenance care) Note: No visit maximum for treatment of back pain	10% coinsurance after deductible for up to 30 visits per plan year	25% coinsurance after deductible for up to 30 visits per plan year	10% coinsurance after deductible for up to 30 visits per plan year	25% coinsurance after deductible for up to 30 visits per plan year	Lesser of \$15 copay or 20% coinsurance (Referrals required through PCP)	Not covered	15% coinsurance for up to 30 visits per plan year	20% coinsurance after deductible for up to 30 visits per plan year



Benefit Summary Comparison

Plan Options	DVHT PPO \$500/\$1,000		DVHT PPO \$1,500/\$3,000		DVHT HMO \$15/\$25		DVHT PPO \$20/\$30	
Plan Feature	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Physical Therapy (Requires medical necessity) Note: No visit maximum for treatment of back pain	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance for up to 45 visits per illness/injury (Referrals required through PCP)	Not covered	15% coinsurance	20% coinsurance after deductible
Specialist Visit (In-person or virtual)	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	\$25 copay per visit (Referrals required for certain services through PCP)	Not covered	\$30 copay per visit	20% coinsurance after deductible
Lab Work (Blood Work) Note: Lab Work at a non-preferred non-hospital affiliated lab may not be covered	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	LabCorp and Quest Diagnostics Lab (Preferred): \$10 copay per visit	Not covered	In-Network Non-Hospital Affiliated Lab (Preferred): \$10 copay per visit	20% coinsurance after deductible
				Hospital/Other Lab Facility: \$50 copay per visit	Hospital/Other Lab Facility: \$50 copay per visit			
Basic Imaging/Radiology (i.e., X-Ray, Ultrasound)	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	Non-Hospital Affiliated Freestanding Facility (Preferred): \$0 copay per visit (Referrals required through PCP)	Not covered	Non-Hospital Affiliated Freestanding Facility (Preferred): \$0 copay per visit	20% coinsurance after deductible
					Hospital Affiliated Facility: \$50 copay per visit (Referrals required through PCP)		Hospital Affiliated Facility: \$50 copay per visit	
High-Tech Imaging/Radiology (i.e., MRI, CT Scan) Note: Requires a prior authorization	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	Non-Hospital Affiliated Freestanding Facility (Preferred): \$0 copay per visit	Not covered	Non-Hospital Affiliated Freestanding Facility (Preferred): \$0 copay per visit	20% coinsurance after deductible
					Hospital Affiliated Facility: \$100 copay per visit		Hospital Affiliated Facility: \$100 copay per visit	



Benefit Summary Comparison

Plan Options		DVHT PPO \$500/\$1,000		DVHT PPO \$1,500/\$3,000		DVHT HMO \$15/\$25		DVHT PPO \$20/\$30	
Plan Feature		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health, Behavioral Health, and Substance Abuse	Outpatient Services	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	\$15 copay per visit	Not covered	\$20 copay per visit Intensive Outpatient Care 100% covered	20% coinsurance after deductible
	Inpatient Services	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	\$100 copay per day with max of \$200 per admission	Not covered	\$100 copay per day with max of \$200 per admission	20% coinsurance after deductible
Outpatient Surgery		10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	Non-Hospital Affiliated Ambulatory Surgery Center (Preferred): \$50 copay per visit	Not covered	Non-Hospital Affiliated Ambulatory Surgery Center (Preferred): \$50 copay per visit	20% coinsurance after deductible
						Hospital Affiliated Facility: \$150 copay per visit		Hospital Affiliated Facility: \$150 copay per visit	
Hospital Admission		10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	\$100 copay per day with max of \$200 per admission	Not covered	\$100 copay per day with max of \$200 per admission	20% coinsurance after deductible
<p align="center">Center of Excellence (COE)*: Costs noted are for an inpatient stay. Note: Highmark refers to COE facilities as Blue Distinction Centers and Aetna refers to COE facilities as Institutes of Quality and Institutes of Excellence.</p>									
Plan Feature		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Orthopedic (hip replacement/ knee replacement) Note: Requires a prior authorization		10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	COE Facility* (Preferred): \$100 copay per day; \$200 copay max per admission	Not covered	COE Facility* (Preferred): \$100 copay per day; \$200 copay max per admission	20% coinsurance after deductible
						Non-COE Facility: \$500 copay per admission		Non-COE Facility: \$500 copay per admission	



Benefit Summary Comparison

Plan Options	DVHT PPO \$500/\$1,000		DVHT PPO \$1,500/\$3,000		DVHT HMO \$15/\$25		DVHT PPO \$20/\$30	
Center of Excellence (COE)*: Costs noted are for an inpatient stay. Note: Highmark refers to COE facilities as Blue Distinction Centers and Aetna refers to COE facilities as Institutes of Quality and Institutes of Excellence.								
Plan Feature	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Spine (i.e., Cervical and lumbar fusion, cervical laminectomy, and lumbar laminectomy/discectomy procedures) Note: Requires a prior authorization	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	COE Facility* (Preferred): \$100 copay per day; \$200 copay max per admission Non-COE Facility: \$500 copay per admission	Not covered	COE Facility* (Preferred): \$100 copay per day; \$200 copay max per admission Non-COE Facility: \$500 copay per admission	20% coinsurance after deductible
Bariatric Note: Requires a prior authorization	Inpatient 10% coinsurance after deductible Outpatient 10% coinsurance after deductible	Inpatient 30% coinsurance after deductible Outpatient 30% coinsurance after deductible	Inpatient 10% coinsurance after deductible Outpatient 10% coinsurance after deductible	Inpatient 30% coinsurance after deductible Outpatient 30% coinsurance after deductible	Inpatient \$100 copay per day with max of \$200 per admission Outpatient Non-Hospital Affiliated Ambulatory Surgery Center (Preferred): \$50 copay per visit; Hospital Affiliated Facility: \$150 copay per visit	Inpatient Not covered Outpatient Not covered	Inpatient \$100 copay per day with max of \$200 per admission Outpatient Non-Hospital Affiliated Ambulatory Surgery Center (Preferred): \$50 copay per visit; Hospital Affiliated Facility: \$150 copay per visit	Inpatient 20% coinsurance after deductible Outpatient 20% coinsurance after deductible
Transplants** (For Highmark plans, does not apply to kidney and bone marrow/stem cell) Note: Requires a prior authorization	COE Facility* (Preferred): 10% coinsurance after deductible	30% coinsurance after deductible	COE Facility* (Preferred): 10% coinsurance after deductible	30% coinsurance after deductible	COE Facility* (Preferred): \$100 copay per day \$200 copay max per admission	Not covered	COE Facility* (Preferred): \$100 copay per day; \$200 copay max per admission	20% coinsurance after deductible



Benefit Summary Comparison

Plan Options	DVHT PPO \$500/\$1,000		DVHT PPO \$1,500/\$3,000		DVHT HMO \$15/\$25		DVHT PPO \$20/\$30	
Center of Excellence (COE)*: Costs noted are for an inpatient stay. Note: Highmark refers to COE facilities as Blue Distinction Centers and Aetna refers to COE facilities as Institutes of Quality and Institutes of Excellence.								
Plan Feature	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription Coverage (Administered by CVS Caremark)	Retail: \$10 Generic/\$32 Preferred Brand/\$60 Non-Preferred Brand, up to a 30 day supply (Preventive Drugs \$0). \$20 Generic/\$64 Preferred Brand/\$120 Non-Preferred Brand, up to a 90 day supply for maintenance drugs at retail pharmacies.	Not covered	Retail: \$10 Generic/\$32 Preferred Brand/\$60 Non-Preferred Brand, up to a 30 day supply (Preventive Drugs \$0). \$20 Generic/\$64 Preferred Brand/\$120 Non-Preferred Brand, up to a 90 day supply for maintenance drugs at retail pharmacies.	Not covered	Retail: \$10 Generic/\$32 Preferred Brand/\$60 Non-Preferred Brand, up to a 30 day supply (Preventive Drugs \$0). \$20 Generic/\$64 Preferred Brand/\$120 Non-Preferred Brand, up to a 90 day supply for maintenance drugs at retail pharmacies.	Not covered	Retail: \$10 Generic/\$32 Preferred Brand/\$60 Non-Preferred Brand, up to a 30 day supply (Preventive Drugs \$0). \$20 Generic/\$64 Preferred Brand/\$120 Non-Preferred Brand, up to a 90 day supply for maintenance drugs at retail pharmacies.	Not covered
	Mail: \$20 Generic/\$64 Preferred Brand/\$120 Non-Preferred Brand, up to a 90 day supply		Mail: \$20 Generic/\$64 Preferred Brand/\$120 Non-Preferred Brand, up to a 90 day supply		Mail: \$20 Generic/\$64 Preferred Brand/\$120 Non-Preferred Brand, up to a 90 day supply		Mail: \$20 Generic/\$64 Preferred Brand/\$120 Non-Preferred Brand, up to a 90 day supply	
	Specialty: \$0 copay, up to a 30 day supply (available ONLY at CVS Specialty pharmacy through home delivery). No member cost for enrollment in PrudentRx program - applies to all specialty medications on the CVS Caremark Specialty Drug List.	Specialty: 30% coinsurance if not enrolled in PrudentRx	Specialty: \$0 copay, up to a 30 day supply (available ONLY at CVS Specialty pharmacy through home delivery). No member cost for enrollment in PrudentRx program - applies to all specialty medications on the CVS Caremark Specialty Drug List.	Specialty: 30% coinsurance if not enrolled in PrudentRx	Specialty: \$0 copay, up to a 30 day supply (available ONLY at CVS Specialty pharmacy through home delivery). No member cost for enrollment in PrudentRx program - applies to all specialty medications on the CVS Caremark Specialty Drug List.	Specialty: 30% coinsurance if not enrolled in PrudentRx	Specialty: \$0 copay, up to a 30 day supply (available ONLY at CVS Specialty pharmacy through home delivery). No member cost for enrollment in PrudentRx program - applies to all specialty medications on the CVS Caremark Specialty Drug List.	Specialty: 30% coinsurance if not enrolled in PrudentRx



Benefit Summary Comparison

Plan Options	DVHT PPO \$500/\$1,000		DVHT PPO \$1,500/\$3,000		DVHT HMO \$15/\$25		DVHT PPO \$20/\$30	
Center of Excellence (COE)*: Costs noted are for an inpatient stay. Note: Highmark refers to COE facilities as Blue Distinction Centers and Aetna refers to COE facilities as Institutes of Quality and Institutes of Excellence.								
Plan Feature	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription Coverage (Administered by CVS Caremark)	Annual Out of Pocket Maximums: \$2,100 per Employee, \$4,200 per Family	N/A	Annual Out of Pocket Maximums: \$2,100 per Employee, \$4,200 per Family	N/A	Annual Out of Pocket Maximums: \$2,100 per Employee, \$4,200 per Family	N/A	Annual Out of Pocket Maximums: \$2,100 per Employee, \$4,200 per Family	N/A

*Aetna and Highmark Delaware have designated certain healthcare facilities within their provider network as Centers of Excellence, or simply COE Facilities. COE Facilities have been identified as delivering high-quality services and superior outcomes for specific procedures or conditions. This means improved outcomes and reduced cost, which includes delivering surgery and post-operative care more efficiently and with lower risk of complications and readmissions.

Important Note on Allowable Charge and Coinsurance:

- Allowable Charge is the price your health carrier (Highmark or Aetna) determines is reasonable for care or supplies. The amount the plan pays for covered services received in or out-of-network is based on the allowable charge and this may be different than the billed amount shown on your Explanation of Benefits (EOB). If an out-of-network provider bills more than the allowable charge, you may have to pay the difference.
- Coinsurance is the part of the allowable charge that you pay after you satisfy your deductible and is typically a percentage of the allowable charge for a service. For example, if the health plan covers 90% of the allowable charge for a specific service, you may be required to pay the remaining 10% as coinsurance. If your in-network allowable charge for covered medical services is \$100 and your coinsurance is 10%, you would pay \$10. The health plan would pay the remaining \$90.

Additional benefits automatically included with your Health Plan enrollment:

SurgeryPlus (Surgeons of Excellence) Alternative benefits for non-emergency, planned procedures (Joint Replacement & Revision, Spine, Cardiac, GYN, Bariatric, Hernia, Gallbladder, Thyroid, Orthopedics, ENT, Gastroenterology (i.e., Colonoscopy, Endoscopy), Pain Management, Other Minor/Misc. Procedures (i.e., Biopsy, Excision of Mass))	N/A	N/A	N/A	N/A
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Benefit Summary Comparison

Additional benefits automatically included with your Health Plan enrollment:

Employee Assistance Program (Administered by HealthAdvocate) Note: Members can obtain a maximum of 5 one-on-one professional counseling sessions annually	Included	Included	Included	Included
Wellness and Condition Care Coordination (Provided through your health plan)	DVHT Wellness Program Highlights: Wellness Incentives including \$150 Biometric Screening; \$150 Colonoscopy; \$100 Health Education; \$50 Women's Well Visit; \$50 Mammogram Reimbursements including up to \$300 for gym membership; up to \$200 race event registration; up to \$200 WW; up to \$25 bike/sport helmet	DVHT Wellness Program Highlights: Wellness Incentives including \$150 Biometric Screening; \$150 Colonoscopy; \$100 Health Education; \$50 Women's Well Visit; \$50 Mammogram Reimbursements including up to \$300 for gym membership; up to \$200 race event registration; up to \$200 WW; up to \$25 bike/sport helmet	DVHT Wellness Program Highlights: Wellness Incentives including \$150 Biometric Screening; \$150 Colonoscopy; \$100 Health Education; \$50 Women's Well Visit; \$50 Mammogram Reimbursements including up to \$300 for gym membership; up to \$200 race event registration; up to \$200 WW; up to \$25 bike/sport helmet	DVHT Wellness Program Highlights: Wellness Incentives including \$150 Biometric Screening; \$150 Colonoscopy; \$100 Health Education; \$50 Women's Well Visit; \$50 Mammogram Reimbursements including up to \$300 for gym membership; up to \$200 race event registration; up to \$200 WW; up to \$25 bike/sport helmet
DVHT - Healthcare BlueBook	As a Delaware Valley Health Trust enrollee, you and your covered dependents have access to Healthcare Bluebook. Every time you search for eligible procedures on the Healthcare Bluebook tool and pick a Fair Price (green) facility for your care, you can earn a cash reward.	As a Delaware Valley Health Trust enrollee, you and your covered dependents have access to Healthcare Bluebook. Every time you search for eligible procedures on the Healthcare Bluebook tool and pick a Fair Price (green) facility for your care, you can earn a cash reward.	As a Delaware Valley Health Trust enrollee, you and your covered dependents have access to Healthcare Bluebook. Every time you search for eligible procedures on the Healthcare Bluebook tool and pick a Fair Price (green) facility for your care, you can earn a cash reward.	As a Delaware Valley Health Trust enrollee, you and your covered dependents have access to Healthcare Bluebook. Every time you search for eligible procedures on the Healthcare Bluebook tool and pick a Fair Price (green) facility for your care, you can earn a cash reward.

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"**

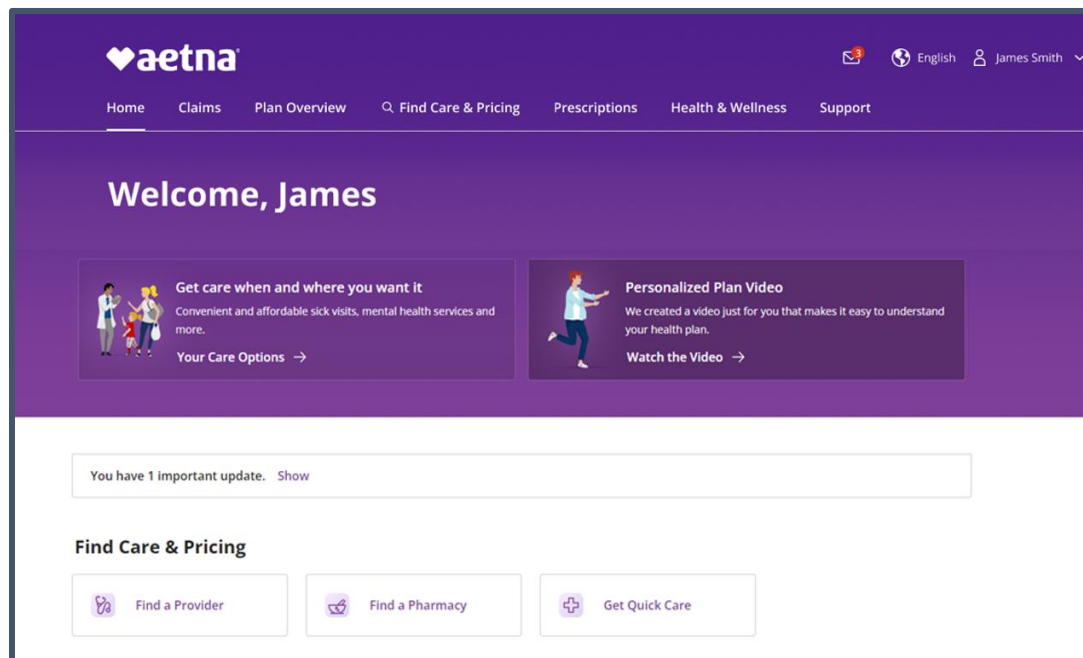
*****Non-urgent services (such as follow-up visits, suture removal, etc.) rendered at urgent care facility are not covered**

Aetna Member Services

- Track claims (Explanation of Benefits)
- Find a provider
- Check the prescription drug formulary (“preferred” class drugs)
- Compare the cost of prescription drug alternatives
- Health and Wellness resources
- Discount programs
- And more!

Aetna Member Website

- New design – simple, fresh, modern and convenient
- Improved navigation to guide members
- Emphasis on relevant tools
- Simplified provider search



Aetna Customer Service
1-800-308-7344



Determine If Your Doctor Is In-Network

Search on Aetna.com:

1. Visit “Find a doctor” on Aetna.com and under “Guests,” choose “Plan from an employer.”
2. Enter your home location (zip, city, county, or state) to access providers specific to plan benefits.
3. Set range of miles around home location (up to 100-mile radius).
4. You can enter the name of the plan and search, or you can scroll and pick the plan.
 - Members would choose “**Open Choice PPO or HMO**”
 - If you do not know your potential plan offering, select “Skip Plan Selection.”
5. You can search using a doctor or facility’s name, or by:
 - City, state, ZIP code
 - Specialty
 - Common procedure types, such as flu/vaccine shots or back care
 - You can search for doctors who treat specific conditions
 - You will also have the option to search by category: *Medical Doctors & Specialists, Hospitals & Facilities, Urgent Care, Walk-in Clinics, Pharmacies, Behavioral Health, Dental Care, Vision, Labs & Testing, Alternative Medicine, Durable Medical Equipment, Common Procedures & Conditions, Institutes of Quality/Institutes of Excellence.*
6. Explore providers in list view or map view.

Pharmacy Benefits (All Plans)

- Mail-Order Service for Maintenance Medications
- Some “specialty drugs” require prior authorization - DVHT will honor any open Prior Authorizations through the expiration of the PA. Contact DVHT Claims Specialist.
- Periodic adjustments to the formulary can occur.
- No change in formulary: *Standard Control Formulary with Advanced Control Specialty Formulary and PrudentRx.*
- Weight loss drugs are covered subject to medical necessity.

Aetna Standard Plan Drug Guide

1. <https://www.aetna.com/individuals-families/find-a-medication.html>
2. Then once on the site, scroll down until you see the below drop downs.
3. Choose the drop downs below to get to the ASP formulary for 2025.
4. Then click the purple “Go to Aetna Standard Plan”.
5. From there, you can choose “**Find medicine**” from the left column Or download from the middle column “**2025 Aetna Standard Plan drug guide**”.

Ready to search drug info? Follow these steps:

Step 1: Choose a plan year

Step 2: Choose a plan

1 results returned based on your selections.

[Go to Aetna Standard Plan >](#)



Is my medicine covered?

Search for generic and brand-name drugs to check if they're covered.

[Find medicine](#)



Pharmacy drug guide

Find a list of commonly used prescription drugs covered by this plan.

[2025 Aetna Standard Plan drug guide \(PDF\)](#)
[Drug guide changes >](#)



Questions about pharmacy coverage?

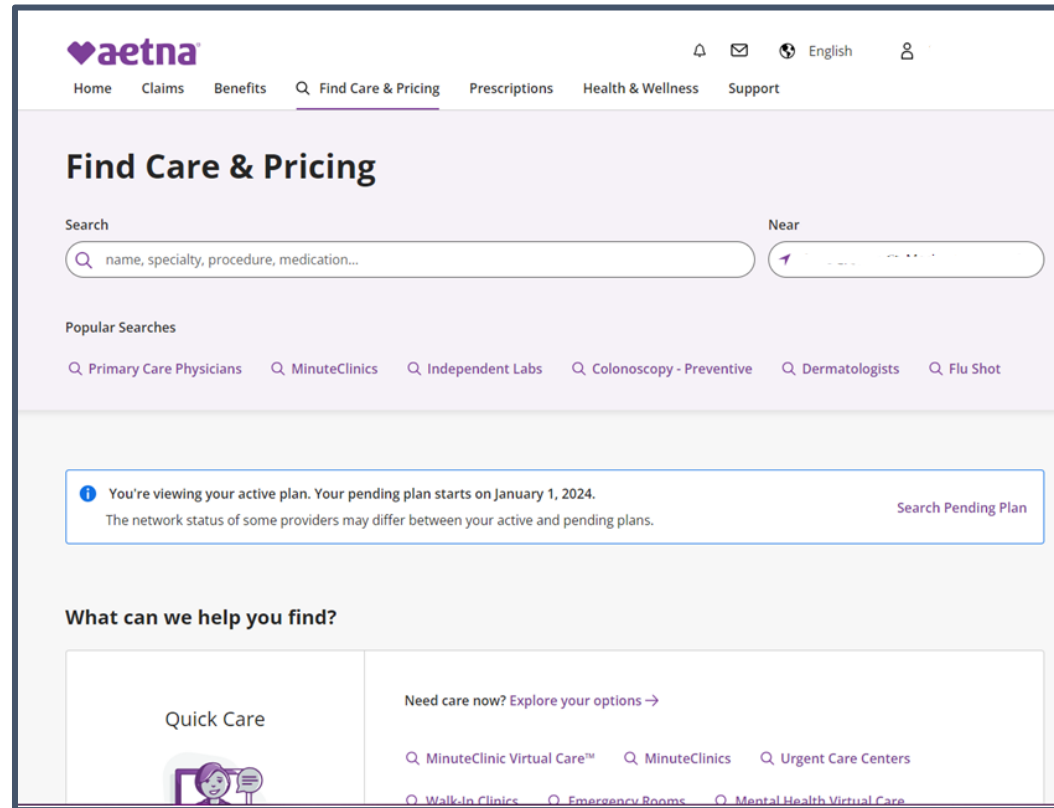
Find answers to your questions about drug coverage, costs, plan guidelines, home delivery and more.

[Visit our FAQ page >](#)



Improved Cost Transparency

- Integrated cost estimation and provider search
- Streamlined transparency tool design and experience
- Quality provider information, Including patient ratings and reviews



Estimate Medication Pricing

We're here to help with pricing and coverage information, medication details and more.

Search for a medication by:

- Name: Enter at least 3 letters of the medication name
- National Drug Code (NDC): Enter the 10-11 digit NDC number without hyphens

Plan Overview

Covered Prescription Drug List (Formulary)

Learn which drugs your plan covers and whether there are any rules for coverage.

[View Covered Prescriptions](#) → 

CVS Specialty®

Enroll, order refills, and manage delivery of specialty medications.

[Go to CVS Specialty](#) →

Plan Summary

Review your plan's pharmacy benefits, coverage details, and spending limits.

[View Plan Summary](#) →

Coverage Exceptions

Request a coverage exception for a medication that isn't covered by your plan.

[Request an Exception](#) →



Aetna Member Website



Women's Health Support Center

Find resources and information on women's health to help you through life stages and health events.

[Explore Women's Health](#) →



Condition Management Programs

Get healthy now. Receive the help of an Aetna nurse who will act as your health coach. Our health programs come at no extra cost to you — they're part of your plan!

[Explore Programs](#) →



Aetna Health Your Way™

Personalized support to help you achieve your health goals, powered by ActiveHealth. Get your MyHealth100 score, choose your health pathway, review your recommended health actions, and so much more.

[Engage in Health Your Way](#) ↗



Healthwise® Knowledgebase

Get expert information on health conditions, treatments, and everyday health and wellness with one of the most advanced online knowledge databases available. Explore a wide variety of health topics, medical tests, procedures and medications.

[Visit Healthwise Knowledgebase](#) ↗



Fitness

Save on gym memberships, virtual fitness programs, workout apparel, sports accessories and more.

[Get Fitness Discounts](#) →



Weight Management

Save on meal plans, healthy home meal deliveries, workout programs, scales and healthy weight resources.

[Get Weight Care Discounts](#) →



At Home Products

Save on blood pressure monitors, activity trackers, electrotherapy TENS units, EKG devices and more.

[Get Home Discounts](#) →



Maternity Support Center

Find resources and information to guide you through topics related to fertility, maternity, postpartum wellness and newborn safety.

[Access Support](#) →



Lasik

Discounted rates on Lasik screening, surgery and follow-up care.

[Get Lasik Discounts](#) →



Natural Products & Services

Discounts on acupuncture, chiropractic, massage and nutrition, along with a variety of wellness products.

[Get Natural Discounts](#) →



Senior Wellness

Discounted medical alert systems in-home care and meal delivery.

[Get Senior Care Discounts](#) →



Aetna® Back and Joint Care Program

Through the Aetna Back and Joint Care Program, Hinge Health offers digital exercise therapy programs designed to address acute and chronic back, knee, hip, neck and shoulder pain. There is also a downloadable prevention program tailored to your needs.

[Explore Hinge Health](#) ↗



Vision Benefits

Key Reminders-Vision

- Carrier remains EyeMed
- A new group number will be assigned effective July 1, 2026
- Plan accumulators reset July 1



Town of Ocean View Vision Benefits – Plan 1

Vision Plan Summary		
Vision Plan Design	EyeMed Plan 1	
	In Network Member Cost	Out of Network Member Reimbursement
Frequency Type	Vision Exam (EE/SP/CH): 12 Months Lenses (EE/SP/CH): 12 Months Frames (EE/SP/CH): 12 Months Contact Lenses (EE/SP/CH): 12 Months	
Dependent Age	Under age 19	
Exam Services		
Exam	\$10 copay	up to \$40
Retinal Imaging	Up to \$39	
Contact Lens Fit and Follow up		
Fit and Follow up - Standard	up to \$40	
Fit and Follow up - Premium	10% off retail price	
Frame		
Frame	\$0 copay; 20% off balance over \$160 allowance	up to \$80
Lenses		
Single Vision	\$20 copay	up to \$30
Bifocal	\$20 copay	up to \$50
Trifocal	\$20 copay	up to \$70
Lenticular	\$20 copay	up to \$70
Progressive - Standard	\$85 copay	up to \$50
Progressive - Premium Tier 1	\$105 copay	up to \$50
Progressive - Premium Tier 2	\$115 copay	up to \$50
Progressive - Premium Tier 3	\$130 copay	up to \$50
Progressive - Premium Tier 4	\$85 copay, 20% off retail price less \$120 allowance	up to \$50
Lens Options		
Anti Reflective Coating - Standard	\$45	
Anti Reflective Coating - Premium Tier 1	\$57	
Anti Reflective Coating - Premium Tier 2	\$68	
Anti Reflective Coating - Premium Tier 3	20% off retail price	
Photochromic - Non-Glass	\$75	
Polycarbonate - Standard - age 19 and over	\$40	up to \$20
Polycarbonate - Standard - under age 19	\$0 copay	up to \$8
Scratch Coating - Standard Plastic	\$0 copay	
Tint - Solid and Gradient	\$15	
UV Treatment	\$15	
All Other Lens Options	20% off retail price	
Contact Lenses		
Contacts - Conventional	\$0 copay, 15% off balance over \$160 allowance	up to \$80
Contacts - Disposable	\$0 copay, 100% of balance over \$160 allowance	up to \$80
Contacts - Medically Necessary	\$0 copay, paid in full	up to \$300



Town of Ocean View Vision Benefits – Plan 2

Vision Plan Summary		
Vision Plan Design	EyeMed Plan 2	
	In Network Member Cost	Out of Network Member Reimbursement
Frequency Type	Vision Exam (EE/SP/CH): 12 Months Lenses (EE/SP/CH): 12 Months Frames (EE/SP/CH): 12 Months Contact Lenses (EE/SP/CH): 12 Months	
Dependent Age	Under age 19	
Exam Services		
Exam	\$5 copay	up to \$40
Retinal Imaging	\$0 copay	up to \$20
Contact Lens Fit and Follow up		
Fit and Follow up - Standard	up to \$40	
Fit and Follow up - Premium	10% off retail price	
Frame		
Frame	\$0 copay; 20% off balance over \$210 allowance	up to \$105
Lenses		
Single Vision	\$10 copay	up to \$30
Bifocal	\$10 copay	up to \$50
Trifocal	\$10 copay	up to \$70
Lenticular	\$10 copay	up to \$70
Progressive - Standard	\$75 copay	up to \$50
Progressive - Premium Tier 1	\$95 copay	up to \$50
Progressive - Premium Tier 2	\$105 copay	up to \$50
Progressive - Premium Tier 3	\$120 copay	up to \$50
Progressive - Premium Tier 4	\$75 copay, 20% off retail price less \$120 allowance	up to \$50
Lens Options		
Anti Reflective Coating - Standard	\$0 copay	up to \$23
Anti Reflective Coating - Premium Tier 1	\$57 copay	up to \$23
Anti Reflective Coating - Premium Tier 2	\$68 copay	up to \$23
Anti Reflective Coating - Premium Tier 3	\$100 copay	up to \$23
Photochromic - Non-Glass	\$75	
Polycarbonate - Standard - age 19 and over	\$0 copay	up to \$20
Polycarbonate - Standard - under age 19	\$0 copay	up to \$20
Scratch Coating - Standard Plastic	\$15	
Tint - Solid and Gradient	\$0 copay	up to \$8
UV Treatment	\$0 copay	up to \$8
All Other Lens Options	20% off retail price	
Contact Lenses		
Contacts - Conventional	\$0 copay, 15% off balance over \$210 allowance	up to \$105
Contacts - Disposable	\$0 copay, 100% of balance over \$210 allowance	up to \$105
Contacts - Medically Necessary	\$0 copay, paid in full	up to \$300



Dental Benefits

Key Reminders-Dental

- New carrier will be Delta Dental effective July 1, 2026
- Plan accumulators reset July 1
- Enhanced Out of Network benefits (\$1,500 annual maximum)



Town of Ocean View Dental Plan Summary

Dental Plan Summary		
Benefits	Delta Dental PPO & Premier Dentists	Non-Delta Delta Dentists**
<i>Annual Deductible</i>	\$50 individual / \$150 family	
<i>Annual Benefit Maximum</i>	\$1,500	
<i>Maximum Rollover</i>	N/A	
<i>Diagnostic & Preventive Services</i> <i>Exams, cleanings, x-rays, sealants</i>	100%	100%
<i>Basic Services</i> <i>Fillings, Scaling and Root Planing, Simple Extractions</i>	80%	80%
<i>Major Services</i> <i>Dentures, Single Crowns</i>	50%	50%
<i>Orthodontic Benefits</i> <i>Dependent Children (to age 19)</i>	N/A	N/A
<i>Orthodontic Maximums</i>	N/A	N/A

*Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

**Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and Premier contracted fees for non-Delta Dental dentists.



Keep smiling

Delta Dental PPO™

Stay in network to save

Visit a dentist in the PPO¹ network to maximize your savings.² These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.³ Find a PPO dentist at deltadentalins.com.

If you can't find a PPO dentist, consider a Delta Dental Premier® dentist. These dentists have agreed to set fees and offer another opportunity to save.

Set up an online account

Get information about your plan, check benefits and eligibility information, find a network dentist and more. Sign up for an online account at deltadentalins.com.

Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or Social Security number. If your family members are covered under your plan, they'll need to

provide your information. Prefer to have an ID card? Simply log in to your account to view or print your card.

Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim — we'll handle the rest.

Understand transition of care

Generally, multi-stage procedures are covered under your current plan only if treatment began after your plan's effective date of coverage.⁴ Log in to your online account to find this date.

Get LASIK and hearing aid discounts

With access to QualSight and Amplifon Hearing Health Care⁵, you can receive significant savings on LASIK procedures and hearing aids. To take advantage of these discounts, call QualSight at **855-248-2020** and Amplifon at **888-779-1429**.

Save with a PPO dentist



PPO



PREMIER



NON-DELTA DENTAL

¹ In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan

² You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

³ You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums and charges for non-covered services. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's maximum contract allowance.

⁴ Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. If you are currently undergoing active orthodontic treatment, you may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

⁵ Vision corrective services and Amplifon's hearing health care services are not insured benefits. Delta Dental makes the vision corrective services program and hearing health care services program available to you to provide access to the preferred pricing for LASIK surgery and for hearing aids and other hearing health services.

West Virginia: Learn about our commitment to providing access to a quality dentist network at deltadentalins.com/about/legal/index-enrollee.html.



Find an in-network dentist



Follow these easy steps to find an in-network Delta Dentist in your area.



Step 1:

Go to deltadentalins.com and choose “Find a dentist”.



Step 2:

Enter your location. This could be your home address or even your office address—choose the location that’s most convenient for you.



Step 3:

Select your network. Choose the Delta Dental PPO™ network from the options provided.



Step 4:

Tap on “Find a dentist”.



Step 5:

Review, pick and call a dentist from the list provided.

If you would like to refine your search results, go to the “Refine your search” field.

- **Update your location** using your preferred city, state or zip code and apply keywords like a specific dentist’s or practice’s name.
- **To further filter your results**, choose “Filter” from the right side of the screen. Review the list of filter options including Language, Distance, Specialized Care and more. Tap on “Apply”.
- **Didn’t find a PPO dentist that fit your needs?** Try selecting the Delta Dental Premier® network. You’ll save the most by visiting a Delta Dental PPO dentist but your next best bet is the Delta Dental Premier network, the largest dental network nationwide.¹

¹ Delta Dental Premier is the largest dentist network nationwide based on total unique dentists, as of September 2023, according to Zelis Network360.

Our Delta Dental enterprise includes these companies in these states: Delta Dental of California — CA, Delta Dental of the District of Columbia — DC, Delta Dental of Pennsylvania — PA & MD, Delta Dental of West Virginia, Inc. — WV, Delta Dental of Delaware, Inc. — DE, Delta Dental of New York, Inc. — NY, Delta Dental Insurance Company — AL, DC, FL, GA, LA, MS, MT, NV, TX and UT. West Virginia: Learn about our commitment to providing access to a quality dentist network at deltadentalins.com/about/legal/index-enrollee.html.



deltadentalins.com/members

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#224633 (rev. 10/24)

etary and Confidential Information.

Delta Dental - SmileWay™

Support for chronic conditions

Enhanced coverage for enrollees
with chronic conditions



Did you know the health of teeth and gums is tied to overall wellness? Gum disease and tooth decay are associated with a number of systemic conditions, and enrollees with certain medical chronic conditions may benefit from additional teeth and gum cleanings.

Your Delta Dental PPO™ enrollees can take advantage of expanded coverage if they've been diagnosed with:

- Amyotrophic lateral sclerosis (ALS)
- Cancer
- Chronic kidney disease
- Diabetes
- Heart disease
- HIV/AIDS
- Huntington's disease
- Joint replacement
- Lupus
- Opioid misuse and addiction
- Parkinson's disease
- Rheumatoid arthritis
- Sjögren's syndrome
- Stroke



Wellness Incentives

Earn cash incentives for preventive behaviors.

Wellness Program

- Enrollees and covered spouses eligible
- Can be earned at any time in the calendar year
- 90-Day lookback for new members

Wellness Program

Incentives

\$150 Biometric Screening

**Must be completed on My.QuestForHealth.com*

\$150 Colonoscopy

\$100 Health Education

**DVHT eligible sessions available at www.dvtrusts.com/events*

\$50 Mammogram

\$50 Women's Well Visit

Reimbursements

Up to \$300 Gym Membership

Up to \$200 Fitness Race Registration

Up to \$200 Weight Watchers

Up to \$25 Bike (Sport) Helmet



Health Trust Resources

Benefits of your membership.

Employee Assistance Program

- Provided through Health AdvocateSM
- Employee Assistance and Work/Life Balance
 - Personal, family, and work issues
 - Childcare Services
 - Eldercare Services
 - Legal Services
 - Financial Services
- Eligible for up to 5 free visits with an HMS clinician.

We're here 24/7

Get the support you need, right when you need it, so you can be healthy and do the things you love. **We can help you in any language.**

877.240.6863

answers@HealthAdvocate.com

HealthAdvocate.com/delawarevalleytrusts

Registration Code: DVTRUSTS

Call • Email • Message • Live Chat 

Scan Me



Hinge Health™



Care for chronic muscle and joint pain as well as recent acute injuries



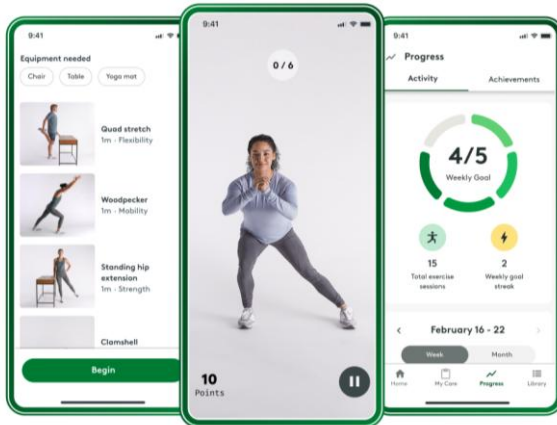
Custom exercise therapy program planned by a PT with ongoing support from certified Health Coaches



All body parts covered including Women's Pelvic Health



Enso: FDA-cleared wearable device that treat mild to intense joint and muscle pain



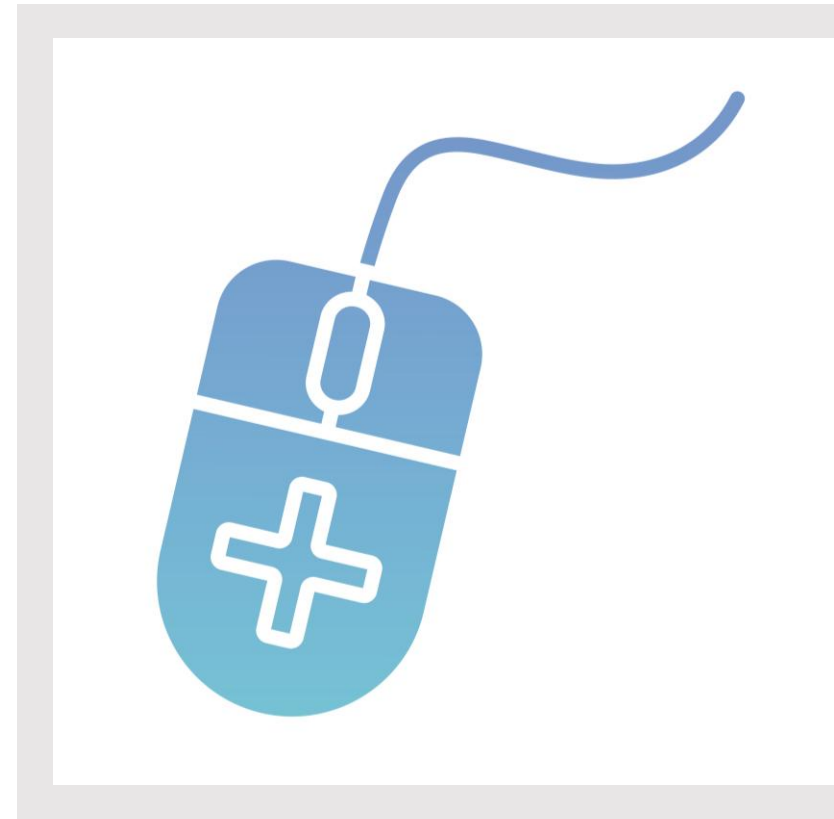
Download the app to get started




scan the QR code*



- Access to a doctor 24/7/365
- General Medicine:
 - Sinusitis, Respiratory infection, UTI and more
 - Provider can e-prescribe to your local pharmacy
- Behavioral Health
- Dermatology
- Cost share varies-consult plan summary



Download the app to talk to a doctor for \$40 or less/visit

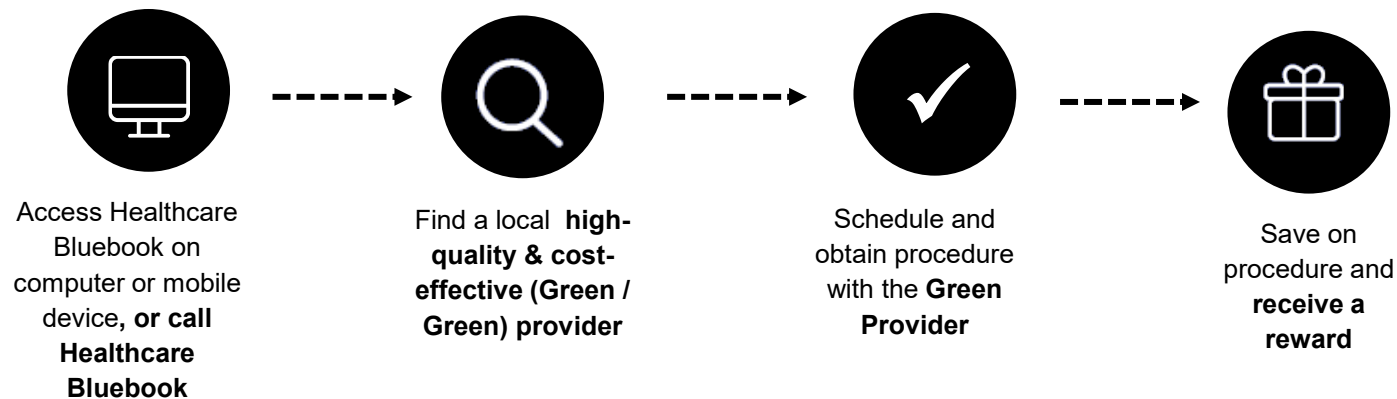
Download the app 

Teladoc.com/Aetna | 1-855-TELADOC (835-2362)

Your cost share follows the PCP office visit cost share not to exceed \$40

Healthcare Bluebook

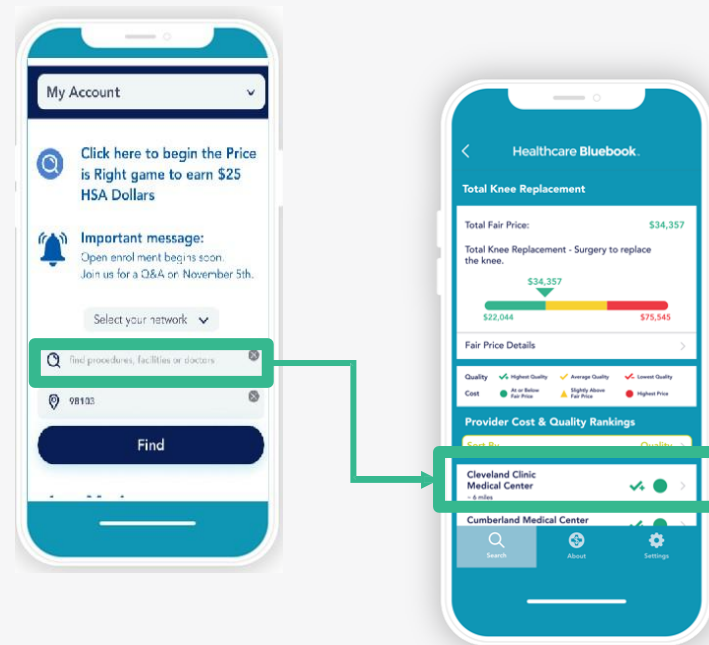
- Earn rewards for being a well-informed healthcare consumer
- Reward amounts range from \$25 - \$1,500 for ShopSmart™ procedures
- www.healthcarebluebook.com/cc/dvht, code DVHT1





Mobile Experience

Mobile Code: DVHT1



Get the free mobile app

Mobile Code - dvht1

Once installed, tap Log In With Mobile Code and enter "dvht1" for your Mobile Code to gain access to your custom content.

[Mobile app download instructions](#)



Ask Bluebot

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Procedure Specific Cost Comparison – Imaging (19970)

Knee MRI (no contrast)

The Fair Price™ for Knee MRI (no contrast) is \$710 in 19970.



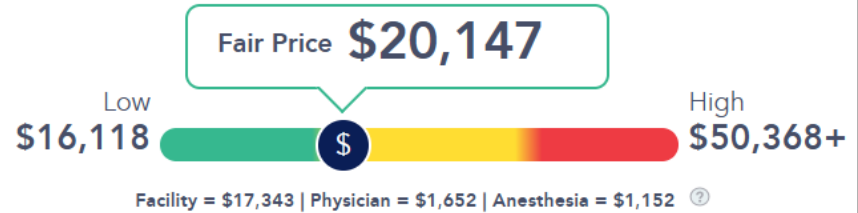
ONI - Orthopaedic & Neuro Imaging - Millsboro 302-644-7335	26744 John J Williams Hwy Millsboro , DE 19966 ~ 7 miles	\$ \$100 Reward
Aspirian Open MRI of Southern Delaware 302-644-7335	34435 King St Row Lewes , DE 19958 ~ 13 miles	\$ \$100 Reward
Progressive Radiology - Berlin 410-641-9560	314 Franklin Ave Berlin , MD 21811 ~ 17 miles	\$ \$100 Reward
Ocean Medical Imaging of Delaware 302-646-5151	611 Federal St Milton , DE 19968 ~ 19 miles	\$ \$100 Reward
Delaware Open MRI of Seaford 302-628-3500	303 Health Services Dr Seaford , DE 19973 ~ 27 miles	\$ \$100 Reward
Progressive Radiology - Salisbury 410-546-3390	1820 Sweetbay Dr Salisbury , MD 21804 ~ 27 miles	\$ \$100 Reward
Akumin Imaging - Seaford 302-628-3500	300 Health Services Dr Seaford , DE 19973 ~ 28 miles	\$ \$100 Reward



Procedure Specific Cost Comparison – Surgeries (19970)

Total Knee Replacement

The Fair Price™ for Total Knee Replacement is \$20,147 in 19970.



Deer Pointe Surgical Center 410-341-9002	6503 Deer Pointe Dr Salisbury, MD 21804 ~ 26 miles	✓+	\$ \$1000 Reward
Delaware Surgery Center 302-346-4000	200 Banning St Dover, DE 19904 ~ 47 miles	✓+	\$ \$1000 Reward
University of Maryland Shore Medical Center at Easton 410-822-1000	219 S Washington St Easton, MD 21601 ~ 55 miles	✓+	\$ \$1000 Reward
AtlantiCare Surgery Center - Egg Harbor Township 609-407-2200	2500 English Creek Ave Egg Harbor Township, NJ 08234 ~ 66 miles	✓+	\$ \$1000 Reward
Atlanticare Center For Orthopaedic Surgery 609-383-6488	2500 English Creek Ave Egg Harbor Township, NJ 08234 ~ 66 miles	✓+	\$ \$1000 Reward
Peninsula Regional Medical Center 410-546-6400	100 E Carroll St Salisbury, MD 21801 ~ 30 miles	✓	\$
Cape Regional Medical Center 609-463-2273	2 Stone Harbor Blvd Cape May Court House, NJ 08210 ~ 40 miles	✓	\$



Digital Tools

- [Delaware Valley Trusts](#)
- [DVHT Portal](#)
- [Aetna](#)
- [Employee Assistance Program \(EAP\)](#)

Contact Us

Aetna Member Services

1.800.308.7344

Claims

Ashley Mason

Health Claims Specialist

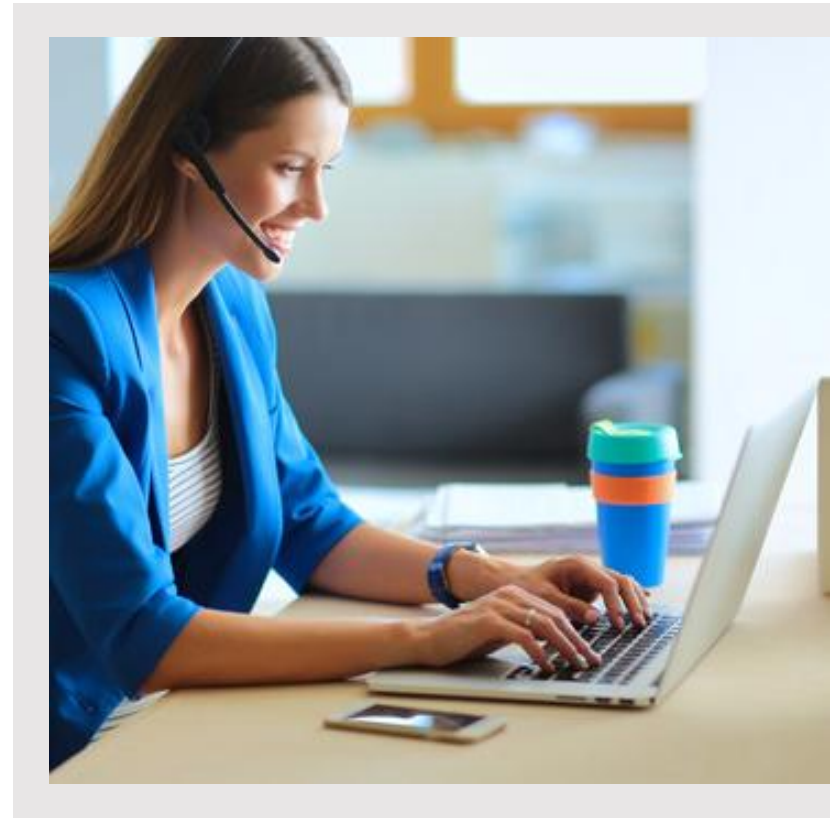
amason@dvtrusts.com

267.803.5746

Wellness

wellness@dvtrusts.com

267.803.5721



Thank you.



DELAWARE VALLEY
HEALTH TRUST