SCANTIC VALLEY REGIONAL HEALTH TRUST (SVRHT)

IMPORTANT - PLEASE READ

The attached benefit comparison chart is a high level overview of the plans offered by SVRHT.
The plan documents available to registered users on the carrier websites are the documents that describe full and complete plan details.
The carrier documents are the only documents that coverage is based on.
Should you have a question about specific coverage, you will need to contact the Member Service number on your ID card for detail or visit the carrier website.

SVRHT Plan Benefit Comparison

Effective 7-1-16

These pages summarize benefits of the plan(s). The Subscriber Certificate(s) & applicable riders define the terms & conditions of these benefits in greater detail. Should any questions arise, the certificate(s) & riders will govern.

Changes/clarifications in red font

	BLUE CROSS BLUE SHIELD			HEALTH NEW ENGLAND	TUFTS HEALTH PLAN
		BLUE CARE ELECT PREFERRED PPO			
BENEFIT	**NETWORK BLUE HMO**	**In-Network**	**Out-of-Network**	**HMO**	**Choice Copay EPO**
Deductible	None	None	$400 Individual $800 Family	None	None
Out-of-Pocket (OOP) Maximum - *Once your out-of-pocket expenses for applicable services reaches this amount, you pay $0 for remainder of plan year* ***(July 1 to June 30).***	**Medical:** $2,000 per member $4,000 per family **Prescription:** $3,000 per member $6,000 per family	**Medical:** $2,000 per member $4,000 per family **Prescription:** $3,000 per member $6,000 per family	**Medical:** $3,000 per member	**Medical:** $2,000 per member $4,000 per family **Prescription:** $3,000 per member $6,000 per family	**Medical:** $2,000 per member $4,000 per family **Prescription:** $3,000 per member $6,000 per family
Lifetime Benefit Maximum	None	None	None	None	None
INPATIENT	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
General Hospital/Mental Hospital/Substance Abuse Facility (semi-private room and board and special services)	$500 copay	$500 copay	20% coinsurance* Nothing for emergency/accident admissions	$500 copay	$500 copay
Physician Services	Nothing	Nothing	20% coinsurance* Nothing for emergency/accident admissions	Nothing	Nothing
Skilled Nursing Facility	Nothing to 100 days per calendar year benefit maximum	Nothing to 100 days per calendar year benefit maximum combined with out of network days	20% coinsurance* to 100 days per calendar year benefit maximum, combined with in-network days	Up to 100 days per calendar year, combined with inpatient rehabilitation	Nothing up to 100 days per plan year
Rehabilitation Hospital	Nothing to 60 days per calendar year benefit maximum	Nothing to 60 days per calendar year benefit maximum	20% coinsurance* to 60 days per calendar year benefit maximum	Up to 100 days per calendar year, combined with skilled care.	Nothing up to 100 days per plan year

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		BLUE CARE ELECT PREFERRED PPO			
BENEFIT	**NETWORK BLUE HMO**	**In-Network**	**Out-of-Network**	**HMO**	**Choice Copay EPO**
OUTPATIENT HOSPITAL	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Emergency Room Visits for Emergency or Accident Care	$100 copay (waived if admitted or for observation stay)	$100 copay (waived if admitted or for observation stay)	$100 copay (waived if admitted or for observation stay)	$100 copay, (waived if admitted)	$100 copay, (waived if admitted)
Emergency Room Visits for Medical Care	$100 copay (waived if admitted or for observation stay)	$100 copay (waived if admitted or for observation stay)	$100 copay (waived if admitted or for observation stay)	$100 copay, waived if admitted	$100 copay, waived if admitted
Surgery	$150 copay	$150 copay	20% coinsurance*	$150 copay	$150 copay
Radiation and Chemotherapy	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay
Diagnostic X-ray and Lab	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay
Routine Colonoscopy *(without symptoms)*	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay
High Cost Radiology (MRI, CT & PET)	$100 copay* - copay waived if received at non-hospital facilities	$100 copay* - copay waived if received at non-hospital facility	20% coinsurance*	$100 copay*	$100 copay* waived when there is an active cancer diagnosis
Hemodialysis	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay
Physical Therapy	$20 copay to 60 visits per calendar year	$20 copay to 100 visits per calendar year	20% coinsurance* to 100 visits per calendar year	$20 copay (two months or 25 visits)	$35 co-pay - 30 visits per year

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		BLUE CARE ELECT PREFERRED PPO			
BENEFIT	**NETWORK BLUE HMO**	**In-Network**	**Out-of-Network**	**HMO**	**Choice Copay EPO**
PHYSICIAN'S OFFICE	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Surgery	$20 PCP Office $35 Specialists Office	$20 PCP Office $35 Specialists Office	20% coinsurance*	$20 PCP Office $35 Specialists Office	$20 PCP Office $35 Specialists Office
Adult Preventative Exam *(includes preventative lab*	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay
PCP Medical Care/ Mental Health Care/ Substance Abuse Care	$20 copay	$20 copay	20% coinsurance*	$20 copay	$20 copay
Well Child Care *(includes preventative lab tests)*	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay
Routine GYN Exam *(one per calendar year, includes preventative lab tests)*	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay
Routine Mammogram	$0 copay	$0 copay	20% coinsurance*	$0 copay	$0 copay
Routine Vision Exam	$0 copay (once every 12 months)	$0 copay (once per calendar year)	All charges	$0 copay (once per calendar year)	$20 copay (once per plan year)
Specialist Office Visit	$35 copay	$35 copay	20% coinsurance*	$35 copay	$35 copay
OTHER OUTPATIENT	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Visiting Nurse Home Health Care	Nothing (Includes Hospice Care)	Nothing	20% coinsurance*	Nothing	Nothing
Durable Medical Equipment	Member pays 20%, plan pays 80% with no limit	Member pays 20%, plan pays 80% with no limit	Member pays 20%, plan pays 80% with no limit	Member pays 20%, plan pays 80% with no limit	Member pays 30%, plan pays 70% with no limit **breast, hand, arm and feet prosthetics Member pays 20%, plan pays 80%

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BENEFIT	BLUE CROSS BLUE SHIELD			HEALTH NEW ENGLAND	TUFTS HEALTH PLAN
	NETWORK BLUE HMO	BLUE CARE ELECT PREFERRED PPO In-Network	BLUE CARE ELECT PREFERRED PPO Out-of-Network	HMO	Choice Copay EPO
Ambulance	Nothing (for emergency or medically necessary transport)	Nothing (for emergency or medically necessary transport)	Nothing for accident or emergency; 20% coinsurance* other medically necessary ambulance transport	$25 co-pay per member per day (included Chair Van services)	Nothing (for emergency or medically necessary transport)
Routine Pediatric Dental (through age 11)	Nothing (covered services each six months)	All charges	All charges	Not covered	Not Covered
Chiropractor Visits	All charges	$20 copay per visit (up to 12 visits per calendar year)	20% coinsurance* (up to 12 visits per calendar year)	All charges (% discount through Optum Health)	$20 copay per visit (up to 12 visits per year)
Prescription Drugs	Retail: (30 day supply) Tier 1: $10.00 copay Tier 2: $25.00 copay Tier 3: $50.00 copay Mail Order: (90 day supply) Tier 1: $20.00 copay Tier 2: $50.00 copay Tier 3: $110.00 copay Express Scripts, Inc. (ESI) is the PBM	Retail: (30 day supply) Tier 1: $10.00 copay Tier 2: $25.00 copay Tier 3: $50.00 copay Mail Order: (90 day supply) Tier 1: $20.00 copay Tier 2: $50.00 copay Tier 3: $110.00 copay Express Scripts, Inc. (ESI) is the PBM	Retail: (30 day supply) Tier 1: $10.00 copay Tier 2: $25.00 copay Tier 3: $50.00 copay Mail Order: (90 day supply) Tier 1: $20.00 copay Tier 2: $50.00 copay Tier 3: $110.00 copay Express Scripts, Inc. (ESI) is the PBM	Retail: (30 day supply) Tier 1: $10.00 copay Tier 2: $25.00 copay Tier 3: $50.00 copay Mail Order: (90 day supply) Tier 1: $20.00 copay Tier 2: $50.00 copay Tier 3: $110.00 copay OptumRx is the PBM for retail and mail order.	Retail: (30 day supply) Tier 1: $10.00 copay Tier 2: $25.00 copay Tier 3: $50.00 copay Mail Order: (90 day supply) Tier 1: $20.00 copay Tier 2: $50.00 copay Tier 3: $110.00 copay CVS Caremark is the PBM
Fitness Benefit	Up to $150 reimbursement toward membership or exercise classes at a health club. See plan details. $150 reimbursement per calendar year, WeightWatchers®	Up to $150 reimbursement toward membership or exercise classes at a health club. See plan details. $150 reimbursement per calendar year, WeightWatchers®	Up to $150 reimbursement toward membership or exercise classes at a health club. See plan details. $150 reimbursement per calendar year, WeightWatchers®	Up to $150 reimbursement per calendar year fitness club membership, Aerobic and Wellness classes, Personal Trainer fees and school and town sports registration fees. $150 reimbursement per calendar year, WeightWatchers®	Up to $150 fitness reimbursement per household, per plan year $150 reimbursement per plan year when enrollmed in a weight loss program.

***After Deductible**