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

Deductible Plans - Effective 7-1-19

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.

*After Deductible	HEALTH NEW ENGLAND	TUFTS HEALTH PLAN	BLUE CROSS BLUE SHIELD		
				BLUE CARE ELECT PREFERRED PPO	
BENEFIT	**HMO**	**Advantage EPO**	**NETWORK BLUE HMO**	**In-Network**	**Out-of-Network**
Deductible	$250 per member up to $750 per family	$250 per member up to $750 per family	$250 per member up to $750 per family	$250 per member up to $750 per family	$400 Individual $800 Family
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:** $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
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) - Deductible Applies	$500 copay*	$500 copay*	$500 copay*	$500 copay*	20% coinsurance* Nothing for emergency/accident admissions
Physician Services	Nothing	Nothing	Nothing	Nothing	20% coinsurance* Nothing for emergency/accident admissions
Skilled Nursing Facility - Deductible Applies	$0 copay for up to 100 days per calendar year, combined with inpatient rehabilitation	Nothing* up to 100 days per plan year	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
Rehabilitation Hospital - Deductible Applies	$0 copay for up to 100 days per calendar year, combined with inpatient rehabilitation	Nothing* up to 100 days per plan year	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

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				BLUE CARE ELECT PREFERRED PPO	
BENEFIT	HMO	Advantage EPO	NETWORK BLUE HMO	In-Network	Out-of-Network
OUTPATIENT HOSPITAL	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Emergency Room Visits for Emergency or Accident Care -Deductible Applies	$100 copay*, (waived if admitted)	$100 copay*, (waived if admitted)	$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)
Emergency Room Visits for Medical Care - Deductible Applies	$100 copay*, waived if admitted	$100 copay*, waived if admitted	$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)
Surgery - Deductible Applies	$150 copay*	$150 copay*	$150 copay*	$150 copay*	20% coinsurance*
Radiation and Chemotherapy - Deductible Applies	$0 copay*	$0 copay*	$0 copay*	$0 copay*	20% coinsurance*
Diagnostic X-ray and Lab - Deductible Applies	$0 copay*	$0 copay*	$0 copay*	$0 copay*	20% coinsurance*
Routine Colonoscopy *(without symptoms)*	$0 copay	$0 copay	$0 copay	$0 copay	20% coinsurance*
High Cost Radiology (MRI, CT & PET) - Deductible Applies	Outpatient hospital based services $100 copay*; non-hospital based services $0	$100 copay*	$100 copay* - copay waived if received at non-hospital facilities	$100 copay* - copay waived if received at non-hospital facility	20% coinsurance*
Hemodialysis - Deductible Applies	$0 copay*	$0 copay*	$0 copay*	$0 copay*	20% coinsurance*
Physical Therapy - Deductible Applies	$20 copay (two months or 25 visits per condition per calendar year)	$35 copay to 30 visits per plan year	$20 copay to 60 visits per calendar year	$20 copay to 100 visits per calendar year	20% coinsurance* to 100 visits per calendar year

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

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*After Deductible	HEALTH NEW ENGLAND	TUFTS HEALTH PLAN	BLUE CROSS BLUE SHIELD		
				BLUE CARE ELECT PREFERRED PPO	
BENEFIT	HMO	Advantage EPO	NETWORK BLUE HMO	In-Network	Out-of-Network
Ambulance - Deductible Applies	$25 co-pay per member per day (included Chair Van services)	Covered in full after deductible	Covered in full after ded (for emergency or medically necessary transport)	Covered in full after deductible (for emergency or medically necessary transport)	Deductible then 20% coinsurance* other medically necessary ambulance transport
Routine Pediatric Dental (through age 11)	Not Covered	Not Covered	Nothing (covered services each six months)	Not Covered	Not Covered
Chiropractor Visits	All charges (% discount through Optum Health)	$20 copay per visit (up to 12 visits per year)	All charges	$20 copay per visit (up to 12 visits per calendar year)	20% coinsurance* (up to 12 visits per calendar 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 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	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
Fitness Benefit	Up to $200/ind and $400/fam reimbursement per calendar year towards fitness club membership, Aerobic and Wellness classes, Personal Trainer fees and school and town sports registration fees and for Weight Watchers® program.	Up to $150 fitness reimbursement per household, per plan year $150 reimbursement per plan year, when enrolled in a weight loss program	Up to $150 per family toward fees paid hospital-based or non-hospital-based weight loss programs that focus on eating and physical activity habits and behavioral/lifestyle counseling with certified health professionals.	Up to $150 reimbursement per family a health club with cardiovascular and strength-training equipment; or a fitness studio offering instructor-led group classes for certain cardiovascular and strength-training programs.	Up to $150 reimbursement toward membership or exercise classes at a health club. See plan details. $150 reimbursement per calendar year, WeightWatchers®