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 7-1-21

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

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*After Deductible	BLUE CROSS BLUE SHIELD			HEALTH NEW ENGLAND	TUFTS HEALTH PLAN
BENEFIT	**NETWORK BLUE New England HMO**	**BLUE CARE ELECT PREFERRED PPO**		**Exclusive HMO**	**Advantage EPO**
		In-Network	**Out-of-Network**		
Emergency Room Visits for Medical Care - Deductible Applies	$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 - Deductible Applies	$150 copay*	$150 copay*	20% coinsurance*	$150 copay*	$150 copay*
Radiation and Chemotherapy - Deductible Applies	$0 copay*	$0 copay*	20% coinsurance*	$0 copay*	$0 copay*
Diagnostic X-ray and Lab - Deductible Applies	$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) - Deductible Applies	$100 copay* - copay waived if received at non-hospital facilities	$100 copay* - copay waived if received at non-hospital facility	20% coinsurance*	Outpatient hospital based services $100 copay*; $0 for non-hospital based services	$100 copay*
Hemodialysis - Deductible Applies	$0 copay*	$0 copay*	20% coinsurance*	$0 copay*	$0 copay*
Physical Therapy - Deductible Applies	$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 (60 visits per calendar year for PT and OT)	Deductible, then covered in full
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% coinsurance*	$20 PCP Office $35 Specialists Office	$20 PCP Office $35 Specialists Office
Adult Preventative Exam *(includes preventative lab tests)*	$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

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*After Deductible	BLUE CROSS BLUE SHIELD			HEALTH NEW ENGLAND	TUFTS HEALTH PLAN
BENEFIT	**NETWORK BLUE New England HMO**	**BLUE CARE ELECT PREFERRED PPO**		**Exclusive HMO**	**Advantage EPO**
		In-Network	**Out-of-Network**		
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 - Deductible Applies	Nothing* (Includes Hospice Care)	Nothing*	20% coinsurance*	Nothing*	Nothing*
Durable Medical Equipment - Deductible Applies	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	Covered in full after deductible *breast, hand, arm and feet prosthetics Member pays 20%, plan pays 80%
Ambulance - Deductible Applies	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	$25 co-pay per member per day (included Chair Van services)	Covered in full after deductible
Routine Pediatric Dental (through age 11)	Nothing (covered services each six months)	Not Covered	Not Covered	Not Covered	Not Covered
Chiropractor Visits	$20 copay per visit (up to 12 visits per calendar year)	$20 copay per visit (up to 12 visits per calendar year)	20% coinsurance (up to 12 visits per calendar year)	$20 copay per visit (up to12 visits per calendar year)	$20 copay per visit (up to 12 visits per year)

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BENEFIT	**NETWORK BLUE New England HMO**	**BLUE CARE ELECT PREFERRED PPO In-Network**	**BLUE CARE ELECT PREFERRED PPO Out-of-Network**	**Exclusive HMO**	**Advantage EPO**
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
Weight Loss	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, WeightWatchers®	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, WeightWatchers®	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, WeightWatchers®		
Fitness Benefit	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; or virtual /online fitness memberships, subscriptions, programs providing the same.	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; or virtual /online fitness memberships, subscriptions, programs providing the same.	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; or virtual /online fitness memberships, subscriptions, programs providing the same.	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, wellness and fitness apps, nutrition apps, mindfulless apps, bike shares and 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