

SCANTIC VALLEY REGIONAL HEALTH TRUST

Effective July 1, 2011	BCBSMA Blue Care Elect PPO		BCBSMA Network Blue HMO	Health New England HMO	Tufts Health Plan* HMO
	In-Network	Out-of-Network			
Deductible	None	\$250 per member \$500 per family	None	None	None
Coinsurance Maximum	None	\$1000 per member \$2000 per family	None	None	None
Lifetime Benefit Maximum	None	None	None	None	None
	In-Network	Out-of-Network			
INPATIENT	<i>Member Pays</i>	<i>Member Pays</i>	<i>Member Pays</i>	<i>Member Pays</i>	<i>Member Pays</i>
General Hospital Mental Hospital, Substance Abuse Facility (semi-private room and board and special services)	Nothing	20% coinsurance after deductible (Nothing - no deductible - for emergency/accident admissions)	Nothing	Nothing	Nothing
Physician Services	Nothing	20% coinsurance after deductible (Nothing - no deductible - for emergency/accident admissions)	Nothing	Nothing	Nothing
Skilled Nursing Facility	Nothing to 100 days per calendar year benefit maximum combined with out of network days	20% coinsurance after deductible to 100 days per calendar year benefit maximum combined with out of network days	Nothing to 100 days per calendar year benefit maximum	No charge (up to 100 days per calendar year) combined with inpatient rehabilitation	Nothing up to 100 days per calendar year
Rehabilitation Hospital	Nothing to 60 days per calendar year benefit maximum	20% coinsurance after deductible to 60 days per calendar year benefit maximum combined with in-network days	Nothing to 60 days per calendar year benefit maximum	No charge (up to 100 days per calendar year) combined with Skilled Nursing Facility	Nothing up to 100 days per calendar year

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OUTPATIENT HOSPITAL	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Emergency Room Visits for Emergency or Accident Care	\$50 co-payment per visit (waived if admitted or for an observation stay)	\$50 co-payment per visit (waived if admitted or for an observation stay)	\$50 co-payment per visit (waived if admitted or for an observation stay)	\$50 co-payment per visit (waived if admitted directly from the ER)	\$50 co-payment per visit
Emergency Room Visits for Medical Care	\$50 co-payment per visit (waived if admitted or for an observation stay)	\$50 co-payment per visit (waived if admitted or for an observation stay)	\$50 co-payment per visit (waived if admitted or for an observation stay)	\$50 co-payment per visit (waived if admitted directly from the ER)	\$50 co-payment per visit
Surgery	Nothing	20% coinsurance after deductible	Nothing	Nothing	Nothing
Radiation & Chemotherapy	Nothing	20% coinsurance after deductible	Nothing	Nothing	Nothing
Diagnostic X-ray and Lab	Nothing	20% coinsurance after deductible	Nothing	Nothing	Nothing
Hemodialysis	Nothing	20% coinsurance after deductible	Nothing	Nothing	Nothing
Physical Therapy	\$15 per visit to 100 visits per calendar year benefit maximum combined with out of network days	20% coinsurance after deductible to 100 visits per calendar year benefit maximum combined with out of network days	\$10 per visit to 60 visits per calendar year benefit maximum	\$10 co-payment per visit (Limited to 2 months or 25 visits whichever is greater per condition per calendar year)	\$10 per visit , 30 visit annual limit.

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PHYSICIAN'S OFFICE	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Surgery	\$15 co-payment per visit	20% coinsurance after deductible	Nothing	Nothing	Nothing
Medical Care, Mental Health, Substance Abuse Care	\$15 co-payment per visit	20% coinsurance after deductible	\$10 co-payment per visit	\$10 co-payment per visit	\$10 co-payment per visit
Well Child Care	\$15 per visit; 10 visits 1st year 3 visits 2nd year 1 visit / year age 2-11 1 visit / 2 yrs age 12-18	20% coinsurance after deductible 10 visits 1st year 3 visits 2nd year 1 visit / year age 2-11 1 visit / 2 yrs age 12-18	\$10 co-payment per visit	\$10 co-payment per visit	Covered in full
Routine GYN Exam	\$15 co-payment per visit (1 visit per calendar year in and out of network combined)	20% coinsurance after deductible	\$10 co-payment per visit (1 visit per calendar year)	\$10 co-payment per visit (1 visit per calendar year)	Covered in full (no PCP referral is necessary)
Routine Vision Exam	\$15 per visit (1 visit per calendar year)	All charges	\$10 co-payment per visit (1 visit per calendar year)	\$10 co-payment per visit (1 visit per calendar year)	\$10 co-payment per visit (1 visit every 24 months) (no PCP referral is necessary)
Adult Routine Physicals	\$15 co-payment per visit 1 visit / 5 yrs age 19-29 1 visit / 3 yrs age 30-39 1 visit / 2 yrs age 40-54 1 visit / year age 55+	20% coinsurance after deductible 1 visit / 5 yrs age 19-29 1 visit / 3 yrs age 30-39 1 visit / 2 yrs age 40-54 1 visit / year age 55+	\$10 co-payment per visit	\$10 co-payment per visit	Covered in full per visit

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OTHER OUTPATIENT	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Visiting Nurse Home Health Care	Nothing	20% coinsurance after deductible	Nothing (includes Hospice Care)	Nothing	Nothing
Durable Medical Equipment	Nothing to \$1500 per calendar year benefit maximum combined with out-of-network maximum	20% coinsurance after deductible to \$1500 per calendar year benefit maximum combined with in-network maximum	Nothing up to \$1,500 per calendar year benefit maximum	20% copayment for DME and Prosthetic Devices (some items require prior approval)	Plan covers 70% member pays 30% no benefit limit
Ambulance	Nothing (for emergency or medically necessary transport)	Nothing (for emergency transport) 20% after deductible (medically necessary transpor	Nothing	\$25 co-payment per member per day (includes Chair Van services)	Nothing (when medically necessary)
Routine Pediatric Dental	All charges	All charges	Nothing (covered services each six months)	Preventive dental only; no charge after \$25 deductible per child per calendar year (for children under age 12)	Not covered
Chiropractor Visits	\$15 per visit (up to 12 visits per calendar year)	20% coinsurance after deductible (up to 12 visits per calendar year)	All charges	All charges % discount through Optum Health	Not covered

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PRESCRIPTION DRUGS	<i>Member Pays</i>	<i>Member Pays</i>	<i>Member Pays</i>	<i>Member Pays</i>	<i>Member Pays</i>
Retail prescription (30-day supply)	Tier 1: \$10 Tier 2: \$20 Tier 3: \$35	Same as PCP/Plan Approved at retail pharmacies outside of Massachusetts	Tier 1: \$10 Tier 2: \$20 Tier 3: \$35	\$10 generic \$20 brand (formulary) \$35 non-preferred (non-formulary)	Tier 1: \$10 Tier 2: \$20 Tier 3: \$35
Mail order maintenance prescription (90-day supply)	Tier 1: \$20 Tier 2: \$40 Tier 3: \$70	Same as PCP/Plan Approved at retail pharmacies outside of Massachusetts	Tier 1: \$20 Tier 2: \$40 Tier 3: \$70	\$20 generic \$40 brand (formulary) \$105 non-preferred (non-formulary)	Tier 1: \$20 Tier 2: \$40 Tier 3: \$70
	Express Scripts, Inc. (ESI) is the PBM	Express Scripts, Inc. (ESI) is the PBM	Express Scripts, Inc. (ESI) is the PBM	MedMetrics Health Partners MHP is the PBM Well-Dyne for mail order	CVS/Caremark is the PBM
OTHER	<i>Member Pays</i>	<i>Member Pays</i>	<i>Member Pays</i>	<i>Member Pays</i>	<i>Member Pays</i>
Fitness	Up to \$150 reimbursement toward membership or exercise classes at a health club See plan details	Up to \$150 reimbursement toward membership or exercise classes at a health club See plan details	Up to \$150 reimbursement toward membership or exercise classes at a health club See plan details	Up to \$150 reimbursement per calendar year	\$150 fitness reimbursement per household per calendar year
This is an abbreviated description of benefits. Details of coverage are available from each health plan provider. Health plans provided the information in this summary. The SVRHT is not responsible for the accuracy of this summary of benefits.					

**NOTE: All self-funded health plans offered by the Scantic Valley Health Care Trust are Grandfathered under the Patient Protection and Affordable Care Act.
*Tufts Health Plan HMO is an Insured plan and is not Grandfathered under the Patient Protection and Affordable Care Act.**