

**SCANTIC VALLEY REGIONAL HEALTH TRUST - RETIREE SUPPLEMENT PLAN BENEFITS** effective: 7/1/11

PLAN FEATURES	TUFTS MEDICARE COMPLEMENT HMO MEDIWRAP	TUFTS MEDICARE PRIME SUPPLEMENT Plan Freedom of Choice	HNE MEDWRAP HMO MEDIWRAP	BCBS MANAGED BLUE FOR SENIORS HMO MEDIWRAP	MEDEX STANDARD Indemnity Type Medicare Supplement	MEDEX ENHANCED w/OBRA90 Indemnity Type Medicare Supplement
	You Pay	You Pay	You Pay	You Pay	You Pay	You Pay
<b>INPATIENT CARE</b>						
General Hospital: Semi-private room & board and special services	Covered in full when medically necessary	Member pays \$300 deductible per year, Then Plan provides full coverage of: - Medicare deductible and coinsurance up to 90 days per benefit period  - Lifetime reserve day coinsurance  - Up to 365 additional hospital days in your lifetime when Medicare benefits are used up. (Lifetime 365 days are a combination of days in a general, acute rehabilitation and/or mental hospital)	Covered in full for unlimited days when medically necessary.	Covered in full for unlimited days when medically necessary	Full coverage of Medicare deductible and co-insurance  Full coverage of lifetime reserve day co-insurance  Full coverage for days 91–365 <b>per benefit period</b> , when Medicare benefits are used up^ ^	Full coverage of Medicare deductible and co-insurance  Full coverage of lifetime reserve day co-insurance  Full coverage up to 365 additional hospital days in your <b>lifetime</b> when Medicare benefits are used up*
Rehabilitation Hospital	Covered in full for 100 days per benefit period.	Acute rehabilitation hospital covered the same as General Hospital.	Covered in full up to 100 days per calendar year. (Combined with Skilled Nursing Facility)	Covered in full (365 days in a lifetime)	Covered in full for 100 days after 3-day or longer hospital stay. Then \$16 per day from day 101 thru day 365.	Covered in full for 100 days after 3-day or longer hospital stay. Then \$16 per day from day 101 thru day 365.

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. 1

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INPATIENT CARE	TUFTS MEDICARE COMPLEMENT	TUFTS MEDICARE PREFERRED Supplement Prime Plan	HNE MEDWRAP	BCBS MANAGED BLUE FOR SENIORS	MEDEX STANDARD	MEDEX ENHANCED w/OBRA90
	You Pay	You Pay	You Pay	You Pay	You Pay	You Pay
Skilled Nursing Facility	Covered in full for up to 100 days per benefit period.	Covered in full for 100 days per benefit period: <ul style="list-style-type: none"> <li>▪ Medicare covers up to 20 days after a hospital stay of 3 days or longer</li> </ul> Then Plan covers, in full, Medicare daily coinsurance for days 21-100 per benefit period.	Covered in full up to 100 days per calendar year. (Combined with Rehabilitation Hospital)	Covered in full for 100 days in benefit period.	With Medicare – Full coverage of Medicare daily co-insurance for days 21-100. Then \$16 per day from day 101 thru day 365. Without Medicare - \$16 per day per benefit period.	With Medicare – Full coverage of Medicare daily co-insurance for days 21-100. Then \$16 per day from day 101 thru day 365. Without Medicare - \$16 per day per benefit period.
Mental Health & Substance Abuse Care in a Psychiatric Hospital	190-day lifetime limit in a psychiatric hospital	<i>General or Psychiatric hospital</i> - Full coverage of Medicare deductible and coinsurance up to 90 days per benefit period. - Full coverage of lifetime reserve day coinsurance - Full coverage up to 365 additional hospital days in your lifetime when Medicare benefits are used up. (Lifetime 365 days are a combination of days in a general, acute rehabilitation and/or mental hospital]	Covered in full, no day limit.	Covered in full, no day limit.	<i>General or Psychiatric hospital</i> - Full coverage of Medicare deductible and co-insurance - Full coverage of lifetime reserve day co-insurance - Full coverage for days 91-365 per benefit period, when Medicare benefits are used up. (Lifetime 365 days are a combination of days in a general or mental hospital	

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OUTPATIENT CARE	TUFTS MEDICARE COMPLEMENT	TUFTS MEDICARE PREFERRED Supplement Prime Plan	HNE MEDWRAP	BCBS MANAGED BLUE FOR SENIORS	MEDEX STANDARD	MEDEX ENHANCED w/OBRA90
	You Pay	You Pay	You Pay	You Pay	You Pay	You Pay
Routine Annual Physical Exams	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Medical Office Visits	\$10 co-pay per visit	\$15 co-pay per visit	\$10 co-pay per visit	\$10 co-pay per visit	Subscriber owes 20% co-insurance unless within 100 days of a hospital stay of at least 3 days	Covered in full
Consult & Care by Specialists	\$10 co-pay per visit	\$15 co-pay per visit	\$10 co-pay per visit	\$10 co-pay per visit (& referral from PCP)	Subscriber owes 20% co-insurance unless within 100 days of a hospital stay of at least 3 days	Covered in full.
Day Surgery	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Diagnostic Lab & X-ray Services	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Radiation & Chemotherapy	Covered in full	Covered in full	Covered in full	Covered in full	Covered in Full	Covered in full
Urgent & Emergency Care	\$10 co-pay for office; \$50 co-pay for ER	\$15 co-pay for office; \$50 co-pay for ER	\$10 co-pay for urgent care office visit; \$50 co-pay per visit for ER (waived if admitted)	\$50 co-pay per visit for ER (waived if admitted)	Full coverage for emergency services	Full coverage for emergency services
Ambulance Services	Covered in full	\$50 co-pay per day.	\$25 co-pay per member per day	Emergency Transportation covered in full. Medically necessary transportation \$40 member co-pay	Covered in full (if medically necessary)	Covered in full (if medically necessary)

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Mental Health & Substance Abuse	\$10 co-pay per visit when medically necessary	<p><b>Biologically based mental conditions:</b></p> <ul style="list-style-type: none"> <li>- When covered by Medicare, full coverage of deductible and coinsurance after \$15 copayment per visit. There is no visit limit.</li> <li>- When not covered by Medicare, \$15 copayment per visit for up to 24 visits per calendar year.</li> </ul> <p><b>Non-biologically-based mental conditions:</b></p> <ul style="list-style-type: none"> <li>- When covered by Medicare, full coverage after \$15 copayment per visit</li> <li>- When not covered by Medicare, \$15 copayment per visit for up to 24 visits per calendar year.</li> </ul> <p><i>* Includes drug addiction and alcoholism.</i></p>	<p>\$10 co-pay per visit when medically necessary</p> <p>There is a Prior Authorization requirement after the 15th visit for Outpatient Mental Health and Outpatient Substance Abuse, combined.</p>	\$10 co-pay, unlimited visits	When covered by Medicare, full coverage of deductible and co-insurance w/no visits max. When not covered by Medicare, full Medex benefits with no visit max.	When covered by Medicare, full coverage of deductible and co-insurance w/no visits max. When not covered by Medicare, full Medex benefits with no visit max.
Routine Vision & Hearing Screenings	\$10 co-pay per visit for annual routine eye exam & hearing exam. Hearing aids not covered	<p><u>Hearing</u> - Covered up to \$100 per cal yr.  <u>Hearing Aid</u> - \$500 every 3 yrs purchase or repair  <u>Vision</u> – covered up to \$100 per cal yr.  <u>Glasses or contacts</u> - covered up to \$150 per cal year.</p>	\$10 co-pay per visit for annual routine eye and hearing exams	\$0 co-pay per visit	Covered in Full	Covered in Full

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Preventive Dental	Not covered	Not covered	Preventive dental services for children under the age of 12 (you pay the first \$25 per child per calendar year)	Not covered	Not covered	Not covered
Prescription drugs	<p><b>Retail:</b>  <u>30 day</u> supply:                      Tier 1: \$8 co-pay                      Tier 2: \$20 co-pay                      Tier 3: \$35 co-pay</p> <p><b>Mail Order:</b>  <u>90 day</u> supply:                      Tier 1: \$16 co-pay                      Tier 2: \$40 co-pay                      Tier 3: \$70 co-pay</p>	<p><b>Retail:</b>  <u>30 day</u> supply:                      \$10 generic                      \$20 preferred brand                      \$35 non-preferred brand</p> <p><b>Mail Order:</b>  <u>90 day</u> supply:                      \$20 generic                      \$40 preferred brand                      \$70 non-preferred brand</p>	<p><b>Retail:</b>  <u>30 day</u> supply:                      Generic: \$10 co-pay                      Formulary:                      \$20 co-pay                      Non-Formulary:                      \$35 co-pay</p> <p><b>Mail Order:</b>  <u>90 day</u> supply:                      (maintenance medication)                      Generic:                      \$20 co-pay                      Formulary:                      \$40 co-pay                      Non-Formulary:                      \$105 co-pay</p>	<p><b>Retail:</b>                      Up to <u>60 day</u> supply:                      Tier 1: 25% co-ins.                      Tier 2: 50% co-ins.                      Tier 3: 75% co-ins.</p> <p><b>Mail Order:</b>  <u>90 day</u> supply:                      Tier 1: \$5 co-pay                      Tier 2: \$30 co-pay                      Tier 3: \$50 co-pay</p>	<p><b>Retail:</b>  <u>30 day</u> supply:                      After \$25 deductible per calendar year, 100% coverage for generic                      80% coverage for brand for <u>30-day</u> supply</p> <p><b>Mail Order:</b>  <u>90 day</u> supply:                      \$2 generic                      \$15 brand  <i>(no deductible applies to mail order)</i></p>	<p><b>Retail:</b>  <u>30 day</u> supply:                      After \$25 deductible per calendar year, 100% coverage for generic                      80% coverage for brand</p> <p><b>Mail Order:</b>  <u>90 day</u> supply:                      \$2 generic                      \$15 brand  <i>(no deductible applies to mail order)</i></p>
<b>FITNESS</b>	<b>TUFTS MEDICARE COMPLEMENT</b>	<b>TUFTS MEDICARE PREFERRED Supplement Prime Plan</b>	<b>HNE MEDWRAP</b>	<b>BCBS MANAGED BLUE FOR SENIORS</b>	<b>MEDEX STANDARD</b>	<b>MEDEX ENHANCED w/OBRA90</b>
Fitness Center Benefit	20% discount on an annual membership at any participating fitness club, with no initiation or joining fees.  See plan for details.	Up to \$150 reimbursement per calendar year at any participating fitness club.  See plan for details.	Up to \$150 reimbursement per calendar year at an eligible health club or weight watchers, per family.  See plan for details.	Up to \$150 reimbursement per calendar year per subscriber at a health club or Weight Watchers® or hospital based weight loss program.  See plan for details.	No Fitness Benefit	No Fitness Benefit