SCANTIC VALLEY REGIONAL HEALTH TRUST
Effective July 1, 2009

	BCBSMA Blue Care Elect PPO		BCBSMA Network Blue HMO	HNE HMO	THP 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	*Member Pays*	*Member Pays*	*Member Pays*	*Member Pays*	*Member Pays*
General Hospital (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 to 60 days per calendar year benefit maximum

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	In-Network	**Out-of-Network**			
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 (assuming the dx is one BCBSMA would pay)	$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

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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	$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	$10 co-payment per visit
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)	$10 co-payment per visit (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 (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	$10 co-payment per visit

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	In-Network	Out-of-Network			
MENTAL HEALTH	*Member Pays*	*Member Pays*	*Member Pays*	*Member Pays*	*Member Pays*
BIOLOGICALLY-BASED CONDITIONS+ **Inpatient admissions in a general or mental hospital**	Nothing	20% coinsurance after deductible	Nothing	Nothing no day limits for inpatient or outpatient care	Nothing
Outpatient Visits	$15 co-payment per visit	20% coinsurance after deductible	$10 co-payment per visit	$10 co-payment per visit	$10 co-payment per visit (up to 24 visits per cal yr)
NON-BIOLOGICALLY BASED CONDITIONS **Inpatient admissions in a general hospital**	Nothing	20% coinsurance after deductible	Nothing	No day limits	Nothing
Inpatient admission in a mental hospital facility (up to 60 days per calendar year)	Nothing	20% coinsurance after deductible	Nothing	Nothing (may substitute 2 days of partial hosp-italization for each day of inpatient care)	Nothing
Outpatient visits	$15 per visit	20% coinsurance after deductible	$10 co-payment per visit	$10 co-payment per visit (care for some conditions may be limited to 24 visits per calendar year)	$10 co-payment per visit (up to 24 per cal yr)

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	In-Network	**Out-of-Network**			
INPATIENT	*Member Pays*	*Member Pays*	*Member Pays*	*Member Pays*	*Member Pays*
ALCOHOLISM TREATMENT (IN ADDITION TO BIOLOGICALLY BASED MENTAL CONDITIONS) **INPATIENT** admissions in a general hospital	Nothing	20% coinsurance after deductible	Nothing	Nothing	Nothing (services provided through a Designated Facility Program for up to 30 days per calendar year
INPATIENT admissions in a substance abuse treatment facility (to 30 days per calendar year)	Nothing	20% coinsurance after deductible	Nothing	Nothing	Nothing
OUTPATIENT visits ++ (to 8 / yr)	$15 per visit	20% coinsurance after deductible	$10 co-payment per visit	$10 co-payment per visit 1-8 $20 co-payment per visit 9-20	$10 co-payment per visit (THP pays up to $500 per calendar year
	In-Network	**Out-of-Network**			
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	$3,000 annual calendar year maximum with a 20% co-payment for DME (some DME items require prior approval) & a separate $3,000 annual calendar year maximum with a $0 co-payment for Prosthetics	20% coinsurance ($5,000 calendar year maximum)

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	In-Network	**Out-of-Network**		per visit 9-20	per calendar year
OTHER OUTPATIENT	*Member Pays*	*Member Pays*	*Member Pays*	*Member Pays*	*Member Pays*
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)	Nothing (children under 12)
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 American Chiropractic Network (ACN)	All charges
	In-Network	**Out-of-Network**			
PRESCRIPTION DRUGS	*Member Pays*	*Member Pays*	*Member Pays*	*Member Pays*	*Member Pays*
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 (MM) is the PBM Well-Dyne for mail order	PCS is the PBM AdvanceRx for mail order

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.