

SCANTIC VALLEY REGIONAL HEALTH TRUST - RETIREE SUPPLEMENT PLAN BENEFITS effective: 7/1/09

PLAN FEATURES	TUFTS MEDICARE COMPLEMENT HMO MEDIWRAP	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
INPATIENT CARE					
General Hospital: Semi-private room & board and special services	Covered in full when medically necessary	Covered in full for unlimited days when medically necessary.	Covered in full for unlimited days when medically necessary	Full coverage for first 365 days per benefit period.	Full coverage for first 365 days per benefit period.
Rehabilitation Hospital	Covered in full for 100 days per benefit period.	Covered in full up to 100 days per calendar year.	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.
Skilled Nursing Facility	Covered in full for up to 100 days per benefit period.	Covered in full up to 100 days per calendar year.	Covered in full for 100 days in benefit period.	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.
Mental Health & Substance Abuse Care in a Psychiatric Hospital	190-day lifetime limit in a psychiatric hospital	Covered in full, no day limit.	Biologically based conditions: Covered in full, no day limit. Non-biologically based conditions: Covered in full, no day limit	Biologically based conditions: Covered in full up to 365 days in a benefit period. Non-biologically based conditions: Covered in full up to 120 days per benefit period (at least 60 days per calendar year).	Biologically based conditions: Covered in full up to 365 days in a benefit period. Non-biologically based conditions: Covered in full up to 120 days per benefit period (at least 60 days 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.

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OUTPATIENT CARE	TUFTS MEDICARE COMPLEMENT	HNE MEDWRAP	BCBS MANAGED BLUE FOR SENIORS	MEDEX STANDARD	MEDEX ENHANCED w/OBRA90
	You Pay	You Pay	You Pay	You Pay	You Pay
Medical Office Visits	\$10 co-pay per visit	\$10 co-pay per visit	\$10 co-pay per visit	Covered in full when furnished within 100 days of inpatient discharge, otherwise 80% coverage of Medicare approved services	Covered in full.
Consult & Care by Specialists	\$10 co-pay per visit	\$10 co-pay per visit	\$10 co-pay per visit (& referral from PCP)	Medicare 20% coinsurance not covered.	Covered in full.
Routine Physical Exams	\$10 co-pay per visit	\$10 co-pay per visit	\$10 co-pay per visit	Not covered	Not covered
Diagnostic Lab & X-ray Services	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Day Surgery	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
Urgent & Emergency Care	\$10 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	\$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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OUTPATIENT CARE <i>(cont'd)</i>	TUFTS MEDICARE COMPLEMENT	HNE MEDWRAP	BCBS MANAGED BLUE FOR SENIORS	MEDEX STANDARD	MEDEX ENHANCED w/OBRA90
	You Pay	You Pay	You Pay	You Pay	You Pay
Mental Health & Substance Abuse	\$10 co-pay per visit when medically necessary	\$10 co-pay per visit for mental health outpatient visits; \$10 co-pay per visit for visits 1 thru 8 for substance abuse outpatient visits; \$20 co-pay per visit for visits 9 thru 20 for substance abuse outpatient visits	Biologically based: \$10 co-pay, unlimited visits Non-biologically based: When covered by Medicare, \$10 co-pay, no visit max. When <u>not</u> covered by Medicare, \$10 co-pay, 24 visits per calendar year. Includes drug addiction & alcoholism.	Biologically-based mental conditions: 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. Non-biologically-based mental conditions *: Covered in full through 24 th visit per calendar year; then for Medicare covered services, 50% coinsurance from the 25 th visit. <i>*Includes drug addiction & alcoholism.</i>	Biologically-based mental conditions: Covered in full. Non-biologically-based mental conditions *: Covered in full through 24 th visit per calendar year; then covered in full from 25 th visit for Medicare covered services. <i>* Includes drug addiction and alcoholism.</i>
Routine Vision & Hearing Screenings	\$10 co-pay per visit for annual routine eye exam & hearing exam. Hearing aids not covered	\$10 co-pay per visit for annual routine eye exam; \$10 co-pay per visit for hearing tests	\$10 co-pay per visit	Not covered	Not covered
Preventive Dental	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

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	TUFTS MEDICARE COMPLEMENT	HNE MEDWRAP	BCBS MANAGED BLUE FOR SENIORS	MEDEX STANDARD	MEDEX ENHANCED w/OBRA90
	You Pay	You Pay	You Pay	You Pay	You Pay
Prescription drugs	<p>Retail: <u>30 day</u> supply: Tier 1: \$8 co-pay Tier 2: \$20 co-pay Tier 3: \$35 co-pay</p> <p>Mail Order: <u>90 day</u> supply: Tier 1: \$16 co-pay Tier 2: \$40 co-pay Tier 3: \$70 co-pay</p>	<p>Retail: <u>30 day</u> supply: Generic: \$10 co-pay Formulary: \$20 co-pay Non-Formulary: \$35 co-pay</p> <p>Mail Order: <u>90 day</u> supply: (maintenance medication) Generic: \$20 co-pay Formulary: \$40 co-pay Non-Formulary: \$105 co-pay</p>	<p>Retail: Up to <u>60 day</u> supply: Tier 1: 25% co-ins. Tier 2: 50% co-ins. Tier 3: 75% co-ins.</p> <p>Mail Order: <u>90 day</u> supply: Tier 1: \$5 co-pay Tier 2: \$30 co-pay Tier 3: \$50 co-pay</p>	<p>Retail: <u>30 day</u> supply: After \$25 deductible per quarter year, 100% coverage for generic 80% coverage for brand for <u>30</u>-day supply</p> <p>Mail Order: <u>90 day</u> supply: \$2 generic \$15 brand <i>(no deductible applies to mail order)</i></p>	<p>Retail: <u>30 day</u> supply: After \$25 deductible per quarter year, 100% coverage for generic 80% coverage for brand</p> <p>Mail Order: <u>90 day</u> supply: \$2 generic \$15 brand <i>(no deductible applies to mail order)</i></p>
FITNESS					
Fitness Center Benefit	20% discount on an annual membership at any participating fitness club, with no initiation or joining fees.	Up to \$150 reimbursement per calendar year at an eligible health club or weight watchers, per family. See plan for details.	Up to \$150 reimb per calendar year per subscriber at a health club or Weight Watchers® or hospital based weight loss program. See plan details.	No Fitness Benefit	No Fitness Benefit