BLUE Benefit ADMINISTRATORS OF MASSACHUSETTS

Valley Health Systems, Inc.

Benefit Year: January 1, 2020–December 31, 2020
Benefits Covered: Medical, RX
Revision Date: 10/23/2019

BluePrint™ Valley Health Systems, Inc. - EPO Plan

Valley Health Systems, Inc. Employee Group Health Care Plan
Summary of Benefits Effective: January 1, 2020

BENEFIT CATEGORY	Tier 1 Holyoke Medical Center[1] (You Pay)	Tier 2[2] (You Pay)	Tier 3 BlueCard®[3] (You Pay)
Calendar Year Deductible The amount a member or family must pay each calendar year before payments begin for services. **Per Individual** **Per Family**	 $0 $0	 $0 $0	 $2,000 $4,000
Out-of-Pocket Maximum Limit The maximum amount of money that any member or family will have to pay towards covered health expenses during any one calendar year. Includes the calendar year deductible, coinsurance, medical/prescription co-payments. Out-of-pocket maximums cross accumulate between network tiers. **Per Individual** **Per Family**		 $7,350 $14,700	
Plan Coinsurance	Plan pays 100% (unless otherwise stated)	Plan pays 80% (unless otherwise stated)	Plan pays 80% (unless otherwise stated), after the deductible is met
PREVENTIVE SERVICES	**Tier 1 Holyoke Medical Center[1] (You Pay)**	**Tier 2[2] (You Pay)**	**Tier 3 BlueCard®[3] (You Pay)**
Routine Preventive Care Examinations Includes immunizations and flu shots	No charge	No charge	No charge
Routine Annual Gynecological Exam	No charge	No charge	No charge
Routine Diagnostic Tests, Lab, and X-rays	No charge	No charge	No charge
Contraceptive Services and Supplies for Women (FDA approved only; includes education and counseling)	No charge	No charge	No charge
Routine Colonoscopies, Sigmoidoscopies, and Similar Routine Surgical Procedures	No charge	No charge	No charge
Routine Mammograms and Breast Exams Maximum of ONE exam per calendar year including 3D mammograms for preventive screenings	No charge	No charge	No charge
Routine Autism Screening	No charge	No charge	No charge
Routine PSA Test and Prostate Exams	No charge	No charge	No charge
Routine Hearing Exams	No charge	No charge	No charge
Routine Eye Exam and Glaucoma Testing One exam every calendar year	No charge	No charge	No charge

PHYSICIAN'S SERVICES	Tier 1 Holyoke Medical Center[1] (You Pay)	Tier 2[2] (You Pay)	Tier 3 BlueCard®[3] (You Pay)
Physician Office Visits Primary Care Physician Specialty Care Physician	$20 copay per visit $35 copay per visit	$20 copay per visit $35 copay per visit	$20 copay per visit $35 copay per visit
Nutritional Counseling Up to 4 visits per person per calendar year. (Not part of preventive care services as required under ACA)	No charge	No charge	No charge
Diabetes Treatment	No charge	20% coinsurance	20% (after deductible)
Diabetic Counseling	$35 copay per visit	$35 copay per visit	$35 copay per visit
Allergy Injections and Sublingual Drops	$20 copay per visit	$20 copay per visit	$20 copay per visit
Diagnostic Hearing Exams/Tests	No charge	20% coinsurance	20% (after deductible)
Routine Prenatal Maternity Care Services	No charge	No charge	No charge
In-Vitro Fertilization Infertility Treatment[4] One Cycle maximum benefit per lifetime To age 40, includes diagnosis **Intrauterine Insemination Infertility Treatment[4]** Three Cycles maximum benefit per lifetime To age 40, includes diagnosis	No charge	20% coinsurance	20% (after deductible)
HOSPITAL SERVICES - OUTPATIENT	**Tier 1 Holyoke Medical Center[1] (You Pay)**	**Tier 2[2] (You Pay)**	**Tier 3 BlueCard®[3] (You Pay)**
Emergency Room Expenses Includes facility, lab, x-ray and physician services. Copay waived if admitted as inpatient within 24 hours or held for observation longer than 20 hours	$150 copay per visit	$150 copay per visit	$150 copay per visit
Ambulance Services (ground or air ambulance transport)	$25 copay per day	$25 copay per day	$25 copay per day
Urgent Care Facility	$35 copay per visit	$35 copay per visit	$35 copay per visit
Walk-in Retail Health Clinics	$20 copay per visit	$20 copay per visit	$20 copay per visit
Outpatient Surgery (includes removal of impacted teeth that are fully or partially imbedded in the bone)	No charge	20% coinsurance, plus $650 copay per surgery	20% after deductible, plus $650 copay per surgery
Outpatient Physician/Surgeon Charges	No charge	20% coinsurance	20% (after deductible)

HOSPITAL SERVICES – INPATIENT	Tier 1 Holyoke Medical Center[1] (You Pay)	Tier 2[2] (You Pay)	Tier 3 BlueCard®[3] (You Pay)
Inpatient Hospital Services - Facility[4]	No charge	$650 copay per admission, plus 20% coinsurance	20% after deductible, plus $650 copay per admission
Cardiac Inpatient Services	No charge	No charge	20% after deductible, plus $650 copay per admission
Inpatient Physician Charges	No charge	20% coinsurance	20% (after deductible)
Inpatient Maternity Care[4]	No charge	$650 copay per admission, plus 20% coinsurance	20% after deductible, plus $650 copay per admission
Maternity Neonatal Intensive Care Unit	No charge	No charge	20% after deductible, plus $650 copay per admission
Inpatient Physician Charges for Maternity Care	No charge	20% coinsurance	20% (after deductible)
Pediatric Inpatient Services	No charge	No Charge	20% after deductible, plus $650 copay per admission
MENTAL HEALTH/SUBSTANCE ABUSE SERVICES	**Tier 1 Holyoke Medical Center[1] (You Pay)**	**Tier 2[2] (You Pay)**	**Tier 3 BlueCard®[3] (You Pay)**
Inpatient Mental Health/Substances Use Disorder, And Chemical Dependency Benefits - Facility[4] As many days as medically necessary.	No charge	$650 copay per admission, plus 20% coinsurance	20% after deductible, plus $650 copay per admission
Inpatient Mental Health/Substances Use Disorder, And Chemical Dependency Benefits – Physician fees	No charge	20% coinsurance	20% (after deductible)
Outpatient Mental Health/Substances Use Disorder (Includes Partial – Hospitalization)	No charge	$20 copay per visit	$20 copay per visit
OTHER COVERED SERVICES	**Tier 1 Holyoke Medical Center[1] (You Pay)**	**Tier 2[2] (You Pay)**	**Tier 3 BlueCard®[3] (You Pay)**
Durable Medical Equipment[4] Pre-certification required for amounts over $3,500	No charge	No charge	No charge
Breast Pumps One breast pump per pregnancy in conjunction with childbirth	No charge	No charge	No charge
Outpatient Diagnostic X-Ray & Lab Diagnostic services	No charge	20% coinsurance	20% (after deductible)
3D Mammograms for Diagnostic Treatment	No charge	20% coinsurance	20% (after deductible)
Outpatient High Tech Radiology Includes MRI, PET, CAT Scan and nuclear cardiac imaging test	No charge	$650 copay per admission, plus 20% coinsurance	20% after deductible, plus $650 copay per admission
Outpatient High Tech Radiology Physician Charges	No charge	20% coinsurance	20% (after deductible)
Hospice Care/Bereavement Counseling/Respite Care	No charge	20% coinsurance	20% coinsurance
Skilled Nursing Facility/Convalescent/Subacute facility[4] Up to 100 days per person per calendar year.	No charge	No charge	No charge
Home Health Care	No charge	20% coinsurance	20% coinsurance

OTHER COVERED SERVICES - CONTINUED	Tier 1 Holyoke Medical Center[1] (You Pay)	Tier 2[2] (You Pay)	Tier 3 BlueCard®[3] (You Pay)
Outpatient Short Term Rehabilitation Physical therapy, Occupational therapy, Respiratory therapy, Aquatic therapy, Speech therapy & Hearing therapy Unlimited visit benefit limit per member per calendar year Visit limit does not apply to the treatment of autism spectrum disorders and developmental delays.	No charge	$35 copay per visit	$35 copay per visit
Chiropractic Office Visits Up to 12 visits per person per calendar year. Includes spinal manipulation	$35 copay per visit	$35 copay per visit	$35 copay per visit
Outpatient Cardiac Rehabilitation – Phase 2	No charge	$35 copay per visit	$35 copay per visit
Hearing Aids – To age 22 Limited to $2,000 for one hearing aid for each hearing-impaired ear every 36 months Includes Implantable Devices	No charge	No charge	No charge
Dental Services (See medical covered expenses section for covered services)	No charge	No charge	No charge
Developmental Delays For an eligible child to age 3	No charge	20% coinsurance	20% (after deductible)
Shoe Inserts Custom – Molded Limited to 1 pair of custom molded shoes (including inserts provided with those shoes) and 2 additional pairs of inserts **OR** 1 pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with those shoes).	No charge	No charge	No charge
Prosthetic Devices[4] Pre-certification required for amounts over $3,500	No charge	No charge	No charge
Wigs - (Cranial Prostheses) Toupees, or hairpieces related to cancer treatment and alopecia Areata (Limited to 1 per calendar year)	No charge	No charge	No charge
Outpatient Sleep Studies Limited to 2 visits per person per calendar year **Home Sleep Studies**	No charge No charge	$650 copay per admission, plus 20% coinsurance No charge	20% after deductible, plus $650 copay per admission No charge
Sterilization	No charge	No charge	No charge
Oral Surgery (includes removal of impacted teeth that are fully or partially imbedded in the bone)	No charge	No charge	No charge
Wellness Reimbursement Program Maximum Benefit Per Family Per Calendar Year	$300		
PRESCRIPTION DRUG BENEFITS[5]	**Network Pharmacy**		
Retail (Per 30 Day Supply) Generic Drug Preferred Brand Drug Non-Preferred Brand Drug	 $15 co-payment $30 co-payment $50 co-payment		
Mail Order (31 to 90 Day Supply) Generic Drug Preferred Brand Drug Non-Preferred Brand Drug	 $30 co-payment $60 co-payment $100 co-payment		
Diabetic and Asthma medications & supplies are paid as follows: No charge (generic & preferred brand); $10 copay per prescription (non-preferred brand)			

Important Additional Information:

[1]Valley Health System's – Tier 1, medical plan encourages the use of Holyoke Medical Center services to receive the highest benefit level available under the plan.

[2]Services render at a Tier 2 facility will provide the second highest level benefits available under the plan.

[3]Valley Health System's – Tier 3, plan requires the use of National BlueCard® Network providers in order to receive the BlueCard® benefit level. To verify that your provider(s) participate in the BlueCard® Network, you may view an electronic directory by visiting www.bluebenefitma.com/members. From the Members page, select "Search the National BlueCard® Network" to begin your search.

[4] Requires pre-certification. If you fail to follow the pre-certification requirements, benefits may be reduced. Please call the BBA Utilization Review Department at 1.877.707.2583 Opt 6 in advance. **Note:** Medical Necessity and Prior Authorizations will be waived for services performed at Holyoke Medical Center.

[5]Your Prescription Drug Program provides you access to a **retail** pharmacy network managed by Express Scripts. To locate a network pharmacy or access the Express Scripts formulary, go to www.express-scripts.com. Your prescription drug program also provides you access to a valuable Home Delivery Program through Express Scripts. To take advantage of this service, obtain a 90 day prescription from your doctor and visit www.express-scripts.com to create an online account and begin the process.

Tier 2 Hospitals

- Athol Hospital
- Harrington Memorial Hospital
- Hartford Hospital
- Heywood Hospital
- Mercy Hospital
- MetroWest Medical Center
- Saint Francis
- St. Vincent Hospital

Baystate Health including full Baystate Health System

- Baystate Medical Center
- Baystate Franklin Medical Center
- Baystate Mary Lane Outpatient & Emergency
- Baystate Noble Hospital
- Baystate Wing Hospital

- *Services performed at Tier 2, but not available at HMC will be reimbursed at Tier 1benefit level*
- *Services not available at HMC or Tier 2, and performed at Tier 3 will be reimbursed at Tier 1 benefit level*

[Your Summary Plan Description Defines The Full Terms & Conditions In Greater Detail. Should Any Questions Arise Concerning Benefits; the Summary Plan Description Shall Govern]