



Network Blue[®] New England \$250 Deductible

Plan-Year Deductible: \$250/\$750

Scantic Valley Trust



This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.

Your Care

Your Primary Care Provider (PCP)

When you enroll in this health plan, you must choose a primary care provider. Be sure to choose a PCP who can accept you and your family members and who participates in the network of providers in New England. For children, you may choose a participating network pediatrician as the PCP.

For a list of participating PCPs or OB/GYN physicians, visit the Blue Cross Blue Shield of Massachusetts website at www.bluecrossma.com; consult the Provider Directory; or call the Physician Selection Service at **1-800-821-1388**.

If you have trouble choosing a doctor, the Physician Selection Service can help. They can give you the doctor's gender, the medical school she or he attended, and whether there are languages other than English spoken in the office.

Referrals

Your PCP is the first person you call when you need routine or sick care. If your PCP decides that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist, who is likely affiliated with your PCP's hospital or medical group.

You will not need prior authorization or referral to see a HMO Blue New England network provider who specializes in OB/GYN services. Your providers may also work with Blue Cross Blue Shield of Massachusetts regarding referrals and Utilization Review Requirements, including Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. For detailed information about Utilization Review, see your benefit description.

Your Deductible

Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for most benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is **\$250** per member (or **\$750** per family).

Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical benefits is **\$2,000** per member (or **\$4,000** per family). Your out-of-pocket maximum for prescription drug benefits is **\$3,000** per member (or **\$6,000** per family).

Emergency Room Services

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call **911** (or the local emergency phone number). After meeting your deductible, you pay a copayment per visit for emergency room services. This copayment is waived if you're admitted to the hospital or for an observation stay. See the chart for your cost share.

Service Area

The plan's service area includes all cities and towns in the Commonwealth of Massachusetts, State of Rhode Island, State of Vermont, State of Connecticut, State of New Hampshire, and State of Maine.

When Outside the Service Area

If you're traveling outside the service area and you need urgent or emergency care, you should go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. Any additional follow-up care must be arranged by your PCP. See your benefit description for more information.

Dependent Benefits

This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. See your benefit description (and riders, if any) for exact coverage details.

Your Medical Benefits

Covered Services	Your Cost
Preventive Care	
Well-child care visits	Nothing, no deductible
Preventive dental care for children under age 12 (one visit each six months)	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible
Hearing aids (up to \$2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum, no deductible
Routine vision exams (one every 12 months)	Nothing, no deductible
Family planning services—office visits	Nothing, no deductible
Outpatient Care	
Emergency room visits	\$100 per visit after deductible (copayment waived if admitted or for observation stay)
Office visits, when performed by: <ul style="list-style-type: none"> Your PCP, OB/GYN physician, network nurse practitioner or nurse midwife Other network providers 	\$20 per visit, no deductible \$35 per visit, no deductible
Mental health or substance abuse treatment	\$20 per visit, no deductible
Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year*)	\$20 per visit, no deductible
Speech, hearing, and language disorder treatment—speech therapy	\$20 per visit, no deductible
Diagnostic X-rays and lab tests, excluding CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests <ul style="list-style-type: none"> Hospitals Other network providers 	\$100 per category per service date after deductible Nothing after deductible
Home health care and hospice services	Nothing after deductible
Oxygen and equipment for its administration	Nothing after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	20% coinsurance after deductible**
Prosthetic devices	20% coinsurance after deductible
Surgery and related anesthesia in an office, when performed by: <ul style="list-style-type: none"> Your PCP or OB/GYN physician Other network providers 	\$20 per visit***, no deductible \$35 per visit***, no deductible
Surgery in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	\$150 per admission after deductible
Inpatient Care (including maternity care)	
General or chronic disease hospital care (as many days as medically necessary)	\$500 per admission after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	\$500 per admission after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing after deductible

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.

** Cost share waived for one breast pump per birth.

*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

Prescription Drug Benefits*	Your Cost**
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	No deductible \$10 for Tier 1 \$25 for Tier 2 \$50 for Tier 3
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	No deductible \$20 for Tier 1*** \$50 for Tier 2 \$110 for Tier 3

* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred drugs.

** Cost share may be waived for certain covered drugs and supplies.

*** Certain generic medications are available through the mail service pharmacy at \$9. For more information, go to www.bluecrossma.com/mail-service-pharmacy.

Get the Most from Your Plan

Visit us at www.bluecrossma.com or call 1-800-782-3675 to learn about discounts, savings, resources, and special programs available to you, like those listed below.

<p>Wellness Participation Program</p> <p>Reimbursement for a membership at a health club or for fitness classes</p> <p>This fitness program applies for fees paid to: privately-owned or privately-sponsored health clubs or fitness facilities, including individual health clubs and fitness centers; YMCAs; YWCAs; Jewish Community Centers; and municipal fitness centers. (See your benefit description for details.)</p>	\$150 per calendar year per policy
<p>Reimbursement for participation in a qualified weight loss program</p> <p>This weight loss program applies for fees paid to: a qualified hospital-based weight loss program or a Blue Cross Blue Shield of Massachusetts designated weight loss program. (See your benefit description for details.)</p>	\$150 per calendar year per policy
Blue Care Line®—A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583)	No additional charge

Questions?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-782-3675, or visit us online at www.bluecrossma.com. Interested in receiving information from us via e-mail? Go to www.bluecrossma.com/email to sign up.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: chiropractor services; cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders.

Note: Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.