Summary of Benefits - Bay State College

Blue Care® Elect Student Health Plan

Blue Care Elect Preferred 80 With Copay Plan Option

This is the Summary of Benefits. This chart describes the cost share amounts that you must pay for covered services. It also shows the benefit limits that apply for covered services. Do not rely on this chart alone. Be sure to read all parts of your Subscriber Certificate to understand the requirements that you must follow to receive all of your coverage. To be sure that you receive in-network benefits, you must obtain all of your health care services and supplies from covered providers who participate in the Blue Cross Blue Shield PPO health care network. If you obtain covered services from a covered provider who does not participate in the Blue Cross Blue Shield PPO health care network you will usually receive out-of-network benefits.

Get the most from your plan:

Visit us at www.bluecrossma.com/membercentral or call 1-800-262-BLUE (2583) to learn about discounts, savings, resources, and special programs like those listed below that are available.

A Fitness Benefit toward membership at a health club or for fitness classes: Reimbursement for 3 months of membership fees, per individual or family per calendar year.

A Weight Loss Program Benefit toward participation in a qualified weight loss program: Reimbursement for up to 3 months of membership fees individual or family per calendar year.

Blue Care Line — A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583)

Overall Member Cost Share Provisions	In-Network Benefits	Out-of-Network Benefits
Deductible Your deductible per Plan Year: This deductible applies to all covered services except in-network preventive health services, prescription drugs and supplies, and certain other covered services as noted in this chart.	None This deductible applies for in-network and out-of-network benefits combined.	
Out-of-Pocket Maximum Your out-of-pocket maximum per Plan Year: This out-of-pocket maximum is a total of your deductible, copayments and coinsurance. You will still have to pay any costs not included in this out-of-pocket maximum.	$5,000 per *member* (excluding cost share amounts for prescription drugs) separate *out-of-pocket maximum* for prescription drug benefits: $1,000 per *member* This out-of-pocket maximum applies for in-network and out-of-network benefits combined. The family out-of-pocket maximum can be met by eligible costs incurred by any combination of members enrolled under the same family plan. But, no one member will have to pay more than the per member out-of-pocket maximum.	
Overall Benefit Maximum	None	

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Covered Services		In-Network Benefits Member Cost is:	Out-of-Network Benefits Member Cost* is:
Admissions for Inpatient Medical and Surgical Care	• In a General Hospital	20% coinsurance after deductible	40% coinsurance after deductible
	• In a Chronic Disease Hospital	20% coinsurance after deductible	40% coinsurance after deductible
	• In a Rehabilitation Hospital (60-day benefit limit per member per calendar year)	20% coinsurance after deductible up to benefit limit; then, you pay all costs	40% coinsurance after deductible up to benefit limit; then, you pay all costs
	• In a Skilled Nursing Facility (100-day benefit limit per member per calendar year)	20% coinsurance after deductible up to benefit limit; then, you pay all costs	40% coinsurance after deductible up to benefit limit; then, you pay all costs
Ambulance Services (ground or air ambulance transport)	• Emergency ambulance	20% coinsurance (deductible does not apply)	20% coinsurance (deductible does not apply)
	• Other ambulance	20% coinsurance after deductible	40% coinsurance after deductible
Cardiac Rehabilitation	Outpatient services	$25 copayment per visit (deductible does not apply)	20% coinsurance after deductible
Chiropractor Services (for members of any age)	• Outpatient lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	• Outpatient medical care services, including spinal manipulation	$25 copayment per visit (deductible does not apply)	20% coinsurance after deductible
Dialysis Services	Outpatient services and home dialysis	20% coinsurance after deductible	40% coinsurance after deductible
Durable Medical Equipment	• Covered medical equipment rented or purchased for home use	20% coinsurance after deductible	40% coinsurance after deductible
	• One breast pump per birth (rented or purchased)	No charge (deductible does not apply)	20% coinsurance after deductible
		No coverage is provided for hospital-grade breast pumps.	
Early Intervention Services	(for an eligible child through age two)	No charge (deductible does not apply)	No charge (deductible does not apply)
Emergency Medical Outpatient Services	• Emergency room services	$150 copayment per visit (deductible does not apply)	$150 copayment per visit (deductible does not apply)
		The emergency room copayment is waived if the visit results in your being held for an overnight observation stay or being admitted for inpatient care within 24 hours.	

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Emergency Medical Outpatient Services (continued)	• Office, health center, and hospital services	$25 copayment per visit (deductible does not apply)	20% coinsurance after deductible
		When a preferred provider is not reasonably available for emergency medical care, in-network benefits are provided.	
Home Health Care	Home care program	20% coinsurance after deductible	40% coinsurance after deductible
Hospice Services	Inpatient or outpatient hospice services for terminally ill	20% coinsurance after deductible	40% coinsurance after deductible
Infertility Services	• Inpatient services	See Admissions for Inpatient Medical and Surgical Care	See Admissions for Inpatient Medical and Surgical Care
	• Outpatient surgical services	See Surgery as an Outpatient	See Surgery as an Outpatient
	• Outpatient lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	• Outpatient medical care services	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits
Lab Tests, X-Rays, and Other Tests (diagnostic services)	• Outpatient lab tests	20% coinsurance after deductible	40% coinsurance after deductible
	• Outpatient x-rays	20% coinsurance after deductible	40% coinsurance after deductible
	• Outpatient CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	20% coinsurance after deductible	40% coinsurance after deductible
	• Other outpatient tests and preoperative tests	20% coinsurance after deductible	40% coinsurance after deductible
Maternity Services and Well Newborn Inpatient Care (includes $90/$45 for childbirth classes; deductible does not apply)	• Maternity services (includes delivery and postnatal care)	20% coinsurance after deductible	40% coinsurance after deductible
	• Prenatal care	No charge (deductible does not apply)	20% coinsurance after deductible
	• Well newborn care during enrolled mother's maternity admission	No charge (deductible does not apply)	20% coinsurance (deductible does not apply)
Medical Care Outpatient Visits (includes syringes and needles dispensed during a visit)	• Office, health center, and home services	$25 copayment per visit (deductible does not apply)	20% coinsurance after deductible
	• Hospital outpatient services	$25 copayment per visit (deductible does not apply)	20% coinsurance after deductible

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Covered Services		In-Network Benefits Member Cost is:	Out-of-Network Benefits Member Cost* is:
Medical Formulas (includes certain medical formulas and low protein foods)	$5,000 benefit limit per member per calendar year for low protein foods	Covered as a pharmacy benefit; refer to your Blue Cross and Blue Shield prescription drug plan subscriber certificate.	Covered as a pharmacy benefit; refer to your Blue Cross and Blue Shield prescription drug plan subscriber certificate.
		If you do not have Blue Cross and Blue Shield pharmacy coverage, you pay 20% coinsurance after deductible for these covered services; otherwise, you pay all costs.	
Mental Health and Substance Abuse Treatment	• Inpatient admissions in a General Hospital	20% coinsurance after deductible	40% coinsurance after deductible
	• Inpatient admissions in a Mental Hospital or Substance Abuse Facility	20% coinsurance after deductible	40% coinsurance after deductible
	• Outpatient services	$25 copayment per visit (deductible does not apply)	20% coinsurance after deductible
Oxygen and Respiratory Therapy	• Oxygen and equipment for its administration	20% coinsurance after deductible	40% coinsurance after deductible
	• Outpatient respiratory therapy	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits
Podiatry Care	• Outpatient lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	• Outpatient surgical services	See Surgery as an Outpatient	See Surgery as an Outpatient
	• Outpatient medical care services	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits
Prescription Drugs and Supplies Drug Formulary (includes syringes and needles) For insulin infusion pumps, you pay nothing	• Retail Pharmacy Tier 1: Tier 2: Tier 3:	(up to 30-day supply) $10 copayment per supply $15 copayment per supply $30 copayment per supply	Not covered; you pay all costs
	• Mail Pharmacy Tier 1: Tier 2: Tier 3:	(up to 90-day supply) $20 copayment per supply $30 copayment per supply $60 copayment per supply	Not covered; you pay all costs
Preventive Health Services Includes: Fitness Benefit Weight Loss Benefit	• Routine pediatric care (ten visits first year of life, three visits second year of life, two visits for age 2, and one visit per calendar year for age 3 through 18)	No charge for covered services; otherwise, you pay all costs	20% coinsurance after deductible for covered services; otherwise, you pay all costs
		These covered services include (but are not limited to): routine exams for age-based schedule; immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning.	

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Covered Services		In-Network Benefits Member Cost is:	Out-of-Network Benefits Member Cost* is:
Preventive Health Services (continued)	• Preventive dental care	No charge for a member under age 18 for treatment of cleft lip and cleft palate; otherwise, you pay all costs	20% coinsurance after deductible for a member under age 18 for treatment of cleft lip and cleft palate; otherwise, you pay all costs
	• Routine adult exams and tests (one exam per member per calendar year)	No charge for covered services; otherwise, you pay all costs	20% coinsurance after deductible for covered services; otherwise, you pay all costs
		These covered services include (but are not limited to): one routine exam per member per calendar year; immunizations; routine lab tests and x-rays; routine mammograms once between age 35 through 39 and once per calendar year for age 40 or older; blood tests to screen for lead poisoning; and routine colonoscopies.	
	• Routine GYN exams (once per member per calendar year)	No charge for covered services; otherwise, you pay all costs	20% coinsurance after deductible for covered services; otherwise, you pay all costs
		These covered services include a routine Pap smear test once per member per calendar year.	
	• Family planning	No charge	20% coinsurance after deductible
	• Routine hearing care services	Routine Hearing Exams/Tests: No charge	Routine Hearing Exams/Tests: 20% coinsurance after deductible
		These covered services include newborn hearing screening tests.	
		Hearing Aids/Related Services (for member age 21 or younger): No charge for covered services; otherwise, you pay all costs	Hearing Aids/Related Services (for member age 21 or younger): 20% coinsurance after deductible for covered services; otherwise, you pay all costs
		For the hearing aid device itself, this coverage is limited to $2,000 for one hearing aid per hearing-impaired ear every 36 months (benefit limit does not apply to related covered services).	
	• Routine vision exams (one exam per member every 24 months)	No charge for covered exams; otherwise, you pay all costs	20% coinsurance after deductible for covered exams; otherwise, you pay all costs
Prosthetic Devices	• Ostomy supplies	20% coinsurance after deductible	40% coinsurance after deductible
	• Artificial limb devices (includes repairs) and other external prosthetic devices	20% coinsurance after deductible	40% coinsurance after deductible
Radiation Therapy and Chemotherapy	Outpatient services	20% coinsurance after deductible	40% coinsurance after deductible
Second Opinions	Outpatient second and third surgical opinions	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits

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Covered Services		In-Network Benefits Member Cost is:	Out-of-Network Benefits Member Cost* is:
Short-Term Rehabilitation Therapy	Outpatient physical, occupational, and speech therapy (100-visit benefit limit per member per calendar year)	$25 copayment per visit (deductible does not apply) for covered services; otherwise, you pay all costs	20% coinsurance after deductible for covered services; otherwise, you pay all costs
		This benefit limit does not apply for: speech therapy; and when any of these covered services are furnished to treat autism spectrum disorders or as part of covered home health care.	
Speech, Hearing, and Language Disorder Treatment	• Outpatient diagnostic tests	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	• Outpatient speech therapy	See Short-Term Rehabilitation Therapy	See Short-Term Rehabilitation Therapy
	• Outpatient medical care services	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits
Surgery as an Outpatient (excludes removal of impacted teeth whether or not the teeth are imbedded in the bone)	• Surgical day care unit of hospital, ambulatory surgical facility, and hospital surgery services	$250 copay after deductible	20% coinsurance after deductible
	• Sterilization procedure for a female member when performed as the primary procedure for family planning reasons	No charge (deductible does not apply)	20% coinsurance after deductible
	• Office and health center services	$25 copayment per visit (deductible does not apply)	20% coinsurance after deductible
TMJ Disorder Treatment	• Outpatient x-rays	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	• Outpatient surgical services	See Surgery as an Outpatient	See Surgery as an Outpatient
	• Outpatient physical therapy (short-term rehabilitation therapy benefit limit applies)	See Short-Term Rehabilitation Therapy	See Short-Term Rehabilitation Therapy
	• Outpatient medical care services	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits