This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at http://www.bu.edu/hr/ or by calling **1-800-814-4371.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250** member / **$500** family for Boston Medical Center and other BCBS providers; **$500** member / **$1,000** family out-of-network. Does not apply to in-network preventive care; most office visits, therapy visits, mental health visits; emergency room; and prescription drugs.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$2,500** member / **$5,000** family for Boston Medical Center and BCBS Providers; **$5,000** member / **$10,000** family out-of-network.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
Is there a separate **out–of–pocket limit** on my expenses for prescription medications?	Yes. **$2,000** member / **$4,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See www.bluecrossma.com/findadoctor or call **1-800-821-1388** for a list of network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.
Do I need a referral to	No.	You can see the **specialist** you choose without permission from this plan.

see a specialist?		
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 11. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** (or provider's charge if it is less than the **allowed amount**) for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000 (and it is less than the provider's charge), your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use lowest cost share in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts. (If you are eligible to elect a Health Reimbursement Account (HRA), Flexible Spending Account (FSA) or you have elected a Health Savings Account (HSA), you may have access to additional funds to help cover certain **out-of-pocket** expenses such as **copayments**, **coinsurance**, **deductibles** and costs related to services not otherwise covered.)

Common Medical Event	Services You May Need	Your cost if you use			Limitations & Exceptions
		Boston Medical Center	BCBS In-Network (Other than BMC)	Out-of-Network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 / visit	$30 / visit	30% coinsurance	Deductible applies first for out-of-network
	Specialist visit	$15 / visit	$30 / visit	30% coinsurance	Deductible applies first for out-of-network
	Other practitioner office visit	$30 / chiropractor visit	$30 / chiropractor visit	30% coinsurance	Deductible applies first for out-of-network; limited to 20 visits per calendar year
	Preventive care/screening/immunization	No charge	No charge	30% coinsurance	Deductible applies first for out-of-network; limited to age-based schedule and / or frequency

Common Medical Event	Services You May Need	Your cost if you use			Limitations & Exceptions
		Boston Medical Center	BCBS In-Network (Other than BMC)	Out-of-Network	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	10% coinsurance for certain low-cost providers; 20% coinsurance for other providers	30% coinsurance	Deductible applies first
	Imaging (CT/PET scans, MRIs)	No charge	10% coinsurance for certain low-cost providers; 20% coinsurance for other providers	30% coinsurance	Deductible applies first
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com/myCatamaranRx	Generic drugs	$8 copay for retail; $16 copay for mail order		Not covered	30 day supply limit at retail; 90 day supply limit at mail-order
	Preferred brand drugs	20% coinsurance; Min $40 and max $60 for retail; Min $80 and max $120 for mail-order		Not covered	30 day supply limit at retail; 90 day supply limit at mail-order
	Non-preferred brand drugs	30% coinsurance; Min $60 and max $80 for retail; Min $120 and max $160 for mail-order		Not covered	30 day supply limit at retail; 90 day supply limit at mail-order
	Specialty drugs	Covered at same levels as other drugs		Not covered	30 day supply limit for specialty drugs

Common Medical Event	Services You May Need	Your cost if you use			Limitations & Exceptions
		Boston Medical Center	BCBS In-Network (Other than BMC)	Out-of-Network	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	10% coinsurance for certain low-cost providers; 20% coinsurance for other providers	30% coinsurance	Deductible applies first; pre-authorization required for certain services
	Physician/surgeon fees	No charge	10% coinsurance	30% coinsurance	Deductible applies first; pre-authorization required for certain services

Common Medical Event	Services You May Need	Your cost if you use			Limitations & Exceptions
		Boston Medical Center	BCBS In-Network (Other than BMC)	Out-of-Network	
If you need immediate medical attention	Emergency room services	$100 / visit	$100 / visit	$100 / visit	Copayment waived if admitted or for observation stay
	Emergency medical transportation	10% coinsurance	10% coinsurance	10% coinsurance	Deductible applies first
	Urgent care	$15 / visit	$30 / visit	30% coinsurance	Deductible applies first for out-of-network
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	10% coinsurance for certain low-cost providers; 20% coinsurance for other providers	30% coinsurance	Deductible applies first; pre-authorization required
	Physician/surgeon fee	No charge	10% coinsurance	30% coinsurance	Deductible applies first pre-authorization required

Common Medical Event	Services You May Need	Your cost if you use			Limitations & Exceptions
		Boston Medical Center	BCBS In-Network (Other than BMC)	Out-of-Network	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 / visit	$30 / visit	30% coinsurance	Deductible applies first for out-of-network
	Mental/Behavioral health inpatient services	No charge	No charge for certain low-cost providers; 20% coinsurance for other providers	30% coinsurance	Deductible applies first; pre-authorization required
	Substance use disorder outpatient services	$15 / visit	$30 / visit	30% coinsurance	Deductible applies first for out-of-network
	Substance use disorder inpatient services	No charge	No charge for certain low-cost providers; 20% coinsurance for other providers	30% coinsurance	Deductible applies first; pre-authorization required
If you are pregnant	Prenatal and postnatal care	No charge	No charge for prenatal care 10% coinsurance for postnatal care	30% coinsurance	Deductible waived for in-network prenatal care

Common Medical Event	Services You May Need	Your cost if you use			Limitations & Exceptions
		Boston Medical Center	BCBS In-Network (Other than BMC)	Out-of-Network	
	Delivery and all inpatient services	No charge	10% coinsurance for certain low-cost providers; 20% coinsurance for other providers	30% coinsurance	Deductible applies first

Common Medical Event	Services You May Need	Your cost if you use			Limitations & Exceptions
		Boston Medical Center	BCBS In-Network (Other than BMC)	Out-of-Network	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	10% coinsurance	30% coinsurance	Deductible applies first; pre-authorization required
	Rehabilitation services	$15 / visit	$30 / visit	30% coinsurance	Deductible applies first for out-of-network; limited to 60 visits per calendar year (other than for home health care and speech therapy); cost share waived for visits at Trustees of Boston University rehabilitation facility; pre-authorization required for certain services
	Habilitation services	$15 / visit	$30 / visit	30% coinsurance	Deductible applies first for out-of-network; rehabilitation therapy coverage limits apply; coverage limits waived for early intervention services for eligible children; pre-authorization required for certain services
	Skilled nursing care	10% coinsurance	10% coinsurance	30% coinsurance	Deductible applies first for out-of-network; limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	10% coinsurance	10% coinsurance	30% coinsurance	Deductible applies first; in-network cost share waived for one breast pump per birth
	Hospice service	10% coinsurance	10% coinsurance	30% coinsurance	Deductible applies first; pre-authorization required for certain services

Common Medical Event	Services You May Need	Your cost if you use			Limitations & Exceptions
		Boston Medical Center	BCBS In-Network (Other than BMC)	Out-of-Network	
If your child needs dental or eye care	Eye exam	No charge	No charge	30% coinsurance	Deductible applies first for out-of-network; limited to one exam every 12 months
	Glasses	Not covered	Not covered	Not covered	—— none ——
	Dental check-up	Not covered	Not Covered	Not Coverer	—— none ——

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture	• Dental care	• Private-duty nursing
• Children's glasses	• Long-term care	
• Cosmetic surgery		

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery	• Infertility treatment	• Routine foot care (only for patients with systemic circulatory disease)
• Chiropractic care (20 visits per calendar year)	• Non-emergency care when traveling outside the U.S.	• Weight loss programs ($150 per calendar year per policy)
• Hearing aids ($2,000 per ear every 36 months for members age 21 or younger)	• Routine eye care - adult (one exam every 12 months)	

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact your plan sponsor. Note: A plan sponsor is usually the member's employer or organization that provides group health coverage to the member. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on your ID card or contact your plan sponsor. Note: A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Assistance

To obtain language assistance, please call the toll-free Member Service number on your ID card.

SPANISH (Español): Para obtener asistencia en español, llame al número gratuito de Servicio de Atención al Miembro que figura en su tarjeta de identificación.

TAGALOG (Tagalog): Kung kailangan ninyo ng tulong sa Tagalog tumawag sa libreng numero ng telepono ng Serbisyo sa Miyembro na nakasulat sa inyong ID card.

CHINESE (中文): 如果您需要中文語言幫助，請撥打會員卡上的客戶服務免費電話號碼

NAVAJO (Dine): Dinek'ehjí shika' a'dowoł ninizingo, kwojí hodiiłné t'áá jííkeh béésh bee' hane'jį T'áá doolé'é bina'íshdiłkidgo yeeháká'adoojah éí binumber bee néého'dolzin biniiyé naanitinígíí bikáá' doo.

Disclaimer:

This document contains only a partial description of the benefits, limitations, exclusions and other provisions of this health care plan. It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan.
The actual care you receive will be different from these examples, and the cost of that care

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,500
- **Patient pays** $1,040

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$250
Copays	$20
Coinsurance	$620
Limits or exclusions	$150
Total	**$1,040**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,280
- **Patient pays** $1,120

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$140
Copays	$900
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,120**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums.**
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network lowest cost share **providers**. If the patient had received care from other in-network or out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.