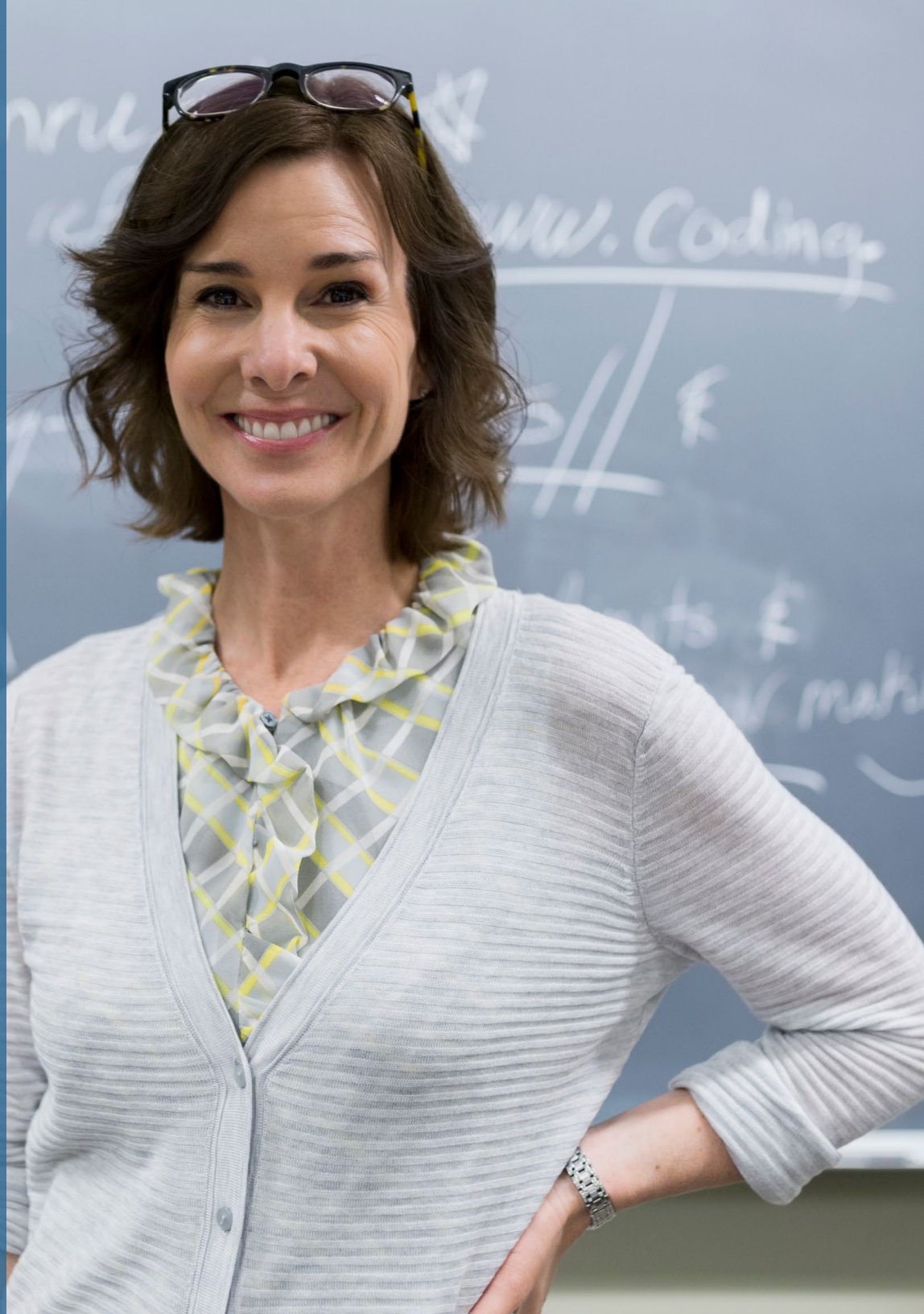


BOSTON
UNIVERSITY

Use Well

A Guide to Making the
Most of the PPO Plan

2019



Use Well

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INTRODUCTION / / / / /



INTRODUCTION

At Boston University, we support a culture of health and wellness. An important aspect of managing your health is knowing how to use your Boston University health plan to your advantage. The choices you make about care directly affect not only your out-of-pocket costs, but your overall health and well-being.

This guide is intended to make your health options clear, and to help you make the most of your PPO medical plan benefits throughout the plan year. We want you to be informed and in control of your healthcare decisions.

Here, you'll learn what to expect when you use the plan, plus important tools, resources and tips to help you manage your expenses and maximize your health benefits.

The plan descriptions contained in this Guide were written from the documents that legally govern how the plans work. In the event of any discrepancy between the plan descriptions in this Guide and the controlling contracts or plan documents, the language in the controlling contracts or plan documents will govern.

Use Well

A Guide to Making the Most of the PPO Plan

/ KNOW YOUR NETWORK /

KNOW YOUR NETWORK

When you need care, choose a network provider to make the most of negotiated network rates and avoid spending unnecessary money.

Before you see a doctor, make sure you know whether the provider is in the BCBS PPO Network, or be prepared to pay a higher cost.

BCBS National PPO Network		
\$ BMC Provider	\$ \$ All Other BCBS PPO Network Providers	\$ \$ \$ Out-of-Network Providers
- You pay the least out-of-pocket costs when you use a Boston Medical Center (BMC) provider. \$250 individual deductible and \$500 annual deductible for the entire family for certain services \$0 for X-rays, labs and diagnostic tests, after the annual deductible \$0 for outpatient and inpatient hospital charges, after the annual deductible \$15 copay for doctor visits - For a list of BMC providers, visit www.bluecrossma.com/search/boston-university.	- You pay more when you use any other BCBS PPO Network provider. \$250 individual deductible and \$500 annual deductible for the entire family for certain services 10%* of the cost of X-rays, labs and diagnostic tests, after the annual deductible 10%* of the cost of outpatient and inpatient hospital charges, after the annual deductible \$30 copay for doctor visits - For a list of BCBS providers, visit https://myfindadoctor.bluecrossma.com/?ci=boston-university. - Select the Blue Care Elect Network with Hospital Choice Cost Sharing feature to access the network of providers covered under this plan. *If you use a <u>high-cost hospital</u> you'll pay 20% of the cost after the deductible.	- You pay substantially more if your provider is not in the BCBS National PPO Network. \$500 individual deductible and \$1,000 annual deductible for the entire family for certain services 30% of the cost of care, after the deductible - The provider's actual charge will apply, unlike the lower, negotiated rate in-network providers agree to accept.

Use Well

A Guide to Making the Most of the PPO Plan

/ KNOW YOUR NETWORK /

DID YOU KNOW?

Avoid High-Cost Hospitals

The great majority of hospitals in the BCBS National PPO Network are considered low-cost hospitals. However, the Network has designated a handful of hospitals in Massachusetts as high cost.

To avoid paying double the coinsurance for X-rays, tests or admission at a high-cost hospital, review the [current list of high-cost hospitals](#).



Facilities—Not Physicians—Are Designated High-Cost

Remember, only hospitals are designated as high-cost—not physicians. Seeing a doctor affiliated with a high-cost hospital does not affect your copay for a doctor visit. However, if you need imaging, testing or hospital admission, the hospital that you use matters. You may ask the doctor to submit the medical order to a hospital that is not on the high-cost list.

For instance, if you visit a BCBS network physician in a high-cost hospital for an office visit, you will pay the standard office visit copay. However, if that same physician then refers you out for bloodwork within the same (high cost) hospital, you will pay 20% of the cost of the test after the deductible. If you ask the physician to order a test from a low-cost hospital or facility, you'll pay just 10%.



Request Labs and X-rays at Boston Medical Center (BMC)

To keep your costs as low as possible, ask your provider to order tests at BMC.

Boston Medical Center offers a full-service [Radiology Department](#) as well as several walk-in lab facilities where you can complete your diagnostic tests. where you can complete all of your imaging studies. You, or your referring physician, can call **617-414-XRAY (9729)** to schedule your test.

UNDERSTAND RX BENEFITS

Your prescription drug coverage is provided through **OptumRx**. When your doctor prescribes medication, you have choices about where and how the prescription is filled. These choices will directly impact how much you pay for your medication.

If you take a maintenance medication, consider the savings and convenience of using the mail order pharmacy. When you receive your medication through mail order, you save big: you receive a 90-day supply of medication for the same price you would pay for a 60-day supply at a retail pharmacy. That's 3 months for the price of 2 – and all delivered right to your door.

Type of Medication	Your Cost*
<i>Retail pharmacy (per 30-day supply)</i>	
Generic	\$8 copay
Preferred brand	20% coinsurance (\$40 minimum, \$60 maximum)
Non-preferred brand	30% coinsurance (\$60 minimum, \$80 maximum)
<i>Mail order (per 90-day supply)</i>	
Generic	\$16 copay
Preferred brand	20% coinsurance (\$80 minimum, \$120 maximum)
Non-preferred brand	30% coinsurance (\$120 minimum, \$160 maximum)

**Prescriptions are not covered if you use an out-of-network pharmacy. You can look up network pharmacies when you log into your account at OptumRx.*

Medications that Require Prior Authorization

Some medications require prior authorization which entails a clinical review and approval before the plan will cover the cost. Your pharmacist will let you know if your medication needs approval, and either you or your pharmacist will need to notify your doctor. Your doctor might switch you to another drug that doesn't need prior authorization. Or, your doctor can contact OptumRx to start the approval process.



Certain medications that may require prior authorization include drugs:

- With dangerous side effects,
- That are harmful when combined with other drugs,
- That have been shown to be misused often,
- Prescribed by a doctor when less expensive drugs work just as well.

Obtaining prior authorization simply means that OptumRx will cover the drug under the plan. Once OptumRx approves, you'll pay the appropriate copay or coinsurance, depending on whether the medication is generic, preferred brand or non-preferred brand.

If you don't obtain prior authorization from OptumRx and have your prescription filled anyway, you are responsible for paying the full cost of the drug, and plan benefits do not apply.

USE A FLEXIBLE SPENDING ACCOUNT

If you contribute to the Health Care Flexible Spending Account (FSA)—congratulations! You’re saving money by paying for eligible health care expenses with tax-free dollars. Remember, the full amount of your annual contribution (and BU’s contribution if applicable) is available at any time during the year—less the amount of any reimbursements you’ve already received.

BU Contributions to the FSA

BU may contribute to your Health Care FSA, depending on your salary and coverage level. This contribution is deposited to your account and may be used to pay for eligible health expenses.

Under \$70,000	\$70,000 – \$99,999	\$100,000 and over
Single : \$250 Family: \$500	Single: \$125 Family: \$250	No BU contribution.

Manage Your Account Online

P&A Group administers the Health Care FSA. You can visit the P&A Group website at www.padmin.com to view your account balance(s), upload a claim form, check the status of a claim and more.

To register your online account:

- Go to www.padmin.com and select the tab for Participants.
- On the right hand side of the page there is a section titled, “Log into My Benefits.” Just click on the link “First time logging in, click here.”
- When prompted to enter your Social Security Number, you should provide your University ID# instead. Then follow the instructions to set up your account and your preferences.

How to Pay with an FSA

You have two ways to pay for eligible expenses from your FSA:



Pay Your Provider with Your Debit Card

You will receive a MasterCard debit card to pay for your eligible expenses. Use your debit card like any other debit card to pay at the pharmacy or provider's office. Be sure to keep your receipts in case P&A Group

needs to validate your expenses to comply with IRS regulations. P&A Group will notify you in writing if you need to submit documentation, such as a receipt.



Reimburse Yourself for Out-of-Pocket Expenses

If you pay for your eligible expenses, you may submit a claim to be reimbursed.

Submit an electronic claim

1. Visit www.padmin.com. Register your account online if you have not done so already.
2. Complete the online claim form.
3. Sign electronically.
4. Electronically upload the documentation.

Submit a paper claim

1. First, download the claim form on www.padmin.com.
2. Complete the form and make sure to sign and date it.
3. You must submit an itemized receipt or an Explanation of Benefits (EOB), if covered by your insurance, with the claim form.
4. You can submit the claim form via:

Fax: Toll-free 1-877-855-7105 or 1-716-855-7105

Mail: Flex Department
P&A Group
17 Court Street, Suite 500
Buffalo, NY 14202-3204

P&A Group customer service representatives are available Monday through Friday, 8:30 a.m. – 8:00 p.m. EST. Call 1-800-688-2611.

Eligible Expenses

Examples of eligible expenses include:

- Copays, deductibles and coinsurance for medical, prescription drugs, dental or vision services
- Charges above reasonable and customary plan limits
- Eyeglasses, contact lenses and solution
- LASIK eye surgery
- Orthodontia

For a complete list, see [IRS Publication 502](#), "Medical and Dental Expenses."

DID YOU KNOW?

According to IRS rules, you will forfeit any unused FSA dollars for which you have not incurred eligible expenses through March 15 following the calendar year during which you contributed to your FSA. Your claims must be submitted no later than March 31 following the calendar year during which you contributed to your FSA.



TIP: FSA debit cards are available for a spouse and/or dependent over 18 years of age at no additional cost. You can order your additional debit cards online at www.padmin.com.

EXAMPLES

Navigating the healthcare system can be overwhelming and time-consuming. To help you make the most of your PPO plan benefits, review the following examples that show how making smart decisions about your care keep your costs as low as possible. All examples assume that care is provided in the BCBS National PPO Network.



Each example highlights bright ideas—choices along the way that help Amy, Ted and Maya save money. Knowing your options and making smart choices can help you save money, too.



AMY

Amy has an accident and visits her doctor. The doctor orders an MRI for her back.



TED

Ted's doctor orders a prescription to help Ted manage his high cholesterol.



MAYA

Maya's doctor orders pain medication following surgery. The medication requires prior authorization.

DID YOU KNOW?

Preventive care is covered at 100% when you see a BCBS National PPO Network provider.

Preventive care includes:

- Annual check-ups
- Immunizations
- Well-woman exams
- Mammograms
- Depression screenings, vision screenings, autism screenings, and many more.

Note: Preventive care does not include sick office visits or a visit to the doctor in order to diagnose a condition. If you schedule a preventive check-up that results in diagnosing an illness or condition you may be charged a copay for the visit. If you receive a bill for services that you believe to be "preventive care services," contact your provider's office for further details about your visit.

For a complete list of covered preventive care, contact Human Resources at hr@bu.edu.

Use Well

A Guide to Making the Most of the PPO Plan

EXAMPLES



AMY'S ACCIDENT



Amy chooses a doctor in the BCBS network. Smart choice! She could have saved even more money if she had seen a BMC physician. In that case, her copay for the office visit would be just \$15.



By asking her doctor to order the MRI at BMC, Amy's tests were paid in full after she met the deductible, saving her **\$75**, depending on the facility she chose.



If Amy had a Health Care Flexible Spending Account, she could pay the \$30 copay and \$250 deductible with pre-tax dollars by using her FSA debit card at the physician's office and BMC facility. See [page 3](#) to learn more.



Amy fell while skiing and injured her back. She has had prolonged pain in her back making it uncomfortable to walk. She makes an appointment with her **BCBS network primary care physician, Dr. Lin.**



Bright Idea



After hearing her symptoms and checking her back, Dr. Lin thinks Amy may have some nerve damage to her spine. He submits an order for her to get an MRI.



Even though Dr. Lin is a non-BMC doctor, Amy knows that Dr. Lin can write a referral (prescription) for her to have the MRI done at a BMC network facility. Amy asks Dr. Lin to submit the MRI order for a **BMC facility.**



Bright Idea



Because Dr. Lin is a BCBS network doctor, Amy pays a **\$30** copay at the time of her visit.



Bright Idea



Dr. Lin submits a claim to BCBS on Amy's behalf.

- Dr. Lin's full charge for the visit is \$150, but the negotiated network rate is \$100.
- Dr. Lin receives \$70 from the plan (\$100 network rate less Amy's \$30 copay).



Amy receives her MRI at the BMC facility.



The facility bills BCBS directly, and Amy does not have to file a claim. She pays the \$250 individual deductible, and then diagnostic testing is covered at 100% by all BMC provider facilities.

- The facility charges for the MRI: \$1,400
- The negotiated rate for the BCBS network: \$1,000
- The facility files the claim with BCBS for the balance and receives \$750 as payment from the plan after Amy pays the annual deductible of **\$250.**



Bright Idea

Amy has now met her annual deductible. She will only pay copays and coinsurance for the remainder of the year.

Use Well

A Guide to Making the Most of the PPO Plan

/ EXAMPLES /



TED'S MAIL ORDER PRESCRIPTION



By opting for mail order, Ted not only enjoys the convenience of home delivery, but **he also saves \$8 on each 90-day supply** (\$32 annually) for his generic medication.



Register with **OptumRx** to Manage Your Prescriptions

As a registered member, you can use the site to manage your prescription drug benefits.

Through your online account, you can order refills, sign up for text message reminders, track your orders, view the status of your claims, use their mobile website and more.

Read [Home Delivery Service tips for prescribing physicians](#) to learn how your provider can call in a mail order prescription for you.



During his annual screening, Ted finds out he has high cholesterol.



Ted's doctor prescribes him a **generic** cholesterol maintenance drug, Atorvastatin. She wants Ted to start on the medication immediately, and calls the prescription into Ted's local retail pharmacy.



Bright Idea



Ted fills the prescription, and pays \$8 for a 30-day supply. Because Ted has an FSA, he uses his debit card at the pharmacy to pay.



Even though Ted has already saved money by using a generic drug, he realizes he will save even more in the long run by using the mail-order pharmacy to fill his maintenance medication. **He registers his account online through OptumRx, and completes the mail order pharmacy information (including sending in the prescription from his doctor to have his next refill come through mail order).**



Bright Idea



After his first month's supply is up, Ted receives a 90-day supply of medication from the mail order pharmacy—saving himself a third of the cost he would have spent if he continued to use his retail pharmacy. He sets up auto-pay from his FSA to pay the \$16 copay for each 90-day supply.



MAYA'S PRESCRIPTION REQUIRING PRIOR AUTHORIZATION



By working with her doctor to complete the steps for prior authorization, Maya ensures her prescription is covered by the plan. If she did not obtain prior authorization, the medication would not be covered, and Maya would be responsible for the full cost.



Following a double knee replacement surgery, Maya is prescribed a powerful pain medication.



Because the pain medication has a reputation associated with drug misuse, the pharmacist notifies Maya that she is required to obtain prior authorization before the prescription is filled.



Maya contacts OptumRx, and they fax a prior authorization form to her doctor. Her doctor completes the form and returns it to OptumRx for review. Maya also contacts her doctor's office to inform them about the prior authorization.



Bright Idea



OptumRx notifies Maya that the prior authorization was approved. She can then fill her prescription and receive her medication, paying the appropriate copay or coinsurance.

CONTACTS

Human Resources Service Center

email: hr@bu.edu

617-353-2380

Health Insurance

Blue Cross Blue Shield of Massachusetts
www.bluecrossma.com/nm/boston-university/index.html

1-800-814-4371

Find a Doctor
<https://myfindadoctor.bluecrossma.com/?ci=boston-university>

Health Care FSA

P&A Group
www.padmin.com

1-800-688-2611

Mail Order Pharmacy

OptumRx
www.mycatamaranrx.com/PortalCentral

Customer Service:
1-888-863-8578

GLOSSARY

Annual Deductible

Individual coverage: The plan begins to pay benefits when the individual deductible is met. In-network individual deductible: \$250.

Spouse and dependent coverage: The plan begins paying benefits for a covered person when he or she meets the individual deductible amount. It then pays benefits for all covered family members when the family deductible amount is met by any combination of the remaining covered family members. In-network family deductible: \$500.

The copays and co-insurance for prescriptions and office visit copays are not included in the medical deductible.

Copay

A copay is the flat dollar amount you pay for office visits, generic prescription drugs and emergency room visits. Copays are not charged for preventive care. Copays do not count toward satisfying the annual deductible, but they do count toward the annual out-of-pocket maximum, as described below.

Coinsurance

Once you meet the annual deductible, you pay a percentage of the total cost for diagnostic tests (blood tests, imaging, etc.) and inpatient and outpatient care subject to coinsurance, and the plan pays a percentage of the total cost of care. The percentage you pay is called your "coinsurance." Services for which you pay coinsurance in the PPO Plan include hospital and outpatient facilities, as well as labs and other tests (after the deductible is met).

Out-of-pocket Maximum

The out-of-pocket maximum limits the amount you pay each calendar year for covered services. Your out-of-pocket maximum includes the deductible, coinsurance and any copays. Once you reach this maximum, the plan covers 100% of the cost of any additional eligible expenses you incur for the rest of the plan year. Separate out-of-pocket limits apply to medical and prescription drug expenses. In-network out-of-pocket max: \$2,500 individual/\$5,000 family.