The Boston University Health Plan offers various options for medical coverage for you and your eligible family members. Each option offers certain benefits to protect you against the medical expenses that would accompany an illness or injury. There are differences in coverage levels and how services are obtained in each option. You should give serious consideration to which option will best meet your needs for health care benefits. The cost of coverage under the Health Plan is shared by you and the University. The information provided in this section will help you decide which type of coverage under the Boston University Health Plan is best for you and your family. Please note: The descriptions of coverages and benefits in this handbook are based on the provisions of the Health Plan in effect on the date of this handbook. The terms of the Health Plan or the University’s contracts with vendors may change. Actual rights and benefits under the Health Plan are based on the terms of the Health Plan documents in effect at any particular time, and those terms will govern over any inconsistent descriptions in this handbook. Furthermore, it is common for annual changes to be made in the Health Plan. Such annual changes are usually described in the annual enrollment materials.

Eligibility
If you are classified by Boston University (the “University”) as a regular employee, work 50% or more of a full-time schedule, and have an appointment of nine months’ or more duration, you and your eligible family members may participate in the Boston University Health Plan. If you are eligible and elect coverage, it will start on the first day of the month coincident with or next following your date of hire (depending on your date of hire).

Your eligible family members include:
- Your legally married spouse
- Under certain circumstances, your former spouse (see “Special Provisions for Former Spouses”)
- To the extent required by law, your children up to age 26 who are:
  - Your biological children
  - Your legally adopted children and children lawfully placed with you for legal adoption
  - Your step-children
- Your unmarried, dependent children age 26 and over who are mentally or physically handicapped and unable to support themselves as determined by the health benefits provider, e.g., Blue Cross Blue Shield. (To continue coverage, your child must have been handicapped before age 26 and you must contact Human Resources before your child’s 26th birthday.)

Employees whose percentage time worked decreases below the eligibility requirements for the Boston University Health Plan as of January 1, 2015, will no longer be able to participate in the Boston University Health Plan (subject to COBRA).

Coverage Levels
There are four levels of coverage available under the Health Plan:
- Individual coverage (yourself only)
- Individual plus spouse (you and your spouse)
- Individual plus child(ren) (you and one or more of your children)
- Family coverage (you and your eligible family members)

Special Provisions for Former Spouses
If you have family coverage including your spouse and you divorce, your spouse may continue to be covered under your family coverage if the divorce order specifically calls for this and if you are eligible for your former spouse’s eligibility for coverage ends. Once coverage ends, your former spouse may continue coverage on an individual basis under COBRA for the remaining period (if any) until 36 months have gone by since your divorce.

If your divorce order specifically requires coverage for your former spouse to continue beyond the COBRA continuation period, your former spouse may be eligible to continue coverage under an individual plan (if available, under the Health Plan and the various vendors providing benefits). This coverage will continue as long as you continue to be employed at the University and have made the appropriate payment for coverage or until you no longer require the divorce order or no longer available.

Special Tax Considerations
Under current tax laws, the value of your former spouse’s health coverage is subject to federal income and Social Security taxes. These taxable amounts are based on the full amount of an individual plan (that is, employee pre-tax contribution plus employer contribution) and are called imputed income. Imputed income for your former spouse’s health coverage will be reported as income on each paycheck, and will be included in the taxable earnings shown on your W-2 Form. Coverage for your former spouse is subject to imputed income for tax purposes.

Enrollment
To elect this coverage, new employees must go to Employee Self Service at www.bu.edu/hr/documents/BN_enrollment_form.pdf. Alternatively, you may complete a Benefits Enrollment Form available at www.bu.edu/hr/documents/BN_enrollment_form.pdf. This form will authorize a pre-tax reduction in your pay for your share of the cost under Section 125 of the Internal Revenue Code.

If you choose coverage that includes your spouse or dependent children, coverage is available only for the family members who are listed on your enrollment. If you wish to enroll newly eligible family members (for example, a newborn, an adopted child, or a new spouse),
When Coverage Starts
You have 30 days following your new employee orientation date to enroll. If you enroll, coverage will become effective on the first day of the month coincident with or following the date you become eligible. If you do not enroll during this period, your next opportunity to enroll will be during the next open enrollment period unless you have a qualifying change in family status, as determined by the University.

Cost
You and the University share the cost of your coverage under the Health Plan. Currently, the University pays a portion of the coverage cost as determined by the University. Your share of the cost is the difference between the total cost of coverage and the amount that Boston University pays. Costs are subject to change at the beginning of each plan year. Also, the University may change the percentage of the cost that it will pay.

How Health Plan Contributions Are Paid
You pay for your portion of the contributions for your Health Plan coverage with pre-tax dollars. This is because Boston University automatically reduces your pay by the amount of your payments—before federal income taxes, state income taxes, and Social Security taxes are taken out.

Automatic before-tax premium payments are allowed under the provisions of Section 125 of the Internal Revenue Code. These are explained in more detail in the “Flexible Benefits” section of this handbook.

Claim and Appeal Time Frames for Group Health Claims
Group health claims will be reviewed and appeals processed by the applicable Plan Vendor within the time periods required by law. You may contact the applicable Plan Vendor for more information about claim procedures relating to health benefits administered by that Vendor under the Plan. Additional information about claim and appeal procedures under a Plan Vendor’s coverage may also be available in the Plan Vendor’s benefit description.

Under ERISA claims and appeals must be decided within a reasonable time, subject to certain maximum limits summarized as follows:

**Initial Claims**
- After receipt of the claim, the claim must be decided no later than:
  - As soon as possible but no later than 72 hours for urgent care claims
  - 15 days for pre-service claim
  - 30 days for post-service claims

**Appeals of Denied Claims**
- After receipt of the request for review, the appeal must be decided no later than:
  - As soon as possible but no later than 72 hours for urgent care claims
  - 30 days for pre-service claims
  - 60 days for post-service claims

Special rules apply for the continuation or extension of approved benefits or services to be provided over time ("concurrent care decisions"). Individuals receiving approved care over a period of time must have an opportunity for review before benefits are reduced or terminated. Also, urgent care requests for an extension of approved benefits must be decided within 24 hours.

**Right to an External Review of Claims**
For certain types of denied claims (e.g., a claim denied for a lack of medical necessity), the law provides that a claimant may be entitled to request an independent, external review after the Plan’s final internal adverse benefit determination. A claimant may contact the applicable Plan Vendor with any questions on his or her rights to external review by an independent organization.

After a final internal adverse benefit determination, the applicable Plan Vendor will advise the claimant of any right the claimant may have to an independent external review and the procedure to request such a review. If the claimant believes his or her situation is urgent (generally one in which the claimant’s health may be in serious jeopardy or in the opinion of the claimant’s physician, the claimant may experience pain that cannot be adequately controlled while the claimant waits for a decision on the external review of his or her claim), the claimant may request an expedited appeal by contacting the applicable Plan Vendor for more information.

**Out-of-Network Coverage**
When you choose non-preferred providers you must pay a calendar-year deductible for most out-of-network services. The calendar-year deductible begins on January 1 and ends on December 31 each year. The deductible is $500 for each member (or $1,000 for all family members enrolled under the same coverage). After you have met your deductible, you pay 20% coinsurance for most out-of-network covered services. When the money you paid for the 20% coinsurance equals $2,500 (this is the out-of-pocket limit) for a member in a calendar year (or $5,000 for all family members covered under the same membership covered benefits for that member (or that family) will be provided in full, based on the allowed charge, for the rest of that calendar year (but charges in excess of reasonable and customary will not be covered). Bills for covered outpatient services are paid by you and then submitted on claim forms for reimbursement.

**In-Network Coverage**
When you choose preferred providers you must pay a calendar-year deductible for most in-network services. The calendar-year deductible begins on January 1 and ends on December 31 each year. The deductible is $1,500 for individual coverage or $3,000 for any family coverage. After you have met your deductible, you pay 10% coinsurance for most in-network covered services. When the money you paid for the 10% coinsurance equals $3,000 for individual coverage or $6,000 for any family coverage, benefits will be provided in full, based on the allowed charge, for the rest of that calendar year. Bills for covered outpatient services are paid by you and then submitted on claim forms for reimbursement.

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When you choose non-preferred providers you must pay a calendar-year deductible for most out-of-network services. The calendar-year deductible begins on January 1 and ends on December 31 each year. The deductible is $3,000 for individual coverage or $6,000 for any family coverage. After you have met your deductible, you pay 10% coinsurance for most in-network covered services. When the money you paid for the 10% coinsurance equals $3,000 for individual coverage or $6,000 for any family coverage, benefits will be provided in full, based on the allowed charge, for the rest of that calendar year. Bills for covered outpatient services are paid by you and then submitted on claim forms for reimbursement.

Just like the PPO plan, you are not required to get referrals from a primary care provider. You decide which doctor you want to see. You pay less when you see “Preferred Providers” that are part of our nationwide network, but the choice is always yours.

**Out-of-Network Coverage**
When you choose non-preferred providers you must pay a calendar-year deductible for most out-of-network services. The calendar-year deductible begins on January 1 and ends on December 31 each year. The deductible is $3,000 for individual coverage or $6,000 for any family coverage. After you have met your deductible, you pay 10% coinsurance for most in-network covered services. When the money you paid for the 10% coinsurance equals $3,000 for individual coverage or $6,000 for any family coverage, benefits will be provided in full, based on the allowed charge, for the rest of that calendar year. Bills for covered outpatient services are paid by you and then submitted on claim forms for reimbursement.

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the allowed charge, for the rest of that calendar year. Bills for cov- ered outpatient services are paid by you and then submitted on claim forms for reimbursement.

Health Savings Account: A Health Savings Account (HSA) is a tax-advantaged account used in con- junction with an HSA-eligible high deductible health plan (HDHP) that eligible individuals may establish to pay for current and future qualified medical expenses for themselves, their spouse, and their qualifying dependents. The BU Health Savings Plan is an HSA-eligible HDHP. In connec- tion with the BU Health Savings Plan, access is provided to an HSA administered by Fidelity Investments. If you would like to make your own pre-tax pay- roll deductions, and/or wish to receive the BU HSA contribution.

BCBS PPO

How the BCBS PPO Works

The BCBS PPO is a preferred pro- vider organization (PPO) that com- bines the advantages of a national network with the option to use physicians and facilities outside the network, but at a higher cost. When you join the BCBS PPO, you are not required to choose a pri- mary care physician. There are two levels of coverage. The amount of coverage depends on where you receive treatment.

When you receive care from a BCBS PPO participating provider, you are covered in full, in and out of the hospital. You pay only $20 for office visits and $100 for emergency room care (this fee is waived if you are immediately hospitalized).

The BCBS PPO also gives you the option to use non-participating physicians, specialists, and health care facilities; your benefits cov- erage, however, will be lower. If you receive care outside the plan network, you will receive 80% cov- erage for most services (based on reasonable and customary charges) after you meet an annual deductible of $500 (individual coverage) or $1,000 (family coverage). You pay the remaining 20% (your coinsur- ance) and any charges above rea- sonable and customary limits. Once your 20% coinsurance reaches the annual out-of-pocket limit of $2,500 (individual coverage) or $5,000 (family coverage), the plan will pay 100% of covered expenses for the rest of the calendar year. In some cases for out-of-network benefits, you may also have to pay any balance that is in excess of Blue Cross Blue Shield’s allowed charge. Certain expenses do not apply toward your out-of-pocket limit. They include the following:

• Charges in excess of reasonable and customary
• Expenses for services not cov- ered by the plan
• Charges you incur for not follow- ing precertification procedures

Emergency Care

Blue Cross Blue Shield provides benefits for emergency medical ser- vices whether you are in or outside of Massachusetts. These emer- gency medical services may include inpatient or outpatient services by providers qualified to furnish emer- gency medical care and that are needed to evaluate or stabilize your emergency medical condition.

In an emergency, such as a sus- pected heart attack, stroke, or poi- soning, you should go directly to the nearest medical facility or call 911 (or the local emergency phone num- ber). You pay a $100 copayment for

in-network or out-of-network emer- gency room services. This copay- ment is waived if you are admitted to the hospital or for an observation stay. The out-of-network deductible does not apply.

Within the Enrollment Area

You will receive full coverage after a $100 copayment per person per visit for hospital emergency room treat- ment you receive at a hospital in the plan network. This copayment will be waived, however, if you are immedi- ately admitted to the hospital.

Outside the Enrollment Area

When you are temporarily outside the enrollment area, the BCBS PPO will cover emergency room treat- ment in full (up to reasonable and customary charges) after a $100 copayment if the illness or injury is sudden and life-threatening. Emergency treatment received at a physician’s office outside the enroll- ment area will be covered in full after a $20 copayment per person per visit.

Preventive Care

Preventive care is covered 100% in- network; and 80% after the deduct- ible for out-of-network services.

Preventive care includes:

- Well-child care exams, including routine tests, according to age- based schedule as follows:
  - Ten visits during the first year of life
  - Three visits during the second year of life
  - One visit per calendar year from age 2 through age 18
- Routine adult physical exams, including related tests, for mem- bers age 19 or older (one per calendar year)
- Routine GYN exams, including related lab tests (one per calen- dar year)
- Routine hearing exams, including routine tests
- Routine vision exams (one every 12 months)
- Family planning services (office visits)
- Preventive care also includes any care that the Affordable Care Act (ACA) classifies as preven- tive care. See www.healthcare.gov for more information.

Home Health Care Benefits

The BCBS PPO pays benefits for medically necessary home care services and supplies, such as inter- mittent skilled nursing care and physical therapy, at 100% when you use a participating provider, and at 80% (after the deductible) when you use an out-of-network provider. Coverage is also provided for the following services when deter- mined to be a medically necessary component of the intermittent skilled nursing home care or physical therapy:

- Occupational therapy
- Speech therapy
- Medical social work
- Nutritional consultation
- Home health aide
- Durable medical equipment

Out-of-Network Benefits

You may have to file your claim when you receive a covered service from a non-preferred provider in Massachusetts or a non-preferred provider outside of Massachusetts who does not have a payment agreement with the local Blue Cross Blue Shield Plan. Claims for out-of- network services should be filed, along with Blue Cross Blue Shield claim form (available online from Human Resources), within two years of the date charges for the service were incurred to:

BCBSMA P.O. Box 986030 Boston, MA 02298

Note: When you receive cov- ered services outside the United States, you must file your claim to the Blue Card Worldwide Service Center. (The Blue Card Worldwide International Claim Form you receive from Blue Cross Blue Shield will include the address to mail your claim.) The service center will prepare your claim, including the conversion to US currency, and for- ward it to Blue Cross Blue Shield for repayment to you.

Utilization Review Requirements

Utilization Review is an impor- tant feature of the out-of-network portion of the BCBS PPO. It helps to ensure that you receive the appro- priate level of care in the most cost-efficient setting—whether it is the hospital, a specialty facility, or your own home.

Utilization Review includes:

- Preadmission Review—For all non-emergency and non- maternity hospital admissions in the United States, you must call 1-800-327-6716 in advance to get your stay approved. Within two working days of receiving all necessary information, Blue Cross Blue Shield will determine if the health care setting is suit- able to treat your condition. Failure to follow the preadmis- sion review procedure may result in your having to pay for expenses that otherwise would be covered.

- Concurrent Review/Discharge Planning—This program auto- matically monitors your stay in the hospital to help ensure that you are discharged on time and receive necessary services once you are discharged.

Be sure to follow Utilization Review pro- visions. If you do not follow these provi- sions, plan benefits will be reduced. The BCBS PPO benefits are automatically subject to Utilization Review without any steps on your part.

Services Not Covered

Under the BCBS PPO, no benefits are provided for the following:

- Ambulance services unless necessitated by an emergency or medical necessity or author- ized by Blue Cross Blue Shield
- Care for transfer from one facility to another
- Any claim submitted more than two years from the date the ser- vice was rendered
- Blood and blood products
- Care for military service- connected disabilities for which the member is legally entitled to treatment or services
- Charges in excess of the plan maximum amount or other limit
- Commercial diet plans or weight- loss programs
- Cosmetic procedures, except when medically necessary or consid- ered medical care under the Internal Revenue Code
- Cost for any services for which the member is entitled to treat- ment at government expense or under Workers’ Compensation or occupational disability
• Court-ordered examinations and services
• Custodial or domiciling care to assist a member in the activities of daily living or provide room and board, training in personal hygiene, and other forms of self-care; personal care in the home except when medically necessary as part of a treatment plan for a medical condition
• Dental services, including periodontal, restorative, and orthodontic services
• Educational services (including problems of school performance) or testing for developmental, educational, or behavioral problems except as medically necessary under an early intervention program
• Equipment for environmental control or general household use, such as air filters, air conditioners, air purifiers, liquidizers, bath warmers, elevators, heating pads, hot water bottles, and humidifiers
• Eyeglasses, contact lenses, and fittings. This exclusion does not apply to contact lenses that are required due to cataract surgery, covered corneal transplants, and required due to cataract surgery, or to corrective lenses.
• Health care services that are not medically necessary
• Health care services that are considered experimental
• Health care services that are considered obsolete and no longer medically justified
• Health care services furnished to someone other than the member
• Hearing aids
• Infertility services for members who are not medically infertile
• Missed appointments
• Non-covered services, even if pre-certification was mistakenly given
• Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services
• Orthotics
• Osteopathic manipulation, electrovulsion, routine foot care, biofeedback, pain management programs, massage therapy, and acupuncture
• Personal comfort items
• Personal items
• Private duty nursing
• Private room unless medically necessary
• Refractive eye surgery
• Rest or custodial care; personal comfort or convenience items
• Reversal or attempted reversal of voluntary sterilization (including procedures necessary for conception following voluntary sterilization)
• Sensory integrative praxis test; testing for central auditory processing
• Services for any person who is not covered under the plan when the services are rendered
• Services for which no charges would have been made in the absence of coverage under this plan
• Services incurred after termination of coverage under the plan
• Services incurred prior to the effective date of coverage
• Services not specifically described in this plan document
• Services not within the scope of the physician’s, provider’s, or hospital’s licensure
• Services or supplies given to you by anyone related to you by blood, marriage, or adoption or who ordinarily lives with you
• Surrogate pregnancy (any form of surrogacy)
• Temporomandibular joint dysfunction treatment limited to medical services only
• The portion of the charge for a service or supply in excess of the usual, customary, and reasonable (UCR) charge
• Weight-loss programs or charges for weight reduction except when extreme obesity adversely affects another medical condition and treatment is medically necessary as determined by the plan

For a comprehensive list of services and conditions not covered by the BCBS PPO, please refer to the description for the BCBS PPO available from Human Resources.

Appealing a Denied Claim
If a claim for benefits is partially or fully denied, you will receive written notification, which will include the reasons for the denial, a description of any information necessary to complete the processing of your claim, and information on how to submit the claim for review.

If you have a question regarding the payment of a claim, you may write or call:

Member Grievance Program
Blue Cross Blue Shield of Massachusetts
One Enterprise Drive
Quincy, MA 02171-2126

Phone: 1-800-472-2689
Fax: 617-246-3616
Email: grievances@bcbsma.com

If you write, be sure to include your identification number and your telephone number. Letters will be answered within 30 days or earlier if required by law.

You have a right to request a full and fair review of any claim. If you believe you or a covered family member were wrongly denied all or part of your benefits, you may appeal the decision. You may submit questions and comments in writing and review all pertinent plan documents.

Blue Cross Blue Shield of Massachusetts must review your appeal and make a final decision within a reasonable period of time. The final written decision must state specific reasons and plan provisions on which the review decision was based.

Network Blue New England

How Network Blue New England Works

Network Blue New England is a health plan with a group of affiliated physicians similar to a health maintenance organization. When you join Network Blue, you and each of your enrolled family members must choose a primary care physician (PCP) from the directory of network doctors. Your PCP will coordinate all of your medical care. You may choose a different PCP for each family member (for example, an internist for you and a pediatrician for your children).

Under the Affordable Care Act (ACA), you have the right to designate any primary care provider who participates in the Blue Cross Blue Shield network and who is available to accept you or your family members. For dependent children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider and for a list of the participating primary care providers, contact Blue Cross Blue Shield at the address below.

You do not need prior authorization from Blue Cross Blue Shield or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Blue Cross Blue Shield network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Blue Cross Blue Shield at the address below.

Blue Cross Blue Shield
Landmark Center
401 Park Drive
Boston, MA 02215
1-800-814-4371

Your Primary Care Physician (PCP)

Your copayment for office visits will depend on where your PCP practices.

If your PCP is affiliated with Boston Medical Center (BMC), your copayments for office visits will be $15 per visit. Office visits with a specialist to whom you are referred by your BMC PCP will also be $15 per visit.

If your PCP is not affiliated with Boston Medical Center, your copayments for office visits will be $30 per visit. Office visits with a specialist to whom you are referred by your non-BMC affiliated PCP will be $40 per visit.

When you receive care in the Network Blue New England network, you are covered in full, in and out of the hospital. You pay $15 for BMC PCP office visits, $30 for non-BMC PCP office visits, or $100 for emergency room care (this fee is waived if you are immediately hospitalized).

You receive full coverage for routine preventive physicals without a copayment. Your PCP will be part of a team of specialists affiliated with the health center or hospital where your PCP practices. If your PCP determines that you need to see a specialist, your PCP will refer you to a specialist within the plan network.

If you require hospitalization, your PCP (and specialist, if necessary) will coordinate your admission, and you will be covered at 100%. You pay $30 BMC PCP/$40 non-BMC PCP for specialist office visits.

Out-of-Pocket Maximum

In 2015, your out-of-pocket costs will not exceed $2,500 for individual coverage and $5,000 for the entire family. Once the out-of-pocket maximum is reached, services are covered 100% for the remainder of the plan year.

Urgent vs. Emergency Care

Blue Cross Blue Shield provides benefits for emergency medical services whether you are in or outside of Massachusetts. These emergency medical services may include inpatient or outpatient services by providers qualified to furnish emergency medical care and that are needed to evaluate or stabilize your emergency medical condition. 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 nearest emergency room).
local emergency phone number). You pay a $100 copayment for in-network or out-of-network emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay.

Routine Physicals
Routine physical exams are covered in full.

Home Health Care Benefits
People often recover more quickly when recuperating at home, provided appropriate care is available. Needed treatment or therapy—such as services from nurses or physical therapists—can be provided in the comfort of your own home as long as services are ordered by your PCP or treating physician and are provided by a participating Coordinated Home Health Care agency and as long as your condition warrants these services. Network Blue New England pays benefits for covered charges made by a participating Coordinated Home Health Care agency or a participating Visiting Nurse Association at 100% when you use a Network Blue network provider.

Medically necessary home health care services and supplies include:
• Part-time home health aide services, consisting primarily of care for the patient
• Part-time nursing care
• Physical therapy

Services Not Covered
Under Network Blue New England, no benefits are provided for the following:
• Ambulance services unless necessitated by an emergency or medical necessity or authorized in advance by the plan for transfer from one facility to another
• Any claim submitted more than two years from the date the service was rendered
• Blood and blood products
• Care for military service-connected disabilities for which the member is legally entitled to treatment or services
• Charges in excess of the plan maximum amount or other limit
• Commercial diet plans or weight-loss programs
• Cosmetic procedures, except when medically necessary and considered medical care under the Internal Revenue Code
• Cost for any services for which the member is entitled to treatment or payment at government expense or under Workers’ Compensation or occupational disability laws
• Court-ordered examinations and services (unless deemed medically necessary by the plan)
• Custodial or domiciliary care to assist a member in the activities of daily living or provide room and board, training in personal hygiene, and other forms of self-care; personal care in the home except when medically necessary as part of a treatment plan for a medical condition
• Dental services, including periodontal, restorative, and orthodontic services, and dentures
• Educational services (including problems of school performance) or testing for developmental, educational, or behavioral problems except as medically necessary under an early intervention program
• Equipment for environmental control or general household use, such as air filters, air conditioners, air purifiers, liquidizers, bath seats, bedpans, dehumidifiers, elevators, heating pads, hot water bottles, and humidifiers
• Eyeglasses, contact lenses, and fittings. This exclusion does not apply to eyeglasses and contact lenses that are required due to cataract surgery, covered corneal transplants, and keratorefractive procedures.
• Hearing aids
• Infertility services for members who are not medically infertile
• Missed appointments
• Non-covered services even if precertification was mistakenly given
• Non-dental medical care services only to diagnose and treat temporomandibular joint dysfunction
• Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services
• Non-prescription smoking-cessation aids
• Orthotics
• Osteopathic manipulation, electrolysis, routine foot care, biofeedback, pain management programs, massage therapy, and acupuncture
• Personal comfort or convenience items for rest or custodial care
• Physical examinations for insurance, licensing, or employment
• Private duty nursing
• Private room unless medically necessary
• Refractive eye surgery
• Reversal or attempted reversal of voluntary sterilization (including procedures necessary for conception following voluntary sterilization)
• Sensory integrative praxis test; testing for central auditory processing
• Services incurred prior to the effective date of coverage
• Services incurred after termination of coverage under the plan
• Services for any person who is not covered under the plan when the services are rendered
• Services for which no charges would have been made in the absence of coverage under this plan
• Services or supplies from anyone related to you by blood, marriage, or adoption or who ordinarily lives with you
• Services not within the scope of the physician’s, provider’s, or hospital’s licensure
• Services that require precertification, where the precertification was not obtained or the precertification guidance was not followed
• Services that are not medically necessary
• Services that are considered experimental
• Services that are considered obsolete and no longer medically justified
• Services at a residential treatment center
• Surrogate pregnancy (any form of surrogacy)
• The portion of the charge for a service or supply in excess of the usual, customary, and reasonable (UCR) charge
• Weight-loss programs or charges for weight reduction except when extreme obesity adversely affects another medical condition and treatment is medically necessary as determined by the plan

For a comprehensive list of services and conditions not covered by Network Blue New England, please refer to the description for Network Blue New England available from Human Resources.

Appealing a Denied Claim
If a claim for benefits is partially or fully denied, you will receive written notification, which will include the reasons for the denial, a description of any information necessary to complete the processing of your claim, and information on how to submit the claim for review. If you have a question regarding the payment of a claim, you may write or call:

Member Grievance Program
Blue Cross Blue Shield of Massachusetts
One Enterprise Drive
Quincy, MA 02171-2266
Phone: 1-800-472-2689
Fax: 617-246-3616
Email: grievances@bcbsma.com

If you write, be sure to include your identification number and your telephone number. Letters will be answered within 30 days. You have a right to request a full and fair review of any claim. If you believe you or a covered family member were wrongly denied all or part of your benefits, you may appeal the decision. You may submit questions and comments in writing and review all pertinent plan documents.

Blue Cross Blue Shield of Massachusetts must review your appeal and make a final decision within a reasonable period of time. The final written decision must state specific reasons and plan provisions on which the review decision was based.

Additional information about appealing a denial of benefits is included in the “Administrative Information” section of this handbook.

BU Health Savings Plan

How BU Health Savings Plan Works
The BU Health Savings Plan is a high deductible health plan (HDHP) administered by Blue Cross Blue Shield of Massachusetts and Express Scripts. Participants in this HDHP have access to a Health Savings Account (HSA) administered through Fidelity Investments.

The BU Health Savings Plan offers the same network of doctors and hospitals available under the BCBS PPO, including BMC and its affiliated providers. The BU Health Savings Plan prescription drug benefit is administered through Express Scripts and covers the same prescription drugs as the other University offerings.

The BU Health Savings Plan provides both in- and out-of-network coverage, just like the preferred provider organization (PPO) plan. However, the BU Health Savings Plan works differently in these key ways:
• Except for certain in-network preventive care services, all covered health expenses are subject to a plan deductible, including prescription drugs.
• Under employee plus child(ren), employee plus spouse, and family coverage, the entire family deductible must be met before

BU Health Savings Plan
benefits are payable for any covered person.

• There are no copays, just coinsurance (once the deductible is met), even for office and emergency room visits, mental health care, and prescription drugs.

The Deductible

You must meet the plan-year deductible before you can receive coverage for most services under this plan. Your plan year begins January 1 and ends on December 31 each year.

This table shows the deductibles for in-network and out-of-network services.

<table>
<thead>
<tr>
<th>Deductible Level</th>
<th>Annual Deductible In-Network Providers</th>
<th>Annual Deductible Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$3,500 for individual coverage</td>
<td>$6,000 for any family coverage</td>
</tr>
<tr>
<td>Family</td>
<td>$6,000 for family coverage</td>
<td>$12,000 for any family coverage</td>
</tr>
</tbody>
</table>

*If you have a plan that covers employee plus spouse, or employee plus child(ren), or family, you must meet the higher family deductible before you receive coverage.

Services Received from an In-Network Provider

Once the deductible is met, most out-of-network services are covered 100%.

Services Received from an Out-of-Network Provider

Once the deductible is met, most out-of-network services are covered 70%. You pay 30% coinsurance when the amount you have paid in deductible and coinsurance reaches $6,000 for an individual plan, or $12,000 for any family plan, covered benefits will be paid in full (i.e., without any additional deductibles or coinsurance, but subject to all plan provisions, limitations, and exclusions) for the remainder of that plan year.

Certain expenses do not apply toward your out-of-pocket limit and are excluded under the plan. They include the following:

• Charges in excess of reasonable and customary
• Expenses for services not covered by the plan
• Charges you incur for not following precertification procedures

Emergency Care

Blue Cross Blue Shield provides benefits for emergency medical services whether you are in or outside of Massachusetts. These emergency medical services may include inpatient or outpatient services by providers qualified to furnish emergency medical care and that are needed to evaluate or stabilize your emergency medical condition. 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). You pay a 10% coinsurance after the deductible for in-network or out-of-network emergency room services.

Preventive Care

Blue Cross Blue Shield provides preventive care such as intermittent skilled nursing care and physical therapy, at 90% (after the deductible) when you use an in-network provider, and 70% (after the deductible) when you use an out-of-network provider.

Coverage is also provided for the following services when determined to be a medically necessary component of the intermittent skilled nursing care or physical therapy:

• Occupational therapy
• Speech therapy
• Medical social work
• Nutritional consultation
• Home health aide
• Ambulance services unless necessitated by an emergency or medical necessity or authorized by Blue Cross Blue Shield

Durable medical equipment

Utilization Review Requirements

Utilization Review is important for the out-of-network portion of the BU Health Savings Plan. It helps to ensure that you receive the appropriate medical care in the most cost efficient setting—whether it be the hospital, a specialty facility, or your own home.

Utilization Review includes:

• Preauthorization Review—For all non-emergency and non-maternity hospital admissions in the United States, you must call the number on your ID card in advance to get your stay approved. Within two working days of receiving all necessary information, Blue Cross Blue Shield will determine if the health care setting is suitable to treat your condition. Failure to follow the preadmission review procedure may result in your having to pay for expenses that otherwise would be covered.

• Concurrent Review/Discharge Planning—This program automatically monitors your stay in the hospital to help ensure that you are discharged on time and receive necessary services once you are discharged.

• Court-ordered examinations and services
• Custodial or domiciling care to assist a member in the activities of daily living or provide room and board, training in personal hygiene, and other forms of self-care; personal care in the home except when medically necessary as part of a treatment plan for a medical condition

• Dental services, including periodontal, restorative, and orthodontic services

• Educational services (including problems of school performance) or testing for developmental, educational, or behavioral problems except as medically necessary under an early intervention program

• Equipment for environmental control or general household use, such as air filters, air conditioners, air purifiers, liquidizers, bath seats, bedpans, dehumidifiers, dentures, elevators, heating pads, hot water bottles, and humidifiers

• Eyeglasses, contact lenses, and fittings. This exclusion does not apply to contact lenses that are required due to cataract surgery, covered corneal transplants, and keratoplasty

• Health care services that are not medically necessary

• Health care services that are considered experimental

• Health care services that are considered obsolete and no longer medically justified

• Health care services furnished to someone other than the member

• Hearing aids

• Missed appointments

• Non-covered providers

• Non-covered services

• Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services

• Orthotics

The BU Health Savings Plan pays benefits for medically necessary home care services and supplies, such as intermittent skilled nursing care and physical therapy, at 90% (after the deductible) when you use a participating provider, and at 70% (after the deductible) when you use an out-of-network provider.

Preventive Care

Preventive care is covered 100% with no deductible for in-network care.

Out-of-network preventive care is covered at 70% with no deductible. Preventive care includes:

• Well-child care exams, including routine tests, according to age-based schedule as follows:
  o Ten visits during the first year of life
  o Three visits during the second year of life
  o One visit per calendar year from age 2 through age 18

• Routine adult physical exams, including related tests, for members age 19 or older (one per calendar year)

• Routine GYN exams, including related lab tests (one per calendar year)

• Routine hearing exams, including routine tests

• Routine vision exams (one every 12 months)

• Family planning services (office visits)

• Preventive care also includes any care that the Affordable Care Act (ACA) classifies as preventive. See www.healthcare.gov for more information.

Home Health Care Benefits

The BU Health Savings Plan pays benefits for medically necessary home care services and supplies, such as intermittent skilled nursing care and physical therapy, at 90% (after the deductible) when you use a participating provider, and at 70% (after the deductible) when you use an out-of-network provider.

Be sure to follow Utilization Review provisions. If you do not follow these provisions, plan benefits will be reduced.
• Osteopathic manipulation, electrotherapy, routine foot care, biofeedback, pain management programs, massage therapy, and acupuncture
• Personal comfort items
• Physical examinations for insurance, licensing, or employment
• Private duty nursing
• Private room charges
• Refractive eye surgery
• Rest or custodial care; personal comfort or convenience items
• Reversal or attempted reversal of voluntary sterilization (including procedures necessary for conception following voluntary sterilization)
• Sensory integrative praxis test; testing for central auditory processing
• Services for any person who is not covered under the plan when the services are rendered
• Services for which no charges would have been made in the absence of coverage under this plan
• Services incurred after termination of coverage under the plan
• Services incurred prior to the effective date of coverage
• Services not specifically described in this plan document
• Services not within the scope of the physician’s, provider’s, or hospital’s licensure
• Services or supplies given to you by anyone related to you by blood, marriage, or adoption or who ordinarily lives with you
• Surrogate pregnancy (any form of surrogacy)

• Temporomandibular joint dysfunction treatment limited to medical services only
• The portion of the charge for a service or supply in excess of the usual, customary, and reasonable (UCCR) charge
• Weight-loss programs or charges for weight reduction except when extreme obesity adversely affects another medical condition and treatment is medically necessary as determined by the plan.

Appealing a Denied Claim
If a claim for benefits is partially or fully denied, you will receive written notification, which will include the reasons for the denial, a description of any information necessary to complete the processing of your claim, and information on how to submit the claim for review.

If you have a question regarding the payment of a claim, you may write or call:

Member Grievance Program
Blue Cross Blue Shield of Massachusetts
One Enterprise Drive
Quincy, MA 02171-2126
Phone: 1-800-472-2689
Fax: 617-246-3616
Email: grievances@bcbsma.com

If you write, be sure to include your identification number and your telephone number. Letters will be answered within 30 days.

You have a right to request a full and fair review of any claim. If you believe you or a covered family member were wrongly denied all or part of your benefits, you may appeal the decision. You may submit questions and comments in writing and review all pertinent plan documents.

Blue Cross Blue Shield of Massachusetts must review your appeal and make a final decision within a reasonable period of time. The final written decision must state specific reasons and plan provisions on which the review decision was based.

Additional information about appealing a denial of benefits is included in the “Administrative Information” section of this handbook.

Health Savings Account (HSA)
A Health Savings Account (HSA) is a tax-advantaged account used in conjunction with an HSA-eligible high deductible health plan (HDHP) that eligible individuals may establish to pay for current and future qualified medical expenses for themselves, their spouse, and their qualifying dependents. The BU Health Savings Plan is an HSA-eligible HDHP. In connection with the BU Health Savings Plan, access is provided to an HSA administered by Fidelity Investments if you would like to make your own pre-tax payroll deductions, and/or wish to receive the BU HSA contribution. You are, however, free to choose any HSA vendor for your own after-tax contributions or move money from your Fidelity-administered HSA to an HSA administered by another entity in accordance with IRS rules.

The legal and tax rules relating to HSAs can be complicated. A summary of those rules is contained in IRS Publication 969 “Health Savings Accounts and Other Tax-Favored Health Plans.” If you have an HSA, you should carefully review that publication. If you have legal, tax, or financial questions about HSAs, you should consult your own professional advisor at your own expense. ERIISA does not apply to HSAs and the University is not a fiduciary of any HSA.

HSA Eligibility
You are eligible to open a Fidelity HSA if:
• You become covered under the BU Health Savings Plan, a qualifying high deductible health plan, and
• You are not enrolled in Medicare and have not received medical benefits within the last three months through the Veteran’s Administration (VA), and
• You cannot be claimed as a dependent on another person’s tax return.

You are NOT eligible to open a Fidelity HSA if:
• You are not covered under the BU Health Savings Plan.
• You are enrolled in Medicare or have received medical benefits within the last three months through the VA.

You can be claimed as a dependent on another person’s tax return.

IMPORTANT: You may also not open an HSA while you are covered under another health plan that is not a qualifying HDHP. For example, you cannot also be covered under a health care flexible spending arrangement (FSA) of your own or under an FSA of your spouse through his or her employer. Also, you cannot be covered as a dependent of your spouse under the group health plan of your spouse’s employer if that group health plan is not a qualifying HDHP.

• When you elect the BU Health Savings Plan, you may also elect to open an HSA. If you do, the University will automatically deposit $500 for individual coverage or $1,000 for any family coverage as a contribution to your Fidelity-administered HSA account.*

• You don’t need to use Fidelity for the HSA. However, if you want to automatically have the HSA contributions come from your paycheck, you will have to establish a Fidelity account on their website NetBenefits® at netbenefits.com.

• You may elect to contribute to your HSA, pre-tax, up to the annual limits. For 2015, the limits are $3,350 for employee only and $6,650 if you have family benefits. These limits are reduced by any contributions by the University to your HSA, e.g., if the University contributed $500 to your HSA and you have employee-only coverage under the BU Health Savings Plan, your remaining maximum HSA contribution for the remainder of the year would be $2,850 ($3,350-$500). If you are age 55 or older in 2015, you may make additional pre-tax “catch-up” contributions, up to $1,000 per year.

• You may projectively change your pre-tax salary reduction HSA contribution amounts on a monthly basis.

• You are always 100% vested in both the amount Boston University contributes to your account and in your HSA contributions.

• You decide whether to save for qualified expenses you incur now or in the future; any funds you withdraw to pay for qualified medical expenses are tax-free.

• You may request a debit card and special checkbook to provide you access to your HSA funds, and you may use these even if you terminate employment with Boston University or drop your membership in the BU Health Savings Plan. The debit card can be requested online at netbenefits.com or by phone at 800-343-0860.

* The amount (if any) of University HSA contributions is subject to review and change by the University at any time. The University reserves the right, in its sole discretion, to discontinue HSA contributions at any time.

Opening Your Fidelity HSA
You may enroll in the HSA at any time if you are enrolled in the BU Health Savings Plan. This is the process to follow to establish your account:

1. You may enroll either via Employee Self Service at www.bu.edu/buworkscentral or by completing a paper Benefits Enrollment Form available at: www.bu.edu/hr/documents/BN_enrollment_form.pdf.
Once you have submitted your enrollment, your payroll contributions will be set up.

3. Fidelity Investments will be informed by Human Resources that you have enrolled and are eligible to open your Fidelity HSA.

4. Fidelity will contact you via email or telephone with instructions to set up your account through NetBenefits (www.netbenefits.com).

5. Once you have completed the account setup, payroll deductions will begin and your pre-tax contributions will be sent to Fidelity.

6. After your first contribution, BUs will contribute the $500 seed money for individual coverage or $1,000 for any family plan. Any money in your HSA is immediately available for you to use for qualified medical expenses incurred after you establish your HSA.

Your Fidelity HSA Investments

The Fidelity HSA is a Fidelity brokerage account that has a “core position” through which all contributions are deposited and all disbursements are withdrawn. This “core position” is an FDIC-insured Deposit Sweep. Once your account balance exceeds $2,500, you can choose to invest in a broad range of options, including a full range of Fidelity mutual funds, more than 4,000 non-Fidelity funds, and individual stocks and bonds. Any earnings on your Fidelity HSA investments are automatically reinvested and grow tax free.

Funding Your HSA

- Pre-Tax Contributions—Your pay-roll deductions are taken on a pre-tax basis to fund your account. You may change your payroll deduction amount on a monthly basis. Total contributions to your account do not exceed your maximum annual contribution amount.
- After-Tax Contributions—You may make after-tax contributions by check. After-tax contributions are tax deductible to the extent that total contributions to your account do not exceed your maximum annual contribution amount.

Accessing Your HSA Funds

Fidelity has three methods by which you can access your HSA funds to pay for qualified medical expenses:

- Fidelity BillPay for Health Savings Accounts—You can make online payments to health care providers, companies, and individuals. You can set up an automatic schedule for your payments and keep track of all bill payments for qualified medical expenses.
- Fidelity HSA Debit Card—Use at the point of service.
- Fidelity HSA Checkbook—Use when you need it.

Distribution Records

You must keep all receipts and records of medical expenses paid with your Fidelity HSA funds to document sufficiently that distributions have been made exclusively for qualified medical expenses. You should keep these items for your own records; do not submit them to Fidelity. Distributions from your FSA will also be reported by Fidelity to you and the IRS each tax year on IRS Form 1099-SA. If your tax return is audited by the IRS, you might be asked to provide receipts for qualified medical expenses paid for before receiving distributions from your Fidelity HSA.

Using Your HSA for Nonqualified Medical Expenses

Distributions from your Fidelity HSA that are used to pay for or reimburse nonqualified medical expenses must be included in your gross income for tax purposes and are subject to an additional 20% penalty. The 20% penalty does not apply to distributions made if you become disabled, once you reach age 65, or after your death.

Using Your HSA for a Dependent Child

You may use your HSA to pay for qualified medical expenses incurred by your dependent child as long as your child is considered a dependent for federal tax purposes. Otherwise, you will pay a penalty plus taxes. According to IRS guidelines, a dependent child for tax purposes includes one of the following:

- A dependent who can claim on your tax return
- A dependent that you could have claimed on your tax return except that they had gross income of $3,650 or more

Fidelity HSA Fees

The following fees apply to a Fidelity HSA:

- Generally, Fidelity HSAs are subject to an annual account maintenance fee. This fee is paid by Boston University as long as you are actively contributing to the HSA. If you are not contributing, the fee is deducted from your account on a quarterly basis.
- A fee may apply for ordering checkbooks for your HSA.

Note: Other fees may apply; please refer to the Brokerage Commission and Schedule of Fees in the Fidelity Brokerage HSA Customer Agreement or on www.netbenefits.com for additional information.

Unused Funds

HSAs are not subject to the use-it-or-lose-it rule; therefore, funds remain in your account from year to year. Any unused funds may be used to pay for future qualified medical expenses.

Transfer of Assets

You may transfer funds from another HSA custodian through a transfer of assets transaction as long as the account type is the same. Fidelity will coordinate the transfer from the other institution after you complete and return the completed Transfer of Assets form, which can be found at Fidelity.com > Customer Service > Find a Form.

The transfer will not be considered a taxable event and will not be reported to the IRS. Additionally, Fidelity does not charge fees on this transaction. You should always consult the fee schedule of your other HSA to understand any fees or changes that may apply.

Please note that eligible transfers are not included when calculating your maximum annual contribution amount.

How Medicare Affects Your Fidelity HSA

- Once you are enrolled in Medicare, you will no longer be eligible to make contributions, including catch-up contributions, to your Fidelity HSA.
- You can use funds in your Fidelity HSA to pay Medicare premiums, deductibles, co-pays, and coinsurance under any part of Medicare. If you are retired and have retiree health benefits through a former employer, you can also use your account to pay for retiree medical insurance premiums. You cannot use your account to purchase Medicare supplemental insurance or “Medigap” policies.
- Distributions you take after age 65 to pay for expenses other than qualified medical expenses will still be considered taxable income; however, they will no longer be subject to the 20% penalty.

Express Scripts Prescription Drug Coverage

The guidelines here apply to the BCBS PPO and Network Blue New England. The BU Health Savings Plan offers 80% coverage once the annual deductible is met. There are no copayments for members of the BU Health Savings Plan.

As a member of the Boston University Health Plan, you will automatically be enrolled in the Express Scripts Prescription Drug Coverage. Prescription copays vary depending on whether your prescribed medication is a generic, preferred brand-name, or non-preferred brand-name drug. Preferred brand-name medications are selected based on their clinical effectiveness and opportunities for savings. An independent Pharmacy and Therapeutics Committee at Express Scripts updates this list regularly based on continuous evaluation of medications.

Members can determine if their brand-name medications are preferred or non-preferred by logging on towww.express-scripts.com and choosing the Drug Information option. Many preferred and non-preferred brand-name drugs have a generic alternative. If you use the generic drug, your copayment will be $8 for up to a 30-day supply at a retail pharmacy. Certain medications have quantity and/or dollar limits.

Prior Authorization

The plan covers medically necessary prescription medication. Some drugs require prior authorization in order to be covered by the plan. Visit the Express Scripts website atwww.express-scripts.com and click on Drug Information to find out about a specific medication.

To obtain prior approval, your doctor should call Express Scripts toll-free at 1-800-753-2851. This call will initiate a review that typically takes one to two business days. Once the review is complete, Express Scripts will notify you and your doctor of the decision.

Retail Pharmacy

If you need short-term medication (perhaps for the flu or an ear infection), under the Retail Network Pharmacy Service you can take your prescription to almost any major chain and many independent pharmacies, show your ID card, pay your copayment, and go home with your prescription. For preferred brand-name medications, you will pay 20% coinsurance, and for non-preferred brand-name prescriptions, you will pay 30% coinsurance for up to a 30-day supply of each prescription with a minimum and maximum
Contact Information
To refill a Home Delivery Pharmacy Service prescription, call 1-800-711-0923.

Appealing a Denied Claim
In the event you receive an adverse benefit determination following a request for coverage of a prescription benefit claim, you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. To initiate an appeal for coverage, you or your authorized representative (such as your physician) must provide, in writing your name, member ID, phone number, the prescription drug for which benefit coverage has been denied, and any additional information that may be relevant to your appeal. This information should be mailed to:
Express Scripts
P.O. Box 631850
Irving, TX 75063-0030
Attention: Appeals

In the case of a claim for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim. An urgent care claim must be reviewed to determine whether, or to what extent, benefits are covered. You will be notified within 24 hours after receipt of your appeal of the information necessary to complete the appeal. You will then have four hours to provide the information and will be notified within 48 hours of receipt of the information.

The decision regarding your appeal to an adverse benefit determination if you request coverage of a claim that is urgent. Urgent appeal requests may be oral or written. You or your physician may call 1-800-753-2851 or send a written request to:
Express Scripts
P.O. Box 631850
Irving, TX 75063-0030
Attention: Appeals

Other Information
Coordination of Benefits
The Boston University Health Plan has provisions for coordination of benefits with other health care plans covering you or any of your covered dependents. This prevents overpayments to health care service providers. If a member is covered by more than one insurance or self-insurance plan (including Workers’ Compensation and auto insurance), the plans will coordinate the payment of costs so that total payments will not exceed the member’s actual expenses. If you are covered by more than one medical plan, contact Human Resources for more information on coordination of benefits and how to file a claim.

Subrogation and Reimbursement
The Boston University Health Plan also has a subrogation and reimbursement rule. If another party is, or is claimed to be, responsible (the “responsible party”) for an injury or illness incurred on you or a covered dependent, the Health Plan is entitled to reimbursement out of any recovery from the responsible party (or any insurer, including any liability insurer, uninsured or underinsured motorist insurer, or homeowner insurer) before the Health Plan receives amounts expended for such individual’s care, the covered individual must hold any amounts recovered from the responsible party in trust for the benefit of the Health Plan to the extent of amounts paid by the Health Plan for care, and must repay the Health Plan from the amounts recovered even if the amounts recovered do not fully compensate the covered individual for all of his or her losses, damages, or expenses.

The Health Plan’s Right to Repayment will not be reduced by attorneys’ fees or other expenses incurred by a covered individual. The Health Plan will not pay any portion of those attorneys’ fees or expenses.

If You Incur a Total Disability
If you incur a total disability and begin receiving benefits from the Boston University Long-Term Disability Plan, coverage for you and your eligible dependents in the Boston University Health Plan may continue at no cost to you for the duration of your total disability while you continue to receive benefits under the Boston University Long-Term Disability Plan. Human Resources will explain this feature to you upon notification of your disability. For the first 24 months of your disability, your health plan membership will be continued through Boston University at no cost to you. During this time, your Boston University Health Plan will be your primary health plan provider (except as otherwise provided under coordination of benefits). After you have been disabled for 24 months, you must enroll in Medicare Parts A and B if you are eligible. At this time, Medicare will become your primary health plan.
provider, with your Boston University Health Plan as your secondary health plan provider. In other words, your claims will be paid by Medicare first, Boston University Health Plan will pay for covered services (subject to required deductibles and coinsurance payments) to the extent that Medicare did not pay them. Thus, your overall health benefits will be the same as those of other Health Plan members in the same coverage option as you, except that part of your benefits will come from Medicare. There is, however, a monthly premium for Medicare Part B, which will become your responsibility upon your enrollment in Medicare.

Please note: You are responsible for applying for Medicare coverage after you have been disabled for two years. If you are disabled, your medical claims will be paid by the Boston University Health Plan as though you have Medicare coverage, unless you provide evidence that your application for Medicare coverage was denied.

If You Die While You Are a Member of the Plan
If you die while you are a member of the Health Plan, your enrolled dependents will be entitled to continue coverage under COBRA for up to 36 months.

If You Are Actively Employed When You Reach Age 65
If you are actively employed by Boston University at age 65, your membership in the Boston University Health Plan will continue as your primary insurance. You may delay enrolling in Medicare Part B without a penalty as long as you remain covered as an employee under the Boston University Health Plan as a result of your current employment status.

When you reach age 65, you should contact the Social Security Administration by calling 1-800-772-1213 to enroll in Medicare Part A.

If you retire on or after age 65, your Health Plan coverage will end. You may decide to continue your Health Plan coverage through COBRA.

About Medicare
When you reach age 65, you become entitled to coverage under Medicare, the health plan administered through the Social Security Administration. Medicare coverage is automatic; you must notify Social Security. Medicare coverage has three parts.

• Part A: Provides hospital insurance and requires no premium payment from you.
• Part B: Provides supplementary medical insurance and requires a premium payment from you.
• Part D: Provides prescription drug coverage.

The chart below summarizes health insurance coverage options available to you at age 65.

<table>
<thead>
<tr>
<th>Age</th>
<th>Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>65 and over</td>
<td>Boston University Health Plan, Medicare Parts A, B, D only</td>
</tr>
<tr>
<td>65 and over</td>
<td>AARP Health Care Options</td>
</tr>
</tbody>
</table>

Three months before your 65th birthday, you should contact your local Social Security office regarding Medicare benefits. In addition to Medicare Parts A and B, you may also wish to enroll in a non-group health plan that will augment your Part B coverage. This kind of plan, called a “Medicare Supplement,” will fill in some of the gaps in Medicare, giving you more complete coverage.

The University has entered into an agreement with Ovations of United Health Group to offer retirees the nationwide Medicare supplement plans that are available under AARP Health Care Options. Retirees may also obtain their prescription drug coverage through this program. The cost of the plan must be paid by the retiree in full. This premium for these plans will be the same as the premium paid by all other AARP members; however, the annual AARP membership fee for the first year will be paid on behalf of the retiree to facilitate enrollment from Boston University. In addition, retirees who enroll in one of the AARP Health Care Options through the University will have the option to enroll in a discount program offered by United Health Group which provides discounts for cosmetic dentistry, assisted living, hearing care, and wellness care.

For details about AARP Health Care Options, please call 1-866-524-7865.

For reimbursement once you have retired and paid the first month’s premium, send a copy of your bill or receipt and your Boston University ID number to: Boston University Human Resources, 25 Buck Street, Boston, MA 02215.

Alternatively, various “Medicare Advantage Plans” are available for your consideration. Go to www.medicare.gov for a list of plans available as well as what they cover and the costs. Contact Human Resources for more information.

Leaves of Absence and No-Pay Status
If you are on a leave of absence or no-pay status, you must contact Human Resources to ask what impact your absence may have on your participation in the Health Plan.

• Leave of Absence with Pay If you are granted a leave of absence with pay (including sabbatical), your Health Plan coverage will continue, provided your usual payroll deductions continue.

• Leave of Absence Without Pay and No-Pay Status If you are granted a leave of absence without pay or no-pay status, you may continue your Health Plan coverage during your leave, provided you pay the employee cost of continuing this coverage.

If you choose to continue coverage, you must contact Human Resources before you begin your leave to make the necessary billing arrangements. This coverage will be automatically canceled if you fail to make required payments.

If you do not wish to continue your coverage during your unpaid leave of absence, you may discontinue your membership by notifying, in writing, Human Resources. Re-enrollment in the Boston University Health Plan will be possible when you return from your unpaid leave of absence or no-pay status, as long as you contact Human Resources and enroll within 30 days of the date you return.

When Your Coverage Ends
If your employment with the University terminates for any reason, including retirement at or after age 65, your Health Plan membership will end when your paid-up coverage expires.

The date your paid-up coverage expires depends on your date of hire. If you were hired on or after January 1, 1983, the payroll deductions for your Health Plan coverage are made on a current basis. This means, the deduction taken from your January paycheck or paychecks will pay for January’s coverage. If you were hired before January 1, 1983, deductions are taken one month in advance.

• If you were hired on or after January 1, 1983, your Health Plan membership will end on the last day of the month in which your employment terminates.

• If you were hired before January 1, 1983, and you terminate your employment, your Health Plan membership will end on the last day of the month following the month in which your employment terminates.

Once the payroll system reflects the termination of your employment, Human Resources will automatically notify you in writing of your last day of coverage, and of what to do to continue coverage. A “certificate of creditable coverage” will be provided to you if you lose coverage under the plan as required by the Health Insurance Portability and Accountability Act of 1996.

In addition to any continuation provisions provided by Boston University, you and your covered dependents may have the right to extend your coverage for up to 18 or 36 months under the federal continuation provisions (COBRA).

You may also convert your coverage to a non-group individual policy. Contact Human Resources for details.

Coverage Continuation Provisions
A federal law known as COBRA requires that most employers sponsoring group health plans offer employees and their families (“qualified beneficiaries”) the opportunity to elect and pay for a temporary extension of health coverage called “continuation coverage” at group rates in certain instances (“qualifying events”) where coverage under the employer’s health plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of that law. Both you and your spouse should take time to read this notice carefully.) Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for the coverage.

If you are an employee of the Plan Sponsor (Boston University) covered by one of the medical options maintained by the Plan Sponsor (the “Plan”), you will become a qualified beneficiary if you lose your group health coverage because either one of the following qualifying events happens:

• Your hours of employment are reduced, or

• Your employment ends for any reason other than your gross misconduct.

For more information, contact Human Resources at 1-866-524-7865.
If you are the spouse of an employee covered by the Plan, you will become a qualified beneficiary if you lose your coverage under the Plan because any one of the following qualifying events happens:

- Your spouse dies;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse’s hours of employment are reduced;
- You become divorced or legally separated from your spouse; or
- Your spouse becomes entitled to Medicare (under Part A, Part B, or both).

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any one of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than his or her gross misconduct;
- The parents become divorced or legally separated;
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
- The Plan Sponsor must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse, or a dependent child’s losing eligibility for coverage as a dependent child, etc.), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Plan Contact listed at the end of this summary, along with copies of legal documents substantiating the birth or placement for adoption and the effective date of such event.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage, you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it’s important that you choose carefully between COBRA continuation coverage and other coverage options, because once you’ve made your choice, it can be difficult or impossible to switch to another coverage option.

Health Insurance Marketplace as an Alternative to COBRA—Points to Consider

The Marketplace offers “one-stop shopping” to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace, you’ll also learn if you qualify for free or low-cost coverage from Medicaid or the Children’s Health Insurance Program (CHIP). You can access the Marketplace for your state at www.healthcare.gov. Being offered COBRA continuation coverage won’t limit your eligibility for coverage or for a tax credit through the Marketplace.

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a “special enrollment period.” After 60 days your special enrollment period will end and you may not be able to enroll. In addition, during what is called an “open enrollment” period anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.healthcare.gov.

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a “special enrollment period.” Be careful though—if you terminate your COBRA continuation coverage early without another qualifying event, you’ll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you’ve exhausted your COBRA continuation coverage and the coverage expires, you’ll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended. If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation under any circumstances.

When considering your options for health coverage, you may want to think about:

- **Premiums** Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse’s plan or through the Marketplace, may be less expensive.
- **Provider Networks** If you’re currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health care.
- **Drug Formularies** If you’re currently taking medication, a change in your health coverage may affect your costs for medication—and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- **Severance Payments** If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 866-444-3272 to discuss your options.
- **Service Areas** Some plans limit their benefits to specific service or coverage areas—so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- **Other Cost-Sharing** In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Under the law, you have at least 60 days from the date you would lose coverage because of one of the events described above to inform the Plan Administrator that you want to elect continuation cover-
When the qualifying event is the end of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

When the qualifying event is the death of the employee, the employee’s becoming entitled to Medicare benefits under Part A, Part B, or both, the employee’s legal separation, or a dependent child’s losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. However, when the qualifying event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage
If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled (for purposes of Title II [OASDI] or Title XVI [SSI] of the Social Security Act) and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The qualified beneficiary must notify the Plan Administrator (see Plan Contact Information below) in writing of such a determination of Social Security disability within 60 days of that determination and before the end of the 18-month period of COBRA continuation coverage. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The qualified beneficiary must also notify the Plan Administrator within 30 days of the date of any final determination by the Social Security Administration that she is no longer disabled. You must provide these notices to the Plan Contact listed at the end of this summary, along with copies of documentation substantiating the second qualifying event. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced, legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage
If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator within 60 days of the second qualifying event. You must provide this notice to the Plan Contact listed at the end of this summary, along with copies of documentation substantiating the second qualifying event. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced, legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

When and How Must Payment for COBRA Continuation Coverage Be Made?
First Payment for Continuation Coverage
If you elect continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment for continuation coverage no later than 45 days after the date of your election. (This is the date the election notice is postmarked, if mailed.) If you do not make your first payment for continuation coverage in full no later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the party responsible for COBRA continuation administration under the Plan at the address, phone number, or email address provided at the end of this section to confirm the correct amount of your first payment.

Periodic Payments for Continuation Coverage
After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first day of the month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break.

Grace Period for Periodic Payments
Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

Early Termination of COBRA
COBRA provides that your continuation coverage may be terminated before the end of the maximum coverage period for any of the following reasons:
• The Plan Sponsor no longer provides group health coverage to any of its employees;
• Any required premium for continuation coverage is not paid in full on time;
• A qualified beneficiary becomes covered—after electing COBRA continuation coverage—under another group health plan (as an employee or otherwise) that does not impose any pre-existing condition limitation for a pre-existing condition of the qualified beneficiary;
• A qualified beneficiary becomes entitled to Medicare (under Part A, Part B, or both) after electing COBRA continuation coverage;
• A qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. HIPAA coordinates COBRA’s other coverage cut-off rule (in the third bullet above) with these new limits as follows: If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan’s pre-existing condition does not apply to you by reason of HIPAA’s restrictions on pre-existing conditions.
Keep Your Plan Informed of Address Changes

In order to protect your family’s rights, you should keep Human Resources informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information (Plan Administrator)

Human Resources
Boston University
25 Buick Street
Boston, MA 02215
Phone: 617-353-2380
Email: HR@bu.edu

Special Enrollment Rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 30 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources.

Special Enrollment Relating to (i) Termination of Medicaid or CHIP Coverage and (ii) Eligibility for Employment Assistance Under Medicaid or CHIP

A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, must permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if either of the following conditions is met:

(i) The employee or dependent becomes eligible for assistance, with respect to coverage under the group health plan or health insurance coverage, under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health plan or health insurance coverage not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

(ii) To request special enrollment or obtain more information, contact the Plan Administrator at the address and phone number listed above in this handbook.

Your Rights Under Newborns’ and Mothers’ Health Protection Act of 1996 (NMHPA)

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).


If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

• All stages of reconstruction of the breast on which the mastectomy was performed
• Surgery and reconstruction of the other breast to produce a symmetrical appearance
• Prostheses
• Treatment of physical complications of the mastectomy, including lymphedema

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under your coverage under this Plan. If you would like more information on WHCRA benefits, contact Human Resources.

Qualified Medical Child Support Orders (QMCSOs)

As required by ERISA, the Plan recognizes qualified medical child support orders (QMCSOs). A QMCSO is a court order or an order issued by a state administrative agency in accordance with federal and state laws that requires an alternate beneficiary (for example, a child or stepchild) to be covered by a plan participant’s group health plan.

The Plan honors QMCSOs that meet the legal requirements for such orders. It is important to note that a QMCSO cannot require a plan to provide a type or form of benefit, or an option, that is not currently available from the plan to which the order is directed, unless receiving this benefit or option is necessary to meet the requirements of the Social Security Act, which relates to the enforcement of state child support laws and reimbursement of Medicaid.

A QMCSO must be provided to the Plan Administrator to determine if it meets the legal requirements for a QMCSO. If it does, the alternate beneficiary is considered a beneficiary for the purposes of ERISA and is enrolled as a dependent of the employee participant. If the Plan Administrator receives a medical child support order that relates to you, you will be notified and then informed of the decision as to whether the order is qualified.

A copy of the Plan’s QMCSO procedures is available, free of charge, upon written request to Human Resources.
### Health Plan Comparison

<table>
<thead>
<tr>
<th>Benefit</th>
<th>BCBS PPO</th>
<th>Network Blue New England</th>
<th>BU Health Savings Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefits</strong></td>
<td>In Network</td>
<td>Out of Network</td>
<td>In Network</td>
</tr>
<tr>
<td><strong>Inpatient Services</strong></td>
<td>$20 copayment per visit, up to 20 visits per calendar year</td>
<td>$20 copayment per visit, up to 20 visits per calendar year</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Outpatient Services</strong></td>
<td>$40 copayment per visit</td>
<td>$40 copayment per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Office Visits</strong></td>
<td>$25 copayment per visit</td>
<td>$25 copayment per visit</td>
<td>$25 copayment per visit</td>
</tr>
<tr>
<td><strong>Eye Exams</strong></td>
<td>$15 copayment per visit</td>
<td>$15 copayment per visit</td>
<td>$15 copayment per visit</td>
</tr>
<tr>
<td><strong>Physical Therapy</strong></td>
<td>$30 copayment per visit</td>
<td>$30 copayment per visit</td>
<td>$30 copayment per visit</td>
</tr>
<tr>
<td><strong>Dental Services</strong></td>
<td>$25 copayment per visit</td>
<td>$25 copayment per visit</td>
<td>$25 copayment per visit</td>
</tr>
<tr>
<td><strong>Home Delivery</strong></td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td>$20 copayment per visit</td>
<td>$20 copayment per visit</td>
<td>$20 copayment per visit</td>
</tr>
<tr>
<td><strong>Pharmacy</strong></td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Deductible per Calendar Year</strong></td>
<td>None</td>
<td>None</td>
<td>None</td>
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### Prescription Drug Coverage Through Express Scripts

<table>
<thead>
<tr>
<th>Benefit</th>
<th>BCBS PPO</th>
<th>Network Blue New England</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Rx Exclusions</strong></td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td>$140 for most covered services</td>
<td>$140 for most covered services</td>
<td>$140 for most covered services</td>
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### Coverage Through Retail Pharmacy

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</tr>
</thead>
<tbody>
<tr>
<td><strong>Genetic Testing</strong></td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Out-of-Network</strong></td>
<td>$20 copayment per visit</td>
<td>$20 copayment per visit</td>
<td>$20 copayment per visit</td>
</tr>
<tr>
<td><strong>In-Network</strong></td>
<td>$15 copayment per visit</td>
<td>$15 copayment per visit</td>
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</table>

### Out-of-Pocket Maximum

<table>
<thead>
<tr>
<th>Benefit</th>
<th>BCBS PPO</th>
<th>Network Blue New England</th>
<th>BU Health Savings Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td>$1,000 per person</td>
<td>$1,000 per person</td>
<td>$1,000 per person</td>
</tr>
</tbody>
</table>

### Copayments

<table>
<thead>
<tr>
<th>Benefit</th>
<th>BCBS PPO</th>
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<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td>$20 copayment per visit</td>
<td>$20 copayment per visit</td>
<td>$20 copayment per visit</td>
</tr>
<tr>
<td><strong>In-Network</strong></td>
<td>$15 copayment per visit</td>
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</table>

### Benefits

<table>
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<tr>
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<th>BCBS PPO</th>
<th>Network Blue New England</th>
<th>BU Health Savings Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible per Calendar Year</strong></td>
<td>$200 for most covered services</td>
<td>$200 for most covered services</td>
<td>$200 for most covered services</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td>$50 for most covered services</td>
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### Other Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>BCBS PPO</th>
<th>Network Blue New England</th>
<th>BU Health Savings Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measurable Benefits</strong></td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td>None</td>
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<td>None</td>
</tr>
</tbody>
</table>

### Cost

<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td>$1,000 per person</td>
<td>$1,000 per person</td>
<td>$1,000 per person</td>
</tr>
</tbody>
</table>

*Covered for children between their third and seventh birthdays if they have been diagnosed with an Autism Spectrum Disorder.

†Annual maximums are combined in-network and out-of-network.

**Out-of-pocket maximum is separate for medical and prescription drugs.