BOSTON UNIVERSITY

Use Well

A Guide to Making the Most of the BU Health Savings Plan

2026

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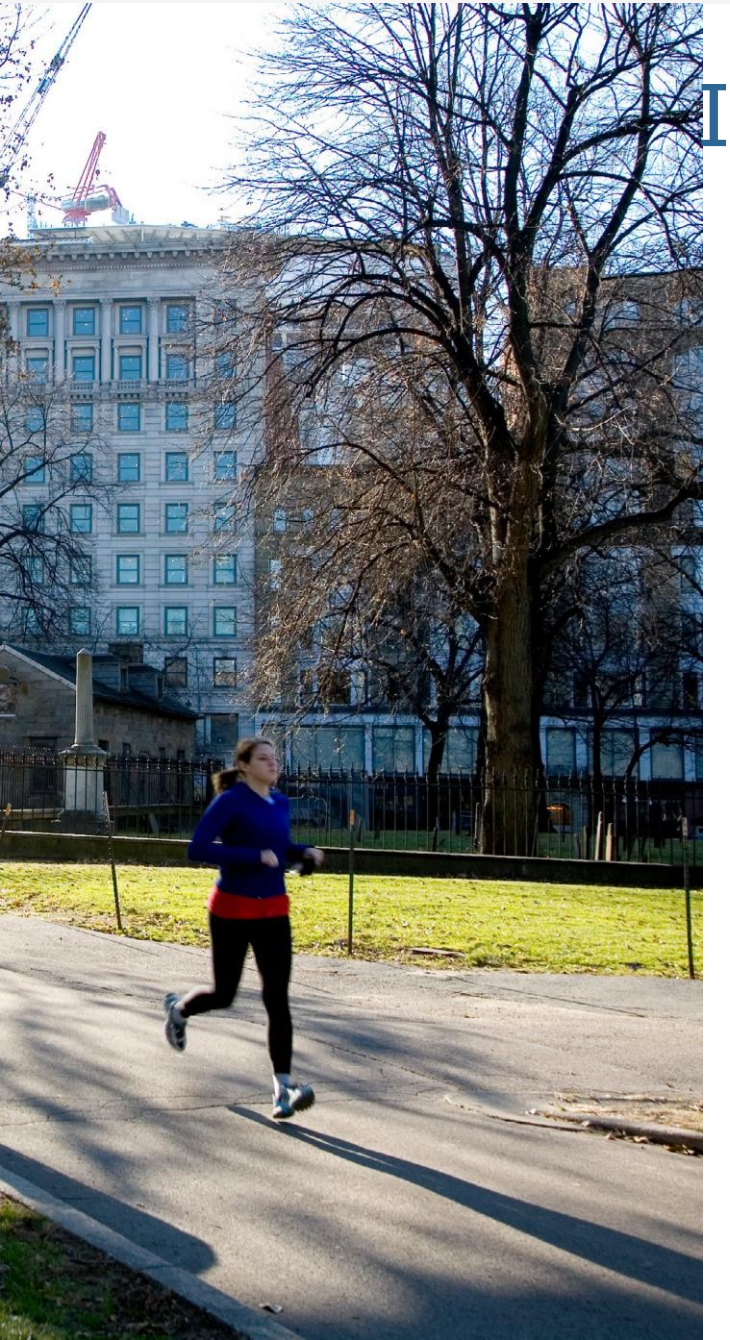


INTRODUCTION

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

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

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

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

KNOW YOUR NETWORK TO PAY LESS

When you need care, choose a provider in the Blue Cross Blue Shield (BCBS) Network to make the most of negotiated network rates and avoid spending unnecessary money.

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

$$ BCBS Network Providers	$$$ Out-of-Network Providers
• Your out-of-pocket costs are lower if you choose a provider from the BCBS National PPO Network. You pay: - $2,000 annual individual deductible and $4,000 annual deductible for any family plan for all services except preventive care - 12% of the cost of care after the annual deductible - $4,000 annual individual out-of-pocket maximum and $8,000 out-of-pocket maximum for family coverage • For a list of BCBS providers, visit https://myfindadoctor.bluecrossma.com/?ci=boston-university. - Select the Blue Care Elect PPO/EPO Network to access the network of providers covered under this plan.	• You pay substantially more if your provider is not in the BCBS National PPO Network. - $4,000 annual individual deductible and $8,000 annual deductible for any family plan for most charges - 30% of the cost of care, after the deductible - $8,000 annual individual out-of-pocket maximum and $16,000 annual family out-of-pocket maximum • The provider's actual charge will apply, unlike the lower, negotiated rate in-network providers agree to accept.

DID YOU KNOW?

Reading Your Explanation of Benefits (EOB)

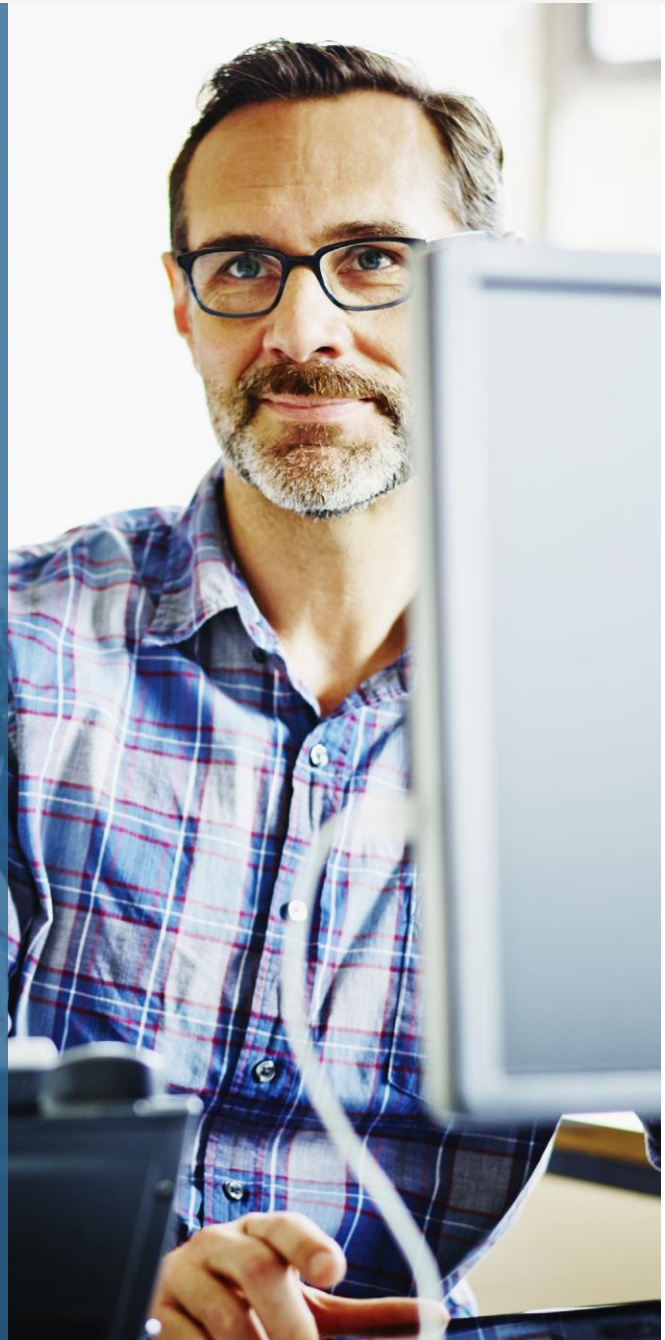
Your EOB is a statement sent by BCBS explaining the cost of the medical care you received, what the plan paid and what you owe. It's important to carefully review your EOB to ensure that all services were received and match the copy of the bill you received from your doctor. You can choose to receive your EOB online, by mail or both. EOBs are available to be reviewed online for up to two years.

Manage Your Claims with BCBS

Through BCBS, you can manage your account 24/7. Through the BCBS website you can:

- Print ID cards
- Search for doctors by location or specialty and compare quality first, and then cost
- Locate health care facilities such as hospitals, urgent care facilities and ERs
- Obtain cost estimates for services at hospitals and other facilities
- Keep your medical history at your fingertips
- Keep track of your claims activity
- Learn about health conditions, symptoms and treatment options

In addition, you can get answers to your non-emergency medical questions from a registered nurse at 1-888-247-BLUE.



Paying for Care

BCBS has negotiated rates with in-network providers, making your out-of-pocket expenses lower when you use an in-network provider. Your doctor's office will bill BCBS, and then BCBS will pay your doctor directly for covered in-network services. If you go to an out-of-network provider, the provider may require partial or full payment at the time of service.

When using an in-network provider, it is important to wait to receive your Explanation of Benefits (EOB) from BCBS before you pay for care. That way you can be sure you are paying only the amount you owe after the BCBS discount and plan payments are applied. Your EOB will provide detail on BCBS's payments and the amounts you owe for each service. Review your EOB carefully.

Your EOB is not a bill. In addition to the EOB, you should wait to receive a bill from the provider. Note that you should send payments to the provider, not to BCBS.

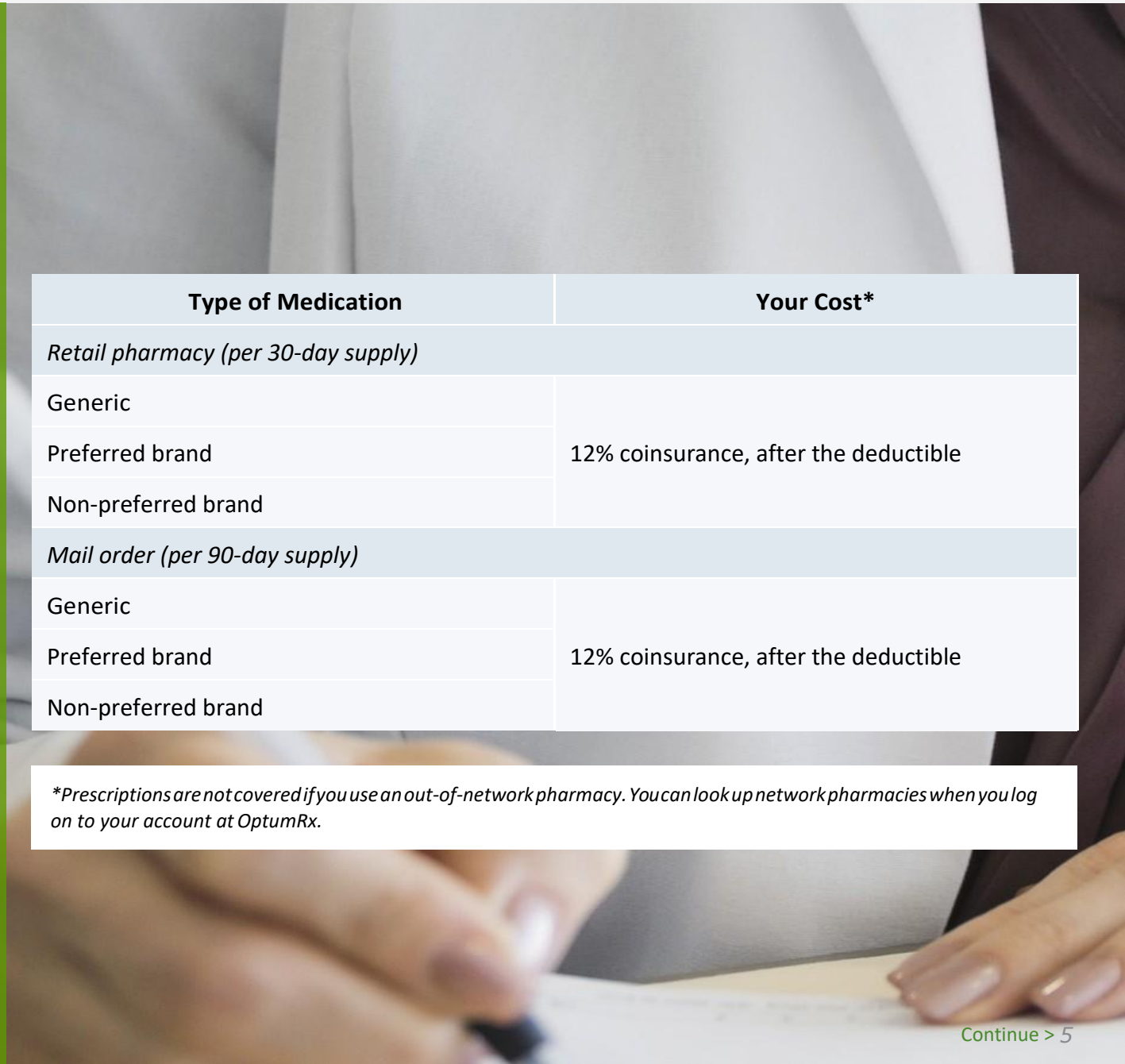
UNDERSTAND PRESCRIPTION BENEFITS

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

Prescription drug expenses count toward the same deductible and out-of-pocket maximum as any other medical expense. **Certain preventive medications are covered at no cost to you.**

For non-preventive medications, you pay the full amount of the prescription drug until you reach the medical plan deductible. Then you pay 12% coinsurance up to the annual out-of-pocket maximum.

The coinsurance percentage you pay is the same, regardless of where and how your prescription is filled.



Type of Medication	Your Cost*
Retail pharmacy (per 30-day supply)	
Generic	12% coinsurance, after the deductible
Preferred brand	
Non-preferred brand	
Mail order (per 90-day supply)	
Generic	12% coinsurance, after the deductible
Preferred brand	
Non-preferred brand	

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

Medications that Require Prior Authorization

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

Certain medications that may require prior authorization include drugs:

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

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

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

USE THE HEALTH SAVINGS ACCOUNT (HSA)

If you contribute to the Health Savings Account—congratulations! You're saving money for both current and long-term health care expenses. Remember, you can contribute pre-tax dollars to an HSA and use that money to pay for eligible expenses such as your deductible, coinsurance and out-of-pocket dental and vision expenses. The IRS sets an annual contribution limit. For 2025, the maximum you and BU can contribute to your HSA depends on your age and coverage level, as follows:

Your Age in 2026	Individual Coverage	All Other Coverage Levels
Under 55	$4,400	$8,750
55 or older	$5,400	$9,750

Open Your Fidelity HSA

You may enroll in the HSA if you are a new employee or during open enrollment. Follow these steps to open your HSA:

1. You may enroll by completing a paper Benefits Enrollment Form or through Employee Self Service.
2. Fidelity Investments will be informed by Human Resources that you have enrolled and are eligible to open your Fidelity HSA.
3. Fidelity will contact you with instructions to set up your account through NetBenefits or you may log on to NetBenefits immediately to set up your HSA account.
4. Once you have completed the account setup, payroll deductions will begin and your pre-tax contributions will be sent to Fidelity.
5. At the time of your first contribution, BU will contribute $500 for individual coverage and $1,000 for any family plan.

BU Contributions to the HSA

If you enroll in and contribute to the Fidelity HSA, BU will contribute an amount to your HSA that can be used to pay for eligible out-of-pocket expenses, like your deductible and coinsurance. The amount BU contributes is based on coverage level, as follows:

If You Enroll In...	BU's 2026 Contribution to Your HSA is...
Individual coverage	$500
Family coverage	$1,000

Fidelity BillPay® for Health Savings Accounts

This online bill paying service enables you to quickly and easily make payments to health care providers, companies and individuals. You can also set up an automatic payment schedule, reimburse yourself for out-of-pocket qualified medical expenses, and keep track of all payments and activity. Visit the Fidelity website at www.netbenefits.com.

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How to Pay with an HSA

You have three ways to pay for health care expenses using your HSA funds:

Pay Your Provider with Your Debit Card

1. Fidelity BillPay — Log on to your NetBenefits account to 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.
2. Fidelity HSA debit card — Use the debit card Fidelity will send you to pay eligible expenses at the pharmacy or other point of service.
3. Fidelity HSA checkbook — If requested, Fidelity will issue you checks you can use to pay doctor and other provider bills.

Whatever way you pay, be sure to keep your receipts for tax purposes. The IRS may ask you to validate that your HSA was used to pay eligible expenses.

If you don't have enough in your HSA to cover the full amount of a provider's bill, pay the bill with other funds (such as from a checking or savings account). Then, reimburse yourself for this payment once your HSA balance rises to cover the cost.

Eligible Expenses

Examples of eligible expenses include:

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

For a complete list, see IRS Publication 502, "Medical and Dental Expenses."

DID YOU KNOW?

You May Reimburse Yourself Later
An HSA works like a checking account; you must have enough money in your account to use it when paying an eligible expense.

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

EXAMPLES

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

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

AMY

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

TED

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

MAYA

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

DID YOU KNOW?

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

Preventive care includes:

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

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

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

AMY'S ACCIDENT

Amy chooses a doctor in the BCBS network. Smart choice! Dr. Lin files the claim and Amy benefits from the negotiated discounted rate.

Since Amy did not have sufficient funds in her HSA, she continues to contribute to her HSA until her balance is sufficient to reimburse herself. She writes herself a check from her Fidelity HSA account.

Amy used the Blue Cross Blue Shield tool to find a provider for the MRI. Access the tool here.

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

Bright Idea

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

Dr. Lin writes a referral (prescription) for her to have the MRI done at a BCBS network facility.

Because Dr. Lin is a BCBS network doctor, Amy does not pay at the time of her visit. Dr. Lin submits a claim to BCBS on Amy's behalf. Amy waits to receive her Explanation of Benefits (EOB) from BCBS that details the amount she owes for the visit.

- Dr. Lin's full charge for the visit is $150, but the negotiated network rate is $100.
- The EOB states that Amy's responsibility is the full cost of the office visit as she has not yet met her deductible.
- Once she receives a bill from her doctor, she writes Dr. Lin a check for $100. **Later, she can reimburse herself** from her HSA.

Bright Idea

Amy gets her MRI at the BMC facility.

Bright Idea

The facility bills BCBS directly, and Amy does not have to file a claim. She waits to receive her EOB from BCBS that details the amount she owes for the visit.

- The facility charges for the MRI: $1,400
- The negotiated rate for the BCBS network: $1,000
- Amy receives an EOB that shows she owes the facility $1,000 for the MRI as she has not yet met her deductible.

Amy pays $500 from her HSA using her Fidelity-provided debit card and pays $500 from her personal checking account.

Amy's contributions over the following two months allow her to reimburse herself the $500 she paid from her personal checking account.

TED'S MAIL ORDER PRESCRIPTION

Register with OptumRx to Manage Your Prescriptions

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

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

By opting for mail order, Ted enjoys the convenience of home delivery.

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

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

Ted fills the prescription for a 30-day supply. Ted has met his annual deductible and is responsible for 12% of the total cost of the drug, which is $101. Ted uses his Fidelity HSA debit card to pay $12.12 for the 30-day supply.

Since Ted will need to refill this prescription every month, he enrolls in the mail-order pharmacy for convenience. **He registers his account online through OptumRx, and completes the mail order pharmacy enrollment (including sending in the prescription from his doctor to have his next refill come through mail order).**

Bright Idea

After his first month's supply is up, **Ted receives a 90-day supply of medication from the mail order** pharmacy — saving himself a trip to the pharmacy. The total cost for a 90-day supply is $303 and Ted pays 12% (or $36.36). The amount is automatically debited from his Fidelity HSA debit card on file.

Bright Idea

MAYA'S PRESCRIPTION REQUIRING PRIOR AUTHORIZATION

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

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

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

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

Bright Idea

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

CONTACTS

Human Resources Service Center	**Health Insurance**	**Health Savings Account**	**Mail Order Pharmacy**
email: hr@bu.edu 617-353-2380	Blue Cross Blue Shield of Massachusetts www.bluecrossma.com/nm/boston-university/index.html 1-800-814-4371 Find a Doctor https://myfindadoctor.bluecrossma.com/?ci=boston-university	Fidelity www.netbenefits.com 1-800-343-0860	OptumRx www.optumrx.com Customer Service: 1-888-863-8578

GLOSSARY

Annual Deductible

Individual coverage: The plan begins to pay benefits when the individual deductible is met. In-network individual deductible: $2,000.

Spouse and dependent coverage: The plan begins to pay benefits for any individual only when the family deductible has been met. The family deductible may be met by any combination of covered family members. Prescription drug expenses count toward the medical deductible. In-network family deductible: $4,000.

Coinsurance

Once you meet the annual deductible, you pay a percentage of the total cost of care subject to coinsurance, and the plan pays a percentage of the total cost of care. The percentage you pay is called your "coinsurance."

Out-of-pocket Maximum

The out-of-pocket maximum limits the amount you pay each calendar year for covered services. Your out-of-pocket maximum includes the deductible and coinsurance. Once you reach this maximum, the plan covers 100% of the cost of any additional eligible expenses you incur for the rest of the plan year. One out-of-pocket limit applies to all eligible medical and prescription drug expenses. In-network out-of-pocket max: $4,000 individual/$8,000 family.