

HEALTH PLAN

BOSTON UNIVERSITY

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The 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 covered 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 handbook will help you decide which type of coverage under the Health Plan is best for you and your family.

Please note: The descriptions of coverage 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 official 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 plans. 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 stepchildren
- Your legal ward.
- Your unmarried, dependent children age 26 and over who are intellectually or physically disabled 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 disabled 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 Health Plan as of January 1, 2015, will no longer be able

to participate in the plan (subject to COBRA).

Dependent Eligibility

Documentation Required

For all eligible dependents whom you wish to cover under the BU plan, you must provide the following documents:

- Spouse: Marriage certificate (government issued)
- Common Law Spouse: Common law marriage certificate (only for those married in a state that accepts common law marriage)
- Child: Birth certificate or adoption certificate or certificate of live birth
- Stepchild: Birth certificate of child plus marriage certificate of current spouse (a stepchild is eligible only if their birth parent is covered as a spouse on the family plan)
- Ward: Court ordered document of legal custody

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 neither you nor your former spouse remarries. If you or your former spouse remarry, 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.

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/buworkscentral and select BU Benefits Center. This enrollment process 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), please notify Human Resources at hr@bu.edu for details on making a change to your benefits.

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 Life or Career event, 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 Program & Flexible Spending Accounts” handbook.

Changing or Stopping Coverage

Because you pay for your coverage with before-tax dollars, the provisions of Section 125 of the Internal Revenue Code also govern how and when you may make changes in your Health Plan coverage. Under the current provisions of Section 125, you may

- Change the level of your coverage (that is, move from individual to family coverage or vice versa), or
- Cancel your coverage once each year, during the annual open enrollment period.

The only other time you may make a change in your Health Plan coverage is if you have an IRS-approved Qualifying Life Event which is explained in the “Flexible

Benefits Program and Flexible Spending Accounts” 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.

Claims and appeals under ERISA 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 claims
- 30 days for post-service claims

Claimants have 180 days to appeal a denied claim.

While the COVID-19 Outbreak Period was in effect, these regular deadlines were extended in accordance with joint Agency guidance published on May 4, 2020. Under the joint Agency guidance, the 180-day deadline for submitting an appeal was extended during the Outbreak Period.

The Outbreak Period is defined as the period from March 1, 2020, until sixty (60) days after the announced end of the National Emergency that was declared on March 1, 2020 regarding the COVID-19 pandemic. The announced end of the National Emergency is effective May 2023. During the Outbreak Period, the 180-day clock on the time to submit an appeal did not run. Beginning 60 days after the end of the National Emergency was announced, the 180-day clock on the time to submit an appeal began running again.

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.

The claimant or someone the claimant names to act for him or her (the claimant’s authorized representative) may file a request for external review. A claimant may contact the applicable Plan Vendor for information on how to designate an authorized representative.

Your Health Plan Options

There are two Blue Cross Blue Shield health plan options from which you may choose:

1. **BCBS PPO** is a health care program that provides two levels of coverage: in-network and out-of-network. You receive the highest level of benefits under

your health care plan when you choose preferred providers. These are called your in-network benefits. You can also choose non-preferred providers, but your out-of-pocket costs are higher. These are called your out-of-network benefits.

In-Network Coverage

- Preventive Care is covered 100%.
- You pay a copayment for physician office visits and emergency room care.
- For diagnostic x-rays, lab and related tests as well as inpatient or outpatient hospital services, you have a calendar-year deductible. In addition, you pay coinsurance if your physician is a non-Boston Medical Center provider.
- The calendar year deductible begins on January 1 and ends on December 31 each year. The in-network deductible is \$500 for each member (or \$1,000 for all family members enrolled under the same coverage). After you have met your in-network deductible, you pay 12% coinsurance for services at low cost providers and 20% coinsurance at high cost providers. When the money you paid for the 20% coinsurance equals \$3,000 (this is the out-of-pocket limit) for a member in a calendar year (or \$6,000 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.

Out-of-Network Coverage When you choose non-preferred providers you must pay a calendar-year out-of-network deductible for most out-of-network services. The calendar year out-of-network deductible begins on January 1 and ends on December 31 each year. The out-of-network deductible is \$1,000 for each member (or \$2,000 for all family members enrolled under the same coverage). After you have met your deductible, you pay 30% coinsurance for most out-of-network covered services. When the money you paid for the 30% coinsurance equals \$6,000 (this is the out-of-pocket limit) for a member in a calendar year (or \$12,000 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.

2. BU Health Savings Plan The BU Health Savings Plan is a High Deductible Health Plan that combines the coverage features of a PPO with the flexibility and tax effectiveness of a Health Savings Account (HSA).

Premiums are lower, but deductibles and out-of-pocket maximums are higher than with the BCBS PPO Plan. 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.

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 \$2,000 for individual coverage or \$4,000 for any family coverage. After you have met your deductible, you pay 12% coinsurance for most in-network covered services. When the money you paid for the 12% coinsurance and deductible equals \$4,000 for individual coverage or \$8,000 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.

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 \$8,000 for individual coverage or \$16,000 for any

family coverage. After you have met your deductible, you pay 30% coinsurance for most out-of-network covered services. When the money you paid for the 30% coinsurance and deductible equals \$8,000 for individual coverage or \$16,000 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.

Health Savings Account 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.

BCBS PPO

How the BCBS PPO Works

The BCBS PPO is a preferred provider organization (PPO) that combines 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 primary care physician. There are two levels of coverage: in-network and out-of-network. The amount of coverage depends on where you receive treatment. You receive the highest level of benefits under your health care plan when you choose preferred providers. These are called your in-network benefits. You can also choose non-preferred providers, but your out-of-pocket costs are higher. These are called your out-of-network benefits.

This health plan option includes a tiered network feature called Hospital Choice Cost Sharing. As a member in this plan, you will pay different levels of in-network cost share (such as copayments and/or coinsurance) for certain services depending on the preferred general hospital you choose to furnish those covered services. For most preferred general hospitals, you will pay the lowest in-network cost sharing level. However, if you receive certain covered services from any of the preferred general hospitals listed below, you pay the highest in-network cost sharing level. The high-cost hospital list may change from time to time.

Please view the HR website for the most up-to-date listing.

Higher Cost Share Hospitals

The Massachusetts hospitals listed below are the hospitals in which your cost share will be higher. Blue Cross Blue Shield will let you know if this list changes. The full list can be found on the Human Resources website.

- Baystate Medical Center
- Boston Children's Hospital (only Boston location is high cost; Lexington, Peabody, and Waltham locations receive the lowest cost share)
- Brigham and Women's Hospital
- Cape Cod Hospital
- Dana-Farber Cancer Institute
- Fairview Hospital
- Massachusetts General Hospital
- UMass Memorial Medical Center—Memorial Campus
- UMass Memorial Medical Center—University Campus

In-Network — BMC Providers

1. Preventive Care is covered 100% when received from a BCBS National PPO provider which includes Boston Medical Center providers.
2. When you receive care from a Boston Medical Center participating provider, you pay a \$15 copayment for office and facility visits. Emergency room visits are covered after a \$100 copayment which is waived if you are admitted to the hospital from the emergency room.
3. Some services are covered fully after you meet your annual deductible of \$500 for each member (or \$1,000 for all family members enrolled under the same coverage). These services are x-rays, labs and related diagnostic testing as well as inpatient and outpatient hospital services.

In-Network—All Other BCBS National PPO Network Providers

1. Preventive Care is covered 100% with a BCBS National PPO provider.
 2. Preventative Mental Health Exam.
 3. As a member in this plan, you will pay different levels of in-network cost share (such as copayments and/or coinsurance) for certain services depending on the preferred general hospital you choose to furnish those covered services. For most preferred general hospitals, you will pay the lowest in-network cost sharing level. However, if you receive certain covered services from any of the higher cost hospitals listed above, you pay the highest in-network cost sharing level.
 4. You pay a \$35 copayment for office and facility visits. Emergency room visits are covered after a \$150 copayment which is waived if you are admitted to the hospital from the emergency room.
 5. For some services you pay coinsurance after you meet your annual deductible of \$500 for each member (or \$1,000 for all family members enrolled under the same coverage). These services are x-rays, labs and related diagnostic testing as well as inpatient and outpatient hospital services.
- Your coinsurance is 12% when you receive care from a low-cost hospital or non-hospital provider and 20% when your care is provided by a high-cost hospital.

In-Network Out-of-Pocket

Maximum

The annual out-of-pocket maximum limits the amount you pay for the deductible, copayments, and coinsurance each calendar year. The in-network out-of-pocket maximum is \$3,000 for each member (or \$6,000 for all family members enrolled under the same coverage). There are separate out-of-pocket maximums for in-network and out-of-network services.

The BCBS PPO also gives you the option to use non-participating physicians, specialists, and health care facilities; your benefits coverage, however, will be lower. If you receive care outside the plan network, you will receive 70% coverage for most services (based on reasonable and customary charges) after you meet an annual deductible of \$1,000 (individual coverage) or \$2,000 (family coverage). You pay the remaining 30% (your coinsurance) and any charges above reasonable and customary limits. Once your 30% coinsurance reaches the annual out-of-pocket limit of \$6,000 (individual coverage) or \$12,000 (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 covered by the plan

- Charges you incur for not following precertification procedures

If you elect the PPO Plan, BU will contribute an amount to your Health Care FSA that can be used to pay for eligible out-of-pocket expenses, like your deductible. The amount BU contributes is based on your salary and family coverage level, as follows:

	FSA Contribution from BU	
Salary Tier	Single	Family
< \$70,000	\$500	\$1,000
\$70,000– \$100,000	\$250	\$500
> \$100,000	No contribution	

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 \$150 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. The out-

of-network deductible does not apply.

Within the Enrollment Area

You will receive full coverage after a \$150-copayment per person per visit for hospital emergency room treatment you receive at a hospital in the plan network. This copayment will be waived, however, if you are immediately admitted to the hospital. For an inpatient admission directly from the emergency room of any of the high-cost hospitals, the lowest hospital cost sharing benefits level will apply.

Outside the Enrollment Area

When you are temporarily outside the enrollment area, the BCBS PPO will cover emergency room treatment in full (up to reasonable and customary charges) after a \$150 copayment if the illness or injury is sudden and life-threatening. Emergency treatment received at a physician's office outside the enrollment area will be covered at 70% after the annual deductible is met.

Preventive Care

Preventive care is covered 100% in-network; and 70% after the deductible for out-of-network services.

Preventive care includes:

- Well-childcare exams, including routine tests, according to age-based schedule as follows:
 - 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 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 intermittent skilled nursing care and physical therapy, at 100% when you use a participating provider, and at 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
- 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 www.bcbssma.com).

https://www.bluecrossma.com/common/en_US/pdfs/New_SOB/00-000_Subscriber_Claim_Form.pdf), 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 covered 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 forward it to Blue Cross Blue Shield for repayment to you.

Utilization Review Requirements
Utilization Review is an important feature of the out-of-network portion of the BCBS PPO. 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:

- **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 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.

Be sure to follow Utilization Review provisions. If you do not follow these provisions, 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 authorized

by Blue Cross Blue Shield for transfer from one facility to another	developmental, educational, or behavioral problems except as medically necessary under an early intervention program	biofeedback, pain management programs, massage therapy, and acupuncture
- 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 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	- 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 keratoconus - 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 - 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, electrolysis, routine foot care,	- Personal comfort items - Physical examinations for insurance, licensing, or employment - 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.

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 OptumRx. 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 Boston Medical Center and its affiliated providers. The BU Health Savings Plan prescription drug benefit is administered through OptumRx and covers the same prescription drugs as the other University offering.

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 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.

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

Annual Deductible	In-Network Providers	Out-of-Network Providers
	\$2,000 for individual coverage, or \$4,000 for any family coverage*	\$4,000 for individual coverage, or \$8,000 for any family coverage*

*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 services are covered 88%. You pay 12% coinsurance. When the amount you have paid in deductible and coinsurance reaches \$4,000 for an individual plan, or \$8,000 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.

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 \$8,000 for an individual plan, or \$16,000 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 12% coinsurance

after the deductible for in-network or out-of-network emergency room services.

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-childcare 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 members age 19 or older (one per calendar year), including preventative mental health exams.
- 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.

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
- Durable medical equipment

Utilization Review Requirements

Utilization Review is an important feature of 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:

- **Preadmission 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.

Be sure to follow Utilization Review provisions. If you do not follow these provisions, plan benefits will be reduced.

Services Not Covered

Under the BU Health Savings Plan, no benefits are provided for the following:

- Ambulance services unless necessitated by an emergency or medical necessity or authorized by Blue Cross Blue Shield for transfer from one facility to another
- Any claim submitted more than two years from the date the service was rendered
- Blood: whole blood; packed red blood cells; blood donor fees; and blood storage fees
- 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 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 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 keratoconus
- 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
- 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
- Osteopathic manipulation, electrolysis, 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 (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

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. ERISA 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 2025, the limits are \$4,300 for employee only and \$8,500 if you have family coverage. 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 \$3,800 (\$4,300-\$500). If you are age 55 or older in 2025, you may make additional pre-tax “catch-up” contributions, up to \$1,000 per year.

2025	Individual	Family
Annual HSA Contribution` Limits	\$4,300	\$8,500
Catch-up Contribution Limit (for those age 55 and older)	\$1,000	\$1,000

- You are not required to contribute to the HSA to participate in the BU Health Savings Plan.
- You must, however, open and contribute to the Fidelity HSA in order to receive the University contribution to that HSA.
- You may also contribute after-tax funds by check and claim them as deductions on your income tax return.
- You may prospectively 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 requested 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 via Employee Self Service at www.bu.edu/buworkscentral. Go to BU Benefits Center and select Manage My Health Savings Account.
2. 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 set up, payroll deductions will begin, and your pre-tax contributions will be sent to Fidelity.
6. After your first contribution, BU 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 payroll deductions are taken on a pretax 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 HSA 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 you can claim on your tax return
- A dependent that you could have claimed on your tax return except that they had gross income of \$4,300 or more in 2020 (as adjusted)

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.

OptumRx Prescription Drug Coverage

As a member of the Health Plan, you will automatically be enrolled in prescription drug coverage through

OptumRx. When your doctor prescribes medication, you have choices about where and how the prescription is filled.

Prescription costs 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. OptumRx updates this list regularly based on continuous evaluation of medications.

You can determine if your brand-name medications are preferred or non-preferred by logging on to www.optumrx.com. Use the Drug Lookup feature to find your medication.

Register with OptumRx to Manage Your Prescriptions

Once you are enrolled in a health plan, you can register with www.optumrx.com. As a registered

member, you can use the site to manage your prescription drug benefits. Order refills, sign up for text message reminders, track your orders, view the status of your claims, use their mobile website, and more.

Prior Authorization

OptumRx covers medically necessary prescription medication. Some drugs require prior authorization in order to be covered by the plan. To learn about a specific medication, visit the OptumRx website at www.optumrx.com.

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 can call OptumRx to start the approval process.

Contact Information

OptumRx Customer Service: 1-888-863-8578.

	BCBS PPO		BU Health Savings Plan	
	OptumRx Network Pharmacies	Out-of-Network Pharmacies	OptumRx Network Pharmacies	Out-of-Network Pharmacies
Retail prescription drugs (up to a 30-day supply) • Generic • Preferred • Non-Preferred	\$10 copay 20% (min \$45 and max \$65) 30% (min \$65 and max \$85)	Not covered	12% after deductible	Not covered
Mail order or CVS retail prescription drugs (up to a 90-day supply) • Generic • Preferred • Non-Preferred	\$20-copay 20% (min \$85-max \$130) 30% (min \$130 and max \$170)	Not covered	12% after deductible	Not covered
Prescription Drug out-of-pocket maximum	\$2,500 employee coverage \$5,000 family coverage	Not applicable	Included in medical out-of-pocket maximum	Not applicable

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.

Receive a 90-day Supply at CVS Pharmacy

In response to employee requests to fill prescriptions for a 90-day supply of medications at a retail pharmacy, OptumRx has partnered with CVS Pharmacy to give BU Health Plan members the option to get 90-days of maintenance medication at retail CVS pharmacies for the cost of a 60-day supply.

The OptumRx CVS90 Saver program allows you to get 90-day supplies of your maintenance medications at nearly 9,700 CVS Pharmacy locations or through OptumRx home delivery — the choice is yours.

Your pharmacy benefit covers only a limited number of 30-day refills of a maintenance medication. After the allowed refills, you must choose to fill your prescription from OptumRx home delivery or CVS Pharmacy, or pay double the 30-day supply cost.

If you decide not to use either home-delivery or the OptumRx CVS90 Saver program, you will pay double the 30-day supply cost.

If you choose to fill a maintenance medication prescription at a non-

CVS retail pharmacy, you will pay double the 30-day supply cost.

The table on page 18 shows how much you will pay for your prescription depending on your health plan and whether your medication is generic, preferred brand-name, or non-preferred brand name.

Home Delivery

Home Delivery is an important element of your care. Home Delivery is a full-service, state-of-the-art home delivery pharmacy. It offers an easy, cost-effective, and convenient way for you to fill prescriptions for maintenance medications.

You'll benefit from lower copays by refilling a 90-day supply rather than the typical 30-day supply. Home Delivery offers convenient delivery to your specified location.

Prescribers may contact the OptumRx pharmacy via electronic means, phone, fax, or mail.

OptumRx
PO Box 2975
Mission, KS 66201-1375

Doctor Call-In Line: 800-791-7658
Doctor Fax Line: 800-491-7997

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.

While the COVID-19 Outbreak Period was in effect, the appeal deadline was extended in accordance with joint Agency guidance published on May 4, 2020. Under the joint Agency guidance, the 180-day deadline for submitting an appeal was tolled during the Outbreak Period. The Outbreak Period was defined as the period from March 1, 2020, until sixty (60) days after the announced end of the National Emergency that was declared on March 1, 2020 regarding the COVID-19 pandemic. The announced end of the National Emergency took effect as of May 2023. During the Outbreak Period, the 180-day clock on the time to submit an appeal did not run. Beginning 60 days after the end of the National Emergency was announced, the 180-day clock on the time to submit an appeal began running again.

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 made in writing to:

OptumRx
c/o Appeals Coordinator
P.O. Box 2975
Mission, KS 66201
Phone: 1-888-403-3398
Fax: 1-877-239-4565

A decision regarding your appeal will be sent to you within 15 days of receipt of your written request. The notice will include the specific reasons for the decision and the plan provisions on which the decision is based. You have the right to receive, upon request and

at no charge, the information used to review your appeal.

If you are not satisfied with the coverage decision made on appeal, you may request in writing, within 180 days of the receipt of notice of the decision, a second-level appeal. To initiate a second-level appeal, 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:

OptumRx
c/o Appeals Coordinator
P.O. Box 2975
Mission, KS 66201
Phone: 1-888-403-3398
Fax: 1-877-239-4565

A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for appeal. You have the right to receive, upon request and at no charge, the information used to review your second-level appeal. The decision made on your second-level appeal is final and binding.

If you are not satisfied with the decision of the second-level appeal, you also have the right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) if your second-level appeal is denied.

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 is any claim for treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed. If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified within 24 hours after receipt of your claim of the information necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 48 hours of receipt of the information.

You have the right to request an urgent appeal of 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 1-888-863-8578 or send a written request to:

OptumRx
c/o Appeals Coordinator
P.O. Box 2975
Mission, KS 66201
Phone: 1-888-403-3398
Fax: 1-877-239-4565

In the case of an urgent appeal for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim. This coverage decision is final and binding. You have the right to receive, upon

request and at no charge, the information used to review your appeal. You also have the right to bring a civil action under section 502(a) of ERISA if your final appeal is denied.

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 Health Plan also has a subrogation and reimbursement rule. If another party is, or is claimed to be, responsible (the "responsible party") for an illness or injury inflicted 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) for amounts expended by the plan for health care to the covered individual. The covered individual must cooperate

with the Health Plan to recover such amounts. If the covered individual receives payment 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 amount 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 Benefits Plan, on or after January 1, 2016, you may continue your membership in the Health Plan at the same contribution rate as for active employees for up to five years. The coverage for the health plan will end as of the end of the 5th year of disability. Human Resources will explain this feature to you upon notification of your disability.

For the first 24 months of your disability, your 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 Health Plan as your secondary health plan provider. In other words, your claims will be paid by Medicare first; the 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 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 Health Plan will continue as your primary insurance. You may delay enrolling in Medicare Parts A and B without a penalty as long as you remain covered as an employee under the Health Plan as a result of your current employment status.

When you retire, you should contact the Social Security Administration by calling 1-800-772-1213 to enroll in Medicare Parts A and B.

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.

Medicare and the Health Savings Account

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. You cannot contribute to a Health Savings Account if you are enrolled in Medicare.

Based on these IRS regulations, you should carefully consider your

health plan options when enrolling in Medicare.

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 not automatic; you must enroll through 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.

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.

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.

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 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.

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 life 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 (Part A, Part B, or both); or
- The child ceases to be eligible for coverage under the Plan as a “dependent child.”

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Plan Sponsor and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee’s spouse or surviving spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee’s becoming 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 all 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. Under joint Agency guidance issued in response to the COVID-19 pandemic, you had 60 days from the

end date of the Outbreak Period to notify the Plan Administrator of the qualifying event if the qualifying event occurred during the Outbreak Period.

What was the Outbreak Period?

The Outbreak Period is defined as the period from March 1, 2020, until sixty (60) days after the announced end of the National Emergency that was declared on March 1, 2020 regarding the COVID-19 pandemic. The announced end of the National Emergency took effect as of May 2023

During the Outbreak Period, you would have been required to provide this notice to the COBRA Administrator listed below, along with documentation substantiating the divorce, legal separation, or loss of dependent status and the effective date of such event.

P&A Group
Dept #652
P.O. Box 8000
Buffalo, NY 14367
1-800-688-2611

A child who is born to or placed for adoption with the covered employee during a period of COBRA continuation coverage will be eligible to become a qualified beneficiary and be added to the covered employee's COBRA continuation coverage. You must notify the Plan Administrator within 60 days after the birth or placement for adoption occurs.

Under joint Agency guidance issued in response to the COVID-19 pandemic, you had 60 days from the end date of the Outbreak Period (defined above) to submit a request to make a change to your enrollment.

During the Outbreak Period, you would have been required to provide this notice to the Plan Contact listed below, along-with copies of legal documents substantiating the birth or placement for adoption and the effective date of such event.

P&A Group
Dept #652
P.O. Box 8000
Buffalo, NY 14367
1-800-688-2611

Are There Other Coverage Options Besides COBRA Continuation?

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” event. **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 866-4443272 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.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period (for more information visit <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>) to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation

coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

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 coverage.

Under joint Agency guidance issued in response to the COVID-19 pandemic, you were allowed the earlier of 60 days from the end date of the Outbreak Period or one year from when the regular deadline would have applied to elect continuation coverage if your qualifying event occurred during the Outbreak Period. The Outbreak Period is defined as the period from March 1, 2020, until sixty (60) days after the announced end of the National Emergency that was declared on March 1, 2020 regarding the COVID-19 pandemic. The announced end of the National Emergency took effect in May 2023.

If you do not elect continuation coverage, your group health coverage will end. If you elect continuation coverage, the Plan Sponsor is required to permit you to elect and purchase coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members.

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), your divorce, 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. Otherwise, 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.

Under joint Agency guidance issued in response to the COVID-19 pandemic, you were allowed the earlier of 60 days from the end date of the Outbreak Period or one year from when the regular deadline would have applied to elect continuation coverage if your qualifying event occurred during the Outbreak Period. The Outbreak Period is defined as the period from March 1, 2020, until sixty (60) days after the announced end of the National Emergency that was declared on March 1, 2020 regarding the COVID-19 pandemic. The announced end of the National Emergency took effect in May 2023.

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 he or 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 correspondence from the Social Security Administration substantiating the disability/loss of disability and the effective date of the applicable SSA determination. Furthermore, during the period after the 18th month through the 29th month of continuation coverage, the monthly premium cost will be increased to 150% of the applicable premium relating to continuation coverage.

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.

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary must pay the entire cost of continuation coverage. The amount a qualified beneficiary must pay may not exceed 102% (or, in the case of an extension of continuation coverage due to disability, 150%) of the cost to the Plan (including both

employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage.

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 not 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 not 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 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.

Under joint Agency guidance issued in response to the COVID-19 pandemic, you were allowed the earlier of 60 days from the end date of the Outbreak Period or one year from when the deadline would have normally applied to elect continuation coverage if your qualifying event occurred during the Outbreak Period. The Outbreak Period is defined as the period from March 1, 2020, until sixty (60) days after the announced end of the National Emergency that was declared on March 1, 2020 regarding the COVID-19 pandemic. The announced end of the National Emergency took effect in May 2023.

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 preexisting 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 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 condition clauses, the Plan Sponsor may terminate your COBRA coverage.

You do not have to show that you are insurable to choose continuation coverage. However, as discussed above, you will have to pay all the required premiums for your continuation coverage.

The law also says that, at the end of the 18-month, 29-month, or 36-month continuation coverage period, you must be allowed to enroll in an individual conversion health plan if such an individual conversion health plan is otherwise generally available under the Plan.

COBRA continuation coverage may be terminated for any reason if the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

If You Have Questions

More complete information regarding your COBRA continuation coverage rights is available from the Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website.)

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.

COBRA Administrator:
P&A Group Dept.
#652
P.O. Box 8000
Buffalo, NY 14267-8000
1-800-688-2611

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.

Under joint Agency guidance issued in response to the COVID-19 pandemic, you were allowed the earlier of 60 days from the end date of the Outbreak Period or one year from when the regular deadline would have applied to elect continuation coverage if your qualifying event occurred during the Outbreak Period. The Outbreak Period is defined as the period from March 1, 2020, until sixty (60) days after the announced end of the National Emergency that was declared on March 1, 2020 regarding the COVID-19 pandemic. The announced end of the National Emergency took effect in May 2023.

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 is covered under a Medicaid plan under Title XIX of the Social Security Act or under a State child health plan ("CHIP") under Title XXI of such Act and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the group health plan (or health insurance coverage) not later than 60 days after the date of termination of such coverage.
- (ii) 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.

Under joint Agency guidance issued in response to the COVID-19 pandemic, you were allowed the earlier of 60 days from the end date of the Outbreak Period or one year from when the regular deadline would have applied to elect continuation coverage if your qualifying event occurred during the Outbreak Period. The Outbreak Period is defined as the period from March 1, 2020, until sixty (60) days after the announced end of the National Emergency that was declared on March 1, 2020 regarding the COVID-19 pandemic. The announced end of the National Emergency took effect in May 2023.

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).

Your Rights Under Women's Health and Cancer Rights Act of 1998 (WHCRA)

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.

Administrative Information

Sponsor for This Plan

This plan is sponsored by the employer, Boston University, Boston, Massachusetts, which is also the Plan Administrator. Eligibility for the benefit plan described in this handbook applies to those University employees on the US payroll.

Boston University's Employer Identification Number

For identification purposes, the Internal Revenue Service has assigned number 04-2103547 to Boston University. You will need to know this number if you write to a government agency about any of the plans.

Type of Plan, Plan Number, and Plan Year

In addition to the University's Employer Identification Number, you need to know the following information:

- **Type of Plan:** The Health Plan is characterized by the federal government as a Welfare Plan.
- **Plan Number:** Boston University has assigned Plan Number 502 to The Health Plan.
- **Plan Year:** The financial records of this plan are kept on a Plan Year basis. The Plan Year for The Health Plan is January 1 to December 31.

Administrator for This Plan

The day-to-day administration of this plan is handled by Human Resources. However, if you have a question or a problem that cannot be resolved by Human Resources, you should contact the Plan Administrator.

The Plan Administrator can be reached by contacting:

Plan Administrator
The Trustees of Boston University
25 Buick Street Boston, MA 02215
Phone: 617-353-4489

Funding and Administration of the Plan

Boston University pays the entire cost of many of the benefit plans described in this handbook. In some cases, you and the University share the cost. In others, you pay the entire cost.

Following is an explanation of how this plan is funded and who is responsible for paying benefits:

Contributions to the Health Plan are used by the following providers, who are responsible for processing claims for benefits. The addresses and telephone numbers of these processors are:

Blue Cross Blue Shield of Massachusetts
101 Huntington Avenue
Boston, MA 02199
Phone: 1-800-814-4371

OptumRxc/o Appeals Coordinator
P.O. Box 2975 Mission, KS 66201
Phone: 1-888-403-3398
Fax: 1-877-239-4565

Agent of Legal Service

The agent for the service of legal

process for this plan is:

University Counsel
125 Bay State Road
Boston, MA 02215

Legal process may be served on the
Plan Administrator.

Fraudulent Claims

Submission of a claim for benefits under any of the plans described in this handbook includes a representation that the claim is bona fide and, to the best knowledge of the employee, dependent, or other claimant, proper for payment. Submission of a fraudulent or knowingly false claim by an employee or an employee's dependent participating in a plan will be grounds for disciplinary action against the employee, including termination of participation by the employee and/or covered dependent(s) under the plan.

Claims for Benefits/Appealing a Denial of Claims for Benefits

When you apply for benefits, there are time periods within which you must receive a decision on your claim for benefits. If you or your beneficiary applies for benefits and either part or all of the request is denied, you have the right to appeal that decision, provided the appeal is made in accordance with the provisions of the plan and applicable laws (e.g., appeals must be filed within required time periods). Appeals are generally decided by the provider of the benefit involved, which is the insurance carrier, claims administrator, or vendor for most benefits, or the University or its Plan

Administration Committee for some benefits.

Appeals to Insurance
Carriers/Claims
Administrators/Other
Vendors

Appeals regarding benefits or other issues affecting plan participants or other persons for The Health Plan should be made to the applicable provider under the Plan.

Details of claims and appeal procedures may vary, but generally the following procedures apply:

- If a claim for benefits is either wholly or partially denied, you will be notified in writing. The notice will state the reasons why the claim was denied and the deadline for requesting review, which is different for different types of plans and/or claims.
- If you wish to appeal, you are entitled to review all documents pertaining to your claim free of charge and may also submit comments pertaining to your claim.
- Your appeal of the denial should be addressed to the applicable provider as directed in the denial of benefits notice.
- The applicable provider will decide the claims and appeals in the time and manner required by law.
- Unless a different time period applies, claims will be decided within 90 days (180 days if special circumstances apply) and appeals for denied claims must be filed within 60 days of denial. A decision must be made within 60 days (or 120 days if special circumstances are present and you are notified).

Appeals may be submitted to the following providers:

Blue Cross Blue Shield
Member Grievance Program
Blue Cross Blue Shield of
Massachusetts
One Enterprise Drive
Quincy, MA 02171-2126
1-800-814-4371

OptumRx
P.O. Box 509075
San Diego, CA 92150-9075
1-888-863-8578

Documents and Laws Governing This Plan

The plan description contained in this handbook was written from the documents that legally govern how the plan works.

In the event of any discrepancy between the plan description in this handbook and the controlling contracts or plan documents, the language in the controlling contracts or plan documents will govern. If you would like a copy of any of these documents, please contact Human Resources.

The plan is also regulated by applicable provisions of applicable laws, which will govern in the event of any conflict between the law and the terms of the plan as described in either the documents or in the summary plan description.

Equal Opportunity/Affirmative Action Policy

Since its founding in 1869, Boston University has been dedicated to equal opportunity and has opened its doors to students without regard to race, sex, creed, or other irrelevant criteria. Consistent with this tradition, it is the policy of Boston

University to promote equal opportunity in educational programs and employment through practices designed to extend opportunities to all individuals on the basis of individual merit and qualifications, and to help ensure the full realization of equal opportunity for students, employees, and applicants for admission and employment. The University is committed to maintaining an environment that is welcoming and respectful to all.

Boston University prohibits discrimination against any individual on the basis of race, color, religion, sex, age, national origin, physical or mental disability, sexual orientation, genetic information, military service, or because of marital, parental, or veteran status. This policy extends to all rights, privileges, programs, and activities, including admissions, financial assistance, educational and athletic programs, housing, employment, compensation, employee benefits, and the providing of, or access to, University services or facilities. Boston University recognizes that that equal opportunity is a reality. Accordingly, the University will continue to take affirmative action to achieve equal opportunity through recruitment, outreach, and internal reviews of policies and practices.

The coordination and implementation of this policy is the responsibility of the Director of Equal Opportunity. The officers of the University and all deans, directors, department heads, and managers are responsible for the proper implementation of equal opportunity and affirmative action in their respective areas, and they

are expected to exercise leadership toward their achievement. It is expected that every employee of Boston University will share this commitment and cooperate fully in helping the University meet its equal opportunity and affirmative action objectives.

Boston University has developed detailed procedures, described in its *Complaint Procedures in Cases of Alleged Unlawful Discrimination or Harassment* (www.bu.edu/eeo/policies-procedures/complaint), by which individuals may bring forward concerns or complaints of discrimination and harassment. Retaliation against any individual who brings forward such a complaint or who cooperates or assists with an investigation of such a complaint is both unlawful and strictly prohibited by Boston University.

Inquiries regarding this policy or its application should be addressed to the Director of Equal Opportunity, Equal Opportunity Office, 888 Commonwealth Avenue, Suite 303, Boston, MA 02215, or call 617-358-1796.

Amendment or Termination of the Plan

Boston University intends to continue maintaining the plan described in this handbook for the exclusive benefit of its employees.

However, the University reserves the right to change or discontinue it, and to implement changes as required by federal, state, or local laws.

You will be informed of any material changes that are made to the plans. If a plan is terminated, your rights, on the date of the termination,

would be governed by the provisions of the plan document.

Your Rights Under ERISA

The Health Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides the participants in this plan with certain rights and protections. The following statement is included here so that you will be aware of your rights under the law.

Under ERISA:

- You may examine, without charge, at Human Resources and at other specified locations, during normal business hours, all plan documents relating to the plan in which you participate. The documents that must be available for your review include insurance contracts, plan and trust documents, collective bargaining agreements, and all documents filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration, for example, detailed annual reports.
- If you wish, you may request your own copies of these plan documents by writing to Human Resources. Where permitted by law, you may have to pay a reasonable charge to cover the costs of copying.
- You will receive summaries of the plan's annual financial report each year, free of charge.

The administrator for the plan is required by law to furnish each participant with a copy of these summary annual reports.

- You have a right to receive a copy of any material change to a plan within 210 days of the plan year in which the change is adopted, unless earlier notice is required by law.

Continue Health Coverage

You may continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Health Plan as a result of a qualifying event. You or your dependents will have to pay for such coverage. Review this handbook and the documents governing the Health Plan on the rules governing your COBRA continuation coverage rights.

You may reduce or eliminate exclusionary periods of coverage for pre-existing conditions under the Health Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Health Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Plan Fiduciaries

Besides giving you certain rights as a participant, ERISA places certain duties upon the people who are responsible for the management of the above-mentioned plans. These people are called “fiduciaries” under the law, and they have the duty to act prudently and in your best interests.

Under ERISA, no one may fire you or discriminate against you to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Enforcing Your Rights

If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to obtain copies, without charge, of documents relating to the decision, and to appeal any denial all within certain time schedules.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 for each day’s delay until you receive the materials, unless the materials were not sent for reasons beyond the administrator’s control. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with a plan’s decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse plan money, or if you are discriminated

against for asserting your rights, you may seek assistance from the U.S. Department of Labor or file suit in a federal court.

In a lawsuit, the court normally decides who pays the court costs and legal fees. If you are successful, the other party might have to pay. But, if you lose, the court might order you to pay these costs and fees, especially if the court finds your claim to be frivolous.

Assistance with Questions

If you have any questions about this statement of your rights under ERISA, contact Human Resources. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

A Final Note

This handbook presents a summary of Boston University’s benefits for faculty and staff. It is designed as a quick reference source and is not intended to cover every point of policy. In certain instances, the

University may exercise discretion, with respect to the administration of the plans described in this handbook. For more in-depth information, contact Human Resources.

Periodically, the University may make changes in policy that may

not be reflected immediately in this handbook.

Again, for complete and up-to-date information about any policy or benefit, you should contact Human Resources.

Please note: The policies described

in this handbook are not intended to create an employment contract between Boston University and its employees. Therefore, they do not alter the University's rights regarding discharges and layoffs.

Health Plan Comparison

PPO PLAN			BU Health Savings Plan	
BCBS National PPO Network		Out-of-Network Providers		
BMC Providers	All Other Network Providers		In-Network	Out-of-Network
Acupuncture				
\$15 copayment per visit (deductible does not apply); 12 visits per calendar year	\$35 copayment per visit (deductible does not apply); 12 visits per calendar year	30% coinsurance (after deductible); 12 visits per calendar year	12% coinsurance after deductible; 12 visits per calendar year	30% coinsurance after deductible; 12 visits per calendar year
Applied Behavior Analysis*				
\$15 copayment per visit (deductible does not apply)	\$35 copayment per visit (deductible does not apply)	30% coinsurance after deductible	Not covered	Not covered
Chiropractic Care				
\$15 copayment per visit (deductible does not apply); 20 visits per calendar year	\$35 copayment per visit (deductible does not apply); 20 visits per calendar year	30% coinsurance after deductible; 20 visits per calendar year	12% coinsurance after deductible; 20 visits per calendar year	30% coinsurance after deductible; 20 visits per calendar year
Drug and Alcohol Treatment				
Inpatient No charge after deductible Outpatient No charge after deductible Office Visits \$15 copayment per visit (deductible does not apply)	Inpatient Low Cost Provider: No charge after deductible High Cost Provider: 20% coinsurance after deductible Outpatient Low Cost Provider: No charge after deductible High Cost Provider: 20% coinsurance after deductible Office Visits \$35 copayment per visit (deductible does not apply)	Inpatient 30% coinsurance after deductible Outpatient 30% coinsurance after deductible Office Visits 30% coinsurance after deductible	Inpatient 12% coinsurance after deductible Outpatient 12% coinsurance after deductible Office Visits 12% coinsurance after deductible	Inpatient 30% coinsurance after deductible Outpatient 30% coinsurance after deductible Office Visits 30% coinsurance after deductible
Durable Medical Equipment				
10% coinsurance after deductible	12% coinsurance after deductible	30% coinsurance after deductible	12% coinsurance after deductible	30% coinsurance after deductible
Emergency Room				
\$150 copayment per visit (deductible does not apply); copayment waived if held for observation or admitted within 24 hours	\$150 copayment per visit (deductible does not apply); copayment waived if held for observation or admitted within 24 hours	\$150 copayment per visit (deductible does not apply); copayment waived if held for observation or admitted within 24 hours	12% coinsurance after deductible	12% coinsurance after deductible
Family Planning				
\$15 copayment per visit (deductible does not apply)	\$35 copayment per visit (deductible does not apply)	30% coinsurance after deductible	12% coinsurance after deductible	30% coinsurance after deductible
Hospital Benefits				
General Hospital No charge after deductible Skilled Nursing Facility 10% coinsurance after deductible; 100-day benefit limit per member per calendar year	General Hospital Low Cost Provider: 12% coinsurance after deductible; High Cost Provider: 20% coinsurance after deductible Skilled Nursing Facility 12% coinsurance after deductible; 100-day benefit limit per member per calendar year	General Hospital 30% coinsurance after deductible Skilled Nursing Facility 30% coinsurance after deductible; 100-day benefit limit per member per calendar year	General Hospital 12% coinsurance after deductible Skilled Nursing Facility 12% coinsurance after deductible; 100-day benefit limit per member per calendar year	General Hospital 30% coinsurance after deductible Skilled Nursing Facility 30% coinsurance after deductible; 100-day benefit limit per member per calendar year

*Covered for children from their third birthday if they have been diagnosed with an Autism Spectrum Disorder.

Health Plan Comparison (continued)

PPO PLAN			BU Health Savings Plan	
BCBS National PPO Network		Out-of-Network Providers		
BMC Providers	All Other Network Providers		In-Network	Out-of-Network
Mental Health Benefits				
Inpatient No charge after deductible Outpatient No charge after deductible Office Visits \$15 copayment per visit (deductible does not apply)	Inpatient Low Cost Provider: No charge after deductible High Cost Provider: 20% coinsurance after deductible Outpatient Low Cost Provider: No charge after deductible High Cost Provider: 20% coinsurance after deductible Office Visits \$35 copayment per visit (deductible does not apply)	Inpatient 30% coinsurance after deductible Outpatient 30% coinsurance after deductible Office Visits 30% coinsurance after deductible	Inpatient 12% coinsurance after deductible Outpatient 12% coinsurance after deductible Office Visits 12% coinsurance after deductible	Inpatient 30% coinsurance after deductible Outpatient 30% coinsurance after deductible Office Visits 30% coinsurance after deductible
MRIs, CT Scans, Nuclear Cardiac Imaging & Lab Tests				
No charge after deductible	Low Cost Provider: 12% coinsurance after deductible; High Cost Provider: 20% coinsurance after deductible	30% coinsurance after deductible	12% coinsurance after deductible	30% coinsurance after deductible
Physical Therapy				
\$15 copayment per visit (deductible does not apply); copayment waived for physical therapy furnished by BU Physical Therapy Center; up to 60 visits per calendar year	\$35 copayment per visit (deductible does not apply); copayment waived for physical therapy furnished by BU Physical Therapy Center; up to 60 visits per calendar year	30% coinsurance after deductible; up to 60 visits per calendar year	12% coinsurance after deductible; up to 60 visits per calendar year	30% coinsurance after deductible; up to 60 visits per calendar year
Physicians' Services				
\$15 copayment per visit (deductible does not apply)	\$35 copayment per visit (deductible does not apply)	30% coinsurance after deductible	12% coinsurance after deductible	30% coinsurance after deductible
Preventive Care and Preventative Mental Health Exams				
You pay nothing			You pay nothing	
Preventive Eye Exams				
You pay nothing			You pay nothing	
Telehealth				
You pay nothing			You pay nothing	
Deductible Per Calendar Year (single/family)				
\$500 per member/\$1,000 per family		\$1,000 per member/\$2,000per family	\$2,000employee only4,000 per family	\$4,000 employee only/\$8,000per family
Out-of-Pocket Maximum				
\$3,000per member/\$6,000per family		\$6,000per member/\$12,000per family	\$4,000 employee only/\$8,000 per family	\$8,000 employee only/\$16,000 per family

Health Plan Comparison (continued)

PPO PLAN			BU Health Savings Plan	
BCBS National PPO Network		Out-of-Network Providers		
BMC Providers	All Other Network Providers		In-Network	Out-of-Network
Lifetime Maximum				
None			None	
Provider Choice				
You must use a BMC network participating provider	You must use a BCBS National PPO network participating provider	You may use the provider of your choice	You must use a BCBS National PPO network participating provider	You may use the provider of your choice
Copayment				
\$15 copayment per visit for most covered services	\$35 copayment per visit for most covered services	Depending on the service, generally 30% coinsurance after deductible	Depending on the service, generally 12% coinsurance after deductible	Depending on the service, generally 30% coinsurance after deductible
Benefit Level				
You pay nothing for inpatient services after deductible is met; \$30 copayment per visit for some services	You pay 12% coinsurance for inpatient services at a low cost provider and 20% coinsurance at a high cost provider after deductible is met; \$30 copayment per visit for some services	30% coinsurance for most covered inpatient and outpatient services after deductible is met	12% coinsurance for most covered inpatient and outpatient services after deductible is met	30% coinsurance for most covered inpatient and outpatient services after deductible is met
Claim Forms				
Not Required		Required	Not Required	Required
Prescription Drugs				
Retail Pharmacy for 30-Day Supply Generic Medications \$10 copayment Preferred Brand Name 20% coinsurance (minimum cost \$45; maximum cost \$65 /prescription Non-preferred Brand Name 30% coinsurance (minimum cost \$65; maximum cost \$85 /prescription Home Delivery or CVS Retail for 90-Day Supply Generic Medications \$20 copayment Preferred Brand Name 20% coinsurance (minimum cost \$85; maximum cost \$130 /prescription Non-preferred Brand Name 30% coinsurance (minimum cost \$130; maximum cost \$170 /prescription		Not covered	12% coinsurance after deductible	Not covered



DENTAL HEALTH PLAN



ou and your eligible family members have the opportunity to enroll in the Boston University Dental Health Plan. You and the University share the cost of your coverage under the Dental Health Plan. The Dental Health Plan is designed to provide you with high-quality care at an affordable price.

There are two different plans from which to choose:

(1) The BU Dental Health Center Plan or (2) The Dental Blue Freedom Plan.

Eligibility

If you are classified by 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 Dental Health Plan starting on the first day of the month coincident with or following your first day of work.

Your eligible family members include:

- Your legally married spouse
- Your children under age 26
- Your unmarried, dependent children age 26 and older who are mentally or physically handicapped

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

Coverage Levels

There are four levels of coverage available under the Dental 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)

Dependent Eligibility Documentation Required

For all eligible dependents whom you wish to cover under the BU plan, you must provide the following documents:

- Spouse: Marriage certificate (government issued)

- Common Law Spouse: Common law marriage certificate (only for those married in a state that accepts common law marriage)
- Child: Birth certificate or adoption certificate or certificate of live birth
- Stepchild: Birth certificate of child plus marriage certificate of current spouse (stepchild is eligible only if one of their birth parents is also covered as a spouse on the family coverage)
- Ward: Court ordered document of legal custody

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 neither you nor your former spouse remarries.

If you or your former spouse remarries, 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 or separation.

Special Tax Considerations

Under current tax laws, the value of your former spouse's dental 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 contribution plus employer contribution) and are called imputed income. Imputed income for your former spouse's dental 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

Participation in the Boston University Dental Health Plan is voluntary. To elect this coverage, new employees must go to Employee Self Service at www.bu.edu/buworkscentral. This process will also authorize a payroll deduction to pay for your share of the cost.

If you choose a coverage level 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, an adopted child or a new spouse), please notify Human Resources at hr@bu.edu for details on making a change to your benefits.

When Coverage Starts

You have 30 days following your benefit orientation date to enroll. If you enroll, coverage will become effective on the first day of the month coincident with or following your first day of work. If you do not enroll during this period, your next opportunity to enroll will be during the next open enrollment period.

Cost

You and the University share the cost of your coverage under the Dental 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 charge the percentage of the of the cost that it will pay.

How Dental Health Plan Contributions Are Paid

You pay for your portion of the contributions for your Dental 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” handbook.

Changing or Stopping Coverage

Because you pay for your coverage with before-tax dollars, the provisions of Section 125 of the Internal Revenue Code also govern how and when you may make changes in your Dental Health Plan coverage. Under the current provisions of Section 125, you may

- Change the level of your coverage (that is, move from individual to family coverage or vice versa), or
- Cancel your coverage once each year, during the annual open enrollment period.

The only other time you may make a change in your Dental Health Plan coverage is if you have an IRS-approved Qualifying Life Event in your family or employment status. Qualified Changes are explained in the “Flexible Benefits Program and Flexible Spending Accounts” handbook.

About the Boston University Dental Health Centers

There are two Boston University Dental Health Centers. Both provide a comprehensive range of dental services, such as X-rays, cleanings, fillings, and crowns.

You will be examined by a licensed staff dentist when you receive your care at one of the Dental Health Centers. Preventive services such as cleanings and X-rays will be provided by licensed dental hygienists.

If you require any specialty services such as orthodontics (braces), oral surgery (extractions), endodontics (root canals), or periodontics (gum surgery),

both centers can refer you to the appropriate licensed specialist and/or postdoctoral resident found within either Center.

Your care will be monitored by your staff dentist at one of the Dental Health Centers. The standard fees-for-service provided through the Dental Health Centers are already far below those charged by most private practices. Therefore, the Dental Health Centers offer you and your family members a unique opportunity to obtain quality dental care at a reasonable price.

The Boston University Dental Health Centers are conveniently located at:

- 930 Commonwealth Avenue near the Charles River Campus Phone: 617-358-1000
- 635 Albany Street at the Boston University Medical Center Phone: 617-358-8300

The BU Dental Health Center Plan

How the Plan Works

If you join this plan, you must receive your dental treatment from one of the BU Dental Health Centers located at 930 Commonwealth Avenue and 100 East Newton Street. There is no coverage for care received outside of the Centers (except for emergency dental treatment at a participating BCBS Dental Blue provider).

Covered Services

The Boston University Dental Health Center Plan covers services listed on the following chart.

Here are two special features of the plan that you should remember:

- There are no deductibles for covered services.
- You do not have to complete claim forms for services provided at the Dental Health Centers.

Boston University Dental Health Center Plan Covered Services

Type of Service	Boston University Dental Health Center Dentists*
Preventive & Diagnostic	100%
Basic Restorative	100%
Major Restorative	60%
Orthodontia	50%
Annual Maximum Benefit**	\$1,700 per person, per year
Orthodontia Lifetime Maximum Benefit	\$2,000 per person, lifetime
<i>*The percentage of the cost of a covered service that is paid by the plan is based on the standard fee schedule established by the Boston University Dental Health Centers. You may obtain a copy of the standard fee schedule by contacting Human Resource at HR@bu.edu or online at www.bu.edu/hr/documents/BN_enrollment_form.pdf.</i>	
<i>**Maximum applies to claims paid for any BCBS dental plan in the same calendar year.</i>	

Preventive and Diagnostic

Diagnostic Services

- One complete initial oral exam, including initial dental history and charting of the teeth and supporting structures
- Single-tooth X-rays as needed
- Bitewing X-rays of the crowns of the teeth (twice per calendar year)
- Full-mouth X-rays (seven or more films, or panoramic X-ray with bitewing X-rays; once each 60 months)
- Study models and casts used in planning treatment (once each 60 months)
- Emergency exams
- Periodic or routine oral exams (twice per calendar year)

Preventive Services

- Routine cleaning, scaling, and polishing of the teeth (twice per calendar year)
- Fluoride treatment for members under age 19 (twice per calendar year)
- Space maintainers required due to premature loss of teeth for members under age 19
- Sealants applied to permanent

premolar and molar surfaces for members under age 14 (one application each 48 months for each premolar or molar surface)

Basic Restorative Services

- Amalgam (silver) fillings (limited to one filling for each tooth surface in each 12 months). No benefits are provided for fillings on tooth surfaces where a sealant was applied within the last 12 months.
- Composite resin (tooth color) fillings on front teeth (limited to one filling for each tooth surface in each 12 months). These benefits include single-surface composite resin fillings on back teeth.
- Pin retention for fillings
- Stainless steel crowns on primary (baby) teeth
- Stainless steel crowns on first permanent (adult) molars for members under age 16

Prosthetic Maintenance

- Repair of partial or complete dentures, crowns, and bridges (once each 12 months)
- Adding teeth to an existing partial or complete denture
- Rebase or reline dentures (once each 36 months)
- Recementing of crowns, inlays, onlays, and fixed bridgework (once each 12 months)

Other Covered Services

- Occlusal adjustments (once each 24 months)
- Services to treat root sensitivity
- General anesthesia when administered in conjunction with covered surgical services
- Emergency dental treatment to relieve acute pain

Major Restorative Services

Oral Surgery

- Tooth extractions
- Root removal
- Biopsies

Periodontics (Gum and Bone)

- Periodontal scaling and root planting (once in each quadrant each 24 months)
- Periodontal surgery (soft and hard tissue surgeries; once in each quadrant each 36 months)
- Periodontal maintenance following active periodontal therapy (once each three months)

Endodontics (Root and Pulp)

- Root canal therapy on permanent teeth (once in a lifetime for each tooth)
- Retreatment root canal therapy on permanent teeth (once in a lifetime for each tooth)
- Therapeutic pulpotomy on primary or permanent teeth for members under age 16
- Other endodontic surgery intended to treat or remove the dental root

Prosthodontics (Tooth Replacement)

- Complete or partial dentures, including services to fabricate, measure, fit, and adjust them (once each 60 months for each arch)
- Fixed bridges, including services to fabricate, measure, fit, and adjust them (once each 60 months for each tooth) Replacement of dentures and bridges, but only when they are installed at least 60 months after the initial placement, and only if the existing appliance cannot be made serviceable

Temporary partial dentures to replace any of the six upper or lower front teeth, but only if they are installed immediately following the loss of teeth and during the

period of healing

Crowns, Inlays, and Onlays

- Crowns for members age 16 or older (once each 60 months for each tooth). **Note:** These benefits include single-tooth dental endosteal implants (the fixture and abutment portion) when the implant replaces permanent teeth through the second molars (once each 60 months for each tooth).
- Metallic, porcelain, and composite resin inlays for members age 16 or older
- Metallic, porcelain, and composite resin onlays for members age 16 or older (once each 60 months for each tooth)
- Replacement of crowns for members age 16 or older (once each 60 months for each tooth)
- Replacement of metallic, porcelain, and composite resin onlays (once each 60 months for each tooth)
- Replacement of metallic, porcelain, and composite resin onlays for members age 16 or older (once each 60 months for each tooth)
- Post and core or crown buildup for members age 16 or older (once each 60 months for each tooth)

Orthodontics

Orthodontic benefits, including braces and related services during treatment, are provided for adults and children when care is provided by a dental located at a Boston University Dental Health Center.

Emergency Care

The plan defines “emergency treatment” as treatment needed to immediately alleviate pain or infection or to treat an injury. Emergency treatment is covered as a basic restorative service, regardless of where it is provided. Emergency treatment does not include any final restorations (i.e., root canal, crowns, and dentures).

Non-Covered Dental Services

No benefits are provided by the Boston University Dental Health Center Plan for:

- Services, supplies, procedures, or appliances to treat an illness or injury for which you have the right to benefits under government programs. These include the Veterans Administration for an illness or injury connected to military service. They also include programs set up by other local, state, federal, or foreign laws or regulations that provide or pay for health care services and supplies or that require care or treatment to be furnished in a public facility. No benefits are provided if you could have received governmental benefits by applying for them on time. This exclusion does not include Medicaid or Medicare.
- Charges that are received for or related to dental care that Blue Cross Blue Shield considers to be experimental. The care must be documented by controlled studies that determine its merits (such as its safety) and include sufficient follow-up studies.
- Charges for appointments that you do not keep. Dentists may charge you for failing to keep your scheduled appointments. They may do so if you do not give reasonable notice to the office.
- Appointments that you do not keep are not counted against any benefit limits described in this BU Dental Health Plan benefit description.
- A service, supply, procedure, or appliance that is not described as a covered dental service in this BU Dental Health Center Plan benefit description
- Services, supplies, procedures, or appliances that do not conform to Blue Cross Blue Shield dental policy guidelines
- Any service or supply furnished along with, in preparation for, or as a result of a non-covered dental service
- Services, supplies, procedures, and appliances that are not considered necessary and appropriate by Blue Cross Blue Shield
- Services, supplies, procedures, and appliances that are furnished to someone other than the patient
- Treatment and related services that are required by third parties
- Free care or care for which you are not required to pay or for which you would not be required to pay if you were not covered under the BU Dental Health Center Plan
- Nutrition counseling or instructions in dental hygiene, including proper methods of tooth brushing, the use of dental floss, plaque control programs, and caries
- Incomplete procedures
- Laboratory or bacteriological tests
- Consultations when the dentist who renders the consultation provides treatment
- Restorations for reasons other than decay or fracture of teeth, such as erosion, abrasion, or attrition
- Sealants applied to permanent premolar or molar surfaces that have decay or fillings
- Fillings on tooth surfaces where a sealant was applied within the last 12 months
- Replacement of a filling within 12 months of the date of the prior restoration
- Stainless steel crowns on permanent (adult) teeth, other than on first permanent (adult) molars for members under age 16
- Fixed or removable prosthodontics or major restorative procedures for members under age 16 (The BU Dental Health Center Plan provides the benefit for a temporary partial denture for replacement of a lost or missing tooth. You pay any balance.)
- Temporary complete dentures or temporary fixed bridges
- Replacement of dentures, bridges, or space maintainers for reasons such as theft, abuse, misuse, misplacement, loss, improper fit, allergies, breakage, or ingestion
- Duplicate dentures or bridges
- Transplants or any related surgical or restorative procedures
- Any procedure to save a tooth when there is a poor statistical probability (less than a 70% chance) that the tooth will last for 60 months (for example, surgical periodontal regenerative procedures to stabilize a tooth loosened due to extensive periodontal disease)
- Cast restorations, copings, or attachments for installing overdentures, including associated endodontic procedures such as root canals
- Precision attachments, semi-precision attachments, or copings
- A service to diagnose or treat temporomandibular joint (TMJ) disorders or myofascial (muscular) pain, including bruxism (grinding of the teeth). This service is covered under the Blue Cross Blue Shield medical policies.
- A service, supply, or procedure when its sole purpose is to increase the height of teeth (vertical dimension) or to restore occlusion
- A separate charge for occlusal analysis, pulp vitality testing, or pulp capping since these services are usually performed as part of another covered procedure
- Drugs, pharmaceuticals, biologicals, or other prescription agents or products
- Photographs

- A dentist's charge to file a claim.
- Also, a dentist's charge to transcribe or copy your dental records
- Services and supplies furnished before your effective date, except for a multi-stage procedure that begins before your effective date and is completed while you are enrolled under the BU Dental Health Center Plan
- Services and supplies furnished after your termination date under the BU Dental Health Center Plan. (If your membership under the BU Dental Health Center Plan is terminated prior to the completion date of a procedure that requires more than one visit, no benefits are provided for the entire procedure.)

How to Obtain Benefits

To obtain benefits for services provided at the Boston University Dental Health Centers, simply show your Blue Cross Blue Shield membership card. You do not have to complete a claim form for services provided at the Dental Health Centers.

The Dental Blue Freedom Plan

How the Plan Works

This is a unique dental plan, designed especially for BU employees who may not be able to conveniently receive all their dental care services at the BU Dental Health Centers. It provides you three choices of

dental providers; you decide where to receive treatment each time you need dental care. You have access to providers at the BU Dental Health Centers; Blue Cross Blue Shield dental network providers; or you may choose your own provider. Plan benefits vary based on where you receive care.

Covered Services

The Dental Blue Freedom Plan covers services listed on the chart below.

Dental Blue Freedom Plan Covered Services				
Service	Coverage at Centers*	BCBS Dental Blue & PPO (in Massachusetts) Networks**	Dental Blue (National) Network**	Out-of-Network Provider***
Deductible	None	\$50 per person	\$50 per person	\$50 per person
Preventive & Diagnostic	100%	80%, no deductible	80%, no deductible	80%, no deductible
Basic Restorative	80%	60%, after deductible	60%, after deductible	60%, after deductible
Major Restorative	50%	40%, after deductible	40%, after deductible	40%, after deductible
Orthodontics	50%	Not covered	Not covered	Not covered
Annual Maximum Benefit ****	\$1,700 per person, per year			
Orthodontia Lifetime Maximum Benefit	\$2,000 per person, lifetime			
*Based on the BU Dental Health Center Table of Allowance **Based on lesser of either the dentist’s actual charge or the allowed charge. If your provider is in the Dental Blue PPO Network, your share of the cost of services may be less than if your provider is in only the Dental Blue Network. To determine which networks your provider participates in, review your provider’s profile on the Blue Cross Blue Shield website at www.bluecrossma.com/findadoctor. ***Based on the actual charge or the allowed charge, whichever is less. The allowed charge is based on a schedule of charges. You may be responsible for any difference between the dentist’s actual charge or the allowed charge, whichever is less. ****Maximum applies to claims paid for any BCBS dental plan in the same calendar year.				

Preventive and Diagnostic Diagnostic Services - One complete initial oral exam, including initial dental history and charting of the teeth and supporting structures - Single-tooth X-rays as needed - Bitewing X-rays of the crowns of the teeth (twice per calendar year) - Full-mouth X-rays (seven or more films, or panoramic X-ray with bitewing X-rays; once each 60 months) - Study models and casts used in planning treatment (once each 60 months) - Emergency exams - Periodic or routine oral exams (twice per calendar year) Preventive Services - Routine cleaning, scaling, and polishing of the teeth (twice per calendar year) - Fluoride treatment for members under age 19 (twice per calendar year) - Space maintainers required due to premature loss of teeth for members under age 19 - Sealants applied to permanent premolar and molar surfaces for members under age 14 (one application each 48 months for each premolar or molar surface) Basic Restorative Services - Amalgam (silver) fillings (limited to one filling for each tooth surface in each 12 months). No benefits are provided for fillings on tooth surfaces where a sealant was applied within the last 12 months - Composite resin (tooth color) fillings on front teeth (limited to one filling for each tooth surface in each 12 months). These benefits include single-surface composite	resin fillings on back teeth - Pin retention for fillings - Stainless steel crowns on primary (baby) teeth - Stainless steel crowns on first permanent (adult) molars for members under age 16 Prosthetic Maintenance - Repair of partial or complete dentures, crowns, and bridges (once each 12 months) - Adding teeth to an existing partial or complete denture - Rebase or reline dentures (once each 36 months) - Recementing of crowns, inlays, onlays, and fixed bridgework (once each 12 months) Other Covered Services - Occlusal adjustments (once each 24 months) - Services to treat root sensitivity - General anesthesia when administered in conjunction with covered surgical services - Emergency dental treatment to relieve acute pain Major Restorative Services Oral Surgery - Tooth extractions - Root removal - Biopsies Periodontics (Gum and Bone) - Periodontal scaling and root planing (once in each quadrant each 24 months) - Periodontal surgery (soft and hard tissue surgeries; once in each quadrant each 36 months) - Periodontal maintenance following active periodontal therapy (once each three months) Endodontics (Root and Pulp)	- Root canal therapy on permanent teeth (once in a lifetime for each tooth) - Retreatment root canal therapy on permanent teeth (once in a lifetime for each tooth) - Therapeutic pulpotomy on primary or permanent teeth for members under age 16 - Other endodontic surgery intended to treat or remove the dental root Prosthodontics (Tooth Replacement) - Complete or partial dentures, including services to fabricate, measure, fit, and adjust them (once each 60 months for each arch) - Fixed bridges, including services to fabricate, measure, fit, and adjust them (once each 60 months for each tooth) - Replacement of dentures and bridges, but only when they are installed at least 60 months after the initial placement, and only if the existing appliance cannot be made serviceable - Temporary partial dentures to replace any of the six upper or lower front teeth, but only if they are installed immediately following the loss of teeth and during the period of healing Crowns, Inlays, and Onlays - Crowns for members age 16 or older (once each 60 months for each tooth) Note: These benefits include single-tooth dental endosteal implants (the fixture and abutment portion) when the implant replaces permanent teeth through the second molars (once each 60 months for each tooth). - Metallic, porcelain, and composite resin inlays for members age 16 or older - Metallic, porcelain, and composite resin onlays for members age 16 or older (once each 60 months for each tooth)
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• Replacement of crowns for members age 16 or older (once each 60 months for each tooth) • Replacement of metallic, porcelain, and composite resin inlays (once each 60 months for each tooth) • Replacement of metallic, porcelain, and composite resin onlays for members age 16 or older (once each 60 months for each tooth) • Post and core or crown buildup for members age 16 or older (once each 60 months for each tooth)	benefits by applying for them on time. This exclusion does not include Medicaid or Medicare. • Charges that are received for or related to dental care that Blue Cross Blue Shield considers to be experimental. The care must be documented by controlled studies that determine its merits (such as its safety) and include sufficient follow-up studies. • Charges for appointments that you do not keep. Dentists may charge you for failing to keep your scheduled appointments. They may do so if you do not give reasonable notice to the office. Appointments that you do not keep are not counted against any benefit limits described in this Dental Blue Freedom Plan benefit description. • A service, supply, procedure, or appliance that is not described as a covered dental service in this Dental Blue Freedom Plan benefit description • Services, supplies, procedures, or appliances that do not conform to Blue Cross Blue Shield dental policy guidelines • Any service or supply furnished along with, in preparation for, or as a result of a non-covered dental service • Services, supplies, procedures, and appliances that are not considered necessary and appropriate by Blue Cross Blue Shield • Services, supplies, procedures, and appliances that are furnished to someone other than the patient • Treatment and related services that are required by third parties • Free care or care for which you are not required to pay or for which you would not be required to pay if you were not covered under the Dental Blue Freedom Plan • Nutrition counseling or instructions in dental hygiene, including proper methods of tooth brushing, the use of dental floss, plaque control programs, and caries (cavity) susceptibility tests	• Incomplete procedures • Laboratory or bacteriological tests • Consultations when the dentist who renders the consultation provides treatment • Restorations for reasons other than decay or fracture of teeth, such as erosion, abrasion, or attrition • Sealants applied to permanent premolar or molar surfaces that have decay or fillings • Fillings on tooth surfaces where a sealant was applied within the last 12 months • Replacement of a filling within 12 months of the date of the prior restoration • Stainless steel crowns on permanent (adult) teeth, other than on first permanent (adult) molars for members under age 16 • Fixed or removable prosthodontics or major restorative procedures for members under age 16. (The Dental Blue Freedom Plan provides the benefit for a temporary partial denture for replacement of a lost or missing tooth. You pay any balance.) • Temporary complete dentures or temporary fixed bridges • Replacement of dentures, bridges, or space maintainers for reasons such as theft, abuse, misuse, misplacement, loss, improper fit, allergies, breakage, or ingestion • Duplicate dentures or bridges • Transplants or any related surgical or restorative procedures • Any procedure to save a tooth when there is a poor statistical probability (less than a 70% chance) that the tooth will last for 60 months (for example, surgical periodontal regenerative procedures to stabilize a tooth loosened due to extensive periodontal disease)
Orthodontics Orthodontic benefits, including braces and related services during treatment, are provided for adults and children when care is provided by a dentist located at a Boston University Dental Health Center.		
Emergency Care The plan defines “emergency treatment” as treatment needed to immediately alleviate pain or infection or to treat an injury. Emergency treatment is covered as a basic restorative service, regardless of where it is provided. Emergency treatment does not include any final restorations (i.e., root canal, crowns, and dentures).		
Non-Covered Dental Services No benefits are provided by the Dental Blue Freedom Plan for: • Services, supplies, procedures, or appliances to treat an illness or injury for which you have the right to benefits under government programs. These include the Veterans Administration for an illness or injury connected to military service. They also include programs set up by other local, state, federal, or foreign laws or regulations that provide or pay for health care services and supplies or that require care or treatment to be furnished in a public facility. No benefits are provided if you could have received governmental		

- Cast restorations, copings, or attachments for installing over-dentures, including associated endodontic procedures such as root canals
- Precision attachments, semi-precision attachments, or copings
- A service to diagnose or treat temporomandibular joint (TMJ) disorders or myofascial (muscular) pain, including bruxism (grinding of the teeth). This service is covered under the Blue Cross Blue Shield medical policies.
- A service, supply, or procedure when its sole purpose is to increase the height of teeth (vertical dimension) or to restore occlusion
- A separate charge for occlusal analysis, pulp vitality testing, or pulp capping since these services are usually performed as part of another covered procedure
- Drugs, pharmaceuticals, biologicals, or other prescription agents or products
- Photographs
- A dentist's charge to file a claim. Also, a dentist's charge to transcribe or copy your dental records
- Services and supplies furnished before your effective date, except for a multi-stage procedure that begins before your effective date and is completed while you are enrolled under the Dental Blue Freedom Plan.
- Services and supplies furnished after your termination date under the Dental Blue Freedom Plan. (If your membership under the Dental Blue Freedom Plan is terminated prior to the completion date of a procedure that requires more than one visit, no benefits are provided for the entire procedure.)

Boston University Dental Health Centers

There are two Boston University Dental Health Centers. Both provide a comprehensive range of dental services, such as X-rays, cleanings, fillings, and crowns. Fees for dental services are found in your dental fee schedule.

Locations: 930 Commonwealth Avenue,
Phone: 617-358-1000

and 635 Albany Street,
Phone: 617-358-8300.

Key services include general dentistry, dental hygiene, orthodontics, pediatric dentistry, periodontics, implantology, prosthodontics, oral and maxillofacial surgery, and endodontics.

In-Network Dentists

BCBS Network

Dental Blue PPO dentists provide you with the greatest value.

If your provider is in the Dental Blue PPO Network, your share of the cost of services may be less than if your provider is in only the Dental Blue Network. To determine which networks your provider participates in, review your provider's profile on the Blue Cross Blue Shield website at www.bluecrossma.com/findadoctor.

How to Locate a Dentist on the Web

Go to the Blue Cross Blue Shield website at www.bluecrossma.com/findadoctor and look under "Dental Blue." If the dentist is in the BCBS Network, his or her name will be listed. You may also want to check to find out if the dentist is in the PPO Network. If he or she is, your coinsurance may be lower than for a dentist not in the PPO Network.

How Fees Are Set

This plan uses dentists in the Dental Blue Network.

You may use dentists in the Dental Blue or the Dental Blue PPO networks. All of these dentists are contracted with Blue Cross Blue Shield. If your dentist is in the PPO Network, your coinsurance may be lower than it would be for a dentist who is not in the PPO Network.

Out-of-Network Dentists

Benefits for covered services by a non-participating dentist outside of Massachusetts are provided based on usual and customary charges. The allowed charge is based on a schedule of charges established by BCBS. You may be responsible for any difference between the dentist's actual charge or the allowed charge, whichever is less. You are also responsible for your deductible and coinsurance (if applicable), and charges beyond your calendar-year maximum.

Out-of-network dentists do not have contracts with Blue Cross Blue Shield. Blue Cross Blue Shield will reimburse you the percentage listed on the chart of the usual and customary charges.

How to File a Claim

BU Dental Health Centers and BCBS Network Dentists

To obtain benefits for services provided at the BU Dental Health Centers or from a Blue Cross Blue Shield network dentist, show the dentist your Dental Blue Freedom identification card. The dentist will file the claim with Blue Cross Blue Shield. You do not have to file a claim form.

Out-of-Network Dentists

The following are procedures for obtaining benefits if your provider is not affiliated with a Boston University Dental Health Center and is not in the Blue Cross Blue Shield network:

1. Obtain a claim form from Human Resources or from the website at www.bu.edu/hr/forms-

documents.

2. Pay your dentist for services.

Submit your claim form with original itemized bills within two years of the date you received the covered dental service to:

Blue Cross Blue Shield of
Massachusetts
P.O. Box 986030
Boston, MA 02298

Blue Cross Blue Shield will review your claim, then reimburse you for the claim to the extent of your benefits described in this handbook.

Appealing a Denial for Either Dental Health Plan

How to Request a Formal Grievance Review

To request a formal review from Blue Cross Blue Shield's Grievance Program, you (or your authorized representative) have three options.

The preferred option is for you to send your grievance in writing to:

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

Blue Cross Blue Shield will let you know that your request was received by sending you a written confirmation within 15 calendar days.

Or, you may email your grievance to Blue Cross Blue Shield's Grievance Program email address at grievances@bcbsma.com. Blue Cross Blue Shield will let you know that your request was received by sending you a confirmation immediately by email.

Or, you may call Blue Cross Blue Shield's Grievance Program at 1-800-462-5601 (extension 63605). When your request is made by telephone, Blue Cross Blue Shield will send you a written account of the grievance within 48 hours of your phone call.

Once your request is received, Blue Cross Blue Shield will research the case in detail, ask for more information as needed, and let you know in writing of the decision or the outcome of the review. If your grievance is regarding termination of coverage for concurrent services that were previously approved by Blue Cross Blue Shield, the disputed coverage will continue until this grievance review process is completed. This continuation of coverage does not apply to services that are limited by dollar or visit maximums and that exceed those maximums, non-covered services, or services that were received prior to the time that you requested a formal grievance review, or when a grievance is not received on a timely basis, based on the course of treatment.

All grievances must be received by Blue Cross Blue Shield within one year of the date of treatment, event, or circumstance, such as the date you were told of the service denial or claim denial.

What to Include in a Grievance Review Request

Your request for a formal grievance review should include: the name and identification number of the member asking for the review; a description of the problem; all relevant dates; names of health care providers or administrative staff involved; and details of the attempt that has been made to resolve the problem. If Blue Cross Blue Shield needs to review the medical/dental records and treatment information that relate to your grievance, Blue Cross Blue Shield will promptly send you an authorization form to sign if needed. You must return this signed form to Blue Cross Blue Shield. It will allow for the release of your medical/dental records. You also have the right to look at and get copies (free of charge) of records and criteria that Blue Cross Blue Shield has and that are relevant to your grievance, including the identity of any experts

who were consulted.

Authorized Representative

You may choose to have another person act on your behalf during the grievance review process. You must designate this person in writing to Blue Cross Blue Shield. Or, if you are not able to do this, a person such as a conservator, a person with power of attorney, or a family member may be your authorized representative. Or, he or she may appoint another party to be the authorized representative. (When you are an inpatient, a health care provider may act as your authorized representative to ask for an expedited grievance review. You do not have to designate the health care provider in writing.)

Who Handles the Grievance Review

All grievances are reviewed by individuals who are knowledgeable about Blue Cross Blue Shield and the issues involved in the grievance. The individuals who will review your grievance will be those who did not participate in any of Blue Cross Blue Shield's prior decisions regarding the subject of your grievance, nor do they work for anyone who did. When a grievance is related to a necessity and appropriateness denial, at least one grievance reviewer is an individual who is an actively practicing health care professional in the same or similar specialty that usually treats the medical/dental condition, performs the procedure, or provides treatment that is the subject of your grievance.

Response Time

The review and response for Blue Cross Blue Shield's formal grievance review will be completed within 30 calendar days. Every reasonable effort will be made to speed up the review of grievances that involve health care services that are soon to be obtained by the member. (When the grievance

review is for services you have already obtained and it requires a review of your medical/ dental records, the 30-day response time will not include the days from when Blue Cross Blue Shield sends you the authorization form to sign until it receives your signed authorization form if needed. If Blue Cross Blue Shield does not receive your authorization within 30 calendar days after you are asked for it, Blue Cross Blue Shield may make a final decision about your grievance without that medical/dental information.)

Note: If your grievance review began after an inquiry, the 30-day response time will begin on the day you tell Blue Cross Blue Shield that you disagree with Blue Cross Blue Shield's answer and would like a formal grievance review.

Blue Cross Blue Shield may extend the time frame to complete a grievance review, with your permission, in cases when Blue Cross Blue Shield and the member agree that additional time is required to fully investigate and respond to the grievance. A grievance that is not acted upon within the specified time frames will be considered resolved in favor of the member.

Written Response

Once the grievance review is completed, Blue Cross Blue Shield will let you know in writing of the decision or the outcome of the review. If Blue Cross Blue Shield continues to deny coverage for all or part of a health care service or supply, Blue Cross Blue Shield's response will explain the reasons. It will give you the specific medical and scientific reasons for the denial and a description of alternative treatment, health care services, and supplies that would be covered.

Grievance Records

Blue Cross Blue Shield will maintain a record of all formal grievances, including the response for each

grievance review, for up to seven years.

Expedited Review for Immediate or Urgently Needed Services

In place of the formal grievance review described above, you have the right to request an "expedited" review right away when your situation is for immediate or urgently needed services. Blue Cross Blue Shield will review and respond to grievances for immediate or urgently needed services as follows:

When your grievance review concerns medical care or treatment for which waiting for a response under the grievance review time frames described above would seriously jeopardize your life or health or your ability to regain maximum function as determined by Blue Cross Blue Shield or your physician, or if your physician says that you will have severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance review, Blue Cross Blue Shield will review your grievance and notify you of the decision within 72 hours after your request is received.

When a grievance review is requested while the member is an inpatient, Blue Cross Blue Shield will complete the review and make a decision regarding the request before the patient is discharged from that inpatient stay. Coverage for those services in dispute will continue until this review is completed.

A decision to deny payment for health care services may be reversed within 48 hours if the member's attending physician certifies that a denial for those health care services would create a substantial risk of serious harm to the member if the member were to wait for the outcome of the normal grievance process.

A grievance review requested by a member with a terminal illness will be completed within five working days of receiving the request. In this

case, if the expedited review results in a denial for health care services or treatment, Blue Cross Blue Shield will send a letter to the member within five working days that explains the specific medical and scientific reasons for the denial and a description of alternative treatment, health care services, and supplies that would be covered and information about requesting a hearing. When the member requests a hearing, the hearing will be held within ten days (or within five working days if the attending physician determines after consultation with Blue Cross Blue Shield's Medical Director and based on standard medical practice that the effectiveness of the health care service, supply, or treatment would be materially reduced if it were not furnished at the earliest possible date). You and/ or your authorized representative(s) may attend this hearing.

Appeals Process for Rhode Island Residents or Services

You may also have the right to appeal as described in this section when a claim is denied as being not necessary and appropriate. If so, these rights are in addition to the other rights to appeal that you have as described in other parts of this handbook. The following provisions apply only to:

A member who lives in Rhode Island and is planning to obtain services that Blue Cross Blue Shield has determined are not necessary and appropriate.

A member who lives outside Rhode Island and is planning to obtain services in Rhode Island that Blue Cross Blue Shield has determined are not necessary and appropriate.

Blue Cross Blue Shield decides which covered services are necessary and appropriate for your dental condition based on a review of your dental records and generally accepted dental

practice. Some of the covered services described in this handbook may not be necessary and appropriate for you. If Blue Cross Blue Shield has determined that services are not necessary and appropriate for you, you have the right to the following appeals process.

Reconsideration

Reconsideration is the first step in this appeals process. If you receive a letter denying payment for your dental services, you may request in writing that Blue Cross Blue Shield reconsider its decision by contacting:

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

You must submit your reconsideration request within 180 days of the adverse decision. Along with your letter, you should include any information that supports your request. Blue Cross Blue Shield will review your request and let you know the outcome of your reconsideration request within 15 calendar days after receipt of all necessary information.

Appeal

An appeal is the second step in this process. If Blue Cross Blue Shield continues to deny benefits for all or part of the original service, you may request an appeal within 60 days of receiving the reconsideration denial letter. Your appeal request should include any information that supports your appeal. You may also inspect and add information to your Blue Cross Blue Shield case file to prepare your appeal. In accordance with Rhode Island state law, if you wish to review the information in your Blue Cross Blue Shield case file, you must make your request in writing and include the name of a dentist who may review your file on your behalf. Your dentist may

review, interpret, and disclose any or all of that information to you. Once received by Blue Cross Blue Shield, your appeal will be reviewed by a dentist in the same specialty as your attending dentist. Blue Cross Blue Shield will notify you of the outcome of your appeal within 15 calendar days of receiving all necessary information.

External Appeal

If your appeal is denied, you have the right to present your case to an appeals agency that is designated by Rhode Island and not affiliated with Blue Cross Blue Shield. If you request this voluntary external appeal, Rhode Island requires you be responsible for half of the cost of the appeal and Blue Cross Blue Shield will be responsible for the remaining half. To file an external appeal, you must send your request in writing to:

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

Along with your request, you must state your reason(s) for your disagreement with Blue Cross Blue Shield's decision and enclose a check payable to one of the following external appeals agencies: MassPRO (your fee is \$147.50) or the MAXIMUS Center for Health Dispute Resolution (your fee is \$144.20).

Within five working days after the receipt of your written request and payment for the appeal, Blue Cross Blue Shield will forward your request to the external appeals agency along with Blue Cross Blue Shield's portion of the fee and your entire Blue Cross Blue Shield case file. The external appeals agency will notify you in writing of the decision within ten working days of receiving all necessary information.

Expedited Appeal

If your situation is an emergency, you have the right to an expedited appeal at all three levels of appeal as stated above. An emergency requires emergency dental treatment to relieve acute pain or to control a dental condition that requires immediate care to prevent permanent harm to the member. You may request an expedited reconsideration or appeal by contacting Blue Cross Blue Shield at the telephone number shown in your letter. Blue Cross Blue Shield will notify you of the result of your expedited appeal within two working days or 72 hours, whichever is sooner, of its receipt. To request an expedited voluntary external appeal, you must send your request in writing to:

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

Your request should state your reason(s) for your disagreement with the decision and include signed documentation from your dentist that describes the emergency nature of your treatment. In addition, you must also enclose a check payable to one of the following external appeals agencies: MassPRO (your fee is \$172.50) or the MAXIMUS Center for Health Dispute Resolution (your fee is \$144.20).

Within two working days after the receipt of your written request and payment for the appeal, Blue Cross Blue Shield will forward your request to the external appeals agency along with Blue Cross Blue Shield's portion of the fee and your entire Blue Cross Blue Shield case file. The external appeals agency will notify you in writing of the decision within two working days or 72 hours, whichever is sooner, of receiving your request for a review.

External Appeal Final Decision

If the external appeals agency upholds the original decision of Blue Cross Blue Shield, this completes the appeals process for your case. But, if the external appeals agency reverses Blue Cross Blue Shield's decision, the claim in dispute will be reprocessed by Blue Cross Blue Shield upon receipt of the notice of the final appeal decision. In addition, Blue Cross Blue Shield will repay you for your share of the cost for the external appeal within 60 days of the receipt of the notice of the final appeal decision.

Disability

If You Incur a Total Disability

If you incur a total disability and begin receiving benefits from the Boston University Long-Term Disability Benefits Plan, on or after January 1, 2016, you may continue your membership in the Boston University Dental Health Plan at the same contribution rate as for active employees for up to five years. The coverage for the BU Dental Health Plan will end as of the end of the 5th year of disability.

If You Die While You Are a Member of the Plan

Your enrolled dependents will be entitled to continue coverage for up to 36 months under COBRA, as described later in this section.

When You Retire

You and your enrolled dependents will be entitled to continue coverage for up to 18 months under COBRA, as described later in this section.

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 Dental Plan.

- *Leave of Absence with Pay* If you

are granted a leave of absence with pay (including sabbatical), your Dental 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 Dental 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 obtaining the necessary forms from Human Resources. Re-enrollment in the Boston University Dental Health Plan will be possible when you return from a leave of absence or no-pay status, as long as you contact Human Resources and enroll within 30 days of the date you return.

The COBRA continuation of coverage provisions would also apply in this situation should you wish to elect COBRA coverage.

When Your Coverage Ends

If your employment with the University terminates for any reason, including retirement, your Dental Plan membership will end on the last day of 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.

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

Coverage Continuation Provisions

A federal law known as COBRA requires that most employers sponsoring group dental health plans offer employees and their families ("qualified beneficiaries") the opportunity to elect and pay for a temporary extension of dental health coverage called "continuation coverage" at group rates in certain instances ("qualifying events") where coverage under the employer's dental 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 dental health plan options maintained by the Plan Sponsor (the "Plan"), you will become a qualified beneficiary if you lose your group dental 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.
- If you are the spouse of an employee covered by the Dental Plan, you will become a qualified beneficiary if you lose your

coverage under the Dental 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 Dental 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 (Part A, Part B, or both); or
- The child ceases to be eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Dental Plan Sponsor and that bankruptcy results in the loss of coverage of any retired employee covered under the Dental Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse or surviving spouse and dependent children will also become

qualified beneficiaries if bankruptcy results in the loss of their coverage under the Dental Plan.

When Is COBRA Coverage Available?

The Dental Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Sponsor must notify the Plan Administrator of the qualifying event.

Under joint Agency guidance issued in response to the COVID-19 pandemic, you had 60 days from the end date of the Outbreak Period to notify the Plan Administrator of the qualifying event if the qualifying event occurred during the Outbreak Period.

What was the Outbreak Period?

The Outbreak Period is defined as the period from March 1, 2020, until sixty (60) days after the announced end of the National Emergency that was declared on March 1, 2020 regarding the COVID-19 pandemic. The announced end of the National Emergency took effect as of May 2023

During the Outbreak Period, you would have been required to provide this notice to the COBRA Administrator listed below, along with documentation substantiating the divorce, legal separation, or loss of dependent status and the effective date of such event.

P&A Group
Dept #652
P.O. Box 8000
Buffalo, NY 14367
1-800-688-2611

A child who is born to or placed for

adoption with the covered employee during a period of COBRA continuation coverage will be eligible to become a qualified beneficiary and be added to the covered employee's COBRA continuation coverage. You must notify the Plan Administrator within 60 days after the birth or placement for adoption occurs.

Under joint Agency guidance issued in response to the COVID-19 pandemic, you had 60 days from the end date of the Outbreak Period (defined above) to submit a request to make a change to your enrollment.

During the Outbreak Period, you would have been required to provide this notice to the Plan Contact listed below, along-with copies of legal documents—substantiating the birth or placement for adoption and the effective date of such event.

P&A Group
Dept #652
P.O. Box 8000
Buffalo, NY 14367
1-800-688-2611

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 dental 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.

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 documentation substantiating the divorce, legal separation, or loss of dependent status and the effective date of such event.

A child who is born to or placed for adoption with the covered employee during a period of COBRA continuation coverage will be eligible to become a qualified beneficiary and be added to the covered employee's COBRA continuation coverage. You must notify the Plan Administrator within 60 days after the birth or placement for adoption 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.

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 coverage. If you do not elect continuation coverage, your group dental health coverage will end. If you elect continuation coverage, the Plan Sponsor is required to permit you to elect and purchase coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members.

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), your divorce, 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. Otherwise, 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.

Under joint Agency guidance issued in response to the COVID-19 pandemic, you were allowed the earlier of 60 days from the end date of the Outbreak Period or one year from when the regular the regular deadline would have applied to elect continuation coverage if your qualifying event occurred during the Outbreak Period. The Outbreak Period is defined as the period from March 1, 2020, until sixty (60) days after the announced end of the National Emergency that was declared on March 1, 2020 regarding the COVID-19 pandemic. The announced end of the National Emergency took effect in May 2023.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Dental 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 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 he or 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 correspondence from the Social Security Administration substantiating the disability/loss of disability and the effective date of the applicable SSA determination. Furthermore, during the period after the 18th month through the 29th month of continuation coverage, the monthly premium cost

will be increased to 150% of the applicable premium relating to continuation coverage.

Under joint Agency guidance issued in response to the COVID-19 pandemic, you were allowed the earlier of 60 days from the end date of the Outbreak Period or one year from when the regular the regular deadline would have applied to elect continuation coverage if your qualifying event occurred during the Outbreak Period. The Outbreak Period is defined as the period from March 1, 2020, until sixty (60) days after the announced end of the National Emergency that was declared on March 1, 2020 regarding the COVID-19 pandemic. The announced end of the National Emergency took effect in May 2023.

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. 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 Dental 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.

How Much Does COBRA Continuation

Coverage Cost?

Each qualified beneficiary must pay the entire cost of continuation coverage. The amount a qualified beneficiary must pay may not exceed 102% (or, in the case of an extension of continuation coverage due to disability, 150%) of the cost to the Dental Plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage.

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 not 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 not 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 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.

Under joint Agency guidance issued in response to the COVID-19 pandemic, you were allowed the earlier of 60 days from the end date of the Outbreak Period or one year from when the regular the regular deadline would have applied to elect continuation coverage if your qualifying event occurred during the Outbreak Period. The Outbreak Period is defined as the period from March 1, 2020, until sixty (60) days after the announced end of the National Emergency that was declared on March 1, 2020 regarding the COVID-19 pandemic. The announced end of the National Emergency took effect in May 2023.

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 dental 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 dental health plan (as an employee or otherwise) that does not impose any preexisting 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 dental 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 dental health plan and that plan contains a pre-existing 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 condition clauses, the Plan Sponsor may terminate your COBRA coverage.

You do not have to show that you are insurable to choose continuation coverage. However, as discussed above, you will have to pay all the required

premiums for your continuation coverage.

The law also says that, at the end of the 18-month, 29-month, or 36-month continuation coverage period, you must be allowed to enroll in an individual conversion dental health plan if such an individual conversion dental health plan is otherwise generally available under the Plan.

COBRA continuation coverage may be terminated for any reason if the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

If You Have Questions

More complete information regarding your COBRA continuation coverage rights is available from the Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group dental health plans, contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website.)

Plan Contact Information (Plan Administrator)

COBRA Administrator:
P&A Group
Dept. #652
P.O. Box 8000
Buffalo, NY 14267-8000
1-800-688-2611

Administrative Information

Sponsor for This Plan

This plan is sponsored by the employer, Boston University, Boston, Massachusetts, which is

also the Plan Administrator. Eligibility for the benefit plan described in this handbook applies to those University employees on the US payroll.

Boston University's Employer Identification Number

For identification purposes, the Internal Revenue Service has assigned number 04-2103547 to Boston University. You will need to know this number if you write to a government agency about any of the plans.

Type of Plan, Plan Number, and Plan Year

In addition to the University's Employer Identification Number, you need to know the following information:

- **Type of Plan:** The Dental Health Plan is characterized by the federal government as a Welfare Plan.
- **Plan Number:** Boston University has assigned Plan Number 703 to The Dental Health Plan.
- **Plan Year:** The financial records of this plan are kept on a Plan Year basis. The Plan Year for The Dental Health Plan is January 1 to December 31.

Administrator for This Plan

The day-to-day administration of this plan is handled by Human Resources. However, if you have a question or a problem that cannot be resolved by Human Resources, you should contact the Plan Administrator.

The Plan Administrator can be reached by contacting:

Plan Administrator
The Trustees of Boston University
25 Buick Street Boston, MA 02215
Phone: 617-353-4489

Boston University pays the entire cost

of many of the benefit plans described in this handbook. In some cases, you and the University share the cost. In others, you pay the entire cost.

Funding and Administration of the Plan

Following is an explanation of how this plan is funded and who is responsible for paying benefits:

Contributions to the Dental Health Plan are used by the following providers, who are responsible for processing claims for benefits. The addresses and telephone numbers of these processors are:

Blue Cross Blue Shield of Massachusetts
101 Huntington Avenue
Boston, MA 02199
Phone: 1-800-814-4371

Agent of Legal Service

The agent for the service of legal process for this plan is:

University Counsel
125 Bay State Road
Boston, MA 02215

Legal process may be served on the Plan Administrator.

Fraudulent Claims

Submission of a claim for benefits under any of the plans described in this handbook includes a representation that the claim is bona fide and, to the best knowledge of the employee, dependent, or other claimant, proper for payment. Submission of a fraudulent or knowingly false claim by an employee or an employee's dependent participating in a plan will be grounds for disciplinary action against the employee, including termination of participation by the employee and/ or covered dependent(s) under the plan.

Claims for Benefits/Appealing a Denial of Claims for Benefits

When you apply for benefits, there are

time periods within which you must receive a decision on your claim for benefits. If you or your beneficiary applies for benefits and either part or all of the request is denied, you have the right to appeal that decision, provided the appeal is made in accordance with the provisions of the plan and applicable laws (e.g., appeals must be filed within required time periods).

Appeals are generally decided by the provider of the benefit involved, which is the insurance carrier, claims administrator, or vendor for most benefits, or the University or its Plan Administration Committee for some benefits.

Appeals to Insurance Carriers/Claims Administrators/Other Vendors

Appeals regarding benefits or other issues affecting plan participants or other persons for The Dental Health Plan should be made to the applicable provider under the Plan.

Details of claims and appeal procedures may vary, but generally the following procedures apply:

- If a claim for benefits is either wholly or partially denied, you will be notified in writing. The notice will state the reasons why the claim was denied and the deadline for requesting review, which is different for different types of plans and/or claims.
- If you wish to appeal, you are entitled to review all documents pertaining to your claim free of charge and may also submit comments pertaining to your claim.
- Your appeal of the denial should be addressed to the applicable provider as directed in the denial of benefits notice.
- The applicable provider will decide the claims and appeals in the time and manner required by law.
- Unless a different time period

applies, claims will be decided within 90 days (180 days if special circumstances apply) and appeals for denied claims must be filed within 60 days of denial. A decision must be made within 60 days (or 120 days if special circumstances are present and you are notified).

Appeals may be submitted to:

Blue Cross Blue Shield
Member Grievance Program
Blue Cross Blue Shield of
Massachusetts
One Enterprise Drive
Quincy, MA 02171-2126
1-800-814-4371

Documents and Laws Governing This Plan

The plan description contained in this handbook was written from the documents that legally govern how the plan works. In the event of any discrepancy between the plan description in this handbook and the controlling contracts or plan documents, the language in the controlling contracts or plan documents will govern. If you would like a copy of any of these documents, please contact Human Resources.

The plan is also regulated by applicable provisions of applicable laws, which will govern in the event of any conflict between the law and the terms of the plan as described in either the documents or in the summary plan description.

Equal Opportunity/Affirmative Action Policy

Since its founding in 1869, Boston University has been dedicated to equal opportunity and has opened its doors to students without regard to race, sex, creed, or other irrelevant criteria. Consistent with this tradition, it is the policy of Boston University to promote equal opportunity in educational programs and employment through practices designed to extend

opportunities to all individuals on the basis of individual merit and qualifications, and to help ensure the full realization of equal opportunity for students, employees, and applicants for admission and employment. The University is committed to maintaining an environment that is welcoming and respectful to all.

Boston University prohibits discrimination against any individual on the basis of race, color, religion, sex, age, national origin, physical or mental disability, sexual orientation, genetic information, military service, or because of marital, parental, or veteran status. This policy extends to all rights, privileges, programs, and activities, including admissions, financial assistance, educational and athletic programs, housing, employment, compensation, employee benefits, and the providing of, or access to, University services or facilities. Boston University recognizes that that equal opportunity is a reality. Accordingly, the University will continue to take affirmative action to achieve equal opportunity through recruitment, outreach, and internal reviews of policies and practices.

The coordination and implementation of this policy is the responsibility of the Director of Equal Opportunity. The officers of the University and all deans, directors, department heads, and managers are responsible for the proper implementation of equal opportunity and affirmative action in their respective areas, and they are expected to exercise leadership toward their achievement. It is expected that every employee of Boston University will share this commitment and cooperate fully in helping the University meet its equal opportunity and affirmative action objectives.

Boston University has developed detailed procedures, described in its *Complaint Procedures in Cases of Alleged Unlawful Discrimination or*

Harassment (www.bu.edu/eeo/policies-procedures/complaint), by which individuals may bring forward concerns or complaints of discrimination and harassment. Retaliation against any individual who brings forward such a complaint or who cooperates or assists with an investigation of such a complaint is both unlawful and strictly prohibited by Boston University.

Inquiries regarding this policy or its application should be addressed to the Director of Equal Opportunity, Equal Opportunity Office, 888 Commonwealth Avenue, Suite 303, Boston, MA 02215, or call 617-358-1796.

Amendment or Termination of the Plan

Boston University intends to continue maintaining the plan described in this handbook for the exclusive benefit of its employees.

However, the University reserves the right to change or discontinue it, and to implement changes as required by federal, state, or local laws.

You will be informed of any material changes that are made to the plans. If a plan is terminated, your rights, on the date of the termination, would be governed by the provisions of the plan document.

Your Rights Under ERISA

The Dental Health Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides the participants in the plan with certain rights and protections. The following statement is included here so that you will be aware of your rights under the law.

Under ERISA:

- You may examine, without charge, at Human Resources and at other specified locations, during normal

business hours, all plan documents relating to the plan in which you participate. The documents that must be available for your review include insurance contracts, plan and trust documents, collective bargaining agreements, and all documents filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration, for example, detailed annual reports.

- If you wish, you may request your own copies of these plan documents by writing to Human Resources. Where permitted by law, you may have to pay a reasonable charge to cover the costs of copying.
- You will receive summaries of the plans' annual financial report each year, free of charge. The administrator for the plan is required by law to furnish each participant with a copy of these summary annual reports.
- You have a right to receive a copy of any material change to a plan within 210 days of the plan year in which the change is adopted, unless earlier notice is required by law.

Continue Health Coverage

You may continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Dental Health Plan as a result of a qualifying event. You or your dependents will have to pay for such coverage. Review this handbook and the documents governing the Dental Health Plan on the rules governing your COBRA continuation coverage rights.

You may reduce or eliminate exclusionary periods of coverage for pre-existing conditions under the

Dental Health Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group dental health plan or dental health insurance issuer when you lose coverage under the Dental Health Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Plan Fiduciaries

Besides giving you certain rights as a participant, ERISA places certain duties upon the people who are responsible for the management of the above-mentioned plans. These people are called “fiduciaries” under the law, and they have the duty to act prudently and in your best interests.

Under ERISA, no one may fire you or discriminate against you to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Enforcing Your Rights

If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to obtain copies, without charge, of documents relating to the decision, and to appeal any denial all within certain time schedules.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 for each day’s delay until you

receive the materials, unless the materials were not sent for reasons beyond the administrator’s control. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with a plan’s decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse plan money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or file suit in a federal court.

In a lawsuit, the court normally decides who pays the court costs and legal fees. If you are successful, the other party might have to pay. But, if you lose, the court might order you to pay these costs and fees, especially if the court finds your claim to be frivolous.

Assistance with Questions

If you have any questions about this statement of your rights under ERISA, contact Human Resources. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

A Final Note

This handbook presents a summary of

Boston University’s benefits for faculty and staff. It is designed as a quick reference source and is not intended to cover every point of policy. In certain instances, the University may exercise discretion, with respect to the administration of the plans described in this handbook. For more in-depth information, contact Human Resources.

Periodically, the University may make changes in policy that may not be reflected immediately in this handbook.

Again, for complete and up-to-date information about any policy or benefit, you should contact Human Resources.

Please note: The policies described in this handbook are not intended to create an employment contract between Boston University and its employees. Therefore, they do not alter the University’s rights regarding discharges and layoff.

LONG-TERM DISABILITY PLAN





Once you have completed two years of continuous full-time service with the University, you will automatically be enrolled in the Long-Term Disability (LTD) Plan, if you are eligible at that time. The LTD Plan is designed to provide a continuing income to you and your family after a six-month waiting period if you are unable to work for longer than six months because of a total disability or if you are partially disabled and are suffering a 20% or greater earnings loss.

Boston University pays the entire cost of your Long-Term Disability Plan.

You may also be eligible for coverage under certain disability plans not mentioned in this handbook. These may include the Temporary Disability Plan, or other government-sponsored plans such as Social Security or Workers' Compensation. For additional information, see your Employee Handbook, the Faculty Handbook, your collective bargaining agreement, and the "Other Benefits" handbook.

Eligibility

If you are classified by the University as a regular employee, work a full-time schedule, and have an appointment of nine months' or more duration, you automatically become a member of the Long-Term Disability Plan on the first day of the month coincident with or following your completion of two years of continuous full-time service, if you are at work on that day. If you are not at work on the day you would normally become a member, you will become a member in the plan on the day you return to work performing your normal duties.

The two-year service requirement may be waived, allowing you to become a member on your first day of work, if you meet the following requirements:

1. You have a regular full-time appointment of at least nine months' duration with the University; and
2. You provide Human Resources with satisfactory evidence that you had been covered by your previous employer's long-term disability program at the time you left that employer, and no more than three months have passed between the termination of such coverage and your first day of employment with the University; and
3. You submit the evidence of coverage within 90 days from the date of termination with your previous employer.

You pay nothing for your coverage under the Long-Term Disability Plan. The University pays the entire cost of this plan.

Employees whose percentage time worked decreases below the eligibility requirements for the Long-Term Disability Plan as of January 1, 2015, will no longer be able to participate in the Long-Term Disability Plan.

Plan Benefits

As explained below, you may receive benefits from the plan if you are a member and become totally disabled or partially disabled while you are covered under the plan.

No benefits are provided for any disabilities commencing before you were covered under the plan or after your coverage under the plan terminates.

"Totally disabled," for purposes of the plan, means that, because of medically determinable illness or injury:

- You cannot perform each of the material duties of your own occupation for which you are reasonably fitted by training, education, or experience during the elimination period and the next 24 months, and thereafter, unable to perform the material duties of any occupation.

"Partial disability," for purposes of the plan, means that, because of your medically determinable illness or injury:

- While unable to perform all the material duties of your regular occupation on a full-time basis because of injury or illness, you are:
 - a. Performing at least one of the material duties of your regular occupation or another occupation on a part-time or full-time basis; and,

- b. Earning currently at least 20% less per month than your pre-disability earnings.

Note: Either or both of these can satisfy the elimination period.

"Elimination period," for purposes of the plan, refers to the six-month 180 - day period during which you must continuously have a total disability or partial disability before you can begin receiving benefits from the plan.

You must be totally disabled or partially disabled and suffering a 20% earnings loss for at least six consecutive months before you can begin receiving benefits. Benefit payments will begin on the date you complete 180 days of continuous total and/or partial disability.

After completing the elimination period, you will receive monthly disability benefit payments while you remain totally or partially disabled.

If you are totally disabled, each monthly payment will be 60% of your monthly base salary, up to a maximum monthly benefit amount of \$14,500. This means the maximum covered salary is \$24,166.67 per month (or \$290,000 per year), since \$24,166.67 times 60% equals \$14,500.

If you are partially disabled, the amount of your monthly disability benefit will be adjusted, taking into consideration the amount of your earnings while partially disabled. The monthly benefit for partial disability is 75% of the difference

between your full-time monthly base salary and your monthly base salary while you are partially disabled. For example, if your regular full-time monthly base salary is \$1,000 and your salary while you are partially disabled is \$650, you deduct \$650 from \$1,000 to get \$350. Multiply \$350 by 75% to get \$262.50, which is the amount of your monthly disability benefit.

Your monthly disability payments from the plan will be reduced by any payments you receive from any of the following sources:

- Social Security Retirement or Disability Benefits (including any benefits for dependents) or similar government programs
- Workers' Compensation or similar payments, except when they result from previous, unrelated injuries or disabilities
- Any group disability benefits payable under any group insurance or retirement plan to which the University contributes
- Sick pay

The plan does, however, guarantee you a minimum benefit of \$100 per month regardless of your income from other sources.

You are required to apply for any Social Security benefits for which you are eligible, should your disability be expected to extend for 12 months.

On July 1 following the first 12 months during which you have received disability payments, and each July 1 thereafter, the

amount of your monthly disability income from this plan will be increased by 3%. These increases apply for the first 5 years of disability under this plan and then stop.

Benefit Duration

The following table illustrates benefit duration periods under the plan.

This is the maximum period that the plan will pay you benefits as long as you remain disabled.

Once Long-Term Disability benefits cease, depending on your age, you may be eligible for benefits from your participation in a retirement plan or for Social Security retirement benefits.

Age When Benefits Commence	Duration of Benefits
60 or younger	to age 65 but not less than 5 years
61 to 64	5 years
65 to 69	to age 70 but not less than 1 year
70 and older	1 year

Federal Income Tax on Long-Term Disability Income

Under present federal income tax laws, your disability benefits are considered taxable income to you in the year they are received.

Three-Month Survivor Benefit

The Claims Administrator, on behalf of the University, will pay a lump sum survivor benefit when proof is received that the Participant died (a) after that Participant's Total Disability or Partial Disability had continued for one hundred eighty (180) or more consecutive days, and (b) while the Participant was receiving a Total Disability or Partial Disability benefit. The lump sum benefit amount will be equal to three times the last gross monthly benefit amount payable to the Participant prior to their death

without any reduction for earnings received from employment (the "Three Month Survivor Benefit").

Subrogation and Reimbursement

The Boston University Long-Term Disability Plan also has a subrogation and reimbursement rule. If another party is legally responsible to pay lost earnings resulting from an illness or injury inflicted on you, the Long-Term Disability Plan is entitled to reimbursement out of any recovery from the responsible party (or from any insurer) for the amount of Long-Term Disability benefits paid by the plan. The covered individual must cooperate with the Long-Term Disability Plan to recover such amounts. If the covered individual receives payment from the responsible party (or any insurer) before the Long-Term Disability Plan receives amounts paid as Long-Term Disability benefits, the covered individual must hold any amount recovered from the responsible party in trust for the benefit of the Long-Term Disability Plan to the extent of the Long-Term Disability benefits paid by the Long-Term Disability Plan, and must repay the Long-Term Disability Plan from the amounts recovered, even if the amounts recovered do not fully compensate the covered individual for all of his or her losses or damages or expenses. The Long-Term Disability Plan's right to repayment will not be reduced by any attorney fees or other expenses incurred by the covered individual. The Long-Term Disability Plan will not pay any portion of those attorneys' fees or expenses.

How to Obtain Benefits

To claim benefits from the Long-Term Disability Plan, you should contact the administrator of the benefit, Sedgwick at 877-708-0037. (You should also contact your local Social Security office to apply for any

Disability Insurance benefits for which you are eligible.)

To process your claim, the Claims Processor may require you to be examined by a physician or other specialist from time to time, at its own expense. Long-term disability benefits will be discontinued if you fail to provide proof of continued disability or partial disability and regular attendance of a physician or refuse to be examined or evaluated at reasonable intervals or refuse to receive appropriate available treatment. The employee bears the cost of regular physician visits while the Claims Processor bears the cost of required examinations.

Proof of claim must be given no later than 30 days after the end of the elimination period.

Once the Claims Processor receives your application for benefits and supporting documentation, it will be paid promptly (as long as it is a valid claim).

If your claim is denied, the Claims Processor will notify you of the adverse decision within a reasonable period of time, but not later than 45 days after receiving the claim. This 45-day period may be extended for up to 30 days, if the Claims Processor: (1) determines the extension is necessary because of matters beyond the plan's control, and (2) notifies you, before the end of the 45-day period, why the extension is needed and the expected decision date. If, before the end of the first 30-day extension, the Claims Processor determines, due to matters beyond the plan's control, a decision cannot be rendered within that

extension period, the determination period may be extended for up to an additional 30 days, provided the Claims Processor notifies you, before the end of the first 30-day extension period, why the extension is needed and the expected decision date.

The notice of extension shall explain: (1) the standards on which benefit entitlement is based, (2) the unresolved issues that prevent a claim decision, and (3) the additional information needed. You have at least 45 days to provide the information.

The claim determination time frame begins when a claim is filed, without regard to whether all the information necessary to make a claim determination accompanies the filing.

If an extension is necessary because you failed to submit necessary information, the days from the date the Claims Processor sends you the extension notice until you respond to the request for additional information are not counted as part of the elimination period.

Any denial will be in writing and will include specific reasons for the denial, and the provisions of the Claims Processor contract on which the denial is based. If there was any disagreement between the Claims Processor and (1) any health care or vocational professionals providing your treatment, (2) any medical and vocational experts whose advice was obtained by the plan, or (3) any determination made by the Social Security Administration, regarding your claim, the denial will include an explanation of the basis for the disagreement.

The denial will also explain how to apply for a review of the denied claim. Where appropriate, it will also include a description of any material that is needed to complete or perfect

your claim and will explain why such material is necessary.

Appealing a Denial

The Claims Processor is solely responsible for determining what constitutes a covered claim under this plan. If the Claims Processor denies your claim for benefits, in whole or in part, you have a right to appeal the denial. You have 180 days to appeal a denied claim. After the receipt of the request for review, the appeal must be decided within 45 days unless special circumstances apply, and notice is given before the first 45-day period expires. In this case, the decision on appeal must be rendered within 45 days from the extension. Prior to rendering a decision on appeal, the Claims Processor will provide you with any new or additional evidence considered, relied upon, or generated in connection with your claim. When appropriate, the Claims Processor will also provide any new or additional rationale used in making the decision on appeal before rendering the decision. Any new or additional evidence or rationale will be provided free of charge and sufficiently in advance of the issuance of the decision on appeal to allow you a reasonable opportunity to respond. Appeals may be submitted to the following provider:

National Appeals Unit
PO Box 14446
Lexington, KY 40512-4446
Fax: (888) 488-9536
Email: NAU@sedgwickcms.com

Monthly Retirement Plan Waiver Benefit

The Monthly Retirement Plan Waiver Benefit is a special feature of this plan for those who participate in the Boston University Retirement Plan. (See the “Retirement Plan” handbook.) This feature provides for the Long-Term Disability Plan to pay the University’s Core Contributions to your Boston University Retirement Plan account while you are receiving payments from this plan. In this way, the plan allows your Boston University retirement benefits to accumulate even while you are receiving disability income. The contribution will continue to be made for you for the duration of the disability if you qualify for Social Security Disability Income (SSDI). If you do not qualify for SSDI, the contribution will continue for the first five years of your disability. The following is how this monthly benefit works.

The monthly waiver benefit equals the University’s Core Contribution. In addition, on July 1 following the first 12 months during which you have received disability payments, the amount of your waiver benefit contributions is increased by 3%. These increases apply on each subsequent July 1 for the first 5 years of disability and then stop. The Monthly Retirement Plan Waiver benefit does not apply to any payments you were making. For more information about how the Monthly Retirement Plan Waiver Benefit operates, you should contact Human Resources. If you are eligible for the University contribution at the time of your disability, please refer

to the table below which shows the University’s Core Contribution based on your age and salary.

University Core Contribution		
Attained Age	Up to the Integration Level*	Above the Integration Level
Under 45	4%	6%
45 through 49	6%	8%
50 and above	7%	9%
*2025 Integration Level is \$70,600		

Exclusions and Limitations

As in most plans of this type, there are some disabilities which are not covered. Examples of disabilities excluded from this plan are as follows:

1. war, declared or undeclared, or any act of war,
2. intentionally self-inflicted injuries,
3. participation in a riot,
4. the committing of or attempting to commit a felony or misdemeanor,
5. cosmetic surgery unless such surgery is in connection with an injury or sickness sustained while the individual is a covered person,

No benefit will be payable during any period of incarceration.

For more information on exclusions and limitations, you should contact Human Resources.

Leaves of Absence

If you leave work for any reason for a prolonged period, you should contact Human Resources to ask how your absence may affect your participation in this plan.

When Plan Membership Ends

If you are a member of this plan and you are not disabled, your participation will end on the earlier day that either of the following events occurs:

- You terminate your employment with Boston University, or
- Your status as a regular full-time employment ends.

If one of these events occurs and you are disabled under the plan but not yet receiving benefits, you should contact Human Resources.

Administrative Information

Sponsor for This Plan

This plan is sponsored by the employer, Boston University, Boston, Massachusetts, which is also the Plan Administrator. Eligibility for the benefit plan described in this handbook applies to those University employees on the US payroll.

Boston University’s Employer Identification Number

For identification purposes, the Internal Revenue Service has assigned number 04-2103547 to Boston University. You will need to know this number if you write to a government agency about any of the plans.

Type of Plan, Plan Number, and Plan Year

In addition to the University’s Employer Identification Number, you need to know the following information:

- **Type of Plan:** The Long-Term Disability Plan is characterized by the federal government as a Welfare Plan.
- **Plan Number:** Boston University has assigned Plan Number 507 to The Long-Term Disability Plan.
- **Plan Year:** The financial records of this plan are kept on a Plan Year basis. The Plan Year for The Long-Term Disability Plan is January 1 to December 31.

Administrator for This Plan

The day-to-day administration of this plan is handled by Human Resources. However, if you have a question or a problem that cannot be resolved by Human Resources, you should contact the Plan Administrator.

The Plan Administrator can be reached by contacting:

Plan Administrator
The Trustees of
Boston University
25 Buick Street
Boston, MA 02215
Phone: 617-353-4489

Funding and Administration of the Plan

Boston University pays the entire cost of many of the benefit plans described in this handbook. In some cases, you and the University share the cost. In others, you pay the entire cost. Contributions to the Long-Term Disability Plan are used by the following providers, who are responsible for processing claims for benefits. The addresses and telephone numbers of these processors are:

Sedgwick
National Appeals Unit
PO Box 14446
Lexington, KY 40512-4446
Fax: (888) 488-9536
Email: NAU@sedgwickcms.com

The agent for the service of legal process for this plan is:

University Counsel
125 Bay State Road
Boston, MA 02215

Legal process may be served on the Plan Administrator.

Fraudulent Claims

Submission of a claim for bene-

fits under any of the plans described in this handbook includes a representation that the claim is bona fide and, to the best knowledge of the employee, dependent, or other claimant, proper for payment. Submission of a fraudulent or knowingly false claim by an employee or an employee's dependent participating in a plan will be grounds for disciplinary action against the employee, including termination of participation by the employee and/or covered dependent(s) under the plan.

Documents and Laws Governing This Plan

The plan description contained in this handbook was written from the documents that legally govern how the plan works. In the event of any discrepancy between the plan description in this handbook and the controlling contracts or plan documents, the language in the controlling contracts or plan documents will govern. If you would like a copy of any of these documents, please contact Human Resources.

The plan is also regulated by applicable provisions of applicable laws, which will govern in the event of any conflict between the law and the terms of the plan as described in either the documents or in this summary plan description.

Equal Opportunity/Affirmative Action Policy

Since its founding in 1839, Boston University has been dedicated to equal opportunity and has opened its doors to students without regard to race, sex, creed, or other irrelevant criteria. Consistent with this tradition, it is the policy of Boston University to promote equal opportunity in educational programs and employment through practices designed to extend opportunities to all individuals on the basis of individual merit

and qualifications, and to help ensure the full realization of equal opportunity for students, employees, and applicants for admission and employment. The University is committed to maintaining an environment that is welcoming and respectful to all.

Boston University prohibits discrimination against any individual on the basis of race, color, religion, sex, age, national origin, physical or mental disability, sexual orientation, genetic information, military service, or because of marital, parental, or veteran status. This policy extends to all rights, privileges, programs, and activities, including admissions, financial assistance, educational and athletic programs, housing, employment, compensation, employee benefits, and the providing of, or access to, University services or facilities. Boston University recognizes that that equal opportunity is a reality. Accordingly, the University will continue to take affirmative action to achieve equal opportunity through recruitment, outreach, and internal reviews of policies and practices.

The coordination and implementation of this policy is the responsibility of the Director of Equal Opportunity. The officers of the University and all deans, directors, department heads, and managers are responsible for the proper implementation of equal opportunity and affirmative action in their respective areas, and they are expected to exercise leadership toward their achievement. It is expected that every employee of Boston University will share this commitment and cooperate fully in helping the University meet its equal opportunity and affirmative action objectives.

Boston University has developed detailed procedures, described in its *Complaint Procedures in Cases of Alleged Unlawful Discrimination or Harassment* (www.bu.edu/eeo/policies-procedures/complaint), by which individuals may bring forward concerns or complaints of discrimination and harassment. Retaliation against any individual who brings forward such a complaint or who cooperates or assists with an investigation of such a complaint is both unlawful and strictly prohibited by Boston University.

Inquiries regarding this policy or its application should be addressed to the Director of Equal Opportunity, Equal Opportunity Office, 888 Commonwealth Avenue, Suite 303, Boston, MA 02215, or call 617-358-1796.

Amendment or Termination of the Plan

Boston University intends to continue maintaining the plan described in this handbook for the exclusive benefit of its employees.

However, the University reserves the right to change or discontinue it, and to implement changes as required by federal, state, or local laws.

You will be informed of any material changes that are made to the plans. If a plan is terminated, your rights, on the date of the termination, would be governed by the provisions of the plan document.

Your Rights Under ERISA

The Long-Term Disability Plan is subject to the provisions of the Employee Retirement Income

Security Act of 1974 (ERISA).

ERISA provides the participants in this plan with certain rights and protections. The following statement is included here so that you will be aware of your rights under the law.

Under ERISA:

- You may examine, without charge, at Human Resources and at other specified locations, during normal business hours, all plan documents relating to the plans in which you participate. The documents that must be available for your review include insurance contracts, plan and trust documents, collective bargaining agreements, and all documents filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration, for example, detailed annual reports.
- If you wish, you may request your own copies of these plan documents by writing to Human Resources. Where permitted by law, you may have to pay a reasonable charge to cover the costs of copying.
- You will receive summaries of the plans' annual financial reports each year, free of charge. The administrator for the plans is required by law to furnish each participant with a copy of these summary annual reports.

Plan Fiduciaries

Besides giving you certain rights as a participant, ERISA places certain duties upon the people who are responsible for the management of the above-mentioned plans. These people are called "fiduciaries" under the law, and they have the duty to act prudently and in your best interests.

Under ERISA, no one may fire you or discriminate against you to prevent

you from obtaining a plan benefit or exercising your rights under ERISA.

Enforcing Your Rights

If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to obtain copies, without charge, of documents relating to the decision, and to appeal any denial all within certain time schedules.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 for each day's delay until you receive the materials, unless the materials were not sent for reasons beyond the administrator's control. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with a plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse plan money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or file suit in a federal court.

Any lawsuit on a claim for benefits under the Plan must be initiated within 12 months after the date of final disposition of the claim pursuant to the claims procedures set forth under this plan.

In a lawsuit, the court normally decides who pays the court costs and legal fees. If you are successful, the other party may have to pay. But, if you lose, the court may order you to pay these costs and fees, especially if

the court finds your claim to be frivolous.

Assistance with Questions

If you have any questions about this statement of your rights under ERISA, contact Human Resources. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

A Final Note

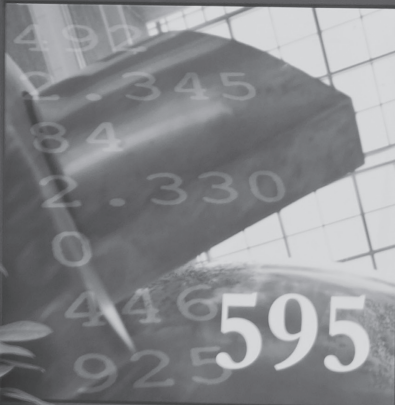
This handbook presents a summary of Boston University's benefits for faculty and staff and is intended to serve as the summary plan description for the Long Term Disability Plan. It is designed as a quick reference source and is not intended to cover every point of policy. In certain instances, the University may exercise discretion, with respect to the administration of the plans described in this handbook. For more in-depth information, contact Human Resources. Periodically, the University may make changes in policy that may not be reflected immediately in this handbook. Again, for complete and up-to-date information about any policy or benefit, you should contact Human Resources. Please note: The policies described in this handbook are not intended

to create an employment contract between Boston University and its employees. Therefore, they do not alter the University's rights regarding discharges and layoff.

INDIVIDUAL DISABILITY INSURANCE BENEFIT

BOSTON UNIVERSITY

Questrom
School of
Business





The Boston University Individual Disability Insurance Benefit (the “IDI Plan”) is a benefit plan that offers protection from a loss of earnings if you are unable to work due to an illness or injury. The IDI Plan is designed to supplement the coverage offered through the Boston University Group Long Term Disability (LTD) Plan. The IDI Plan is offered on a voluntary basis and paid by the employee.

The IDI Plan is fully insured. Benefits are provided under an individual disability income insurance policy issued by The Standard Insurance Company.

The benefits described in this Handbook are subject to the terms and conditions of the individual plan document or insurance policies. If there is a discrepancy between this description and the insurance policies, the terms of the insurance policies will govern.

Eligibility

To be eligible for the IDI Plan you must:

- Be enrolled in Boston University's Group Long Term Disability (LTD) plan; and
- Have current Base Salary of \$100,000 or more, OR current Base Salary plus Bonus and Over Base in the prior year totaling \$100,000 or more.

Enrollment

Enrollment Periods will be conducted for newly eligible employees at a time determined by Boston University. You may enroll in the IDI Plan if you meet the eligibility requirements and the following criteria if you are a newly eligible employee during the enrollment period:

- You must have been working full time and able to perform the duties of your regular occupation without limitation due to sickness or injury for a period of time commencing 90 days prior to and including the date of your application for the IDI benefit.
- You must not have had a previous declination of coverage for disability insurance by The Standard.
- You must not be currently receiving or have received disability or workers compensation benefits in the last twelve months.
- If you are on a sabbatical leave, paid or unpaid leave you must be actively participating in Boston University's Group LTD Plan.

If you do not apply during the designated enrollment period and choose to enroll at a later date, you will be required to provide evidence of good health satisfactory to the

insurance company.

When Your IDI Coverage Begins

The insurance applied for will take effect when premium payment is received by the insurance company, provided you qualify for the coverage under the terms and conditions of the offer.

Individual Disability Insurance Plan Highlights

The IDI Plan benefit is calculated based on 75% of your total insurable income (defined below) less any Group Long Term Disability benefit and other Individual Disability Insurance you may already have. The maximum monthly benefit payable is \$14,500.

The IDI Plan benefit is offered on a voluntary basis and paid by the employee. The amount of such contributions is determined by the amount charged by the insurer under the applicable insurance policy.

Eligible employees who wish to participate must elect coverage and contribute to the cost of the benefit with after-tax payroll deductions.

Insurable Income Definition

The IDI Plan defines insurable income as current base salary plus any Bonus and Over Base earned in the prior calendar year.

If your insurable income decreases, your IDI benefit amount will not decrease as long as premiums continue to be paid.

Definition of Disability

Total Disability

For Occupation classes 5A and 3A, (see "Definition of Occupation Classes" below) you are unable to perform the

substantial and material duties of your regular occupation, you are not engaged in any other job or occupation for wage or profit, and you are receiving regular medical care from one or more physician(s) appropriate for your injury or sickness.

For Occupation classes 5P, 4P, 3P, and 4S, you are unable to perform the substantial and material duties of your regular occupation; and you are receiving regular medical care from one or more physician(s) appropriate for your injury or sickness.

IDI Benefit Occupational Codes

5P, 4P, 4S and 3P

Medical Professionals and affiliated health workers will be assigned an occupational code of

- 5P – Includes medical professionals who do not perform surgery or interventional procedures. Examples include pharmacists and family practice physicians.
- 4P – Most medical professionals who do not perform surgery or interventional procedures. Examples include neurologists, cardiologists and radiologists.
- 4S – Physicians who perform surgery or interventional procedures, with a few exceptions.
- 3P – Physicians with higher-risk practices. Examples are anesthesiologists, emergency room physicians and orthopedic surgeons. All nurses (all types), nurse managers, nurse practitioners and physician assistants.

3D

- Dentists, Staff Dentists, Dental Specialists, Dental Assistants, and Dental Hygienists

3A

- Coaches (Head, Associate or Assistant)
- Facilities and Operations (Specialists, Sr. Specialists, and Managers)
- All Police/Fire Employees (Lieutenants, Sergeants, Directors, Detectives, Deputies, Captains, and Chiefs), Director of Public Safety
- TV and Radio Media (Reporters, Sales, Anchors, Hosts and Marketing)
- Managers of the following departments (Facilities and Infrastructure Project, Custodial, Plumbing, Procurement and Sourcing, Transportation, Maintenance Operations, Building Utilities & Automation Systems)
- All Clinical Managers, Professors, Associate Professors and Assistant Professors who work with different therapies (physical, occupational, rehabilitation, respiratory, human physiology and speech) and Athletic Training
- Any other manually intensive occupations not listed here. Please consult the current The Standard's online IDI Product Reference Guide or contact GSI underwriting at The Standard for any additional occupational questions.

5A

- All other occupations with insurable income in excess of \$100,000, not called out above for a 3A, will be assigned an occupational code of 5A.

Residual Disability Benefit (also known as a Partial Disability Benefit)

Residual disability/residually disabled means you are not totally disabled; and you are working in your regular occupation or any other occupation;

and due to your injury or sickness, you have a loss of income and either a loss of duties or a loss of time of at least 20%; and you are receiving regular medical care from one or more physician(s) appropriate for your injury or sickness.

The monthly residual disability benefit will be a percentage of your total monthly benefit. The monthly residual disability benefit will be determined by your loss of income for the month you are residually disabled divided by your prior income multiplied by your total monthly benefit.

For example, if an individual has a Monthly Benefit Amount of \$5,000, and that individual went on a residual (partial) disability and made half of what they were making previously (for example, pre-disability the individual was making \$100,000 and during the partial disability was making \$50,000), they will receive half of their monthly benefit.

Your loss of income	x	The Basic Monthly Benefit	=	Partial Disability Monthly Benefit
Your indexed pre-disability earnings				
\$50,000 = 5 \$100,000	x	\$10,000	=	\$5,000

When Your IDI Coverage Ends

Your coverage under the IDI Plan will end if any of the following occur:

- The premiums remain unpaid at the end of the 31-day grace period,
- The policy expiration date, if you are not actively employed full time and have extended coverage under the policy's renewal option provision,
- The date you are no longer regulation

for at least 30 hours per week,

- The date you recover from your disability covered by the policy's renewal option provision if the policy was continued under that option,
- The date the policy terminates under the Suspension During Military Service provision,
- The date of your written request to terminate the Policy, or
- You die.

IDI Coverage Portability

The individual policy coverage ensuring the IDI Plan is fully portable and can be maintained with the same terms of coverage by paying premiums directly to the insurance company. At such time as your employment with Boston University ends, a letter explaining how you can maintain your individual policy coverage will be sent to your home address.

When Benefit Payments Begin

The benefit waiting period, sometimes called the elimination period, is the number of days you must be disabled before IDI Plan benefits become payable.

Benefits are payable after 180 days of disability. Subject to the terms of the Recurrent Disability provision, these days need not be consecutive; they can be accumulated during a disability to satisfy an elimination period. Benefits are not payable, nor do they accrue, during an elimination period.

Recurrent Disabilities

If after the end of a disability you become disabled again within twelve months due to the same or related causes, it will be considered to be a continuing disability in order to determine the elimination period and

the maximum benefit period applied to it.

Concurrent Disabilities

Concurrent disability means a disability caused by more than one injury and/or sickness. Benefits for a concurrent disability will be paid as if there was only one injury and/or sickness. Benefits will not be paid for more than one disability benefit for the same period.

Waiver of Premium

After 90 days of disability resulting from injuries or sickness not excluded from coverage, the insurance company will:

- Refund any premiums for the policy that were due and paid while you were disabled; and
- Waive the payment of premiums that thereafter become due for as long as the disability continues, but not beyond the maximum benefit period.

Taxation of Benefits

Generally, disability payments are taxed as income only if the premiums are paid by your employer. Since you are paying the premiums for your IDI Plan coverage with after-tax earnings, any disability benefit payments that you receive under the IDI Plan will be tax-free.

For more specific information on the taxation of disability benefits, you can refer to IRS Publication 525— Taxable and Nontaxable Income, available at www.irs.gov.

How IDI Benefits Coordinate with Other Sources of Disability Income

The IDI benefits do not offset or reduce at time of claim for any other source of disability income benefits.

When Payment of IDI Benefits Ends

Benefits will be payable to you until the earlier of the following:

- The date you no longer meet the definition of disability,
- The date you die,
- After 2 years, if the disability is due to a Mental Disorder and/or Substance Abuse if Occupation Class 5P, 4P, 3P and 4S; or
- The end of the maximum benefit period (as shown in the following table).

Even if your employment with Boston University terminates, your IDI Plan benefits will continue according to the schedule above for as long as you meet the definition of disability.

Special Benefits

Family Care Benefit

This feature provides benefits to replace lost income if you are working at least 20% fewer hours, resulting in an income loss of 20% or more to care for a family member with a serious health condition. You do not have to be disabled to receive this benefit.

Age When Disability Begins	Maximum Benefit Period
61 or younger	To age 67
62	60 months
63	48 months
64	42 months
65	36 months
66	30 months
67	24 months
68	24 months
69	21 months

70	18 months
71	16 months
72	15 months
73	14 months
74	13 months
75 or older	12 months

Recovery Benefit

This feature provides a benefit after a period of disability if you fully recover, return to full-time work in your occupation but you continue to lose earned income due to your prior disability. This provision pays a benefit while you re-establish your earnings base. The amount you get is based on the percentage of earnings you lose.

Rehabilitation Program

This benefit can help you regain your self-sufficiency as soon as possible. While you are disabled and receiving benefits, you can receive help to return to work by participating in a voluntary rehabilitation program approved by the insurance company. Some or all expenses in connection with the rehabilitation program may be paid by the insurance company.

Exclusions

Benefits will not be paid for:

- Disability caused or contributed to by war, declared or undeclared, or any act or incident of war, or which resulted from military training, military action or military conflict while you are on active duty in the military service,
- The first 90 days of your disability due to pregnancy or childbirth, except for complications of pregnancy,

- Disability caused or contributed to by your committing or attempting to commit a felony, or your being engaged in an illegal occupation,
- Disability cause or contributed to by your actively participating in a violent disorder or riot. “Actively participating” does not include your being at the scene of a violent disorder or riot while performing your official duties,
- Disability while you are confined for any reason to a penal or correctional institution for a period of more than 7 days,
- Intentionally self-inflicted injury; or
- Any loss excluded by name or specific description.

Benefits will be paid for disabilities caused or contributed to by a pre-existing condition or by a medical or surgical treatment of a pre-existing condition only if, on the date you became disabled, the policy has been continuously in effect for 12 consecutive months.

Benefits will be limited to an aggregate total of 12 months of benefit for each period of disability while you are not residing in the United States or Canada. If you should return to reside in the United States or Canada, you may become eligible to resume receiving benefits if you satisfy all terms and conditions of the policy.

Severability

The Provisions of the Plan are severable. If any provision of the Plan is deemed illegally or factually invalid or unenforceable to any extent or in any application, then the remainder of the provision and the Plan, except to such extent or in such application, shall not be affected, and each and every other provision of the Plan shall be valid and enforceable to the fullest extent and in

the broadest application permitted by law.

Plan Limitations

Being a participant in a Boston University Individual Disability Insurance Benefit does not give an employee the right to continued employment with Boston University or any of its subsidiaries or affiliates. An employee cannot sell, transfer, pledge or assign either voluntarily or involuntarily the value of his or her benefit.

Administrative Information

Sponsor for This Plan

This plan is sponsored by the employer, Boston University, Boston, Massachusetts, which is also the Plan Administrator. Eligibility for the benefit plan described in this handbook applies to those University employees on the US payroll.

Boston University’s Employer Identification Number

For identification purposes, the Internal Revenue Service has assigned number 04-2103547 to Boston University. You will need to know this number if you write to a government agency about any of the plans.

Type of Plan, Plan Number, and Plan Year

In addition to the University’s Employer Identification Number, you need to know the following information:

- **Type of Plan:** The Individual Disability Insurance Benefit is characterized by the federal government as a Welfare Plan.
- **Plan Number:** Boston University has assigned Plan Number 508 to

The Individual Disability Insurance Benefit.

- **Plan Year** The financial records of this plan are kept on a Plan Year basis. The Plan Year for The Individual Disability Insurance Benefit is April 1 to March 31.

Administrator for This Plan

The day-to-day administration of this plan is handled by Human Resources. However, if you have a question or a problem that cannot be resolved by Human Resources, you should contact the Plan Administrator.

The Plan Administrator can be reached by contacting:

Plan Administrator
The Trustees of Boston University
25 Buick Street Boston, MA 02215
Phone: 617-353-4489

Boston University pays the entire cost of many of the benefit plans described in this handbook. In some cases, you and the University share the cost. In others, you pay the entire cost.

Following is an explanation of how this plan is funded and who is responsible for paying benefits:

Contributions to the Individual Disability Insurance Benefit are used by the following providers, who are responsible for processing claims for benefits. The addresses and telephone numbers of these processors are:

Standard Insurance Company
1100 SW Sixth Avenue
Portland, OR 97204
Phone: 1-888-937-4783

Agent of Legal Service

The agent for the service of legal process for this plan is:

University Counsel
125 Bay State Road
Boston, MA 02215

Legal process may be served on the Plan Administrator.

Fraudulent Claims

Submission of a claim for benefits under any of the plans described in this handbook includes a representation that the claim is bona fide and, to the best knowledge of the employee, dependent, or other claimant, proper for payment. Submission of a fraudulent or knowingly false claim by an employee or an employee's dependent participating in a plan will be grounds for disciplinary action against the employee, including termination of participation by the employee and/or covered dependent(s) under the plan.

Claims for Benefits/Appealing a Denial of Claims for Benefits

When you apply for benefits, there are time periods within which you must receive a decision on your claim for benefits. If you or your beneficiary applies for benefits and either part or all of the request is denied, you have the right to appeal that decision, provided the appeal is made in accordance with the provisions of the plan and applicable laws (e.g., appeals must be filed within required time periods).

Appeals are generally decided by the provider of the benefit involved, which is the insurance carrier, claims administrator, or vendor for most benefits, or the University or its Plan Administration Committee for some benefits.

Appeals to Insurance

Carriers/Claims Administrators/Other Vendors

Appeals regarding benefits or other issues affecting plan participants or other persons for The Individual Disability Insurance Benefit should be made to Standard Insurance Company. The claims filing procedures are set forth in the separate written document, insurance certificate or contract, benefit summary, or other governing document for the Individual Disability Insurance Benefit Plan.

Details of claims and appeal procedures may vary, but generally the following procedures apply:

- If a claim for benefits is either wholly or partially denied, you will be notified in writing. The notice will state the reasons why the claim was denied and the deadline for requesting review, which is different for different types of plans and/or claims.
- If you wish to appeal, you are entitled to review all documents pertaining to your claim free of charge and may also submit comments pertaining to your claim.
- Your appeal of the denial should be addressed to the applicable provider as directed in the denial of benefits notice.
- The applicable provider will decide the claims and appeals in the time and manner required by law.
- Unless a different time period applies, claims will be decided within 90 days (180 days if special circumstances apply) and appeals for denied claims must be filed within 60 days of denial. A decision must be made within 60 days (or 120 days if special circumstances are present and you are notified).

Documents and Laws Governing This

Plan

The plan description contained in this handbook was written from the documents that legally govern how the plan works. In the event of any discrepancy between the plan description in this handbook and the controlling contracts or plan documents, the language in the controlling contracts or plan documents will govern. If you would like a copy of any of these documents, please contact Human Resources.

The plan is also regulated by applicable provisions of applicable laws, which will govern in the event of any conflict between the law and the terms of the plan as described in either the documents or in this summary plan description.

Equal Opportunity/Affirmative Action Policy

Since its founding in 1839, Boston University has been dedicated to equal opportunity and has opened its doors to students without regard to race, sex, creed, or other irrelevant criteria. Consistent with this tradition, it is the policy of Boston University to promote equal opportunity in educational programs and employment through practices designed to extend opportunities to all individuals on the basis of individual merit and qualifications, and to help ensure the full realization of equal opportunity for students, employees, and applicants for admission and employment. The University is committed to maintaining an environment that is welcoming and respectful to all.

Boston University prohibits discrimination against any individual on the basis of race, color, religion, sex, age, national origin, physical or mental disability, sexual orientation, genetic information, military service, or because of marital, parental, or veteran

status. This policy extends to all rights, privileges, programs, and activities, including admissions, financial assistance, educational and athletic programs, housing, employment, compensation, employee benefits, and the providing of, or access to, University services or facilities. Boston University recognizes that that equal opportunity is a reality. Accordingly, the University will continue to take affirmative action to achieve equal opportunity through recruitment, outreach, and internal reviews of policies and practices.

The coordination and implementation of this policy is the responsibility of the Director of Equal Opportunity. The officers of the University and all deans, directors, department heads, and managers are responsible for the proper implementation of equal opportunity and affirmative action in their respective areas, and they are expected to exercise leadership toward their achievement. It is expected that every employee of Boston University will share this commitment and cooperate fully in helping the University meet its equal opportunity and affirmative action objectives.

Boston University has developed detailed procedures, described in its *Complaint Procedures in Cases of Alleged Unlawful Discrimination or Harassment* (www.bu.edu/eoo/policies-procedures/complaint), by which individuals may bring forward concerns or complaints of discrimination and harassment. Retaliation against any individual who brings forward such a complaint or who cooperates or assists with an investigation of such a complaint is both unlawful and strictly prohibited by Boston University.

Inquiries regarding this policy or its application should be addressed to the Director of Equal Opportunity, Equal

Opportunity Office, 888 Commonwealth Avenue, Suite 303, Boston, MA 02215, or call 617-358-1796.

Amendment or Termination of the Plan

Boston University intends to continue maintaining the plan described in this handbook for the exclusive benefit of its employees.

However, the University reserves the right to change or discontinue it, and to implement changes as required by federal, state, or local laws.

You will be informed of any material changes that are made to the plans. If a plan is terminated, your rights, on the date of the termination, would be governed by the provisions of the plan document.

Your Rights Under ERISA

The Individual Disability Insurance Benefit Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides the participants in these plans with certain rights and protections. The following statement is included here so that you will be aware of your rights under the law.

Under ERISA:

- You may examine, without charge, at Human Resources and at other specified locations, during normal business hours, all plan documents relating to the plans in which you participate. The documents that must be available for your review include insurance contracts, plan and trust documents, collective bargaining agreements, and all documents filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security

Administration, for example, detailed annual reports.

- If you wish, you may request your own copies of these plan documents by writing to Human Resources. Where permitted by law, you may have to pay a reasonable charge to cover the costs of copying.
- You will receive summaries of the plans' annual financial reports each year, free of charge. The administrator for the plans is required by law to furnish each participant with a copy of these summary annual reports.

Plan Fiduciaries

Besides giving you certain rights as a participant, ERISA places certain duties upon the people who are responsible for the management of the above-mentioned plans. These people are called "fiduciaries" under the law, and they have the duty to act prudently and in your best interests.

Under ERISA, no one may fire you or discriminate against you to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Enforcing Your Rights

If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to obtain copies, without charge, of documents relating to the decision, and to appeal any denial all within certain time schedules.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to

provide the materials and pay you up to \$110 for each day's delay until you receive the materials, unless the materials were not sent for reasons beyond the administrator's control. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with a plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse plan money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or file suit in a federal court.

In a lawsuit, the court normally decides who pays the court costs and legal fees. If you are successful, the other party might have to pay. But, if you lose, the court might order you to pay these costs and fees, especially if the court finds your claim to be frivolous.

Assistance with Questions

If you have any questions about this statement of your rights under ERISA, contact Human Resources. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

and staff and is intended to serve as the summary plan description for the Individual Disability Plan. It is designed as a quick reference source and is not intended to cover every point of policy. In certain instances, the University may exercise discretion, with respect to the administration of the plan described in this handbook. For more in-depth information, contact Human Resources.

Periodically, the University may make changes in policy that may not be reflected immediately in this handbook.

Again, for complete and up-to-date information about any policy or benefit, you should contact Human Resources.

Please note: The policies described in this handbook are not intended to create an employment contract between Boston University and its employees. Therefore, they do not alter the University's rights regarding discharges and layoff.

A Final Note

This handbook presents a summary of Boston University's benefits for faculty

SURVIVOR INSURANCE



Boston University offers you insurance plans that provide benefits to help maintain financial security for your beneficiaries in the event of your death.

Under the Group Basic Life Insurance Plan, you are automatically provided with basic coverage equal to one times your annual base salary at no cost to you as long as you are actively at work on the day your coverage becomes effective.

If you wish and are eligible, you can, at your expense, also purchase Group Supplemental Life Insurance equal to one, two, three, four, or five times your base annual salary. You may also cover your spouse and children under this plan.

The Travel Accident Insurance Plan is also provided at no cost to you. It provides benefits to you or your beneficiaries if you suffer a covered injury or are injured or killed while traveling on authorized University business.

The Personal and Family Accident Insurance Plan provides benefits should you or your family members suffer a covered injury or be killed as the result of any accident—for University employees this includes accidents on and off the job—on a worldwide, 24-hour basis. You pay the cost for the coverage you choose under this plan.

Once you have completed five years of service, the Supplemental Death Benefit Plan will automatically provide your beneficiaries with a lump sum payment equal to one month's base salary in the event of your death. The benefits under this plan are provided free of charge to you and apply regardless of the amount of coverage you have under other University-sponsored plans.

Basic Life Insurance Plan

Eligibility

If you are classified by the University as a regular employee, work a full-time schedule, and have an appointment of nine months' or more duration, you are eligible to participate in the Basic Life Insurance Plan on your first day of active employment.

Employees whose percentage time worked decreases below the eligibility requirements for the Basic Life Insurance Plan as of January 1, 2015, will no longer be able to participate in the Basic Life Insurance Plan.

Coverage

The University will automatically provide you with basic life insurance equal to one times your annual base salary, rounded up to the next highest \$1,000 if not already an even multiple of \$1,000, to a maximum of \$1,000,000.

For example, if your annual base salary is \$28,100, your basic life insurance coverage is \$29,000. If your annual base salary is exactly \$28,000, your basic life insurance coverage is \$28,000.

Your basic life insurance coverage becomes effective on your first day of active employment. If you are absent from active work and not performing your normal duties on the day your basic life coverage would normally begin, you will not be covered by this insurance until the day you return to active work.

When the amount of your annual base salary changes, the amount of basic life insurance may also change. For example, if your base salary increased from \$29,100 to

\$29,300 per year, you would still have \$30,000 in basic life insurance coverage. If your base salary increased from \$28,800 to \$29,200, your basic life insurance would increase from \$29,000 to \$30,000 of coverage. The change takes effect on the first of the month coincident with or next following the effective date of an increase in your salary.

If your salary decreases, your basic life insurance coverage remains the same. If you are not actively at work performing your duties on the day a change in your basic life coverage would normally become effective, the change will not become effective until the day you return to active work.

Cost

You pay nothing for your basic life insurance under this plan. The cost of this coverage is paid entirely by the University.

Special Tax Considerations

Under current tax laws, all or a portion of the value of employer-paid basic life insurance coverage in excess of \$50,000 is subject to federal income, Massachusetts state income, and Social Security taxes.

This taxable amount is called "imputed income," and will be included in the taxable earnings shown on your W-2 Form.

Payment of Benefits to Your Beneficiary

This plan will pay the full amount of your Group Basic Life Insurance in force at the time of your death to the beneficiary of your choice. You choose your beneficiary by completing a form provided to you by Human Resources, or from the

website at www.bu.edu/hr/documents/group_life_statement.pdf, at the time your coverage begins. You must complete, sign, and return the form to Human Resources for it to become effective. You may change your beneficiary at any time by completing, signing, and returning a new form. If no proper beneficiary designation is in effect at the time of death, the benefit goes to the surviving spouse. In the absence of a surviving spouse, the benefit is paid to any children, parents, and siblings in equal shares.

Events Affecting Your Coverage

If You Become Totally Disabled

Once you begin to receive disability benefits from the University's Long-Term Disability Plan, the amount of life insurance coverage available is equal to your basic insurance in effect on the date you stop working because of your total disability, subject to any subsequent age-related reductions, as explained below. This coverage continues, at no cost to you, while you are receiving benefit payments under the Long-Term Disability Plan.

For full details, contact Human Resources.

If You Continue to Work Beyond Age 65 or Are Covered as a Result of Total Disability after Age 65

If you continue to work beyond age 65 or are covered as a result of total disability after age 65, your basic life insurance will be reduced to a percentage of the coverage in force just prior to your 65th birthday.

The amount of your insurance will be rounded to the next higher \$1,000 and reduced to the percentage noted below.

This reduction in your coverage will be made according to the following schedule:

Attained Age	Percentage of Original Benefit
65	65%
70	45%
75	30%
80 and older	20%

If you enter the plan after age 65, your basic life insurance will be limited to a percentage (determined according to the schedule above) of your base salary in effect upon hire.

How to Obtain Benefits

In the event of your death, your beneficiary should contact Human Resources as soon as possible. The University will then provide claim forms to your beneficiary and assist in submitting the forms to the insurance carrier.

Appealing a Denial

The insurance company is solely responsible for determining what constitutes a covered claim under this plan.

If your beneficiary applies for benefits from this plan and either part or all of the claim is denied, he or she has the right to appeal the denial.

Additional information about how to appeal a denial of benefits is included in the "Administrative Information" section of this handbook.

Termination, Conversion, or

Portability of Coverage

Apply for Coverage Under Portability Plan

Life Insurance ends automatically on the date you are no longer eligible to be a member (see Eligibility section of this handbook). Group Supplemental Life Insurance for your spouse and/or child will also end if you die or receive disability benefits from the University's Long-Term Disability Plan.

The Group Supplemental Life Insurance in effect for you and your dependents at the time that your group coverage ends is portable or convertible.

If your insurance under the Group Policy ends or is reduced, you may be eligible to buy portable group insurance coverage for yourself and your dependents without submitting Evidence of Insurability.

The minimum and maximum amounts that you are eligible to buy under the Group Life Portability Insurance Policy are shown below. You may buy less than the maximum amounts in increments of \$1,000. The combined amounts of insurance purchased under this Portability of Insurance provision and the Right to Convert provision cannot exceed the amount in effect under the Group Policy on the day before your insurance under the Group Policy ends or is reduced.

- For you, the minimum amount is \$10,000, and the maximum amount is \$1,000,000.
- For your spouse, the minimum amount is \$5,000, and the maximum amount is \$100,000.
- For your dependent children, the minimum amount is \$1,000, and the maximum amount is \$10,000.

Administration of your portable coverage is continued on a direct bill basis through

the life insurance company. You must apply for portability and pay your first premium within 31 days after the termination of the coverage. A physical examination will not be required, but you will need to satisfy the insurance company's eligibility requirements as listed above. Your insurance coverage will continue during this 31-day period should you die during this period.

Accelerated Benefit

If you are terminally ill as a result of an illness or physical condition which is expected to result in death within 24 months while you are insured under the Group Policy, you may be able to receive during your lifetime a portion of your insurance as an Accelerated Benefit. You must have at least \$10,000 of insurance in effect to be eligible.

You may receive an accelerated benefit of up to 75% of your insurance. The maximum accelerated benefit is \$500,000. The minimum accelerated benefit is \$5,000 or 10% of your insurance, whichever is greater.

You must apply to the insurance company on their form for an accelerated benefit. You must include a statement from a physician that you have a qualifying medical condition.

Group Supplemental Life Insurance Plan

Eligibility and Coverage

Eligibility for You

If you are classified by the University as a regular employee, work a full-time schedule, and have an appointment of nine months' or more duration, you and your eligible family members are eligible to participate in the Group Supplemental Life Insurance Plan on your first day of active employment.

Employees whose percentage time worked decreases below the eligibility requirements for the Group Supplemental Life Insurance Plan as of January 1, 2015, will no longer be able to participate in the Group Supplemental Life Insurance Plan.

Coverage for You

You have the option of purchasing your own Group Supplemental Life Insurance coverage for you equal to one, two, three, four, or five times the amount of your base annual salary. If that amount is not already an even multiple of \$10,000, it is rounded to the next higher \$10,000 up to \$2,500,000. For example:

- If your annual base salary is \$28,100 and you elect Group Supplemental Life Insurance equal to one times your annual base salary, you will have an additional \$30,000 of insurance for a total amount of \$59,000 including the \$29,000 basic insurance that the University provides.
- If your annual base salary is \$28,100 and you elect Group Supplemental Life Insurance equal to two times your annual base salary, you will have an additional \$60,000 of insurance for a total amount of \$89,000 including the basic insurance that the University provides.
- If your annual base salary is \$28,100 and you elect Group

Supplemental Life Insurance equal to three times your annual base salary, you will have an additional \$90,000 of insurance for a total amount of \$119,000 including the basic insurance that the University provides.

Coverage for Your Spouse

You may also elect to cover your spouse individually for an amount in even multiples of \$10,000 but only if you choose to enroll for supplemental coverage for yourself. The maximum coverage amount you may elect for your spouse is three times your annual base salary (rounded up to the next higher multiple of \$10,000) or \$100,000, whichever is less.

In the event of divorce, your former spouse will no longer be covered by the spousal coverage.

Dependents' Eligibility

Your child(ren) may be covered starting at live birth through their 19th birthday. Dependent child(ren) must be unmarried and considered eligible. You may enroll your children in Group Supplemental Life Insurance coverage if you elect supplemental coverage for yourself.

Coverage for Your Dependents

Your dependents are eligible for coverage amounts of \$5,000 or \$10,000 of insurance for each child.

Enrolling in Group Supplemental Life Insurance

Enrolling Yourself in Group Supplemental Life Insurance

You may enroll in Group Supplemental

Life Insurance coverage for yourself for up to \$500,000 without evidence of insurability, but you must be actively at work, if you complete the enrollment process on Employee Self Service at www.bu.edu/buworkscentral and select BU Benefits Center within 31 days after your benefits orientation, assuming you commence active employment as required by the supplemental life insurance coverage. In this case, your Group Supplemental Life Insurance coverage becomes effective on the date you enroll. Any insurance for which evidence of insurability is required will not become effective until the insurance company approves the evidence and all other policy requirements (e.g., actively-at-work requirements) are also satisfied.

If you do not elect Group Supplemental Life Insurance coverage within 31 days after your orientation or you enroll for coverage that exceeds \$500,000, the insurance company will require you to provide evidence of insurability satisfactory to the insurance company. Any insurance for which evidence is required will not become effective until the insurance company approves the evidence.

If you are absent from active employment and not performing your regular duties on the day your Group Supplemental Life Insurance coverage would normally begin, you will not become covered until the day you return to active work.

If your annual base salary changes, the amount of Group Supplemental Life Insurance you have elected

will automatically change to one, two, three, four, or five times your new base annual salary. This change will be effective on the first of the month on or following the date the change in your base salary becomes effective.

If your salary decreases, your Group Supplemental Life Insurance coverage remains the same.

If you are not at work on the day a change in your Group Supplemental Life Insurance coverage would normally become effective, the change will not become effective until the day you return to work.

Enrolling Your Spouse in Group Supplemental Life Insurance

You may enroll your spouse in Group Supplemental Life Insurance coverage if you elect supplemental coverage for yourself. Coverage is available for your spouse from \$10,000 to \$100,000 (not to exceed three times your base salary rounded up to the next higher multiple of \$10,000). If you complete the enrollment process on Employee Self Service at www.bu.edu.

www.bu.edu/buworkscentral and select BU Benefits Center within 31 days of your benefits orientation, you may enroll your spouse for an amount up to \$20,000 without providing evidence of insurability. In order for dependents (spouse or child) to be eligible for coverage, they cannot be hospital or home confined, and must be able to carry out all their normal activities of daily living.

The eligibility date for your spouse is your eligibility date, or the date of your marriage if later than your eligibility date. If you do not elect Group Supplemental Life Insurance coverage for your spouse within 31 days after your spouse's eligibility date or enroll for coverage that

exceeds \$20,000, the insurance company will require you to provide evidence of insurability. Any insurance for which evidence is required will not become effective until the insurance company approves the evidence.

Enrolling Your Child for Group Supplemental Life Insurance

You may enroll your child for Group Supplemental Life Insurance coverage only if you choose to enroll yourself. Coverage is available for each child for either \$5,000 or \$10,000. You must enroll online at www.bu.edu/buworkscentral. Go to Employee Self Service and select BU Benefits Center within 31 days of the child's eligibility date. In order for dependents (spouse or child) to be eligible for coverage, they cannot be hospital or home confined, and must be able to carry out their normal activities of daily living.

The eligibility date for your child is your eligibility date, or any later date when you first have or adopt a child.

To elect Group Supplemental Life Insurance coverage, go to Employee Self Service at www.bu.edu/buworkscentral. Select BU Benefits Center, then select Update Life Insurance Coverage. This authorizes the University to deduct the cost of the Group Supplemental Life Insurance coverage that you desire from your paychecks. The employee is automatically the beneficiary of spouse or dependent life insurance.

Cost

You pay for Group Supplemental Life Insurance, if you choose it. The cost to you depends on your age and the amount of Group Supplemental Life Insurance you desire.

The cost of Group Supplemental Life Insurance will increase with your age or with an increase in the amount of coverage you have. An increase in cost resulting from a change in your age will become effective on the first of the month in which you have a birthday when your age bracket changes. An increase in the amount of coverage resulting from an increase in your base pay will become effective on the first of the month on or following the date the change becomes effective. You pay for your portion of the premiums for your Group Supplemental Life Insurance with after-tax dollars.

Changing or Stopping Your Supplemental Life Insurance

Because your premiums for Group Supplemental Life Insurance are after-tax contributions, there are no tax law restrictions as to when you can change your amount of coverage, stop your coverage, or begin your coverage. The insurance company may require you to provide evidence of insurability if you increase your coverage or begin coverage after your initial enrollment period of the 30 days following your benefits orientation.

Special Tax Considerations

Under current tax laws, the value of your spouse's life insurance coverage is subject to federal income, Massachusetts state income, and Social Security taxes. These taxable amounts are called "imputed income." Imputed income for your spouse's life insurance benefit 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 spouse is subject to imputed income for tax purposes.

Events Affecting Your Coverage

If You Become Totally Disabled

Once you begin to receive disability benefits from the University’s Long-Term Disability Plan, the amount of life insurance coverage available is equal to your supplemental insurance in effect on the date you stop working because of your total disability, subject to any age-related reductions, as explained below. This coverage continues at no cost to you while you are receiving benefit payments under the Long-Term Disability Plan. For full details, contact Human Resources.

If You Continue to Work Beyond Age 65 or Are Covered as a Result of Total Disability after Age 65

If you continue to work beyond age 65 or are covered as a result of total disability after age 65, your Group Supplemental Life Insurance will be reduced to a percentage of the coverage in force just prior to your 65th birthday. The amount of your insurance will be rounded to the next higher \$10,000 and reduced to the percentage noted below. This reduction in your coverage will be made according to the following schedule:

Attained Age	Percentage of Original Benefit
65	65%
70	45%
75	30%
80 and older	20%

If you enter the plan after age 65, your Group Supplemental Life Insurance will be limited, according to the schedule, to a percentage of the coverage you would have been eligible for before age 65.

If You Retire

When you retire, your Group Supplemental Life Insurance, and/or any spouse or child Group Supplemental Life Insurance you had elected, will end on the last day of the month of your retirement.

How to Obtain Benefits

In the event of your death, your beneficiary should contact Human Resources as soon as possible. Your beneficiary for the Group Supplemental Life Insurance Plan is the same beneficiary as the one you designate for the basic life insurance coverage unless you indicate otherwise. Once notified of your death, the University will provide claim forms to your beneficiary and assist in submitting them to the insurance carrier. You are the beneficiary of your spouse or child coverage. You should contact Human Resources should your spouse or child die.

Appealing a Denial

The insurance company is solely responsible for determining what constitutes a covered claim under this plan.

If your beneficiary applies for benefits from this plan and either part or all of the claim is denied, he or she has the right to appeal the denial.

Additional information about how to appeal a denial of benefits is included in the “Administrative Information” section of this

handbook.

Termination, Conversion, or Portability of Coverage

Apply for Coverage Under Portability Plan

Life Insurance ends automatically on the date you are no longer eligible to be a member (see Eligibility section of this handbook). Group Supplemental Life Insurance for your spouse and/or child will also end if you die or receive disability benefits from the University’s Long-Term Disability Plan.

The Group Supplemental Life Insurance in effect for you and your dependents at the time that your group coverage ends is portable or convertible.

If your insurance under the Group Policy ends or is reduced, you may be eligible to buy portable group insurance coverage for yourself and your dependents without submitting Evidence of Insurability.

The minimum and maximum amounts that you are eligible to buy under the Group Life Portability Insurance Policy are shown below. You may buy less than the maximum amounts in increments of \$1,000. The combined amounts of insurance purchased under this Portability of Insurance provision and the Right to Convert provision cannot exceed the amount in effect under the Group Policy on the day before your insurance under the Group Policy ends or is reduced.

- For you, the minimum amount is \$10,000, and the maximum amount is \$1,000,000.
- For your spouse, the minimum amount is

\$5,000, and the maximum amount is \$100,000.

- For your dependent children, the minimum amount is \$1,000, and the maximum amount is \$10,000.

Administration of your portable coverage is continued on a direct bill basis through the life insurance company. You must apply for portability and pay your first premium within 31 days after the termination of the coverage. A physical examination will not be required, but you will need to satisfy the insurance company's eligibility requirements as listed above. Your insurance coverage will continue during this 31-day period should you die during this period.

Convert Your Coverage to a Non-Group Plan

When your Supplemental Life coverage ends, you may convert your coverage to an individual whole life insurance policy if you apply to the insurance company. If the amount of your supplemental life insurance is reduced because of age, you may also convert the lost coverage to an individual whole life insurance policy issued by the insurance company.

You must apply for conversion, satisfy the insurance company's requirements, and pay your first premium within 31 days after the reduction or termination of the coverage you wish to convert. A physical examination will not be required to convert your coverage.

Your insurance coverage will continue during the 31-day conversion period should you die during this period.

Accelerated Benefit

If you are terminally ill as a result of

an illness or physical condition which is expected to result in death within 24 months while you are insured under the Group Policy, you may be able to receive during your lifetime a portion of your insurance as an Accelerated Benefit. You must have at least \$10,000 of insurance in effect to be eligible.

You may receive an accelerated benefit of up to 75% of your insurance. The maximum accelerated benefit is \$500,000. The minimum accelerated benefit is \$5,000 or 10% of your insurance, whichever is greater.

You must apply to the insurance company on their form for an accelerated benefit. You must include a statement from a physician that you have a qualifying medical condition.

Additional Administrative Information

For additional information such as plan administrative information and your rights under ERISA, please refer to the Administrative Information section of this Handbook.

Personal and Family Accident Insurance Plan

Eligibility

If you are classified by the University as a regular employee, work a full-time schedule, and have an appointment of nine months' or more duration, you and your eligible family members may participate in the Personal and Family Accident Insurance Plan.

For the purposes of the plan, your eligible dependents are your spouse and your unmarried dependent children from birth through 19 years.

To elect Personal and Family

Accident Insurance coverage, complete the enrollment process on Employee Self Service at www.bu.edu/buworkscentral and select BU Benefits Center. Coverage is effective on the first day of the month on or following the date you enroll.

If you do not elect coverage under this plan within 30 days of your benefits orientation meeting, your next opportunity to enroll will be during the open enrollment period. You will not be required to submit evidence of good health if you delay your enrollment.

Employees whose percentage time worked decreases below the eligibility requirements for the Personal and Family Accident Insurance Plan as of January 1, 2015, will no longer be able to participate in the Personal and Family Accident Insurance Plan.

Coverage

The plan covers you and your enrolled dependents against any accidental bodily injuries. For University employees, this includes accidents on or off the job worldwide, 24 hours per day.

Coverage for You

The Personal and Family Accident Insurance provides financial protection to you or your beneficiary if you should die, or lose sight, a limb, speech or hearing, or become paralyzed as the direct result

of an accident. You may choose any amount of coverage in multiples of \$10,000 up to \$350,000 (amounts over \$150,000 cannot exceed ten times your annual base salary).

Coverage for Your Family

If you choose family coverage, the plan will provide you with additional financial protection if your spouse or an eligible dependent dies or becomes dismembered as the direct result of an accident. If you choose family coverage, all of your dependents are “covered members” of the plan.

For every \$10,000 of insurance covering you, the coverage amounts for your family members will be:

- \$6,000 coverage for your spouse, if you have no eligible children; or
- \$5,000 for your spouse and \$1,500 for each eligible child; or
- \$2,000 for each eligible child, if you have children but no spouse.

For example, suppose you chose \$50,000 of coverage for yourself. If you are married with no children, your spouse would be insured for \$30,000 of coverage. If you are married with children, coverage would be \$25,000 for your spouse and \$7,500 for each child. If you have children but no spouse, coverage for each child would be \$10,000.

Cost

The amount you pay depends on the amount of coverage you want or whether or not you want coverage for your family.

How Insurance Premiums Are Paid

You pay for the cost of the premiums

for both you and your family with pre-tax dollars. This is because Boston University automatically takes your payments from your paycheck before federal income, state income, and Social Security taxes are taken out.

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

Changing or Stopping Coverage

Because you pay for your coverage with before-tax dollars, the provisions of Section 125 of the Internal Revenue Code also govern how and when you may make changes in your Personal and Family Accident Insurance coverage. Under the current provisions of Section 125, you may change the amount of your coverage or cancel your coverage once each year, during the annual open enrollment period. The only other time you may make a change in your Personal and Family Accident Insurance coverage is if you have a Qualifying Life Event. Qualifying Life Events are explained in the “Flexible Benefits Program” handbook.

Types of Benefits

Benefits, in the event of a covered loss, are based on the coverage amounts in effect for you and your covered family members at the time of the loss.

Accidental Death Benefits

The plan will pay the full coverage amount to your beneficiary if you die as a direct result of an accident. If a covered member of your family dies as the direct result of an

accident, you will receive the coverage amount applicable to that dependent.

If you or any of your covered family members die as the result of a covered accident that occurs while you are either riding as a passenger or driving a private passenger car while wearing a seat belt, the plan will pay a benefit equal to 10% of your coverage amount or \$25,000 (whichever is less). This benefit will be paid in addition to any other accidental death benefits.

Unless you designate otherwise, the beneficiary for the Personal and Family Accident Plan will be the same as the one you designate for the Basic Life Insurance Plan. Beneficiary designations may be changed at any time by completing a new form.

If you elect family coverage and you die as a result of an accident, the following special provisions apply:

- **Extensions of Family Coverage** Coverage for your surviving family members will continue, at no cost to them, for 90 days from the date of your last premium payment.
- **Education Benefit** The plan will pay, in addition to all other benefits, 2% of your coverage amount on behalf of any dependent child who at the time of your accident was enrolled as a full-time student in a college or university. The

education benefit will also be paid to a dependent child who at the time of your accident is in the twelfth grade, if he/she enrolls as a full-time student in a college or university within 365 days of the accident.

The education benefit is paid annually, for a maximum of four consecutive payments, as long as the dependent child remains in college as a full-time student.

If you have no dependent children who qualify for the education benefit, the plan will pay a one-time additional benefit of 2% of the full coverage amount to your beneficiary.

- **Day Care Benefit** The plan will pay, in addition to all other benefits, the lesser of \$3,000 or 3% of your or your spouse’s coverage amount on behalf of each insured dependent child under age seven who at the time of your accident was attending a day care center or would be attending a day care center within one year. The Day Care benefit is paid annually, for a maximum of four consecutive payments, as long as the dependent child remains enrolled in a day care center and is under age seven. If you have no dependent children who qualify for the Day Care benefit, the plan will pay a one-time additional benefit of 3% of the full coverage amount up to \$3,000 to your beneficiary.

If you have coverage for yourself and your family, and both you and your spouse die within 365 days as a result of the same accident or separate accidents within 24 hours of each other, the amount payable for loss of the life of your spouse will be increased to the same amount payable for your death.

The accidental death benefit is normally paid in a lump sum of cash. However, you or your beneficiary may choose to have all or part of your benefit from the plan paid in a fixed number of monthly installments, rather than in a lump sum, in accordance with the insurance company’s rules.

Accidental Dismemberment Benefits

If you or a covered member of your family should become seriously injured in an accident, the plan will pay to the injured person:

- 100% of the coverage amount for the loss of both feet, hands, the sight of both eyes, speech and hearing, or any combination of two of the following: a hand, a foot, or the sight of one eye.
- 50% of the coverage amount for the loss of one foot, one hand, sight of one eye, speech, or hearing.
- 25% of the coverage amount for the loss of a thumb and an index finger on the same hand.

Loss means complete and irrecoverable loss. The plan will pay for the above losses only if they occur within one year after the date of the accident and as a direct result of that accident.

Accidental dismemberment benefits will be paid in a lump sum of cash.

Type	Percentage of Full Coverage Amount
Quadriplegia (total paralysis* of both upper and lower limbs)	100%
Paraplegia (total paralysis* of both lower limbs)	75%
Hemiplegia (total paralysis* of both	50%

upper and lower limbs on one side of the body)	
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**For plan purposes, “paralysis” means complete and irreversible loss of use of a limb.*

Loss of Use Benefit

The plan will pay you a loss of use benefit if you are determined to be paralyzed within 365 days of an accident. Benefits will be paid according to the schedule above.

If You Continue to Work Beyond Age 70

If you continue to work beyond age 70, your coverage will be reduced to a percentage of the coverage in force just prior to your 70th birthday. This reduction in your coverage will be made according to the schedule below:

If you enter the plan after age 70, your coverage will be limited, according to the schedule, to a percentage of the coverage you would have been eligible for before age 70. The coverage for a spouse under age 70, and any dependent children, will be based on a percentage of your coverage prior to age 70 (see the “Coverage for Your Family” section for examples).

Attained Age	Percentage of Original Benefit
70 through 74	82.5%
75 through 79	57.5%
80 through 84	37.5%
85 and older	20.0%

After you reach age 70, the cost of premiums for coverage for you and your family will be based on the cost of your coverage amount prior to age 70.

Exclusions

Under this plan, coverage for air travel is provided while riding as a passenger, and not as a pilot or crew member, in any aircraft being used for the transportation of passengers except one owned, operated, or leased by or on behalf of Boston University. For a complete explanation of these exclusions, contact Human Resources.

Finally, the plan does not provide coverage for anyone serving full time in the armed forces of any country for more than two months. Premiums paid for coverage during such periods of military service will be refunded

How to Obtain Benefits

To claim benefits from the Personal and Family Accident Insurance Plan, you or your beneficiary should contact Human Resources as soon as possible after the loss. Human Resources will help you complete the claims forms and will forward them to the insurance company. To process an accidental dismemberment or paralysis claim, the insurance company may require you or your family member(s) to be examined by a physician at the company's expense.

Appealing a Denial

The insurance company is responsible for determining when benefits will be paid under this plan. If the insurance company denies your claim for benefits, consult Human Resources for information on the procedure for appealing the denial.

Additional information about how to appeal a denial of benefits is included in the "Administrative Information" section of this handbook.

Leaves of Absence or No-Pay Status

If you leave active work for any reason for a prolonged period of time, you should always contact Human Resources to ask what effect your absence may have on your participation in this plan.

- **Leave of Absence with Pay** If you are granted a leave of absence with pay, your coverage will continue, provided your usual payroll deductions continue.
- **Leave of Absence without Pay or No-Pay Status** If you are granted a leave of absence without pay or are on no-pay status, you may continue your coverage during your leave provided you pay the cost of continuing this coverage. If you choose to continue coverage, you should contact Human Resources before you begin your leave, in order to make the necessary billing arrangements. This coverage will automatically be canceled for non-payment of bills.

If you choose not to continue this insurance, coverage will automatically end on the last day of the month in which you are granted such leave. To reinstate coverage when you return from your leave, you must re-enroll, provided you are still eligible. To do so, contact Human Resources.

Termination and Conversion of Coverage

Your insurance coverage under the Personal and Family Accident Plan will end on the day after you terminate your employment with the University or your status as a regular full-time employee ends.

When your coverage under the plan ends, you may convert your coverage for yourself and your covered dependents to an individual policy at the insurance company's regular individual policy rates. You will not have to submit evidence of good health to convert your coverage. However, you must apply, in writing, to the insurance company within 31 days of the date your coverage under the Personal and Family Accident Insurance Plan ends.

Additional Administrative Information

For additional information such as plan administrative information and your rights under ERISA, please refer to the Administrative Information section of this Handbook.

Travel Accident Insurance Plan Eligibility

If you are classified by the University as a regular employee, work a full-time schedule, and have an appointment of nine months' or more duration, you will automatically become a member of the Travel Accident Insurance Plan. Your coverage becomes effective on your first day of active employment. Employees whose percentage time worked decreases below the eligibility requirements for the Travel Accident Insurance Plan will no longer be able to participate in the Travel Accident Insurance Plan.

Coverage

The Travel Accident Insurance Plan provides financial protection, while you are traveling on authorized University business, against death, paralysis, or loss of sight, speech, hearing, or limbs resulting directly from accidental injuries.

How the Plan Works

This plan protects you while traveling on authorized University business. In general, your destination must be away from the campus or away from your place of employment, if it is off campus.

You are covered:

- The minute you leave your home, place of employment, or other location, whichever occurs last, for travel on authorized University business
- When traveling between the Medical and Charles River Campuses, if such travel is on authorized University business

You are not covered:

- For regular commuting to and from work
- For travel between points on campus (except as described above) including the athletic fields

Your coverage ends:

- When you return to your home, place of employment, or other location, whichever occurs first

Cost

Boston University pays the entire cost of your coverage under this plan.

Types of Benefits

Benefit Amount

Benefits under this plan depend on your Benefit Amount. Your Benefit Amount equals five times your annual base salary up to a maximum of \$1 million of coverage.

Accidental Death Benefit

The plan will pay your Benefit Amount to your chosen beneficiary in the event of your accidental death while traveling on authorized University business.

When you begin your employment with the University, you will be asked to name your beneficiary on Employee Self Service at www.bu.edu/buworkscentral. Select BU Benefits Center. You may change your beneficiary at any time at this same web address.

Accidental death benefits are normally paid in a lump sum of cash. However, your beneficiary may choose to have all, or part of, your death benefit deposited to an individualized account established by the insurance carrier on which your beneficiary may write checks to withdraw funds as needed.

Accidental Dismemberment Benefit

If you become seriously injured in an accident while traveling on authorized University business, the plan will pay you:

- 100% of your Benefit Amount for the loss of both feet, both hands, the sight of both eyes, both speech and hearing, or any combination of two of the following: a hand, a foot, or the sight of an eye

- 50% of your Benefit Amount for the loss of one foot, one hand, the sight of an eye, speech or hearing
- 25% of your Benefit Amount for the loss of a thumb and index finger on the same hand

Loss means complete and irrecoverable loss.

The plan will pay benefits for the above losses only if they are incurred as a direct result of, and within one year after the date of, an accident which occurred while traveling on authorized University business.

Accidental dismemberment benefits are normally paid in a lump sum of cash. However, you may choose to have all, or part of your benefit deposited to an individualized account established by the insurance carrier which you may write checks on to withdraw your funds as needed.

Common Accident Coverage Limitation

The limit of insurance coverage payable as a result of any one accident involving any number of University employees is \$3 million. If the total benefits payable for one accident exceeds those limits, the amount payable to each insured person is reduced proportionately.

Exclusions

Under this plan, coverage for air travel is provided while riding as a passenger, and not as a pilot or crew member, in any aircraft being used for the transportation of passengers except one owned, operated, or leased by or on behalf of Boston University. For a complete explanation of these exclusions, contact the carrier or Human Resources.

How to Obtain Benefits

To claim benefits under the Travel Accident Insurance Plan, you or your beneficiary should contact Human Resources as soon as possible after the loss. Human Resources staff will provide assistance in completing the claim forms and will forward them to the insurance carrier. To process an accidental dismemberment or disability benefit claim, the insurance company may require you to be examined by a physician, at no expense to you.

Appealing a Denial

The insurance company is responsible for determining whether you have suffered a covered loss under circumstances that entitle you or your beneficiary to receive benefits under the plan. If the insurance company denies your claim for benefits, consult Human Resources for information on how to appeal the denial. Additional information about how to appeal a denial of benefits is included in the “Administrative Information” section of this handbook.

Leaves of Absence

If you leave active work for any reason for a prolonged period of time, you should always contact Human Resources to ask how your absence may affect your participation in this plan.

Termination of Coverage

Your insurance coverage under this plan will end on the day you terminate your employment with the University or your status as a regular full-time employee ends.

Supplemental Death Benefit Plan

Eligibility

If you are classified by the University as a regular employee, work a full-time schedule, and have an appointment of nine months’ or more duration, you automatically become a member of the Supplemental Death Benefit Plan on the day that you complete five years of continuous full-time service. If you are not actively at work performing your normal duties on the day you would normally become eligible, you will not become a member of the plan until the day you return to active work.

Employees whose percentage time worked decreases below the eligibility requirements for the Supplemental Death Benefit Plan will no longer be able to participate in the Supplemental Death Benefit Plan.

Cost

The University provides and pays the entire cost of the Supplemental Death Benefit Plan. You are not required to contribute anything for this coverage

Plan Benefits

The Supplemental Death Benefit Plan will automatically provide your beneficiary with a lump sum payment equal to one-twelfth of your annual base salary in effect on the date of your death. The beneficiary of the Supplemental Death Benefit Plan is the beneficiary you have designated for the Basic Life Insurance Plan.

How to Obtain Benefits

In the event of your death, your beneficiary should contact Human Resources as soon as possible. Human Resources staff will assist in submitting the claim.

Appealing a Denial

If a claim for benefits under this plan is denied, your beneficiary has the right to appeal that decision to the Plan Administrator or to the University’s Committee on Employee Benefits.

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

Tax Considerations

Under current laws, the Supplemental Death Benefit payment is taxable as income in the year received by the beneficiary.

Leaves of Absence

If you leave active work for any reason for a period of time beyond one pay period, you should contact Human Resources to ask how your absence may affect your participation in this plan.

When Plan Membership Ends

Your membership in this plan will end when you terminate your employment with the University or when your status as a regular employee ends.

Administrative Information

Sponsor for This Plan

The plans in this handbook are sponsored by the employer, Boston University, Boston, Massachusetts, which

is also the Plan, Administrator. Eligibility for the benefit plans described in this handbook applies to those University employees on the US payroll.

Boston University's Employer Identification Number

For identification purposes, the Internal Revenue Service has assigned number 04-2103547 to Boston University. You will need to know this number if you write to a government agency about any of the plans.

Type of Plans, Plan Numbers, and Plan Years

In addition to the University's Employer Identification Number, you need to know the following information:

Type of Plan: The plans described in this handbook are characterized by the federal government as Welfare Plans.

Name of Plan	Plan Number	Plan Year
Basic Life Insurance Plan and Group Supplemental Life Insurance Plan	504	January 1 – December 31
Travel Accident Insurance Plan	505	May 1 – April 30
Personal and Family Accident Insurance Plan	506	January 1 – December 31
Supplemental Death Benefit Plan	509	July 1 – June 30

Administrator for All Plans

The day-to-day administration of all plans is handled by Human Resources. However, if you have a question or a problem that cannot be resolved by Human Resources, you should contact the Plan Administrator.

The Plan Administrator for all plans can be reached by contacting:

Plan Administrator
The Trustees of Boston University
25 Buick Street
Boston, MA 02215
Phone: 617-353-4489

Funding and Administration of All Plans

Boston University pays the entire cost of many of the benefit plans described in this handbook. In some cases, you and the University share the cost. In others, you pay the entire cost.

Contributions to the Basic and Group Supplemental Life Insurance Plans go to The Standard Insurance Company. Basic and Group Supplemental Life Insurance benefits are paid by The Standard through a contract it has with Boston University. The address and telephone number of The Standard administrative office are:

Standard Insurance Company
1100 SW Sixth Avenue
Portland, OR 97204
1-888-937-4783

You pay for the cost of your Group Supplemental Life Insurance after-tax dollars.

Contributions to the Travel Accident Insurance Plan and the Personal and Family Accident Insurance Plan go to The Hartford. Benefits are paid by The Hartford through a contract it has with Boston University. The address and telephone number of the company's administrative office are:

The Hartford
Group Benefits
P.O. Box 2999
Hartford, CT 06104-2999
1-888-747-8819

You pay for the cost of your Personal and Family Accident Insurance coverage with before-tax dollars.

Agent of Legal Service

The agent for the service of legal process for all plans is:

University Counsel
125 Bay State Road
Boston, MA 02215

Legal process may be served on the Plan Administrator.

Fraudulent Claims

Submission of a claim for benefits under any of the plans described in this handbook includes a representation that the claim is bona fide and, to the best knowledge of the employee, dependent, or other claimant, proper for payment. Submission of a fraudulent or knowingly false claim by an employee or an employee's dependent participating in a plan will be grounds for disciplinary action against the employee, including termination of participation by the employee and/or covered dependent(s) under the plan.

Claims for Benefits/Appealing a Denial of Claims for Benefits

When you apply for benefits, there are time periods within which you must receive a decision on your claim for benefits. If you or your beneficiary applies for benefits and either part or all of the request is denied, you have the right to appeal that decision, provided the appeal is made in accordance with the provisions of the plan and applicable laws (e.g., appeals must be filed within required time periods).

Appeals are generally decided by the provider of the benefit involved, which is the insurance carrier, claims administrator, or vendor for most benefits, or the University or its Plan Administration Committee for some benefits.

Appeals to Insurance Carriers/Claims Administrators/Other Vendors

Appeals regarding benefits or other issues affecting plan participants or other persons for The Travel Accident Insurance Plan, Personal and Family Accident Insurance Plan, Group Supplemental Life Insurance Plan, and Basic Life Insurance Plans should be made to the applicable provider under the Plan.

The claims filing procedures are set forth in the separate written document, insurance certificate or contract, benefit summary, or other governing document for each Plan.

If a claim for claim for benefits is either wholly or partially denied, you will be notified in writing within 90 days (45 days in the case of a claim for disability benefits). If special circumstances require an extension of time to process the claim, written notice of the extension and an explanation of the special circumstances requiring

an extension will be provided to you prior to the termination of the initial 90-day period (45-day period in the case of a claim for disability benefits).

Every notice of an adverse benefit determination will include:

- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a description of any additional information or material needed to support the claim and an explanation why the information or material, if any, is necessary;
- a description of the plan's review procedures and the applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review; and
- if the claim is for disability benefits, the following:
 - a discussion of the decision, including an explanation of the basis for disagreeing with or not following (as applicable) the views of health care professionals treating you and vocational professionals who evaluated you; the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and any disability determination made by the Social Security Administration;
 - upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; and
 - a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and information relevant to your claim.

Your appeal of a denied claim must be filed with the insurance carrier, claims administrator, or vendor for the applicable benefit within 60 days (or 180 days in the case of a claim for disability benefits) after you receive written notice of the decision. Your written request for review must contain all additional information that you want the claim administrator to consider.

Appeals may be submitted to the

following providers:

- *The Group Life Insurance Plan and the Group Supplemental Life Insurance Plan,*

Standard Insurance Company
1100 SW Sixth Avenue
Portland, OR 97204 1-888-
937-4783

- *Travel Accident Insurance Plan and the Personal and Family Accident Insurance Plans*

The Hartford Group Benefits
P.O. Box 2999 Hartford, CT
06104-2999 1-888-747-8819

If a claim is for disability benefits, before issuing an adverse determination on review, the claim administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with the claim, as well as a description of any new or additional rationale on which the denial is based. This information will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

You will be notified of the decision on review within 60 days (45 days in the case of a claim for disability benefits). If special circumstances require an extension of time to process the claim, written notice of the extension and explanation of the special circumstances requiring an extension will be provided prior to the termination of the initial 60-day period (45-day period in the case of a claim for disability benefits).

Every notice of an adverse benefit determination on review will include:

- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information as defined above;
- a statement of your right to bring a civil action under section 502(a) of ERISA and a description of the limitations period provided by the plan, including the date on which the limitations period will expire; and
- if the claim is for disability benefits, the following:
 - a discussion of the decision, including an explanation of the basis for disagreeing with or not following (as applicable) the views of health care professionals treating you and vocational professionals who evaluated you; the views of medical or vocational experts whose advice was obtained on behalf of the plan in

connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and any disability determination made by the Social Security Administration; and upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

Documents and Laws Governing This Plan

The plan descriptions contained in this handbook were written from the documents that legally govern how the plans work. In the event of any discrepancy between the plan descriptions in this handbook and the controlling contracts or plan documents, the language in the controlling contracts or plan documents will govern. If you would like a copy of any of these documents, please contact Human Resources.

The plans are also regulated by applicable provisions of applicable laws, which will govern in the event of any conflict between the law and the terms of the plans as described in either the documents or in this summary plan description.

Equal Opportunity/Affirmative Action Policy

Since its founding in 1839, Boston University has been dedicated to

equal opportunity and has opened its doors to students without regard to race, sex, creed, or other irrelevant criteria. Consistent with this tradition, it is the policy of Boston University to promote equal opportunity in educational programs and employment through practices designed to extend opportunities to all individuals on the basis of individual merit and qualifications, and to help ensure the full realization of equal opportunity for students, employees, and applicants for admission and employment. The University is committed to maintaining an environment that is welcoming and respectful to all.

Boston University prohibits discrimination against any individual on the basis of race, color, religion, sex, age, national origin, physical or mental disability, sexual orientation, genetic information, military service, or because of marital, parental, or veteran status. This policy extends to all rights, privileges, programs, and activities, including admissions, financial assistance, educational and athletic programs, housing, employment, compensation, employee benefits, and the providing of, or access to, University services or facilities. Boston University recognizes that that equal opportunity is a reality. Accordingly, the University will continue to take affirmative action to achieve equal opportunity through recruitment, outreach, and internal reviews of policies and practices.

The coordination and implementation of this policy is the responsibility of the Director of Equal Opportunity. The officers of the University and all deans, directors, department heads, and managers are responsible for the proper implementation of equal

opportunity and affirmative action in their respective areas, and they are expected to exercise leadership toward their achievement. It is expected that every employee of Boston University will share this commitment and cooperate fully in helping the University meet its equal opportunity and affirmative action objectives.

Boston University has developed detailed procedures, described in its *Complaint Procedures in Cases of Alleged Unlawful Discrimination or Harassment* (www.bu.edu/eeo/policies-procedures/complaint), by which individuals may bring forward concerns or complaints of discrimination and harassment. Retaliation against any individual who brings forward such a complaint or who cooperates or assists with an investigation of such a complaint is both unlawful and strictly prohibited by Boston University.

Inquiries regarding this policy or its application should be addressed to the Director of Equal Opportunity, Equal Opportunity Office, 888 Commonwealth Avenue, Suite 303, Boston, MA 02215, or call 617-358-1796.

Amendment or Termination of the Plans

Boston University intends to continue maintaining the plans described in this handbook for the exclusive benefit of its employees.

However, the University reserves the right to change or discontinue any of them, and to implement changes as required by federal, state, or local laws.

You will be informed of any material changes that are made to the plans. If a plan is terminated, your rights, on the date of the termination, would be governed by the provisions of the plan document.

Your Rights Under ERISA

The following Boston University benefit plans are subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA):

- Basic Life Insurance Plan
- Group Supplemental Life Insurance Plan
- Travel Accident Insurance Plan
- Personal and Family Accident Insurance Plan

ERISA provides the participants in these plans with certain rights and protections. The following statement is included here so that you will be aware of your rights under the law.

Under ERISA:

- You may examine, without charge, at Human Resources and at other specified locations, during normal business hours, all plan documents relating to the plans in which you participate. The documents that must be available for your review include insurance contracts, plan and trust documents, collective bargaining agreements, and all documents filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration, for example, detailed annual reports.

- If you wish, you may request your own copies of these plan documents by writing to Human Resources. Where permitted by law, you may have to pay a reasonable charge to cover the costs of copying.
- You will receive summaries of the plans' annual financial reports each year, free of charge. The administrator for the plans is required by law to furnish each participant with a copy of these summary annual reports.

Plan Fiduciaries

Besides giving you certain rights as a participant, ERISA places certain duties upon the people who are responsible for the management of the above-mentioned plans. These people are called "fiduciaries" under the law, and they have the duty to act prudently and in your best interests.

Under ERISA, no one may fire you or discriminate against you to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Enforcing Your Rights

If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to obtain copies, without charge, of documents relating to the decision, and to appeal any denial all within certain time schedules.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 for each day's delay until you

receive the materials, unless the materials were not sent for reasons beyond the administrator's control. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with a plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse plan money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or file suit in a federal court.

In a lawsuit, the court normally decides who pays the court costs and legal fees. If you are successful, the other party might have to pay. But, if you lose, the court might order you to pay these costs and fees, especially if the court finds your claim to be frivolous.

Assistance with Questions

If you have any questions about this statement of your rights under ERISA, contact Human Resources. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-

866-444-3272. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

A Final Note

This handbook presents a summary of Boston University's benefits for faculty and staff and is intended to serve as the summary plan description for The Travel Accident Insurance Plan, Personal and Family Accident Insurance Plan, Group Supplemental Life Insurance Plan, and Basic Life Insurance Plans. It is designed as a quick reference source and is not intended to cover every point of policy. In certain instances, the University may exercise discretion, with respect to the administration of the plans described in this handbook. For more in-depth information, contact Human Resources.

Periodically, the University may make changes in policy that may not be reflected immediately in this handbook.

Again, for complete and up-to-date information about any policy or benefit, you should contact Human Resources.

Please note: The policies described in this handbook are not intended to create an employment contract between Boston University and its employees. Therefore, they do not alter the University's rights regarding discharges and layoff.



RETIREMENT PLAN



Regardless of your age, the time for thinking about retirement is now. With careful planning, you can help make your retirement years a more comfortable and secure time of life for you and your family.

The Boston University Retirement Savings Program, comprised of the Boston University (“BU”) Retirement Plan, the BU Supplemental Retirement and Savings Plan, and the 457(b) Savings Plan, provides you with a convenient way to start saving towards your retirement today.

This summary provides key terms of the BU Retirement Plan in effect as of January 1, 2022. Read the summary carefully to gain an understanding of how the BU Retirement Plan works. Please note that nothing contained in this summary can expand or otherwise modify the benefits available under the BU Retirement Plan, and if any statement in this summary is inconsistent with the terms contained in the plan document the terms of the plan document will govern.

About the BU Retirement Plan

Once you have completed the necessary service requirement, the BU Retirement Plan automatically provides you with retirement benefits in the form of University Core contributions and University Matching contributions.

The amount of these University contributions will depend on your age and eligible compensation, as well as whether you become eligible for a matching contribution by making voluntary salary deferral contributions under the Supplemental Retirement and Savings Plan..

These contributions may be invested in any of the following investment vehicles:

Tier 1: Target Date Fund

Tier 2: Passively Managed Equities

Tier 3: Capital Preservation and Income Funds

Tier 4: Self- Directed Brokerage.

The University's contributions are not taxable to you when made, and investment earnings accumulate tax-free, until your benefits are paid.

Eligibility

If you are an employee of the University (other than a student), have a normal work schedule of at least 50% of a full-time schedule, and have an appointment or expected period of employment of nine months' or more, you are eligible for the BU Retirement Plan.

As an eligible employee, you are automatically enrolled in the plan beginning on the first day of the month in which you complete two

years of service with the University. A year of service is a 12-month period in which you are credited with at least 1,000 hours of service.

Any prior eligible service with Boston University will be applied toward your two-year waiting period. These provisions apply only to the eligibility waiting period.

Automatic Enrollment

Once you complete two years of eligible service, you are automatically enrolled in the BU Retirement Plan.

University contributions made on your behalf are automatically invested in a Vanguard Target Retirement Date Fund which corresponds most closely to the year in which you will turn age 65.

You may change the fund in which your plan account is invested at any time by contacting Fidelity Investments.

Beginning July 1, 2021, all University contributions are invested exclusively through Fidelity Investments. However, you still have access to your TIAA investments

Your ability to change your investment choices, or transfer investments to or from one fund to another, depends on your initial choice of investments. Some funds (such as TIAA's Traditional Annuity) have limitations on withdrawals; other funds may restrict investments in and out within a short time to prevent market timing or other manipulative practices. You should review the restrictions in each fund carefully before making your investment decision.

If you previously participated in another 403(b) plan or other type of

tax-deferred retirement plan (such as a 401(k) plan) with a previous employer, you may be able to roll over your account balances from that plan to the BU Retirement Plan, provided you meet the plan's rules and the rules of the record keepers. Human Resources can provide you with further information on rollovers.

Temporary Suspension of Employer Contributions

Due to the COVID-19 pandemic, all employer contributions to the Plan were suspended for Fiscal Year 2021, from June 1, 2020 through July 31, 2021. This included the University Core, Matching, and Transition Contributions.

If you were eligible to participate in the BU Retirement Plan, you did not receive any University contributions during the suspension period, however, employment during this time did still count towards the two-year waiting period.

If you achieved two years of eligible service during the suspension period, you were automatically enrolled in the BU Retirement Plan and began receiving contributions when they resumed, beginning July 1, 2021.

The University Contributions

The University contributions are comprised of a Core Contribution and a Matching Contribution. In addition, some employees are eligible to receive a Transition Contribution.

Once you become eligible for the plan, you automatically receive the Core Contribution regardless of whether you chose to contribute to the BU Supplemental Retirement

and Savings Plan. You will only receive the Matching Contribution if you are making salary deferral contributions to the BU Supplemental Retirement and Savings Plan. Finally, you are eligible to receive the Transition Contribution only if you were age 50 or more and were participating in the BU Retirement Plan on December 31, 2017, and your eligible compensation is less than \$180,000 in the current plan year.

University Core Contribution

Under the formula that became effective January 1, 2018, the University contributes an amount each payroll period equal to a percentage of your eligible compensation. The contribution percentage varies according to your age and compensation, as follows:

When Your Age Is	The University Contributes
Under 45	4% of your eligible compensation up to the Integration Level PLUS 6% of your eligible compensation above the Integration Level
45 through 49	6% of your eligible compensation up to the Integration Level PLUS 8% of your eligible compensation above the Integration Level
50 and above	7% of your eligible compensation up to the Integration Level PLUS 9% of your eligible compensation above the Integration Level

If you have not made your own investment choices, Core Contributions credited to your plan account are automatically invested in a Vanguard Target Date Fund that most closely

corresponds to the year in which you will turn age 65.

The following terms are important to understand the way contributions work under the BU Retirement Plan:

Eligible Compensation Eligible compensation includes your eligible compensation from the University and, if applicable, any stipend or other payments coded for payroll purposes as benefits-based overbase payments, excluding overtime, one-time payments, other overbase payments, commissions and bonuses, or the value of any employee benefits.

Federal tax law limits the maximum amount of compensation that a BU Retirement Plan may take into account for contribution purposes each year. This annual limit for 2025 is \$350,000. The limit is increased from time to time in \$5,000 increments. Please refer to the Human Resources website at www.bu.edu/hr for updated amounts in subsequent years.

Integration Level The integration level is \$70,600 for 2025. It is adjusted each calendar year based on the Wage Base Increase calculated for purposes of the Social Security law, or the increase in the Consumer Price Index (Wages), whichever is smaller. Please refer to the Human Resources website at www.bu.edu/hr for updated amounts in subsequent years.

An adjustment in the University's contribution percentage based on a change in your age is made at the beginning of the month in which you attain the new age.

University Matching Contribution

After two years of eligible service, the University will automatically

match your salary deferral contribution to the BU Supplemental Retirement and Savings Plan dollar-for-dollar, up to 3% of your eligible compensation.

If you chose to contribute 3% of your eligible compensation to the BU Supplemental Retirement and Savings Plan, your total potential University contribution is as follows:

When Your Age Is	The University Contributes
Under 45	7% of your eligible compensation up to the Integration Level PLUS 9% of your eligible compensation above the Integration Level
45 through 49	9% of your eligible compensation up to the Integration Level PLUS 11% of your eligible compensation above the Integration Level
50 and above	10% of your eligible compensation up to the Integration Level PLUS 12% of your eligible compensation above the Integration Level

If you have not made your own investment choices, Matching Contributions credited to your plan account are automatically invested in a Vanguard Target Date Fund that most closely corresponds to the year in which you will turn age 65.

University Transition Contribution

You are eligible to receive the University Transition Contribution *if and only if* on December 31, 2017 you were: (1) age 50 or more; and (2) a participant in the BU Retirement Plan. If you are an eligible participant, the University will make a special

contribution on your behalf for a Plan Year in which your eligible Compensation is less than \$180,000. If your eligible plan compensation is \$180,000 or more, you will no longer be eligible to receive this contribution. The amount of the transition contribution will be equal to 1% of your eligible compensation for the Plan Year, provided that the aggregate amount of your Transition Contribution plus your Core Contribution may not be more than \$14,822 in 2025. In the case that your core and 1% transition contribution exceed \$14,822, your 1% transition contribution will be decreased to equal the difference between your core contribution and \$14,822.

If you have not made your own investment choices, Transition Contributions credited to your plan account automatically invested in a Vanguard Target Date Fund that most closely corresponds to the year in which you will turn age 65.

Investment Choices

The Boston University Retirement Plan is intended to be a participant-directed plan as described in Section 404(c) of the Employee Retirement Income Security Act of 1974 as amended (ERISA) and Department of Labor regulations governing section 404(c) plans. Therefore, fiduciaries of Boston University Retirement Plan are relieved of liability for any losses that are the result of investment instructions given by a participant or beneficiary under the participant-directed investment feature of the Boston University Retirement Plan. In other words, you choose how contributions to your accounts will be invested from among the investment

options available to you under the Plan. Since you choose the investment options for the account, you bear the risk for the investment results.

You should consult a professional financial advisor for investment advice and financial planning assistance before choosing an investment option. Further information may be obtained directly from the Plan record keeper. You should read the prospectus or other information carefully before investing.

Selected Investments

The investment fund groups currently offered under the BU Retirement Plan are the Vanguard Target Retirement Funds, Core Mutual Funds, and Core Annuity Accounts. These funds were chosen by the University in order to provide participants with the option of managing their own asset allocations or allowing professional investment managers to balance the investments.

To obtain a detailed description of the investment options available, please contact Fidelity at 1-800-343-0860.

Tier 1: Target Date Funds

Investing Style: Diversified portfolio within a single fund that shifts its emphasis to more conservative investments as the year of retirement nears.

Target-date funds are designed for participants who prefer a single fund solution that includes a mix of stocks, bonds, and short-term assets. Each of the funds creates a diversified portfolio within one fund, based on your

expected retirement year (the “target dates” of the fund), or the year in which you turn age 65. These funds automatically rebalance between stocks and bonds to become more conservative as you approach retirement and are also the plan’s Designated Default Investment..

Tier 2: Passively Managed Equities

Investing Style: A broad selection of equity index funds designed to mirror a market index or benchmark.

Passively managed funds – commonly known as “index funds”- seek to approximate their benchmark’s performance, rather than beat their benchmarks. A benchmark is what the investment’s return are compared to in order to measure performance. Because the objective is to simply mirror the holdings and return of an index, less research is needed, transactions occur less frequently, and expenses tend to be lower than those of actively managed funds.

Ultimately, index funds are designed to provide exposure to a broad selection of securities at a relatively low cost. While these funds typically perform very similarly to the index they track, you should be aware that index funds cannot be expected to meet or bear the index’s performance. Tier 3: Capital Preservation and Income Funds.

Investing Style: A broad selection of funds that seek to preserve savings and generate income or produce returns that exceed the inflation rate.

Tier three funds include the New York Life Guaranteed Fixed Interest Account, which is a guaranteed fixed-return annuity is designed to provide you with a high level of principal

stability. In addition, it lets you convert your balance to a guaranteed stream of income when you retire (Any guarantees are subject to the claims paying ability of the issuer).

The remaining funds in Tier 3 focus on income generation and inflation protection for investors who want to produce a growing income distribution while leaving the principal alone or returns that exceed the inflation rate so investors can build future purchasing power and wealth.

Other Investments

Tier 4: Self-Directed Brokerage

Investing Style: For investors who want additional choice and investment flexibility.

Fidelity BrokerageLink® is a self-directed brokerage option, that combines the convenience of the BU Retirement Savings Program with the additional flexibility of an individual brokerage account. If you are a more engaged investor looking for additional investment selection and flexibility, a self-directed brokerage account gives you opportunities to invest in a wide range of mutual funds outside of the Plans’ investment lineup.

While a brokerage account offers expanded flexibility, it also comes with additional personal responsibility and risk. The University does not select or screen these investments. That task falls to you.

Qualified Default Investment

Under the BU Retirement Plan and the Supplemental Retirement and

Savings Plan (the “Plans”), any contributions for which you do not provide investment direction will be invested in the Plans’ default investment fund (the “Plans’ Designated Fund”). The Plans have selected the Vanguard Target Retirement Funds as the Plans’ Designated Fund.

For a description of the Vanguard Target Retirement Funds, see “Investment Choices”.

The Vanguard Target Retirement Funds are the Plans’ Designated Funds and are intended to serve as “qualified default investment alternatives” that meet U.S. Department of Labor requirements. The Designated Fund is based on the assumption that a participant will retire at age 65. If you do not provide investment direction, your contributions will be directed to the Vanguard Target Retirement Fund most closely corresponding to the year in which you turn age 65, as determined by the University, based on your date of birth.

You have the right under the Plans to direct the investment of your existing balances and future University contributions to any of the Plans’ available investment options, including the right to transfer out of the Plans’ Designated Fund to another investment option. Unless you provide alternative direction, the University contributions and/or the portion of your account that is currently invested in the Plans’ Designated Fund will continue to be invested in this option.

Investment Restrictions

There are certain restrictions on your investments. For complete, current details on restrictions, you should

refer to the printed materials available from each of the record keepers. Following are explanations of some of the important restrictions.

The following rules apply to how future contributions to the BU Retirement Plan are invested:

1. You may choose to have any percentage of your contributions contributed to the funds available through Fidelity.
2. You can change your investment choice of where to invest future contributions at any time.

The following rules apply for moving account balances from one record keeper to another:

1. For a TIAA Group Retirement Annuity Contract (GRA) issued after June 1, 2005:

While you are employed at the University transfers can be made out of the TIAA Traditional accumulations into investments available through CREF or Fidelity by use of a transfer payout annuity over a nine-year period. At termination of service, transfers may be made from the TIAA Traditional accumulation to investments available through CREF or Fidelity over a five-year period, or, within the first 120 days following separation from service, in a lump sum, which is subject to a 2.5% surrender fee.

For a TIAA Retirement Annuity Contract (RA) issued prior to June 1, 2005:

Transfers can be made to TIAA- CREF Stock or the Money Market, into investments available through

Fidelity by use of a transfer payout annuity transferred out over a nine-year period.

1. Transfers out of CREF investments into Fidelity investments and TIAA Traditional y may be made in any amount at any time.
2. Transfers among the fund options available through Fidelity may be made at any time, but a fee may be charged if more than four transfers are made in a calendar year.

Other restrictions or requirements may apply. See the disclosure materials for any investment option you are considering.

Statements of Your Accounts

You will receive quarterly statements by mail or online.

Contribution Limitations

Internal Revenue Code Section 415 places a limit on the total amount which may be contributed by the University and by you (before-tax, after-tax Roth, and any other after-tax non-Roth contributions) in a calendar year. If the sum of your contributions to the BU Retirement Plan and the University's contributions to the BU Retirement Plan exceed any of the limits, certain IRS-mandated reductions apply.

Lastly, matching contributions by the University are subject to the requirements of Internal Revenue Code Section 401(m). If these requirements are not satisfied, matching contributions for certain participants may have to be reduced. If the 401(m) limitation should affect you, any amounts that would be reduced or returned on your behalf

will be returned and mailed to you in the form of a check by your record keeper. This amount will be treated as taxable income, and you will receive a Form 1099 for the tax year in which you receive the returned contributions from your record keeper for tax filing purposes.

Refer to "How Much You and the University Contribute" for further contribution limitations.

Note: Special rules and limits apply if, during a calendar year, you also participate in another plan maintained by a business you own or control. For example, if you have consulting or other self-employment income and participate in a self-employed plan to which you make contributions, the special rules may affect you. If this situation applies to you, consult a qualified tax professional for advice.

Human Resources will assist you in calculating the limits that apply to you.

In-Plan Roth Conversion

You may elect to convert all or a portion of your previously contributed employee Roth 403(b) contributions to the BU Retirement Plan Account (other than your Roth Contribution Account) to a Roth Contribution Account as an In-Plan Roth Conversion. This conversion occurs within the BU Retirement Plan. You do not receive a check and then contribute it to the BU Retirement Plan. Note that the conversion is a taxable event but converting to a Roth Contribution Account can be beneficial if you expect your tax rate to increase in the future. You should consult a tax advisor to better understand the consequences of an In-Plan Roth

Conversion before you make the decision to convert your Account. You may take a distribution from your previously contributed employee Roth Account contributions funds only if you are eligible, otherwise your funds are subject to the rules of the BU Retirement Plan. An eligible distribution is (i) a distribution to an active Member on or after attaining age 65; (ii) a distribution made upon termination of employment, becoming disabled, or retirement; (iii) a distribution upon the Member's death; or (iv) any distribution that would otherwise qualify as an eligible rollover distribution.

Forms of Payment

Your BU Retirement Plan benefits will normally start when you retire, or you may also start your benefits once you reach age 65 regardless of whether you are retired or still employed.

You have some choices as to the form of payment of your retirement benefits. However, if you are married and you elect an annuity form of payment, federal law provides that you must receive your benefits in the form of a 50% Joint and Survivor Annuity, with your spouse as beneficiary, unless your spouse agrees in writing to your choice of another annuity form of payment. Your spouse's signature must be witnessed by a plan representative or notarized by a notary public.

Particularly if you have large plan account balances (or other BU Retirement Plan accumulations, including other 403(b) arrangements, employer-qualified plans, or IRAs), your choice of a form of payment may affect your tax and estate planning. Consult a qualified advisor if you have any questions.

CARES Act Distributions

Under the Coronavirus Aid, Relief and Economic Security Act (CARES Act), a participant who is a “qualified individual” was eligible to take penalty-free withdrawals of up to \$100,000 from any funds available through Fidelity and any CREF investments from January 1, 2020, through December 30, 2020.

A “qualified individual” was one who:

- is diagnosed with the virus SARS-CoV-2 or with coronavirus disease 2019 (COVID-19) by a test approved by the Centers for Disease Control and Prevention,
- has a spouse or dependent diagnosed with such virus or disease, or
- experiences adverse financial consequences as a result of:
 - being quarantined, being furloughed or laid off, or having work hours reduced due to COVID-19, being unable to work due to lack of childcare due to COVID-19, or other factors as determined by the Secretary of the Treasury.
 - having a reduction in pay, or a job offer rescinded or start to a job delayed, due to COVID-19
 - having a spouse or member of the individual’s household being quarantined, being furloughed or laid off, having a reduction in pay, or a job offer rescinded or start to a job delayed, or having work hours reduced due to COVID-19, or being unable to work due to lack of childcare due to COVID-19
 - the closing or reducing or hours of a business owned

or operated by the individual’s spouse or a member of the individual’s family due to COVID-19.

Descriptions of the forms of payments

Lump Sum You may elect to receive a lump sum distribution from any funds available through Fidelity and any CREF investments for the full value of your accounts at the time of the payment.

Installment Withdrawal Program As an alternative, you may elect to maintain your account balances with any funds available through Fidelity and any CREF investments and receive periodic withdrawals from your account until you have exhausted your account balances. You may designate the amount and the frequency of these withdrawals (subject to certain minimums required by the tax law).

Rollover You may also elect to roll over all or a portion of the account balances in any funds available through Fidelity and any CREF investments into an individual retirement account (IRA) or another plan you participate in that accepts rollovers, provided you meet certain tax law requirements. If you wish, you may use the proceeds of your account to purchase an annuity through TIAA or another insurance company. Please see Income Solutions, an online annuity comparison tool for more information on annuities. You may wish to consult with your financial advisor before selecting this option.

TIAA Traditional

For Group Retirement Annuity (GRA) contracts issued after June 1, 2005, TIAA Traditional accumulations may be taken over any period between five to thirty years (subject to IRS restrictions). At the end of the fixed period chosen payments will end.

Annuity Options

If you wish, you may use the proceeds of your account to purchase an annuity. Please see Income Solutions, an online annuity comparison tool for more information on annuities. You may wish to consult with your financial advisor before selecting this option.

You also have TIAA or CREF Annuity payment options available to you. Information on these annuity options is available at the following link: <https://www.tiaa.org/public/retire/services/preparing-for-retirement/income-options/employer-plan>

Required Minimum Distribution

Under federal tax law, if you attained age 73 on or before December 31, 2025, you are required to begin required minimum distributions by April 1 following the later of: (1) the calendar year in which you attained age 73, or (2) the calendar year in which you terminated employment with the University.

Under the required minimum distribution requirement, if you have multiple 403(b) accounts, you may calculate your required minimum distribution for each 403(b) accounts, total the amounts, and take the total

required minimum distribution from any one or more of your 403(b) accounts.

Your Spouse's Rights

If you are married and choose any annuity method of payment other than a Survivor Annuity with your spouse as the survivor, your spouse must give written consent which acknowledges that his or her rights to survivor benefits are being waived. Your spouse's signature must be witnessed by a BU Retirement Plan representative or notarized by a notary public.

Under federal law, if you are married at the time of your death, your spouse is entitled to receive, as primary beneficiary, your qualified preretirement survivor death benefits under a retirement or tax-deferred annuity plan covered by ERISA. If you name someone other than your spouse as primary beneficiary, your spouse must consent to this primary beneficiary designation by completing a Spousal Waiver. Then the qualified preretirement survivor death benefits will be payable to such primary beneficiary. If you elected only a portion to be paid to the designated beneficiary, then the remainder will be payable to your spouse.

If you designate your spouse as beneficiary and the individual later ceases to be your spouse, such designation will be deemed void and your ex-spouse will have no rights as a beneficiary unless redesignated as a beneficiary by you subsequent to becoming your ex-spouse or as otherwise provided under a qualified domestic relations order under Internal Revenue Code Section 414(p).

If You Die Before You Begin to Receive Benefits

If you die before your retirement income begins, the current full value of your account balances in all investment options will be payable to your beneficiary under any of the payment options elected by the beneficiary and allowed by the record keeper (subject to the federal income tax laws described in more detail below).

You choose a beneficiary at the time you enroll in the BU Retirement Plan, and you may change your beneficiary at any time by completing a new form through Fidelity and/or TIAA. However, if you are married, federal law requires that your spouse be your beneficiary unless your spouse consents in writing to your naming another beneficiary and this consent is witnessed by a BU Retirement Plan representative or notarized by a notary public.

If your marital status changes after you become a participant in the BU Retirement Plan (you marry, divorce, or separate, or your spouse dies), be sure to contact Human Resources immediately to make any appropriate changes in your designated beneficiary. If you are divorced and then re-marry, your prior beneficiary designation(s) will become invalid and your current spouse will automatically become your beneficiary unless you designate another beneficiary with your current spouse's written consent (witnessed by a Plan representative or notary public).

Current federal income tax laws contain several requirements regarding the distribution of your account balance after you die. If your

designated beneficiary under the BU Retirement Plan is your surviving spouse, a minor child (until reaching the age of majority), is chronically ill, or is not more than 10 years younger than you, your benefits may be paid over the course of your beneficiary's life expectancy. Other beneficiaries designated under the BU Retirement Plan must receive the entire value of your accounts within ten years of your death. Beneficiaries that are not designated under the BU Retirement Plan (for example, your estate and certain trusts) must generally receive the entire value of your accounts within five years of your death.

Generally, annuity or installment payments must begin within one year of your death. However, if your spouse is your sole designated beneficiary, he or she may postpone the start of benefits until a later date, but until no later than the date on which you would have reached age 73.

Your beneficiary may receive a lump sum distribution of the account balances, roll over your account balances into an IRA or other plan with payments under IRS minimum distribution rules, or receive the full value of the account over the maximum distribution period.

In addition, you may choose one of the following options, for payment of the death benefit of your TIAA Traditional or CREF investments, or you may leave the choice to your beneficiary.

1. Income for the life of the beneficiary with payments stopping at the time of his or her death
2. Income for the lifetime of the beneficiary, with a minimum

number of payments guaranteed in any event. The period of guaranteed payments must be 10, 15, or 20 years (subject to IRS rules).

3. Income for a fixed period of years (subject to IRS rules)
4. Subject to IRS rules, the accumulation may be left on deposit with TIAA for future payment under any of the above options
5. A lump sum distribution of the account balances or rollover into an IRA or other plan with payments under IRS minimum distribution rules

Federal pension legislation requires that if you die leaving a surviving spouse and have not named a beneficiary, all of your death benefit will be paid to your spouse. The selection of a beneficiary and the form of payment to the beneficiary should you die can have important income and estate tax consequences. See a qualified advisor if you have questions about these subjects.

Required Minimum Payment Rules

Under federal tax law, if you attained age 70½ on or before December 31, 2019, you are required to begin required minimum distributions by April 1 following the later of: (1) the calendar year in which you attained age 70½, or (2) the calendar year in which you terminated employment with the University.

If you attained age 70½ in 2020 or later, you are required to begin required minimum distributions by April 1 following the later of: (1) the calendar year in which you reach age 73, or (2) the calendar year in which you terminate employment with the University.

Under federal tax law, if you attained age 73 on or before December 31, 2022, you are required to begin required minimum distributions by April 1 following the later of: (1) the calendar year in which you attained age 73, or (2) the calendar year in which you terminated employment with the University.

withdraw funds from their retirement accounts.

Under this requirement, if you have multiple 403(b) accounts, you may calculate your required minimum distribution for each 403(b) accounts, total the amounts, and take the total required minimum distribution from any one or more of your 403(b) accounts. If you do not receive or start your payments on time or if the payments are less than the required minimum amount, you will have to pay a federal tax penalty of 25 of the amount that was required to be distributed but was not distributed (unless you show reasonable cause to the Internal Revenue Service). See the “Forms of Payment” section for your choices.

If You Become Disabled (Contribution Waiver)

If you become disabled and start receiving benefits under the Boston University Long Term Disability Plan or SSDI, the University will continue to make its Core Contribution to the BU Retirement Plan on your behalf.

While you are receiving disability benefits, your University Core Contributions will be based on your annual base salary or basic hourly rate when you became disabled. Your eligibility for University Core Contributions will continue as long as

you remain disabled, but not longer than five years.

The University pays the entire cost of this protection for you.

If You Leave the University

If your employment with Boston University ends at any time before you attain age 65, you are fully “vested” in all your BU Retirement Plan account balances. You will be entitled to receive payment of your accounts as follows:

1. You may elect to receive a lump sum distribution of your moneys invested through Fidelity or CREF.
2. You may roll over moneys invested through Fidelity or CREF to an IRA or other plan that accepts rollovers, provided that you meet federal tax law requirements.
3. You may leave funds on deposit for distribution at a later date. Under current tax laws, payments must start by the April 1 following the calendar year when you reach age 73. You may not make contributions directly to your accounts.

For TIAA Retirement Annuity (RA) contracts issued prior to June 1, 2005:

- (a) If your TIAA Traditional accumulation is less than \$2,000 in value, you may apply for a lump sum distribution of the full value of your account. You may then roll over your lump sum payment into an IRA or other plan that accepts rollovers, provided you meet federal tax law requirements.
- (b) If your TIAA Traditional accumulation is at least \$2,000 in value, you may begin receiving lifetime annuity payments or elect

TIAA's Transfer Payout Annuity. Under current tax laws, payments must start by the April 1 following the year in which you reach age 70½ or upon retirement, whichever is later.

For TIAA Group Retirement Annuity (GRA) contracts issued after June 1, 2005:

a) If your TIAA Traditional accumulation is less than \$5,000 in value, you may apply for a lump sum distribution of the full value of your account. You may then roll over your lump sum payment into an IRA or other plan that accepts rollovers, provided you meet federal tax law requirements. No withdrawal charge applies.

(b) If your TIAA Traditional accumulation is at least \$5,000 in value, you may apply for a lump sum distribution of the full value of your account within a 120-day period following your termination of employment. A withdrawal charge of 2.5% applies to such lump sum withdrawals. You may then roll over your lump sum payment into an IRA or other plan that accepts rollovers, provided you meet federal tax law requirements.

(c) You may receive a fixed-period annuity of five to thirty years (subject to IRS restrictions).

The rights of your spouse, which were described earlier (see "Your Spouse's Rights"), also apply to the choice of a form of payment for benefits due when you terminate your employment with the University.

Tax Considerations When You Receive Benefits

Federal and state income tax must be withheld from the taxable portion of all BU Retirement Plan benefits you or your beneficiary receive, unless you or your beneficiary elect otherwise (but see the last paragraph of this section for an exception).

Under current federal law, ordinary income tax applies to payments to you from your accounts.

In addition, a 10% penalty tax applies to all payments you receive before you reach age 59½, except certain payments in the form of an annuity. The 10% penalty tax does not apply if payments are received because of your death, disability, or early retirement at age 55 or older; or in connection with a Qualified Domestic Relations Order; or in amounts which do not exceed your tax-deductible medical expenses or certain amounts spent for health insurance in the event of your extended unemployment.

You may be able to postpone payment of taxes if you are able to roll over your BU Retirement Plan distribution to an IRA or other plan that accepts rollovers.

Any contributions in the Retirement Plan may be rolled over to an IRA or another 403(b) arrangement or qualified plan that accepts such contributions in order to continue earning tax-deferred interest on investment gains.

All cash distributions from the BU Retirement Plan, except those payable as an annuity or in periodic installments for at least 10 years, those payable to non-spouse beneficiaries, and those mandated by minimum distribution rules, will be eligible for direct rollover to an IRA or

another plan that will accept them. If these distributions are not directly rolled over to an IRA (or to another employer 403(b) plan that will accept them), they will be subject to mandatory 20% federal income tax withholding.

Leaves of Absence

If you are granted a leave of absence at full pay, the University's Core and, if applicable, Matching contributions to the BU Retirement Plan will continue. If you are granted a leave of absence at partial pay, the University's Core and, if applicable, Matching contributions will be based on your reduced eligible compensation.

Contributions will stop if you are granted an unpaid leave of absence. However, they will start again, automatically, with the first paycheck you receive when you return.

If you are granted a military leave of absence, upon your return while you are protected by the veterans' reemployment laws, the University will contribute to the BU Retirement Plan an amount representing the Core contributions that would normally have been made during your military leave. The University Matching contribution will also be made provided you make the salary deferral contributions to the BU Supplemental Retirement and Savings Plan.

Remember, if you leave work for any reason for a prolonged period of time, you should always contact Human Resources to ask what effect your absence may have on this and other University-sponsored benefits plans.

Administrative Fees

Fidelity

A Member with an account at Fidelity will be assessed a fixed quarterly fee, which will be deducted directly from the Member's account and reflected on his or her Fidelity participant account statements. For the most up to date information on this fee, please visit

www.bu.edu/hr/finances/retirementplan/plancosts/.

At distribution, certain Fidelity funds may charge a redemption fee. These fees are described in the fund prospectus. In addition, expenses related to mutual fund management are assessed before mutual fund earnings are credited to your account.

TIAA

A participant with a legacy account at TIAA pays recordkeeping fees through "plan services expense offsets." Plan Services Expense Offsets are determined by TIAA in its capacity as a recordkeeper and notionally represent a portion of the Administration and Distribution expense ratio related to plan services. Any Plan Services Expense Offset is included as part of each investment option's expense ratio (it is not in addition to the expense ratios).

TIAA's recordkeeping fee is automatically deducted from the plan service expense offsets generated by your TIAA or CREF investments each quarter. All plan services expense offsets generated by

TIAA investments are credited back to your account, less the recordkeeping fee assessed by TIAA. If the plan services expense offset amount your investments generate is equal to or less than TIAA's quarterly recordkeeping fee, no plan services expense offsets will be credited back to your account.

Subject to the terms of the plan, lump-sum withdrawals from the TIAA Traditional Annuity held in Group Retirement Annuity (GRA) accounts (in the Boston University Retirement Plan) are available only within 120 days after termination of employment and are subject to a 2.5% surrender charge. All other withdrawals and transfers from the TIAA Traditional Annuity must be spread over ten annual installments (over five years for withdrawals after termination of employment).

Loss of Benefits

There may be circumstances which may result in a reduction in the value of your account(s), such as:

- The fees/redemption charges (described above) that relate directly to your investments will be deducted directly from your account.
- A payment from your account was required under the terms of a Qualified Domestic Relations Order.
- The value of the investments in your BU Retirement Plan account could decrease in response to market conditions.

How to Begin Benefit Payments

You should contact your record keeper for a distribution form. They have counselors who will provide you with information that may help you in deciding which distribution option best meets your financial needs.

Appealing a Denial

If you or your beneficiary apply for benefits and your claim is denied, in whole or in part, you may consult Human Resources for information about how to appeal the denial.

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

Other Important Information

Contributions to the BU Retirement Plan are subject to the provisions and limitations of the Internal Revenue Code and IRS regulations and rulings, including the contribution limits in Internal Revenue Code Sections 402(g), 401(m), and 415.

Correction of Mistakes

All University contributions to the BU Retirement Plan must be used for the benefit of Plan Members and beneficiaries. Once made, the contributions cannot be taken back by the University, except if made as a result of a mistake of fact.

A mistaken excess contribution to your account by the University may be returned to the University.

If an adjustment is necessary to meet one of the tax law limits on contributions to your accounts, the Plan Administrator has the right to correct the mistake or make the necessary adjustment.

Payments to Others

Your rights under the BU Retirement Plan cannot be assigned or used as collateral, and your accounts are not generally subject to attachment or garnishment. However, under federal law, the BU Retirement Plan must honor a Qualified Domestic Relations Order from a court requiring payment to a divorced or separated spouse or for child support or a lien on your accounts for payment of overdue taxes and certain other specified types of liens and attachments. A copy of the Plan's Qualified Domestic Relations Order Procedures is available at no cost upon request to Human Resources.

Termination of Participation

Your participation in the BU Retirement Plan ends when you retire or otherwise terminate your employment with Boston University. From the date that your participation ends until your accounts are fully distributed to you, you will be considered a former Member.

This Plan Is Not Insured by the PBGC

BU Retirement Plan benefits are not guaranteed by the Pension Benefit Guaranty Corporation (PBGC), which does not cover plans such as this one with individual accounts for each participant. Upon termination of the

plan, you would be eligible to receive the total amount in your accounts.

Administrative Information

This plan is sponsored by the employer, Boston University, Boston, Massachusetts. Eligibility for the benefit plan described in this handbook applies to those University employees on the US payroll.

Boston University's Employer Identification Number

For identification purposes, the Internal Revenue Service has assigned number 04-2103547 to Boston University. You will need to know this number if you write to a government agency about any of the plans.

Type of Plan, Plan Number, and Plan Year

In addition to the University's Employer Identification Number, you need to know the following information:

- **Type of Plan:** The BU Retirement Plan is characterized by the federal government as a defined contribution plan and is intended to be tax-exempt under Section 403(b) of the Internal Revenue Code.
- **Plan Number:** Boston University has assigned Plan Number 002 to the BU Retirement Plan.
- **Plan Year:** The financial records of this plan are kept on a Plan Year basis. The Plan Year for The BU Retirement Plan is January 1 to December 31.

Administrator for This Plan

The day-to-day administration of this

plan is handled by Human Resources. However, if you have a question or a problem that cannot be resolved by Human Resources, you should contact the Plan Administrator.

The Plan Administrator can be reached by contacting:

Plan Administrative Committee
The Trustees of Boston University
25 Buick Street
Boston, MA 02215
Phone: 617-353-4489

Funding and Administration of the Plan

The BU Retirement Plan is funded entirely by contributions from Boston University. All Plan contributions are made to the Plan Trustees and are held in trust. The following Trustees for the Plan hold the Plan's assets and are responsible for paying benefits from the participants' accounts:

Fidelity Investments Tax-Exempt Services Company (Fidelity)
82 Devonshire Street
Boston, MA 02109
Phone: 1-800-343-0860

Teachers Insurance and Annuity Association (TIAA)
730 Third Avenue
New York, NY 10017
Phone: 1-800-842-2733

Agent of Legal Service

The agent for the service of legal process for this plan is:

University Counsel
125 Bay State Road
Boston, MA 02215

Legal process may be served on the Plan Administrator.

Claims for Benefits/Appealing a Denial of Claims for Benefits

You may file a claim for benefits with the recordkeeper(s) for the Plan that hold your benefit account balance (Fidelity or TIAA). To initiate payment of your Plan benefits contact:

Fidelity Investments Tax-Exempt Services Company (Fidelity)
82 Devonshire Street
Boston, MA 02109
Phone: 1-800-343-0860

Teachers Insurance and Annuity Association (TIAA)
730 Third Avenue
New York, NY 10017
Phone: 1-800-842-2733

When you apply for benefits, there are time periods within which you must receive a decision on your claim for benefits. If you or your beneficiary applies for benefits and either part or all of the request is denied, you have the right to appeal that decision, provided the appeal is made in accordance with the provisions of the plan and applicable laws (e.g., appeals must be filed within required time periods).

Claims and Appeals to the Plan Administrator

Claims and appeals regarding benefits or other issues affecting plan participants or other persons for the Retirement Plan should be made to the University’s Plan Administration Committee (the Plan Administrator).

For claims and appeals to the University’s Plan Administration

Committee, the following procedures will apply.

If a claim for benefits is either wholly or partially denied, you will be notified in writing within 90 days after receipt of your claim (180 days if special circumstances apply). The notice will state:

- the reasons why the claim was denied,
- the specific references in the plan document that support those reasons,
- the information you must provide to verify your claim and the reasons why that information is necessary,
- the Plan’s review procedures, including your right to bring a civil action following an adverse benefit determination on review,
- and the deadline for requesting review.
- After receiving the notice, you or your beneficiaries may request, in writing, a review of your claim by the University’s Plan Administration Committee by submitting an appeal to:
Plan Administration,
c/o Plan Administrator, Boston
University Human Resources, 25
Buick Street, Boston, MA 02215.
- Your appeal of a denied claim must be submitted within 60 days after your claim has been denied. You (or your representative) may review Plan documents and submit issues and comments orally, in writing, or both.
- The Plan Administration Committee (or Senior Vice President and General Counsel)

will conduct a full and fair review of your claim and appeal, and notify you of the final decision regarding your appeal within 60 days (120 days if special circumstances apply) after your request for review is received. The decision will be in writing and will include:

- the specific reason or reasons for the adverse determination;
- reference to the specific Plan provisions on which the determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information; and
- a statement of your right to bring a civil action under section 502(a) of ERISA and a description of the limitations period provided by the Plan, including the date on which the limitations period will expire.

Documents and Laws Governing This Plan

The plan description contained in this handbook was written from the documents that legally govern how the plan works.

In the event of any discrepancy

between the plan description in this handbook and the controlling contracts or plan documents, the language in the controlling contracts or plan documents will govern. If you would like a copy of any of these documents, please contact Human Resources.

The plan is also regulated by applicable provisions of applicable laws, which will govern in the event of any conflict between the law and the terms of the plan as described in either the documents or in this summary plan description.

Equal Opportunity/Affirmative Action Policy

Since its founding in 1839, Boston University has been dedicated to equal opportunity and has opened its doors to students without regard to race, sex, creed, or other irrelevant criteria. Consistent with this tradition, it is the policy of Boston University to promote equal opportunity in educational programs and employment through practices designed to extend opportunities to all individuals on the basis of individual merit and qualifications, and to help ensure the full realization of equal opportunity for students, employees, and applicants for admission and employment. The University is committed to maintaining an environment that is welcoming and respectful to all.

Boston University prohibits discrimination against any individual on the basis of race, color, religion, sex, age, national origin, physical or mental disability, sexual orientation, genetic information, military service, or because of marital, parental, or veteran status. This policy extends to all rights, privileges, programs, and activities, including admissions, financial assistance, educational and

athletic programs, housing, employment, compensation, employee benefits, and the providing of, or access to, University services or facilities. Boston University recognizes that that equal opportunity is a reality. Accordingly, the University will continue to take affirmative action to achieve equal opportunity through recruitment, outreach, and internal reviews of policies and practices.

The coordination and Implementation of this policy is the responsibility of the Director of Equal Opportunity. The officers of the University and all deans, directors, department heads, and managers are responsible for the proper implementation of equal opportunity and affirmative action in their respective areas, and they are expected to exercise leadership toward their achievement. It is expected that every employee of Boston University will share this commitment and cooperate fully in helping the University meet its equal opportunity and affirmative action objectives.

Boston University has developed detailed procedures, described in its *Complaint Procedures in Cases of Alleged Unlawful Discrimination or Harassment* (www.bu.edu/eeo/policies-procedures/complaint), by which individuals may bring forward concerns or complaints of discrimination and harassment. Retaliation against any individual who brings forward such a complaint or who cooperates or assists with an investigation of such a complaint is both unlawful and strictly prohibited by Boston University.

Inquiries regarding this policy or its application should be addressed to the Director of Equal Opportunity, Equal Opportunity Office, 888

Commonwealth Avenue, Suite 303, Boston, MA 02215, or call 617-358-1796.

Amendment or Termination of the Plan

Boston University intends to continue maintaining the plan described in this handbook for the exclusive benefit of its employees.

However, the University reserves the right to change or discontinue it, and to implement changes as required by federal, state, or local laws.

You will be informed of any material changes that are made to the plans. If a plan is terminated, your rights, on the date of the termination, would be governed by the provisions of the plan document.

Your Rights Under ERISA

The Retirement Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides participants in the plan with certain rights and protections. The following statement is included here so that you will be aware of your rights under ERISA.

Under ERISA:

- You may examine, without charge, at Human Resources and at other specified locations, during normal business hours, all plan documents relating to the plans in which you participate. The documents that must be available for your review include insurance contracts, plan and trust documents, collective bargaining agreements, and all documents filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security

Administration, for example, detailed annual reports.

- If you wish, you may request your own copies of these plan documents by writing to Human Resources. Where permitted by law, you may have to pay a reasonable charge to cover the costs of copying.
- You will receive summaries of the plan's annual financial report each year, free of charge. The administrator for the plans is required by law to furnish each participant with a copy of the summary annual report.
- You may request a statement of your vested benefits under the Boston University Retirement Plan. This statement will be given to you free of charge and may be requested once each year.

Plan Fiduciaries

Besides giving you certain rights as a participant, ERISA places certain duties upon the people who are responsible for the management of the BU Retirement Plan. These people are called "fiduciaries" under the law, and they have the duty to act prudently and in your best interests.

Under ERISA, no one may fire you or discriminate against you to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Enforcing Your Rights

If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to obtain copies, without charge, of documents relating to the decision, and to appeal any denial all within certain time

schedules.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 for each day's delay until you receive the materials, unless the materials were not sent for reasons beyond the administrator's control. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with a plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse plan money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or file suit in a federal court.

In a lawsuit, the court normally decides who pays the court costs and legal fees. If you are successful, the other party might have to pay. But, if you lose, the court might order you to pay these costs and fees, especially if the court finds your claim to be frivolous.

Assistance with Questions

If you have any questions about this statement of your rights under ERISA, contact Human Resources. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

A Final Note

This handbook presents a summary of Boston University's benefits for faculty and staff and is intended to serve as the summary plan description for the Boston University Retirement Plan. It is designed as a quick reference source and is not intended to cover every point of policy. In certain instances, the University may exercise discretion, with respect to the administration of the plans described in this handbook. For more in-depth information, contact Human Resources.

Periodically, the University may make changes in policy that may not be reflected immediately in this handbook.

Again, for complete and up-to-date information about any policy or benefit, you should contact Human Resources.

Please note: The policies described in this SPD are not intended to create an employment contract between Boston University and its employees. Therefore, they do not alter the University's rights regarding discharges and layoffs.

SUPPLEMENTAL RETIREMENT AND SAVINGS PLAN

BOSTON UNIVERSITY

BOSTON UNIVERSITY



As part of the BU Retirement Savings Program, you may accumulate funds for your future through the Supplemental Retirement and Savings Plan. Your contributions to the Supplemental Retirement and Savings Plan are made through payroll deductions and may be invested in a variety of investment vehicles (see “Investment Choices” for details). A brokerage account is also available. Beginning July 1, 2021, all contributions are made through Fidelity Investments. Before that time, contributions were made through Fidelity Investments and Teachers Insurance and Annuity Association (TIAA).

The contributions you make to the Supplemental Retirement and Savings Plan may be matched by the University under the Boston University Retirement Plan (subject to certain eligibility requirements and limitations) and will add to the financial security you can build with Social Security and your personal assets.

You have the choice to make pre-tax contributions to the Supplemental Retirement and Savings Plan, in which case neither contributions nor investment earnings will be subject to income tax until withdrawal. Alternatively, your contributions to the plan may be made as Roth contributions on an after-tax basis. If you make after-tax Roth contributions, your investment earnings will accumulate tax-free and will be considered tax-free at the time of withdrawal as long as your withdrawal is qualified.

This summary provides the key terms of the Supplemental Retirement and Savings Plan in effect as of January 1, 2022. Please read it carefully to gain an understanding of how the Supplemental Retirement and Savings Plan works. Please note that nothing contained in this summary can expand or otherwise modify the benefits available under the Supplemental Retirement and Savings Plan, and if any statement in this summary is inconsistent with the terms contained in the plan document, the terms of the plan document will govern.

About the Supplemental Retirement and Savings Plan

The Supplemental Retirement and Savings Plan offers you the opportunity to set aside money for your future. You have a choice of contributing to the Supplemental Retirement and Savings Plan in the following ways:

Before-Tax Contributions—You pay no federal or state income tax on the before-tax money you put into the Supplemental Retirement and Savings Plan or the accumulated investment earnings until you receive it. These are referred to as “tax-deferred contributions.”

After-Tax Roth Contributions—You pay federal and state income tax on the money you put into the Supplemental Retirement and Savings Plan on an after-tax basis. The investment earnings accumulate tax-free and are paid to you tax-free at the time you receive it as long as the withdrawal is qualified. After-tax Roth contributions may only be made through Fidelity Investments.

You are eligible to participate in the Supplemental Retirement and Savings Plan if you are an employee of the University (other than a leased employee or an employee who is a bona fide University student who is enrolled in and regularly attending University classes).

If eligible, you may begin participating in the Supplemental

Retirement and Savings Plan immediately.

Automatic Enrollment for Eligible New Employees

Participation in the Supplemental Retirement and Savings Plan is automatic for new employees.

You will automatically be enrolled to contribute 3% of your eligible compensation, as defined under the BU Retirement Plan, on a tax deferred basis and your contribution will be invested in a Vanguard Target Date Fund most closely corresponding to the year in which you will turn age 65. Your first contribution to the plan will commence in the month following your hire date.

You may change or stop making automatic enrollment contributions at any time. You may also change the investment allocation and tax status of your contributions at any time.

Temporary Suspension of Employer Contributions

Due to the COVID-19 pandemic, all employer contributions to the Boston University Retirement Plan were suspended for Fiscal Year 2021, which occurred from July 1, 2020 through June 30, 2021. This included the employer core, employer matching, and employer transition contributions effective July 1, 2020 through June 30, 2021.

Despite not receiving any University contributions during the suspension period, employment during this time did still count towards the two-year waiting period. If you achieved two years

of eligible service during the suspension period, you were automatically enrolled in the BU Retirement Plan and began receiving contributions when they resumed, beginning July 1, 2021.

Automatic Enrollment and BU Matching Contribution After Two Years of Service

Once you have completed two “years of service” you will be eligible to receive the University matching contributions to the Boston University Retirement Plan.

In addition, you will be automatically enrolled in the Supplemental Retirement and Savings Plan to contribute 3% of your eligible compensation (as defined in the plan) on a tax-deferred basis, if you are not already doing so, when you complete two years of service. BU matches your contribution dollar-for-dollar up to 3% of your eligible compensation. Matching contributions are made under the BU Retirement Plan.

You may make the following changes at any time:

1. You may choose to reduce your contribution to 2% or 1% and still receive a BU Matching contribution.
2. You may choose to opt out of contributing, however, the BU matching contribution will also cease if you do not contribute at least 1% of your pay.

3. You also have the option to contribute an additional dollar amount beyond 3%, up to the IRS maximum. The University will not, however, match any employee contributions above 3%.

Changing or Stopping Your Elections

You may change or stop your election at any time using the BU Benefits Center on Employee Self-Service at www.bu.edu/buworkscentral or by obtaining the appropriate form from www.bu.edu/hr/forms-documents.

Your change will be reflected in the next payroll run following the date of your online change or the date Human Resources receives and processes your paper form.

As a general rule, you may stop or reduce contributions on a prospective basis only. But under a special rule, you may stop making automatic enrollment contributions and withdraw prior automatic contributions if you complete a written election to do so within 90 days after automatic contributions are first withheld from your pay. Contact Human Resources for information about how the rule works and how to make the election.

Your ability to change your investment choices, or to transfer investments from one investment to another, depends on your initial

choice of investments. You should review the restrictions in each option carefully before making your investment decision.

If you previously participated in another 403(b) plan or other type of tax-qualified plan (such as a 401(k) plan) with a previous employer, you may be able to roll over your account balances from that plan to the Supplemental Retirement and Savings Plan, provided you meet the plan's rules and the rules of the record keepers. Human Resources and Fidelity Investments can provide you with further information on rollovers.

Tax-Deferred Contributions and After-Tax Roth 403(b) Contributions

The Supplemental Retirement and Savings Plan gives you a choice as to whether you make your contributions on a pre-tax or Roth after-tax basis, or a combination of pre-tax and Roth after-tax.

- **Tax-Deferred Contributions**— You will not pay taxes (other than Social Security withholding) on the portion of your pay you contribute to the Supplemental Retirement and Savings Plan until your benefits are paid out to you. You may make pre-tax contributions by entering into a “salary deferral agreement” with the University when you enroll. Your pre-tax contributions, as well as after-tax Roth 403(b) contributions, are subject to applicable Social Security tax withholding.

- **After-tax Roth 403(b) Contributions**— You can choose to make your contributions on an after-tax basis. Earnings on your Roth 403(b) account are tax-free when withdrawn as long as the withdrawal is qualified. A qualified withdrawal is one that is taken (i) no earlier than the fifth calendar year after the year of your first Roth contribution and (ii) after you have attained age 59½, become disabled, or die.

How Much You Can Contribute

You may contribute any portion you choose of your weekly or monthly pay, subject to federal tax law limits. Several limits and rules apply, but the limit that will affect most participants for 2025 is \$23,500 (not yet age 50) or \$31,000 (age 50 or more at the end of the year). These limits apply to your combined contributions on a tax-deferred and after-tax basis to the Supplemental Retirement and Savings Plan.

If you will attain age 60, 61, 62, or 63 in 2025, the annual 403(b) contribution limit you will be able to contribute up to is \$34,750.

These amounts are indexed for inflation each year, but only in \$500 increments. The new limits will be communicated to participants after the IRS announces them for any particular year. Please refer to the Human Resources website at www.bu.edu/hr for limits in future years.

Other limits may apply in certain situations; Human Resources will communicate with you if any limit applies to your contributions.

You must contribute the same portion of your pay each payroll period, and your contribution must be withheld from your weekly or monthly pay. No lump sum cash contributions are permitted.

Note: Special rules and limits apply if, during a calendar year, you also participate in another plan maintained by a business you own or control. For example, if you have consulting or other self-employment income and participate in a self-employed plan to which you make contributions, the special rules may affect you. If this situation applies to you, consult a qualified tax professional for advice on how the limits apply to you.

Investment Choices

The Supplemental Retirement and Savings Plan is intended to be a participant-directed plan as described in Section 404(c) of the Employee Retirement Income Security Act of 1974 as amended (ERISA) and Department of Labor regulations governing section 404(c) plans. Therefore, fiduciaries of the Supplemental Retirement and Savings Plan are relieved of liability for any losses that are the result of investment instructions given by a participant or beneficiary under the participant-directed investment feature of the Supplemental Retirement and Savings Plan. In other words, you choose how contributions to your accounts will be invested from among the investment options available to you under the Plan. Since you choose the investment

options for the account, you bear the risk for the investment results.

You should consult a professional financial advisor for investment advice and financial planning assistance before choosing an investment option. To obtain a detailed description of the investment options available under the Plan, please contact Fidelity at 800-343-0860. You should read the prospectus or other information carefully before investing.

Selected Investments

The investment fund groups currently offered under the Supplemental Retirement and Savings Plan are the following:

Tier 1: Target Date Fund

Tier 2: Passively Managed Equities

Tier 3: Capital Preservation and Income Funds

Tier 4: Self-Directed Brokerage

Tier 1: Target Date Funds

Investing Style: Diversified portfolio within a single fund that shifts its emphasis to more conservative investments as the year of retirement nears.

Target-date funds are designed for participants who prefer a single fund solution that includes a mix of stocks, bonds, and short-term assets. Each of the funds creates a diversified portfolio within one fund, based on your expected retirement year (the “target dates” of the fund), or year in which you turn age 65. These funds automatically rebalance between stocks and bonds to

become more conservative as you approach retirement and are also the plan’s Designated Default Investment.

Tier 2: Passively Managed Equities

Investing Style: A broad selection of equity index funds designed to mirror a market index or benchmark.

Passively managed funds – commonly known as “index funds” – seek to approximate their benchmark’s performance, rather than beat their benchmarks. A benchmark is what the investment’s return are compared to in order to measure performance. Because the objective is to simply mirror the holdings and return of an index, less research is needed, transactions occur less frequently, and expenses tend to be lower than those of actively managed funds.

Ultimately, index funds are designed to provide exposure to a broad selection of securities at a relatively low cost. While these funds typically perform very similarly to the index they track, you should be aware that index funds cannot be expected to meet or bear the index’s performance.

Tier 3: Capital Preservation and Income Funds.

Investing Style: A broad selection of funds that seek to preserve savings and generate income or produce returns that exceed the inflation rate.

Tier three funds include the New York Life Guaranteed Fixed Interest Account, which is a

guaranteed fixed-return annuity is designed to provide you with a high level of principal stability. In addition, it lets you convert your balance to a guaranteed stream of income when you retire (Any guarantees are subject to the claims paying ability of the issuer).

The remaining funds in Tier 3 focus on income generation and inflation protection for investors who want to produce a growing income distribution while leaving the principal alone or returns that exceed the inflation rate so investors can build future purchasing power and wealth.

Other Investments

Tier 4: Self-Directed Brokerage

Investing Style: For investors who want additional choice and investment flexibility.

Fidelity BrokerageLink® is a self-directed brokerage option, that combines the convenience of the BU Retirement Savings Program with the additional flexibility of an individual brokerage account. If you are a more engaged investor looking for additional investment selection and flexibility, a self-directed brokerage account gives you opportunities to invest in a wide range of mutual funds outside of the Plans' investment lineup.

. While a brokerage account offers expanded flexibility, it also comes with additional personal responsibility, risk and applicable fees. The University does not

select or screen these investments. That task falls to you.

Qualified Default Investment

Under the Boston University Retirement Plan and the Supplemental Retirement and Savings Plan (the "Plans"), any contributions for which you do not provide investment direction will be invested in the Plans' default investment fund (the "Plans' Designated Fund"). The Plans have selected the Vanguard Target Retirement Funds as the Plans' Designated Fund. For a description of the Vanguard Target Retirement Funds, see "Investment Choices."

The Vanguard Target Retirement Funds are the Plans' Designated Fund and are intended to serve as "qualified default investment alternatives" that meet U.S. Department of Labor requirements. The Designated Fund is based on the assumption that a participant will retire at age 65. If you do not provide investment direction, your contributions will be directed to the Vanguard Target Retirement Fund most closely corresponding to the year in which you turn age 65, as determined by the University, based on your date of birth.

You have the right under the Plans to direct the investment of your existing balances and future University contributions to any of the Plans' available investment options, including the right to transfer out of the Plans'

Designated Fund to another investment option. Unless you provide another direction, the University contributions and/or the portion of your account that is currently invested in the Plans' Designated Fund will continue to be invested in this option.

Investment Restrictions

There are certain restrictions on your investments. For complete, current details on restrictions, you should refer to the printed materials available from each record keeper. Following are explanations of some of the most important restrictions.

The following rules apply to how future contributions to the plan are invested:

1. You may choose to invest your own future tax-deferred and/or Roth contributions in the investment options available through Fidelity Investments.
2. You may choose to invest your contributions among the investment options available under the Plan in any combination.
3. You can change your choice of which investment options to invest future contributions at any time.

Transfers can be made out of any investment option at Fidelity to another investment option available under the Plan at Fidelity in any amount at any time.

Transfers between existing balances in TIAA Traditional, CREF Money Market, and CREF

Stock Accounts may also be made at any time, however balances at Fidelity may not be transferred to these three funds.

TIAA Traditional, CREF Money Market, and CREF Stock Accounts may also be transferred to Fidelity at any time and in any amount.

In-Plan Roth Conversion

You may elect to convert all or a portion of your Supplemental Retirement and Savings Plan Account (other than your Roth Contribution Account) to a Roth Contribution Account as an In-Plan Roth Conversion. This conversion occurs within the Supplemental Retirement and Savings Plan. You do not receive a check and then contribute it back to the Supplemental Retirement and Savings Plan. Note that the conversion is a taxable event, but converting to a Roth Contribution Account can be beneficial if you expect your tax rate to increase in the future. You should consult a tax advisor to better understand the consequences of an In-Plan Roth Conversion before you make the decision to convert your Account.

You may take a distribution from your Roth Account funds only if you are eligible, otherwise your funds are subject to the rules of the Supplemental Retirement and Savings Plan. An eligible distribution is (i) a distribution to an active Member on or after attaining age 59½; (ii) a

distribution made upon termination of employment, becoming disabled, or retirement; (iii) a distribution upon the Member's death; or (iv) any distribution that would otherwise qualify as an eligible rollover distribution.

Statements of Your Accounts

You will receive quarterly statements by mail or online.

CARES Act Distributions

Under the Coronavirus Aid, Relief and Economic Security Act (CARES Act), a participant who is a "qualified individual" was eligible to take penalty-free withdrawals of up to \$100,000 from any funds available through Fidelity and any TIAA investments from January 1, 2020, through December 30, 2020.

A qualified individual was one who:

- is diagnosed with the virus SARS-CoV-2 or with coronavirus disease 2019 (COVID-19) by a test approved by the Centers for Disease Control and Prevention,
- has a spouse or dependent diagnosed with such virus or disease, or
- experiences adverse financial consequences as a result of:
 - being quarantined, being furloughed or laid off, or having work hours reduced due to COVID-19, being unable to work due to lack of childcare due to COVID-19, or other factors as determined by the Secretary of the Treasury.

- having a reduction in pay, or a job offer rescinded or start to a job delayed, due to COVID-19
- having a spouse or member of the individual's household being quarantined, being furloughed or laid off, having a reduction in pay, or a job offer rescinded or start to a job delayed, or having work hours reduced due to COVID-19, or being unable to work due to lack of childcare due to COVID-19
- the closing or reducing or hours of a business owned or operated by the individual's spouse or a member of the individual's family due to COVID-19.

Withdrawals While Employed by Boston University

The Supplemental Retirement and Savings Plan is intended to provide long-term savings opportunities for your retirement years. However, while you are employed, there may be circumstances in which you will need to make a withdrawal for other important financial needs.

The Internal Revenue Service places restrictions on "in-service" withdrawals. You may not withdraw post-1988 contributions while still employed by Boston University unless you:

- Reach age 59½; or

- Are able to prove financial hardship

For purposes of making financial hardship withdrawals under the Supplemental Retirement and Savings Plan, the IRS defines financial hardship as the need for funds to meet certain immediate and heavy expenses. Funds must not be reasonably available from other sources. Federal tax rules limit hardship withdrawals to needs such as:

- The purchase price of your principal residence
- Higher education expenses for you or your spouse, children, or other tax dependents
- Major uninsured medical expenses for you or your dependents
- Expenses to prevent eviction from your principal residence or mortgage foreclosure
- Funeral expenses for your parents, spouse, children, or other tax dependent
- Expenses for the repair of your principal residence that would qualify for casualty deduction under federal tax rules (but without regard to the 10% limit)

The plan administrator must abide by these rules in considering requests for hardship withdrawals.

You may withdraw contributions credited to your TIAA Group SRA account prior to January 1, 1989, and related earnings at any time.

You may start making withdrawals or start receiving installment or annuity payments from the Supplemental Retirement and Savings Plan once you reach age 59½ even though you are still employed at Boston University.

Withdrawals are paid as a lump sum in cash. To make a withdrawal, you must complete and submit the appropriate withdrawal form by contacting the appropriate record keeper.

Please note: In general, if you are under age 59½ when you make an in-service withdrawal, unless an exception applies, your money will be subject to a 10% penalty tax, in addition to regular income tax (see “Tax Considerations When You Receive Benefits”).

Loans While Employed by Boston University

You may borrow money from your Supplemental Retirement and Savings Plan accounts while employed by the University. IRS rules limit the maximum loan you may take from this Plan. Through this loan feature, you have access to your Supplemental Retirement and Savings Plan accounts, up to permissible limits, without the need to experience a triggering event including meeting the financial hardship provisions listed above. For detailed information about plan loans contact your record keeper (Fidelity or TIAA).

CARES Act Loans

Under the CARES Act, a participant who was a “qualified individual” (as described above in the “CARES

Act Distributions” section) was eligible to increase the maximum loan limit to the lesser of 100% of his or her vested account balance or up to \$100,000 from any funds available through Fidelity and any TIAA investments from March 27, 2020, through September 23, 2020. The first payment date on any such loan was deferred until January 2021.

For repayment of existing loans, the CARES Act allowed a “qualified individual” (as described above in the “CARES Act Distributions” section) to delay loan repayments that would otherwise have been due between March 27, 2020 and December 31, 2020. Loan repayments begin again in January 2021. If you choose to suspend existing loan repayments, interest continues to accrue during the deferment period and the term of the loan was extended by the length of the deferment period.

Forms of Payment

In general, you or your beneficiary may begin receiving payment of your Supplemental Retirement and Savings Plan benefits when you retire, die, become disabled, or terminate your employment with Boston University. Some choices regarding the form of payment are available. However, if your total account balances are \$5,000 or less, the Plan has the right to pay them out in a lump sum in cash.

Any payments you receive before age 59½ may be subject to a 10% penalty tax in addition to regular income tax (see “Tax

Considerations When You Receive Benefits”) unless one of a limited number of exceptions applies.

Contributions made to the Boston University Supplemental Retirement and Savings Plan may be received in one of the following forms.

Lump Sum

You may elect to receive a lump sum distribution for all or part of the full value of your accounts.

Installment Withdrawal Program

As an alternative, you may elect to receive installment withdrawals until you have exhausted your account balances. You may designate the amount and the frequency of these withdrawals (subject to certain minimums required by tax law).

Rollover

You may also roll over lump sum distributions from your account balances into an individual retirement account (IRA) or another 403(b) or 401(k) plan you participate in that accepts rollovers, provided you meet federal tax law requirements.

Annuity Options

If you wish, you may use the proceeds of your account to purchase an annuity. Please see Income Solutions, an online annuity comparison tool for more information on annuities. You may wish to consult with your financial advisor before selecting this option.

You also have TIAA or CREF Annuity payment options available to you.

Information on these annuity options is available at the following link: <https://www.tiaa.org/public/retire/services/preparing-for-retirement/income-options/employer-plan>

Fixed Period Annuity Payments

All TIAA & CREF accumulations may be taken over any period between 5 and 30 years, subject to IRS restrictions. At the end of the selected period, payments will end.

CREF Lifetime Annuity

A lifetime annuity may be received from your CREF Account. Lifetime annuity income is the only payment method that ensures you will never outlive your retirement income. It is also a permanent arrangement. Once you begin receiving payments, you may not stop them. The actual amount of income you receive at retirement depends primarily on the amount in your account, your age when payments begin, and the form of payment you choose (see “Annuity Forms of Payment”).

This annuity form of payment is also available from a TIAA Real Estate account with respect to amounts attributable to contributions made before January 1, 2014.

TIAA Traditional Lifetime Annuity

A lifetime annuity may be received from your TIAA Traditional Annuity Account.

Lifetime annuity income is the only payment method that ensures you will never outlive your retirement income. It is also a permanent arrangement. Once you begin receiving payments, you may not stop them. The actual amount of income you receive at retirement depends primarily on the amount in your TIAA account, your age when payments begin, and the form of payment you choose (see “Annuity Forms of Payment”).

Once the amount of your TIAA guaranteed annuity is determined, it can be increased or decreased by changes in dividends, but cannot fall below the contractually guaranteed level.

Annuity Forms of Payment (TIAA and CREF Payments Only)

The following is a description of the types of annuities TIAA provides for moneys invested with them. These annuity options would also be available if you transferred balances from other Plan accounts. Just before you are scheduled to start receiving your income, you will be asked to choose the option that best meets your needs. Information is available from TIAA to help you decide.

Subject to certain minimum requirements, you also may choose to receive part of an account under one option, and the balance under another option. Of course, when you choose an annuity option, you may also

choose to take a portion of your accounts in cash; however, this will reduce the amount of annuity income you receive. You should note when reviewing these options that the size of the monthly payments depends not only on your age and account balances, but may also depend on the age of your spouse or other beneficiary.

Single Life Annuity Pays you an income for as long as you live. This option provides a larger monthly income for you than the other options. However, all payments will stop at your death.

Life Annuity with 10-, 15-, or 20-Year Guaranteed Period Pays you an income for as long as you live, with installments guaranteed to continue during the first 10, 15, or 20 years, as you select, whether you live or die. If you live beyond the guaranteed period, payments continue for your lifetime. If you die during the guaranteed period, payments continue to your beneficiary for the balance of the guaranteed period.

Joint & Survivor Annuity Pays you an income for life. If your spouse or second annuitant lives longer than you, he or she continues to receive an income for life. The amount of the income continuing to the survivor depends on which option you choose from the four options listed below. The amount of the annuity payable to you at the onset of each of these options is different; the more you choose to make payable to your survivor, the smaller your own income during your lifetime.

Each of these survivor options is available with a 10, 15, or 20 year guaranteed period. This provides that if both you and your spouse or second annuitant die during the first 10, 15, or 20 years (whichever you select), the option that you select continues to another named beneficiary for the balance of the guaranteed period.

1. Full Benefit to Survivor The full amount of the annuity continues for as long as you both live. If your spouse (or other second annuitant) lives longer than you, he or she receives, for his or her remaining lifetime, the full amount of the income you were receiving.

2. Two-Thirds Benefit to Survivor The full amount of the annuity continues for as long as you both live. Upon your death or the death of your spouse (or other second annuitant), the payments are reduced to two-thirds of the amount that you were receiving and are continued to the survivor for life.

3. Three-Fourths Benefit to Annuity Partner The full amount of the annuity continues for as long as you both live. If your spouse (or other second annuitant) lives longer than you, he or she receives, for his or her remaining lifetime, three-fourths of the income you were receiving. If you live longer than your spouse (or other second annuitant), you will

receive three-fourths of the income you were receiving.

4. Half Benefit to Annuity Partner

The full amount of the annuity continues for as long as you both live. If your spouse (or other second annuitant) lives longer than you, he or she receives, for his or her remaining lifetime, one-half of the income you were receiving. If you live longer, the benefit continues at the full amount.

Fixed Period Annuity Pays you an income for a fixed period you choose, from two to 10 years. If you die during the period chosen, payments in the same amount that you were receiving will continue to your beneficiary for the remainder of the period. At the end of the period, all payments stop.

Required Minimum Distribution Option

Under federal tax law, if you attained age 70½ on or before December 31, 2019, you are required to begin required minimum distributions by April 1 following the later of: (1 the calendar year in which you attained age 70½, or (2 the calendar year in which you terminated employment with the University.

If you attained age 70½ in 2020 or later, you are required to begin required minimum distributions by April 1 following the later of: (1 the calendar year in which you reach age 73, or (2) the calendar

year in which you terminate employment with the University.

Notwithstanding the above information, under the CARES Act, required minimum distributions for calendar year 2020 are waived in order to provide relief to individuals who would otherwise be required to withdraw funds from their retirement accounts.

Under this requirement, if you have multiple 403(b) accounts, you may calculate your required minimum distribution for each 403(b) accounts, total the amounts, and take the total required minimum distribution from any one or more of your 403(b) accounts.

Your Spouse's Rights

Under federal law, if you are married and you choose any annuity method of payment other than a survivor annuity with your spouse as the survivor, your spouse must give written consent which acknowledges that his or her rights to survivor benefits are being waived. Your spouse's signature must be witnessed by a plan representative or notarized by a notary public.

The Employee Retirement Income Security Act of 1974 (ERISA) provides that if you are married at the time of your death, your spouse is entitled to receive, as primary beneficiary, your qualified preretirement survivor death benefits under a retirement or tax-deferred annuity plan covered by ERISA. If

you name someone other than your spouse as primary beneficiary, your spouse must consent to this primary beneficiary designation by completing a Spousal Waiver. Then the qualified preretirement survivor death benefits will be payable to such primary beneficiary. If you elected only a portion to be paid to the designated beneficiary, then the remainder will be payable to your spouse.

If you designate your spouse as beneficiary and the individual later ceases to be your spouse, such designation will be deemed void and your ex-spouse will have no rights as a beneficiary unless redesignated as a beneficiary by you subsequent to becoming your ex-spouse or as otherwise provided under a Qualified Domestic Relations Order under Internal Revenue Code Section 414(p).

If You Die Before You Begin to Receive Benefits

If you die before your retirement income begins, the full current value of your account balances in all investment options will be payable to your beneficiary under any of the payment options elected by the beneficiary and allowed by the record keeper (subject to IRS minimum payment rules).

You choose a beneficiary at the time you enroll in the Supplemental Retirement and Savings Plan, and you may change

your beneficiary at any time by filing a new form with Human Resources. However, if you are married, federal law requires that your spouse be your beneficiary, unless your spouse consents in writing to your naming another beneficiary and this consent is witnessed by a Supplemental Retirement and Savings Plan representative or notarized by a notary public.

If you designate your spouse as beneficiary and the individual later ceases to be your spouse, such designation will be deemed void and your ex-spouse will have no rights as a beneficiary unless redesignated as a beneficiary by you subsequent to becoming your ex-spouse or as otherwise provided under a Qualified Domestic Relations Order under Internal Revenue Code Section 414(p).

If your marital status changes after you enroll in the Supplemental Retirement and Savings Plan (you marry, divorce or separate, or your spouse dies), be sure to contact Human Resources immediately to make any appropriate changes in your designated beneficiary. If you marry or you are divorced and then re-marry, your prior beneficiary designation(s) will become invalid and your current spouse will automatically become your beneficiary unless you designate another beneficiary with your current spouse's written consent (witnessed by a plan representative or notary public).

Current federal income tax laws contain several requirements regarding the distribution of your account balance after you die. If your designated beneficiary under the Supplemental Retirement and Savings Plan is your surviving spouse, a minor child (until reaching the age of majority, is chronically ill, or is not more than 10 years younger than you, your benefits may be paid over the course of your beneficiary's life expectancy. Other beneficiaries designated under the Supplemental Retirement and Savings Plan must receive the entire value of your accounts within ten years of your death. Beneficiaries that are not designated under the Supplemental Retirement and Savings Plan (for example, your estate and certain trusts must generally receive the entire value of your accounts within five years of your death.

Generally, annuity or installment payments must begin within one year of your death. However, if your spouse is your sole designated beneficiary, he or she may postpone the start of benefits until a later date, but until no later than the date on which you would have reached age 73.

Your beneficiary may receive a lump sum distribution of the account balances, or to roll over your account balances into an IRA or another plan that accepts such rollovers, or to receive the full value of the account over the maximum distribution period. A non-spouse beneficiary's rollover

option is limited only to a direct rollover to an IRA in accordance with federal tax law.

If you have a TIAA Traditional or CREF Annuity account you may also choose the following options for payment of the death benefit, or you may leave the choice to your beneficiary.

1. Income for the lifetime of the beneficiary with payments stopping at the time of his or her death.
2. Income for the lifetime of the beneficiary, with a minimum number of payments guaranteed in any event. The period of guaranteed payments may be 10, 15, or 20 years (subject to IRS rules).
3. Income for a fixed period (subject to IRS rules).
4. Subject to IRS rules, the accumulation may be left on deposit for future payment under any of the above options.
5. A lump sum distribution of the account balances, or rollover to an IRA or other plan that will accept the rollover.

Required Minimum Payment Rules

Under federal tax law, if you attained age 70 ½ on or before December 31, 2019, you are required to begin required minimum distributions by April 1 following the later of: (1) the calendar year in which you attained age 70 ½, or (2) the calendar year in which you

terminated employment with the University.

If you attain age 70½ in 2020 or later, you are required to begin required minimum distributions by April 1 following the later of: (1) the calendar year in which you reach age 73, or (2) the calendar year in which you terminate employment with the University.

Under this requirement, if you have multiple 403(b accounts, you may calculate your required minimum distribution for each 403(b account, total the amounts, and take the total required minimum distribution from any one or more of your 403(b accounts. If you do not receive or start your payments on time or if the payments are less than the required minimum amount, you will have to pay a federal tax penalty of 25% of the amount that was required to be distributed but was not distributed (unless you show reasonable cause to the Internal Revenue Service. See the "Forms of Payment" section for your choices.

If You Leave the University

You are fully "vested" in all of your Supplemental Retirement and Savings Plan account balances. Therefore, if your employment ends, you will be entitled to receive payment of your accounts as follows:

1. You may elect to receive a lump sum distribution of the

moneys invested in your accounts.

2. You may leave funds on account for distribution at a later date (no later than April 1 following the calendar year when you reach age 70½). You may not make contributions directly to your accounts.
3. You may roll over all or a portion of your account into an IRA or other plan that will accept the rollover, provided you meet federal requirements.

The rights for your spouse, which were described earlier (see “Your Spouse’s Rights”), also apply if you elect an annuity form of payment for benefits due when you terminate your employment with the University.

Tax Considerations When You Receive Benefits

Federal and state income tax must be withheld from the taxable portion of all Supplemental Retirement and Savings Plan benefits you or your beneficiary receive, unless you or your beneficiary elect otherwise (but see the last paragraph of this section for an exception).

Under current federal law, ordinary income tax applies to taxable payments to you from your Supplemental Retirement and Savings Plan accounts.

Qualified withdrawals from a Roth contributions account are tax-free.

A 10% penalty tax applies to all payments you receive before you

reach age 59½, except payments in the form of an annuity. The 10% penalty tax does not apply if payments are received because of your death, disability, or early retirement at age 55 or older; or in connection with a Qualified Domestic Relations Order; or in amounts that do not exceed your tax-deductible medical expenses or certain amounts spent for health insurance in the event of your extended unemployment or to qualified withdrawals from a Roth contributions account.

You may be able to postpone payment of taxes if you are able to transfer or roll over your Supplemental Retirement and Savings Plan distribution to an IRA or another plan that accepts rollovers. All cash distributions from the Supplemental Retirement and Savings Plan except those payable as an annuity or in periodic installments for at least 10 years, those mandated by minimum distribution rules, and hardship withdrawals, will be eligible for direct transfer to an IRA or another plan that accepts rollovers. If these distributions are not directly rolled over to an IRA (or to another employer plan that will accept them), they will be subject to mandatory 20% federal income tax withholding.

Leaves of Absence

If you are granted a leave of absence at full pay or partial pay, your contributions to the Supplemental Retirement and

Savings Plan will continue (unless you make a change).

Your contributions will stop if you are granted an unpaid leave of absence. However, they will start again, automatically, with the first paycheck you receive when you return (unless you make a change).

Remember, if you leave work for any reason for a prolonged period of time, you should always contact Human Resources to ask what effect your absence may have on this and other University-sponsored benefit plans.

Administrative Fees

There are fees associated with loans. These may change from time to time. See Fee Disclosure at www.bu.edu/hr/documents/BN_Fee_Notice.pdf for further details. Fidelity

A Member with an account at Fidelity will be assessed a fixed quarterly fee, which will be deducted directly from the Member’s account and reflected on his or her Fidelity participant account statements. For the most up to date information on this fee, please visit <http://www.bu.edu/hr/finances/supplemental-retirement-savings-plan/plan-costs/>.

At distribution, certain mutual funds available through Fidelity may charge a redemption fee. These fees are described in each such fund’s prospectus. In addition, expenses related to

mutual fund management are assessed before mutual fund earnings are credited to your account.

TIAA

A participant with a legacy account at TIAA pays recordkeeping fees through “plan services expense offsets.” Plan Services Expense Offsets are determined by TIAA in its capacity as a recordkeeper and notionally represent a portion of the Administration and Distribution expense ratio related to plan services. Any Plan Services Expense Offset is included as part of each investment option’s expense ratio (it is not in addition to the expense ratios).

TIAA’s recordkeeping fee is automatically deducted from the plan service expense offsets generated by your TIAA or CREF investments each quarter. All plan services expense offsets generated by TIAA investments are credited back to your account, less the recordkeeping fee assessed by TIAA. If the plan services expense offset amount your investments generate is equal to or less than TIAA’s quarterly recordkeeping fee, no plan services expense offsets will be credited back to your account.

Subject to the terms of the plan, lump-sum withdrawals from the TIAA Traditional Annuity held in Group Retirement Annuity (GRA) accounts (in the Boston University Retirement Plan) are available only within 120 days after termination of employment and are subject to a 2.5% surrender charge. All other withdrawals and transfers from the TIAA Traditional Annuity must be spread over ten annual installments (over five years for withdrawals after termination of employment).

Loss of Benefits

There may be circumstances which may result in a reduction in the value of your account(s), such as:

- The fees/redemption charges (described above) that relate directly to your investments will be deducted directly from your account.
- A payment from your account was required under the terms of a Qualified Domestic Relations Order.
- You failed to repay a participant loan on a timely basis and an offset of that amount occurred in your account.
- The value of the investments in your plan account could decrease in response to market conditions.

How to Begin Benefit Payments

You should contact your record keeper for a distribution form. They have counselors who will provide you with information that may help you in deciding which distribution option best meets your financial needs.

Appealing a Denial

If you or your beneficiary apply for benefits from the Supplemental Retirement and Savings Plan and your claim is denied, in whole or in part, you may consult Human Resources for information about how to appeal the denial.

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

Payment to Others

Your rights under the Supplemental Retirement and Savings Plan cannot be assigned or used as collateral, and your accounts are not generally subject to garnishment. However, under federal law, the Supplemental Retirement and Savings Plan must honor a Qualified Domestic Relations Order from a court requiring payment to a divorced or separated spouse or for child support or a lien on your account for the payment of overdue taxes, or to satisfy certain other court orders. A copy of the Plan's Qualified Domestic Relations Order Procedures is available at no cost upon request to Human Resources.

Correction of Mistakes

If through a payroll processing or other error, the wrong amount is taken from your paycheck or contributed to your Supplemental Retirement and Savings Plan account, or if an adjustment is necessary to meet one of the tax law limits on contributions to your accounts, the Plan Administrator has the right to correct the mistake or make the necessary adjustment.

Any over-contribution amounts debited from your accounts will be repaid to you (less withholdings, if applicable).

Termination of Participation

Your participation in the Supplemental Retirement and Savings Plan ends when you retire or otherwise terminate your employment with the University. From the date that your participation ends until your accounts are fully distributed to you, you will be considered a former Member.

This Plan Is Not Insured by the PBGC

The Supplemental Retirement and Savings Plan benefits are not guaranteed by the Pension Benefit Guaranty Corporation (PBGC), which does not cover plans such as this one with individual accounts for each participant. Upon termination of the Supplemental Retirement and Savings Plan, you would be eligible to receive the total amount in your accounts.

Administrative Information

This plan is sponsored by the employer, Boston University, Boston, Massachusetts, which is also the Plan Administrator. Eligibility for the benefit plan described in this handbook applies to those University employees on the US payroll.

Boston University's Employer Identification Number

For identification purposes, the Internal Revenue Service has assigned number 04-2103547 to Boston University. You will need to know this number if you write to a

government agency about any of the plans.

Type of Plan, Plan Number, and Plan Year

In addition to the University's Employer Identification Number, you need to know the following information:

- **Type of Plan:** The Supplemental Retirement and Savings Plan is characterized by the federal government as a Defined Contribution Plan and is intended to be tax-exempt under Section 403(b) of the Internal Revenue Code.
- **Plan Number:** Boston University has assigned Plan Number 005 to The Supplemental Retirement and Savings Plan.
- **Plan Year:** The financial records of this plan are kept on a Plan Year basis. The Plan Year for The Supplemental Retirement and Savings Plan is January 1 to December 31.

Administrator for This Plan

The day-to-day administration of this plan is handled by Human Resources. However, if you have a question or a problem that cannot be resolved by Human Resources, you should contact the Plan Administrator.

The Plan Administrator can be reached by contacting:

Plan Administration Committee
The Trustees of Boston University
25 Buick Street Boston, MA 02215
Phone: 617-353-4489

Funding and Administration of this Plan

The Supplemental Retirement and Savings Plan is funded entirely by your contributions. All Plan contributions are made to the Plan Trustees and are held in trust. The following Trustees for the Plan hold the Plan's assets and are responsible for paying benefits from the participants' accounts:

Fidelity Investments
82 Devonshire Street
Boston, MA 02109
Phone: 1-800-343-0860

Teachers Insurance and Annuity Association (TIAA)
730 Third Avenue
New York, NY 10017
Phone: 1-800-842-2733

Agent of Legal Service

The agent for the service of legal process for this plan is:

University Counsel
125 Bay State
Road Boston, MA
02215

Legal process may be served on the Plan Administrator.

Claims for Benefits/Appealing a Denial of Claims for Benefits

You may file a claim for benefits with the recordkeeper(s) for the Plan that hold your benefit account balance (Fidelity or TIAA). To initiate payment of your Plan benefits contact:

Fidelity Investments
82 Devonshire Street
Boston, MA 02109
Phone: 1-800-343-0860

Teachers Insurance and Annuity Association (TIAA)
730 Third Avenue
New York, NY 10017
Phone: 1-800-842-2733

When you apply for benefits, there are time periods within which you must receive a decision on your claim for benefits. If you or your beneficiary applies for benefits and either part or all of the request is denied, you have the right to appeal that decision, provided the appeal is made in accordance with the provisions of the plan and applicable laws (e.g., appeals must be filed within required time periods).

Claims and Appeals to the University

Claims and appeals regarding benefits or other issues affecting plan participants or other persons for The Supplemental Retirement and Savings Plan should be made to the University's Plan Administration Committee.

For claims and appeals to the University's Plan Administration Committee, the following procedures will apply.

If a claim for benefits is either wholly or partially denied, you will be notified in writing within 90 days after receipt of your claim (180 days if special circumstances apply). The notice will state:

- the reasons why the claim was denied,
- the specific references in the plan document that support those reasons,

- the information you must provide to verify your claim and the reasons why that information is necessary,
 - the Plan's review procedures, including your right to bring a civil action following an adverse benefit determination on review,
 - and the deadline for requesting review.
- After receiving the notice, you or your beneficiaries may request, in writing, a review of your claim by the University's Plan Administration Committee by submitting an appeal to:
Plan Administration Committee, Boston University Human Resources, 25 Buick Street, Boston, MA 02215.
 - Your appeal of a denied claim must be submitted within 60 days after your claim has been denied. You (or your representative) may review Plan documents and submit issues and comments orally, in writing, or both.
 - The Plan Administration Committee (or Senior Vice President and General Counsel) will conduct a full and fair review of your claim and appeal, and notify you of the final decision regarding your appeal within 60 days (120 days if special circumstances apply) after your request for review is received. The decision will be in writing and will include:

○ the specific reason or reasons for the adverse determination; ○ reference to the specific Plan provisions on which the determination is based; ○ a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information; and ○ a statement of your right to bring a civil action under section 502(a) of ERISA and a description of the limitations period provided by the Plan, including the date on which the limitations period will expire.	laws, which will govern in the event of any conflict between the law and the terms of the plan as described in either the documents or in this summary plan description. <u>Equal Opportunity/Affirmative Action Policy</u> Since its founding in 1839, Boston University has been dedicated to equal opportunity and has opened its doors to students without regard to race, sex, creed, or other irrelevant criteria. Consistent with this tradition, it is the policy of Boston University to promote equal opportunity in educational programs and employment through practices designed to extend opportunities to all individuals on the basis of individual merit and qualifications, and to help ensure the full realization of equal opportunity for students, employees, and applicants for admission and employment. The University is committed to maintaining an environment that is welcoming and respectful to all.	Boston University recognizes that that equal opportunity is a reality. Accordingly, the University will continue to take affirmative action to achieve equal opportunity through recruitment, outreach, and internal reviews of policies and practices. The coordination and implementation of this policy is the responsibility of the Director of Equal Opportunity. The officers of the University and all deans, directors, department heads, and managers are responsible for the proper implementation of equal opportunity and affirmative action in their respective areas, and they are expected to exercise leadership toward their achievement. It is expected that every employee of Boston University will share this commitment and cooperate fully in helping the University meet its equal opportunity and affirmative action objectives.
<u>Documents and Laws Governing This Plan</u> The plan description contained in this handbook was written from the documents that legally govern how the plan works. In the event of any discrepancy between the plan description in this handbook and the controlling contracts or plan documents, the language in the controlling contracts or plan documents will govern. If you would like a copy of any of these documents, please contact Human Resources. The plan is also regulated by applicable provisions of applicable	Boston University prohibits discrimination against any individual on the basis of race, color, religion, sex, age, national origin, physical or mental disability, sexual orientation, genetic information, military service, or because of marital, parental, or veteran status. This policy extends to all rights, privileges, programs, and activities, including admissions, financial assistance, educational and athletic programs, housing, employment, compensation, employee benefits, and the providing of, or access to, University services or facilities.	Boston University has developed detailed procedures, described in its <i>Complaint Procedures in Cases of Alleged Unlawful Discrimination or Harassment</i> (www.bu.edu/eoo/policies-procedures/complaint), by which individuals may bring forward concerns or complaints of discrimination and harassment. Retaliation against any individual who brings forward such a complaint or who cooperates or assists with an investigation of such a complaint is both unlawful and strictly prohibited by Boston University. Inquiries regarding this policy or its application should be addressed to the Director of Equal Opportunity,

Equal Opportunity Office, 888 Commonwealth Avenue, Suite 303, Boston, MA 02215, or call 617-358-1796.

Amendment or Termination of the Plan

Boston University intends to continue maintaining the plan described in this handbook for the exclusive benefit of its employees.

However, the University reserves the right to change or discontinue it, and to implement changes as required by federal, state, or local laws.

You will be informed of any material changes that are made to the plans. If a plan is terminated, your rights, on the date of the termination, would be governed by the provisions of the plan document.

Your Rights Under ERISA

The Supplemental Retirement and Savings Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides participants in the plan with certain rights and protections. The following statement is included here so that you will be aware of your rights under ERISA.

Under ERISA:

- You may examine, without charge, at Human Resources and at other specified locations, during normal business hours, all plan documents relating to the plans in which you participate. The documents that must be available for your review

include insurance contracts, plan and trust documents, collective bargaining agreements, and all documents filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration, for example, detailed annual reports.

- If you wish, you may request your own copies of these plan documents by writing to Human Resources. Where permitted by law, you may have to pay a reasonable charge to cover the costs of copying.
- You will receive summaries of the plan's annual financial report each year, free of charge. The administrator for the plan is required by law to furnish each participant with a copy of this summary annual report.
- You may request a statement of your vested benefits under the Supplemental Retirement and Savings Plan. This statement will be given to you free of charge and may be requested once each year.

Plan Fiduciaries

Besides giving you certain rights as a participant, ERISA places certain duties upon the people who are responsible for the management of the plan. These people are called "fiduciaries" under the law, and they have the duty to act prudently and in your best interests.

Under ERISA, no one may fire you or discriminate against you to

prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Enforcing Your Rights

If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to obtain copies, without charge, of documents relating to the decision, and to appeal any denial all within certain time schedules.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 for each day's delay until you receive the materials, unless the materials were not sent for reasons beyond the administrator's control. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with a plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse plan money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or file suit in a federal court.

In a lawsuit, the court normally decides who pays the court costs and legal fees. If you are successful, the other party might have to

pay. But, if you lose, the court might order you to pay these costs and fees, especially if the court finds your claim to be frivolous.

Assistance with Questions

If you have any questions about this statement of your rights under ERISA, contact Human Resources. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

not be reflected immediately in this handbook.

Again, for complete and up-to-date information about any policy or benefit, you should contact Human Resources.

Please note: The policies described in this handbook are not intended to create an employment contract between Boston University and its employees. Therefore, they do not alter the University's rights regarding discharges and layoffs.

A Final Note

This handbook presents a summary of Boston University's benefits for faculty and staff and is intended to serve as the summary plan description for the Supplemental Retirement and Savings Plan.. It is designed as a quick reference source and is not intended to cover every point of policy. In certain instances, the University may exercise discretion, with respect to the administration of the plans described in this handbook. For more in-depth information, contact Human Resources.

Periodically, the University may make changes in policy that may

TUITION REMISSION PROGRAM





The Tuition Remission Program provides regular full-time employees with an outstanding education benefit. You and your family can take advantage of a wide range of courses and degree programs offered by the University.

Eligibility for benefits for you begin on the first day of the semester on or following your date of hire.

Eligibility for benefits for your spouse and dependent children begin on the first day of the semester after you have completed the appropriate service requirements.

Eligibility		Tuition Remission Benefits
If you are a regular full-time employee and have an appointment of nine months' or more duration you, your spouse, and your dependent children are eligible to participate in the Tuition Remission Program. Your eligible dependent children are those whom you claim as exemptions on your federal income tax return during the calendar years in which they are enrolled in undergraduate degree programs at Boston University. They include: Your unmarried dependent children or stepchildren Certain age limits apply to eligible dependent children (see "Benefits for Your Dependent Children"). Employees whose percentage time worked decreases below the eligibility requirements for the Tuition Remission Program will no longer be able to participate in the Tuition Remission Program.	online at Employee Self Service on the BU Benefits Center at www.bu.edu/buworkscentral. Upon request, paper forms will also be provided to you by Human Resources. Completed paper forms must be returned to Human Resources at hr@bu.edu. You need only use one method of application—online <i>or</i> paper—not both. Covered students under the Tuition Remission Program (employees, spouses, or children) register for classes separately through the Registrar's Office and then receive credit from the Tuition Remission Program on their student accounts for approved credit hours. How Approval Works Employees, spouses, and children receiving benefits are registered for classes on a space-available basis. Participating employees, spouses, or dependents are responsible for meeting admission requirements or prerequisites for any course or program.	Tuition remission benefits are granted on a semester basis. For the purposes of the program, the two summer sessions are treated as one academic semester. If a service requirement applies to the tuition remission benefits for your spouse or dependent children, only continuous and full-time service with Boston University is counted toward fulfilling that requirement. Such service is measured from the date you become an eligible employee (see prior "Eligibility" section) up to and including the first day instruction begins. Full-time employees are only eligible to receive tuition remission benefits as "employees." It is Boston University's policy that if you are a full-time regular employee you may not be enrolled at Boston University as a full-time student. Full-time student status is 12 or more credits. If you are a full-time regular employee, you are not eligible for benefits as a spouse or dependent of another employee.
How the Program Works		
What Is Covered The Tuition Remission Program covers undergraduate and graduate courses taken by you or your spouse and undergraduate courses taken by your dependent children. The Tuition Remission Program applies only to courses offered by Boston University. No assistance is provided for courses taken at other colleges or universities. When to Apply Once you have registered for your class(es), if you would like to apply for the tuition remission benefit for yourself, your spouse, or your unmarried dependent children, you may apply	Tuition Remission Does Not Cover Fees and Other Expenses, (e.g., Books, Lab Fees, Etc.) Registration fees and other fees, not including the Continuing Student Fee, must be paid by covered students when they register for courses as those fees and expenses are not covered by tuition remission. Covered students must also pay for their books, lab fees, late fees, and any necessary classroom materials as those fees and expenses are not covered by tuition remission. Tuition remission also does not cover room and board.	An explanation of the benefits available to you, your spouse, and your dependent children follows. Benefits for You If you were hired on or before July 1, 1981 As an eligible employee you are entitled to 100% tuition remission for up to 8 credit hours of courses you take each semester. This includes graduate and undergraduate courses (see discussion below regarding the taxability of graduate courses). If your employment ends before the first day instruction begins*, you will be required to pay the full tuition for all courses taken that semester.

If your employment ends after the first day instruction begins*, but before the final exam end date** for the semester, your benefits will continue until the end of the semester.

If you were hired on or before June 30, 1985, but after July 1, 1981 As an eligible employee you are entitled to 100% tuition remission for the first 4 credit hours and 90% tuition remission for the next 4 credit hours of courses you take each semester. This includes graduate and undergraduate courses.

If your employment ends before the first day instruction begins*, you will be required to pay the full tuition for all courses taken that semester.

If your employment ends after the first day instruction begins*, but before the final exam end date** for the semester, your benefits will continue until the end of the semester.

If you were hired on or after July 1, 1985 As an eligible employee you are entitled to 100% tuition remission for the first 4 credit hours and 90% tuition remission for the next 4 credit hours of courses you take each semester. This includes graduate or undergraduate courses.

If your employment ends before the final exam end date or the end of session date** for the semester, you will be required to pay full tuition for all courses taken that semester. If you are involuntarily terminated from your position, no payment will be due.

**The first day "instruction begins" for the semester is defined as the date published in the Boston University Office of the University Registrar Official Academic Calendar: Charles River.*

***The "final exam end" date or the "end of session" date for the semester is defined as the date published in the Boston University Office of the University Registrar Official Academic Calendar: Charles River. For the fall and spring semesters, it is the "final exam end date"; for summer session, it is the Summer II "end of session" date. will continue until the end of the semester.*

Courses Scheduled During Work Hours

If a course you want to take is scheduled during normal working hours, you must have your department chair or supervisor sign your tuition remission form in order for the benefit to be approved. The University reserves the right to refuse to allow you to attend a class under the Tuition Remission Program if it conflicts with the needs of your department.

You must report all courses taken, not only courses covered by the Tuition Remission Program, to determine if there is a conflict with the needs of your department.

You will not receive pay while attending a class during scheduled work hours.

If you are taking more than 8 credits, you must have the approval of the Dean or Vice President for your unit before applying for the benefit.

Benefits for Your Spouse

Once you have satisfied the service requirement described below, your spouse will be granted 50% tuition remission each semester for all courses taken at Boston University. This includes graduate and undergraduate courses.

If your employment ends before the first day of class,

your spouse will be required to pay full tuition for the courses taken that semester. If your employment ends before the last day of classes, your spouse's benefits will continue until the end of the semester.

Service Requirement

Your spouse will be eligible for tuition remission benefits once you have completed 12 months of eligible service (i.e., continuous and full-time service) at Boston University.

If you and your spouse are both employed at Boston University and are both eligible for tuition remission benefits, you and your spouse are individually eligible to receive tuition remission as employees. You and your spouse are not eligible to receive benefits as a spouse.

Benefits for Your Dependent Children

Once you have satisfied the service requirement described below, each of your eligible unmarried dependent children may take up to eight semesters through the Tuition Remission Program, as long as they apply, are admitted to, and are enrolled in undergraduate degree programs at Boston University or as seniors at Boston University Academy. The amount of tuition remission benefits granted for their courses depends upon your length of eligible service with the University. Tuition remission is not available for any graduate courses taken by dependent children.

If your employment ends before the first day of classes, your dependent will be required to pay full tuition for the courses taken that semester. If your employment ends before the

last day of classes, your dependent's benefits will continue until the end of the semester.

Service Requirements

Your unmarried dependent children may receive 50% tuition remission for courses taken once you have completed four months of eligible service (i.e., continuous and full-time service) and:

If you were hired prior to January 1, 1995, they may receive 100% tuition remission for courses taken after you have completed 16 months of eligible service.

If you were hired on or after January 1, 1995, they may receive 90% tuition remission for courses taken after you have completed 16 months of eligible service.

In the event your unmarried dependent children have received eight semesters of tuition remission benefits and need an additional semester to complete their undergraduate studies, it may be possible to repay the University for one semester of tuition remission benefits that were previously received in exchange for tuition remission benefits for a prospective semester. Please contact Human Resources for additional information regarding this provision.

Proof of Relationship Requirement

Full-time employees are only eligible to receive tuition remission benefits as an employee. You are not eligible for additional benefits as a dependent child of another employee eligible for tuition remission benefits.

Proof of relationship to the employee must be provided for eligible unmarried dependent children. The employee must provide the following:

- A copy of the dependent's birth certificate, or
- A copy of the adoption certification, or
- A copy of the most recent tax return listing your dependent(s)

These documents will be kept in confidential files in Human Resources.

Age Limit for Dependent Children

Dependent children are no longer eligible for benefits under this program after the end of the semester in which they reach age 27. The exceptions to this provision are:

Military Service For unmarried dependent children who are honorably discharged veterans, the period of eligibility will be extended beyond age 27 by the number of months of their military service, up to a maximum of 48 months.

Disability Dependent children whose disabilities prevent them from completing undergraduate work within eight semesters by the time they reach age 27, must submit a written request for an extension of tuition remission eligibility to Human Resources. A physician's statement indicating diagnosis, period of disability, and prognosis must accompany the request, along with a letter of recommendation from Boston University's Disability Services regarding the student status of your dependent child.

Special Provisions Protecting Benefits for Dependent Children

Once Your Dependent Children Begin Receiving Benefits If you retire from the University at age 55 or later and have completed 10 or more years of continuous full-time service with the University after age 45, your eligible

unmarried dependent children may continue to receive tuition remission benefits in an undergraduate degree program at the University pursuant to terms specified herein.

If you should die while employed at the University, or are receiving disability benefits from the University's Long-Term Disability Plan, your eligible unmarried dependent children may continue to receive tuition remission benefits through the semester in which your death occurred, subject to the Program's limits, as long as they remain eligible. In subsequent semesters, your years of continuous full-time service up to the time when you became disabled or died, will be used to determine the number of additional semesters up to a maximum of eight semesters for which each child is eligible in accordance with the following table:

For example, if you died with 10 or more years of continuous full-time service with Boston University and at the time of your death, your dependent child had received six semesters of tuition remission, he or she would be eligible for two

Employee's years of continuous full-time service	Number of semesters per child
3 but less than 6	2
6 but less than 9	4
9 but less than 10	6

more semesters of tuition remission, for a maximum of eight semesters.

Before Your Dependent Children Begin Receiving Benefits If you retire from the University at age 55 or later and have completed 10 or more years of continuous full-time service with the University after age 45, the University will provide your eligible unmarried dependent children with eight semesters of tuition remission benefits in an undergraduate degree program at the University pursuant to terms specified herein.

If you should die while employed at the University, or are receiving disability benefits from the University's Long-Term Disability Plan, the University will provide your eligible unmarried dependent children with up to eight semesters of tuition remission benefits in an undergraduate degree program at the University depending upon your years of continuous full-time service at the point of your disability or death, in accordance with the following table:

Benefits During Authorized Absences from Work

The following applies to tuition remission benefits for you, your spouse, and your dependent

Employee's years of continuous full-time service	Number of semesters per child
3 but less than 6	2
6 but less than 9	4
9 but less than 10	6
10 or more	8

children while you are on an approved leave of absence or sabbatical.

Paid Leaves of Absence and Sabbaticals

Tuition remission benefits continue while you are on an approved

leave of absence with pay. Tuition remission benefits also continue if you are a faculty member on an approved sabbatical with pay. The period of time you are on leave of absence or sabbatical counts toward any service requirements specified in the program.

Unpaid Leaves of Absence

With prior approval from Human Resources, tuition remission benefits may be continued during an approved unpaid leave of absence that is taken for one of the following reasons:

1. Research purposes
2. Instruction
3. Government or other service deemed by the University to be in the public interest
4. Other activities as may be approved by the University

With the exception of the reasons stated above, tuition remission benefits will terminate for the duration of your unpaid leave of absence. If you take a medical leave as a result of a work-related incident or personal medical condition, your tuition remission benefit will terminate for the duration of your unpaid leave of absence. Tuition remission benefits will terminate for the duration of your leave on the earlier of the following dates:

1. The beginning of a semester following or coincident with the first day of your leave; or
2. At the end of any semester in which you begin your leave.

While you are on approved leave of absence without pay, you can accrue service (up to 24 months) toward meeting the Program's service requirement.

Extended Military Leave

If you go on an extended military leave, you will accrue service toward meeting the Program's service requirements for the entire period of the leave, provided you return to regular, full-time employment with the University following military service and within the time when your veteran's re-employment rights are protected.

Medical Leave of Absence

During an approved leave of absence due to temporary disability, benefits continue for your dependent children until the end of a semester in which you complete six months of such leave without pay. You can accrue up to six months of service toward meeting the Program's service requirements while on a temporary disability.

Boston University Courses Excluded from the Tuition Remission Program

Benefits are not granted for the following:

- Applied music fees
- Courses offered through the School of Medicine (except for courses offered in the Division of Graduate Medical Sciences and master's degree program courses in the School of Public Health)
- Courses offered through the Goldman School of Dental Medicine
- Courses offered for all executive graduate programs, such as the Executive Master of Business Administration
- Non-credit courses or courses awarding Continuing Ed Units (CEUs)
- Online courses

- Room, board, and non-tuition portion of study abroad program (for example, air fare and books)
- Courses not offered for credit, such as the courses offered at the Center for English Language & Orientation Programs, Continuing Education, and some Certificate Programs at Metropolitan College.

Income Tax Considerations

The tuition remission benefits you, your spouse, or your dependent children receive may be subject to federal income taxes, Massachusetts state income taxes, and FICA taxes.

Under current tax laws, the following provisions apply:

Under current tax law effective January 1, 2002, up to \$5,250 in value for graduate tuition remission benefits for employees are, generally, not considered taxable income. Graduate tuition remission in excess of \$5,250 per calendar year for employees and all graduate tuition remission benefits for spouses are generally subject to federal, state, and FICA taxation.

Administrative Information About the Program

Type of Program

The Boston University Tuition Remission Program is an unfunded educational assistance program. It is not subject to the provisions of the Employee Retirement Income Security Act (ERISA) of 1974. Any determinations by Boston University regarding eligibility for the Tuition Remission Program or benefits thereunder are final, binding, and conclusive.

About the Plans

Sponsor for the Plans

All of the plans described in this handbook are sponsored by the employer, Boston University, Boston, Massachusetts, which is also the Plan Administrator. Eligibility for the benefit plan described in this handbook applies to those University employees on the US payroll.

Boston University's Employer Identification Number

For identification purposes, the Internal Revenue Service has assigned number 04-2103547 to Boston University. You will need to know this number if you write to a government agency about any of the plans.

Type of Plan, Plan Number, and Plan Year

In addition to the University's Employer Identification Number, you need to know the following information:

- **Types of Plans** The plan described in this handbook is characterized by the federal government as a Welfare Plan.
- **Plan Numbers** Boston University has assigned Plan Number 701 to all of the Tuition Remission Program.
- **Plan Years** The financial records of this plan are kept on a Plan Year basis. The Plan Year for this plan is January 1 – December 31.

Administrator for the Plan

The day-to-day administration of the plan is handled by Human

Resources. However, if you have a question or a problem that cannot be resolved by Human Resources, you should contact the Plan Administrator.

The Plan Administrator for the plan can be reached by contacting:

Plan Administrator
The Trustees of Boston University
25 Buick Street Boston, MA 02215
Phone: 617-353-4489

Funding and Administration of the Plan

Tuition Remission Program benefits are paid out of the general assets of Boston University.

Agent of Legal Service

The agent for the service of legal process for the plan is:

University Counsel
125 Bay State Road
Boston, MA 02215

Legal process may be served on the Plan Administrator.

Fraudulent Claims

Submission of a claim for benefits under the plan described in this handbook includes a representation that the claim is bona fide and, to the best knowledge of the employee, dependent, or other claimant, proper for payment. Submission of a fraudulent or knowingly false claim by an employee or an employee's dependent participating in a plan will be grounds for disciplinary action against the employee, including termination of participation by the employee and/or covered dependent(s) under the plan.

Claims for Benefits/Appealing a Denial of Claims for Benefits

When you apply for benefits, there are time periods within which you must receive a decision on your claim for benefits. If you or your beneficiary applies for benefits and either part or all of the request is denied, you have the right to appeal that decision, provided the appeal is made in accordance with the provisions of the plan and applicable laws (e.g., appeals must be filed within required time periods).

Claims and Appeals to the University

For the Tuition Remission Plan, appeals regarding benefits or other issues affecting plan participants or other persons should be made to the Office of the Senior Vice President for Operations.

Documents and Laws Governing All Plans

The plan descriptions contained in this handbook were written from the documents that legally govern how the plans work.

In the event of any discrepancy between the plan descriptions in this handbook and the controlling contracts or plan documents, the language in the controlling contracts or plan documents will govern. If you would like a copy of any of these documents, please contact Human Resources.

The plans are also regulated by applicable provisions of applicable laws, which will govern in the event of any conflict between the law and the terms of the plans as described in either the documents or in the summary plan description.

Equal Opportunity/Affirmative Action Policy

Since its founding in 1869, Boston University has been dedicated to equal opportunity and has opened its doors to students without regard to race, sex, creed, or other irrelevant criteria. Consistent with this tradition, it is the policy of Boston University to promote equal opportunity in educational programs and employment through practices designed to extend opportunities to all individuals on the basis of individual merit and qualifications, and to help ensure the full realization of equal opportunity for students, employees, and applicants for admission and employment. The University is committed to maintaining an environment that is welcoming and respectful to all.

Boston University prohibits discrimination against any individual on the basis of race, color, religion, sex, age, national origin, physical or mental disability, sexual orientation, genetic information, military service, or because of marital, parental, or veteran status. This policy extends to all rights, privileges, programs, and activities, including admissions, financial assistance, educational and athletic programs, housing, employment, compensation, employee benefits, and the providing of, or access to, University services or facilities. Boston University recognizes that that equal opportunity is a reality. Accordingly, the University will continue to take affirmative action to achieve equal opportunity through recruitment, outreach, and internal reviews of policies and practices.

The coordination and implementation of this policy is the responsibility of the Director of Equal Opportunity. The officers of the University and all deans, directors, department heads, and managers are responsible for the proper implementation of equal opportunity and affirmative action in their respective areas, and they are expected to exercise leadership toward their achievement. It is expected that every employee of Boston University will share this commitment and cooperate fully in helping the University meet its equal opportunity and affirmative action objectives.

Boston University has developed detailed procedures, described in its *Complaint Procedures in Cases of Alleged Unlawful Discrimination or Harassment* (www.bu.edu/eoo/policies-procedures/complaint), by which individuals may bring forward concerns or complaints of discrimination and harassment. Retaliation against any individual who brings forward such a complaint or who cooperates or assists with an investigation of such a complaint is both unlawful and strictly prohibited by Boston University.

Inquiries regarding this policy or its application should be addressed to the Director of Equal Opportunity, Equal Opportunity Office, 19 Deerfield Street, Boston, MA 02215, or call 617-353-9286.

Amendment of Termination of the Plan

Boston University intends to continue maintaining the plan described in this handbook for the exclusive benefit of its employees.

However, the University reserves

the right to change or discontinue it, and to implement changes as required by federal, state, or local laws.

You will be informed of any material changes that are made to the plan. If a plan is terminated, your rights, on the date of the termination, would be governed by the provisions of the plan document.

A Final Note

This handbook presents a summary of Boston University's Tuition Remission Program for faculty and staff. It is designed as a quick reference source and is not intended to cover every point of policy. In certain instances, the University may exercise discretion, with respect to the administration of the plan described in this handbook. For more in-depth information, contact Human Resources.

Periodically, the University may make changes in policy that may not be reflected immediately in this handbook.

Again, for complete and up-to-date information about any policy or benefit, you should contact Human Resources.

Please note: The policy described in this handbook is not intended to create an employment contract between Boston University and its employees. Therefore, it does not alter the University's rights regarding discharges and layoffs.

TUITION EXCHANGE PROGRAM

UNIVERSITY STREET



oston University is a member of the Tuition Exchange Program, Inc. (TE), a national organization that administers tuition scholarships for dependent children of employees from member colleges and universities.

Each year Boston University's agreement with the Tuition Exchange Program, Inc. permits up to 10 students who are planning to enter their first year of college the following academic year to enroll in undergraduate degree programs at over 675 participating colleges and universities located in the United States and abroad.

Eligibility

Your dependent children are eligible to apply to participate in the Tuition Exchange Program if you are a regular full-time employee with an appointment of nine months' or more duration, and if you will have completed at least 16 months of full-time service prior to the start of the fall semester at Boston University. Only one dependent per family may participate in the program at a time.

Your eligible dependent children are those whom you claim as exemptions on your federal income tax return during the calendar years in which they are enrolled in undergraduate degree programs through the Tuition Exchange Program. Only your unmarried dependent children or stepchildren who are under age 27 qualify for this program.

Your dependent children are not eligible for additional benefits as a dependent child of another employee eligible for Tuition Exchange benefits.

Employees whose percentage time worked decreases below the eligibility requirements for the Tuition Exchange Program will no longer be able to participate in the Tuition Exchange Program.

Proof of Relationship Requirement

Proof of relationship to the employee must be provided for eligible unmarried dependent children. The employee must provide the following:

- A copy of the dependent's birth certificate, or
- A copy of the adoption certification, or
- A copy of the most recent tax return listing your dependent

These documents will be kept in confidential files in Human Resources.

Age Limit for Dependent Children

Dependent children are no longer eligible for benefits under this program after the end of the semester in which they reach age 27. The exceptions to this provision are:

Military Service For unmarried dependent children who are honorably discharged veterans, the period of eligibility will be extended beyond age 27 by the number of months of their military service, up to a maximum of 48 months.

How the Program Works

Students must be admitted as full-time undergraduate degree candidates at Tuition Exchange member institutions in order to be eligible for this program.

All students must apply to the institution in which the dependent child is interested and meet all admissions criteria of the admitting institution. Scholarships are available for a maximum of four years (8 semesters/12 trimesters) of full-time academic study in an undergraduate degree program. Summer sessions are excluded from this scholarship.

Enrollment must be re-certified annually. This means that you must maintain eligibility for Tuition Exchange benefits at Boston University for the full duration of the scholarship period in order to receive full benefits under the Tuition Exchange Program.

Once you have satisfied the Boston University service requirement described above, each of your eligible unmarried dependent children may

take up to 8 semesters or 12 trimesters through the Tuition Exchange Program, as long as they apply, are admitted to, and are enrolled in an undergraduate degree program at a participating Tuition Exchange institution. However, only one of your dependent children may participate in the Tuition Exchange Program at any given time.

Having a child participate in the Tuition Exchange Program does not preclude your other child(ren) from participating in the Tuition Remission Program at Boston University, at the same time.

Boston University will award up to 10 new Tuition Exchange scholarships for undergraduate education in each academic year. Each scholarship is awarded for a maximum of 8 semesters or 12 trimesters to cover four academic years of full-time undergraduate study at participating Tuition Exchange institutions.

Because the University must balance the number of Tuition Exchange students it "exports" to other member institutions with those it "imports" for enrollment at Boston University, the number of scholarships available for eligible dependents of Boston University employees in any academic year is limited. Tuition Exchange scholarship availability is dependent on the availability of spaces at the admitting institution.

The maximum semesters available for Tuition Exchange benefits are aggregated with

Tuition Remission benefits received at Boston University. Therefore, your eligible dependent child may not receive more than 8 semesters/12 trimesters of combined Tuition Remission and Tuition Exchange benefits.

If your employment ends before the first day of classes, and your dependent elects to enroll or continue enrollment at a participating institution, your dependent will be responsible for the full tuition for the courses taken that semester, as determined by the admitting institution. If your employment ends before the last day of classes during a given semester, your dependent's benefits will continue until the end of that semester.

Scholarship Amount

Each Tuition Exchange member institution determines the value of the scholarship it awards to each incoming student and records this on the Tuition Exchange Scholarship Certification Form. Benefits vary by member institution. There is a minimum amount set by the Tuition Exchange, Inc. (\$43,000 for the 2025/2026 academic year). Schools with tuition rates higher than this amount may opt to award only the minimum. Students are responsible for any costs which exceed the awarded benefit level.

How to Apply for Tuition Exchange Benefits

1. Review the list of Tuition Exchange institutions available at the Tuition Exchange, Inc. website at www.tuitionexchange.org.
2. Complete and submit the Boston University Tuition Exchange Preliminary Application to

Human Resources. This application must be received by Human Resources no later than the deadline prior to the beginning of the academic year for which you are applying. Example: Applications for Fall 2025 must be received by December 1, 2024.

3. Tuition Exchange scholarship candidates must apply for admission to each member institution they wish to attend and complete any financial assistance documents required by that institution.

Selection Process

Up to 10 dependent children who are planning to enter their first year of college the following academic year will be selected from the applicant group each academic year as candidates eligible to apply for Tuition Exchange scholarships. Applicant decisions will be made following review of the application submitted by the deadline. All eligible applicants will be notified of their status no later than December 21.

First priority will be given to applicants whose sponsoring employee has the greatest length of employment service at Boston University. Length of service is based on years of continuous full-time service at Boston University.

Among the applicants whose sponsoring employees have the same length of continuous service, priority will be determined by whether another dependent of the employee has used the scholarship. If all selection criteria are equal, a lottery system will be used. Applicants who are not selected will be placed on a wait list using length of service and will be notified if an opening becomes available.

Once a Tuition Exchange scholarship has been awarded, enrollment must be re-certified annually by the Boston

University Tuition Exchange Liaison Officer. Certification must be confirmed for returning students no later than January 15 prior to the beginning of the next academic year. Renewing Tuition Exchange students must meet all required academic and behavioral standards of the admitting institution to qualify for re-certification.

Completion of the application form for participation in the Tuition Exchange Program does not guarantee selection as a candidate, nor admission to the selected participating institutions. Selection as a candidate eligible to receive a Tuition Exchange scholarship also does not guarantee final selection as a Tuition Exchange scholarship recipient. Final selection is determined by the Tuition Exchange membership institution. Your dependent children must meet admission requirements of participating Tuition Exchange institutions and are subject to all academic rules, regulations, and fees which may apply. They must also be accepted by the Tuition Exchange institution as an "import" student eligible for a Tuition Exchange scholarship.

In the event that any or all of the top qualified applicants are unable to enroll at an institution participating in the Tuition Exchange Program in the year of application, eligibility will be

offered to applicants on the wait list.

Special Provisions Protecting Benefits for Dependent Children Once Your Dependent Children Begin

Receiving Benefits If you retire from the University at age 55 or later and have completed 10 or more years of continuous full-time service with the University after age 45, your eligible unmarried dependent children may continue to receive tuition exchange benefits in an undergraduate degree program pursuant to terms specified herein.

If you should die while employed at the University or are receiving disability benefits from the University's Long-Term Disability Plan, your eligible unmarried dependent children may continue to receive Tuition Exchange benefits through the semester subject to the program's limits, as long as they remain eligible. In subsequent semesters, your years of continuous full-time service up to the time when you became disabled or die will be used to determine the number of additional semesters, up to a maximum of 8 semesters/12 trimesters, for which each child is eligible in accordance with the following table:

Employee's years of continuous full-time service	Number of semesters per child
3 but less than 6	2
6 but less than 9	4
9 but less than 10	6
10 or more	8

Paid Leaves of Absence and Sabbaticals

Tuition Exchange benefits continue while you are on an approved leave of absence with pay. Tuition Exchange benefits also continue if you are a faculty member on an approved sabbatical with pay. In addition, the period of time you are on leave of absence or sabbatical will count toward any service requirements specified in the program.

Administrative Information About the Program

Type of Program

The Boston University Tuition Exchange Program is an unfunded educational assistance program. It is not subject to the provisions of the Employee Retirement Income Security Act (ERISA) of 1974.

Program Amendment or Termination

Boston University intends to continue the Tuition Exchange Program indefinitely; however, the University reserves the right in its discretion to amend, suspend, or terminate the program at any time.

Additional Administrative Information

For Additional Information

For additional information concerning the Tuition Exchange Program, contact Human Resources.

**FLEXIBLE BENEFITS PROGRAM &
FLEXIBLE SPENDING ACCOUNTS**

T

he Flexible Benefits Program offers you a substantial tax savings opportunity. It allows you to pay for eligible expenses using pretax dollars—money taken out of your paycheck before income or Social Security taxes have been deducted.

The Flexible Benefits Program has three components:

- *Automatic Before-Tax Health Care and Accident Insurance Contributions* If you enroll in the Boston University Health Plan, the Boston University Dental Health Plan, or elect coverage under the Personal and Family Accident Insurance Plan, your share of the cost for these plans will automatically be deducted from your paycheck on a before-tax basis.
- *Flexible Spending Account—Dependent Care* This account allows you to set aside before-tax dollars to help pay for day care services for your eligible dependents.
- *Flexible Spending Account—Health Care* This account allows you to set aside before-tax dollars to help pay for certain uninsured health care expenses. (If you are enrolled or enrolling in the BU Health Savings Plan, you should NOT enroll in the Flexible Spending Account plan of another employer, e.g., an employer of a spouse.)

Because of its tax-exempt features, the Flexible Benefits Program is strictly regulated by the federal government. If you would like to participate in the program, please read this section carefully, and also discuss how the program may benefit you with your own tax advisor or financial planner.

Eligibility

You are eligible to participate in the Flexible Benefits Program if you are a regular employee of the University and your annual base salary from Boston University is \$10,000 or more.

How the Program Works

The Flexible Benefits Program allows you to use your annual base salary to your best advantage.

It offers the following components:

- **Automatic Before-Tax Health, Dental, and Accident Insurance Contributions** If you participate in the Boston University Health Plan, the Boston University Dental Health Plan, or elect coverage under the Personal and Family Accident Insurance Plan, you will automatically pay your insurance premiums with before-tax dollars. The Flexible Benefits Program does not change the eligibility, benefits, or other features of those plans; it just offers a way to pay the required employee premiums on a before-tax basis. (For information concerning these plans, read the "Health Plan," "Dental Plan," and "Survivor Insurance" handbooks.)
- **Flexible Spending Account—Dependent Care** This voluntary reimbursement account is designed to help you pay for the cost of care for your eligible dependents.
- **Flexible Spending Account—Health Care** This voluntary reimbursement account is designed to help you pay for the cost of healthcare expenses not covered by a group insurance plan.

Under current tax laws, contributions to the Flexible Benefits Program are free from federal income taxes, state income taxes, and Social Security taxes.

Special Temporary COVID-19 Relief for 2020 and 2021

In response to the novel coronavirus outbreak (COVID-19), the federal government enacted laws and issued guidance that provides additional flexibility and enhanced benefits for employees of the University. Below is a summary of the additional flexibility available to employees who are eligible to participate in the Flexible Benefit Program. ***Please note the announced end of the National Emergency took effect as of May 2023.***

Outbreak Period Extensions

During the Outbreak Period, the federal government extended deadlines for taking certain actions under the employee benefit plans sponsored by the University (the "Outbreak Period Relief"). The duration of the Outbreak Period Relief was determined on an individual basis and ended on the earlier of:

- (1) one year from the date you were first eligible for Outbreak Period Relief, or
- (2) 60 days after the announced end of the National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak which took effect in May 2023.

(3) The following deadlines that occurred on or after March 1, 2020, had been delayed by the federal guidance and ended 60 days after the announced end of the National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak which took effect in May 2023.:

(4)

- the 30-day deadline for exercising your HIPAA special enrollment rights for a group health plan,
- Filing a claim for benefits under the Flexible Spending Account – Health Care claims procedure,
- Appealing an adverse benefit determination under the Flexible Spending Account – Health Care,
- Filing a request for external review following receipt of an adverse benefit determination from the Flexible Spending Account – Health Care, and
- Filing a request to perfect a request for external review upon a finding that the initial request was incomplete by the Flexible Spending Account – Health Care,
- Notifying a group health plan of a COBRA qualifying event or determination of disability,
- Electing COBRA continuation coverage under a group health plan, and
- Beginning COBRA premium payments and/or making ongoing, monthly COBRA premium payments.

Flexible Spending Account – Health Care

For the 2020 and 2021 Plan Years, you had the option to elect to increase or reduce your annual contribution amount to your FSA – Health Care account for any reason, at any time.

Please note that in both the 2020 and 2021 Plan Years you could not reduce your contribution amount below the amount you had already contributed to your FSA – Health Care.

Grace Period Extension for 2020 and 2021:

If you were not able to use all your FSA – Health Care funds contributed in 2019 and you had funds remaining in your account in 2020, you could use those funds to reimburse FSA – Health Care expenses incurred at any time in 2020. This same rule applied to the use of FSA – Health Care funds contributed in 2020, which could be used to pay expenses incurred in 2021, and the use of FSA – Health Care funds contributed in 2021 which could be used to pay expenses incurred in 2022.

Claim Submission Period Extension for 2020 and 2021:

Ordinarily you had until March 31 following the end of a plan year to submit claims for reimbursement of expenses incurred during that plan year. For the 2020 and 2021 plan years, however, you had until December 31 of the following year to seek reimbursement of expenses incurred during each of those plan years. For example, you had until December 31, 2022 to seek reimbursement for expenses incurred in 2021.

Dependent Care Flexible Spending Account (DCFSA)

Mid-Year Election Changes:

For the 2020 and 2021 Plan Years, you could elect to increase or reduce your annual contribution amount to your FSA – Dependent Care account for any reason, at any time.

Please note that in both the 2020 and 2021 Plan Years you could not reduce your contribution amount below the amount you had already contributed to your FSA.

Grace Period and Extension for 2020 and 2021:

If you were not able to use all your FSA – Dependent Care funds from your account in 2020, you could use those funds for your 2021 FSA – Dependent Care expenses. Also, if you could not use all FSA – Dependent Care funds contributed in 2021 for FSA – Dependent Care expenses incurred in 2021, any remaining funds remained available for FSA – Dependent Care expenses incurred in 2022.

Claim Submission Period Extension for 2020 and 2021:

Ordinarily you had until March 31 following the end of a plan year to submit claims for reimbursement of expenses incurred during that plan year. For the 2020 and 2021 plan years, however, you had until December 31 of the following year to seek reimbursement of expenses incurred during each of those plan years. For example, you had until December 31, 2022 to seek reimbursement for expenses incurred in 2021.

Dependent Maximum Age Increase

For the 2020 Plan Year, the age limit for qualifying children for whom qualifying dependent care expenses could be reimbursed increased from 13 to 14. Accordingly, you could be reimbursed from your 2020 Plan Year FSA – Dependent Care balance for qualifying dependent care expenses incurred for a child who attained age 13 in 2020 until the child attains age 14 in 2021.

FSA - Dependent Care Maximum Contribution Amount for 2021

For the 2021 plan year, the maximum contributions to the FSA – Dependent Care was increased from \$5,000 to \$10,500 (for employees who are married and filing jointly) and from \$2,500 to \$5,250 (for employees who are married and filing separately for 2021).

Requesting Benefit Election Changes:

Changes to your FSA contribution amounts were made through Human Resources, and all other changes described above must have been requested by contacting the P&A Group customer service department at 800-688-2611.

Participation

Automatic Before-Tax Health, Dental, and Accident Insurance Contributions

If you elect coverage under any of the previously mentioned health, dental, and survivor insurance plans, your participation in this component of the Flexible Benefits Program is automatic. This means that your premium

payments will be deducted from your paycheck using before-tax dollars.

Dependent and Health Care Flexible Spending Accounts (FSAs)

Participation in these accounts is voluntary. You can choose to enroll in one or both. After you enroll, a dependent care Flexible Spending Account and/or a health care Flexible Spending Account will be established in your name and your contributions will be taken from your salary, using before-tax dollars.

Enrollment

Automatic Before-Tax Health and Accident Insurance Contributions

You enroll in the Automatic Before-Tax Health, Dental, and Accident Insurance Contributions component of the Flexible Benefits Program at the same time you enroll in group coverage under the eligible health, dental, and accident insurance plans. Enroll through Employee Self-Service at www.bu.edu/buworkscentral. Select BU Benefits Center.

Flexible Spending Accounts (FSAs)

The open enrollment period for these accounts will be held each year during the Fall semester or such other period as the Plan Administrator may specify.

If you enroll during an open enrollment period, your participation will become effective on the following

January 1. If you are hired after the close of an open enrollment period, you will have 30 days from your benefit orientation date to enroll.

In both cases, participation will continue through the following plan year:

- FSA—Dependent Care Plan Year—January 1 to December 31
- FSA—Health Care Plan Year—January 1 to December 31 with claims incurred until March 15 of the following year

When you complete a Flexible Spending Account enrollment, you must indicate the total amount of money you wish to put into the account during the plan year.

Once you have enrolled, your choices remain in effect until the next open enrollment period, unless:

- You experience a Life or Career Event (examples of Life or Career Events are listed under “Changing or Stopping Your Contributions”), or
- You become ineligible to participate in the Flexible Benefits Program for any reason.

Contributions

Before-Tax Health, Dental, and Accident Insurance Contributions

Your contributions are your portion of the cost for your coverage under the health, dental, and accident insurance plans you elect. Maximum contributions under this component of

the Flexible Benefits Program are the sum of your monthly premiums for the plan year.

Flexible Spending Account (FSA) Contributions

For the 2025 Plan Year you may contribute up to \$5,000 to the FSA—Dependent Care and up to \$3,200 to the FSA—Health Care. However, tax law rules may limit your FSA—Dependent Care maximum (see the heading “Maximum Contributions” heading in the “Flexible Spending Account— Dependent Care” section for more information). Boston University will contribute to the FSA—Health Care if you are enrolled in the BCBS PPO health plan and your BU annual base salary is less than \$100,000. The following table shows the University contribution amounts.

Salary Tier	2025 FSA Contribution from BU	
	Single	Family
< \$70,000	\$500	\$1000
\$70,000– \$100,000	\$250	\$500
> \$100,000	No contribution	

Changing or Stopping Your Contributions

Under current IRS regulations, you may change your participation status in the Flexible Benefits Program *only* during the annual open enrollment period or as the result of a Life or Career Event.

Life or Career Events include:

- Marriage
- Birth or adoption of a child
- Start or loss of your spouse's employment
- Change in employment status (for you or your spouse) from part-time to full-time or from full-time to part-time or other change in percent time worked
- Change in your daycare provider or the cost of care (Dependent FSA)
- Divorce
- Death of your spouse or other dependent
- Your death
- Your dependent turning age 26
- Unpaid leave of absence or sabbatical for you or your spouse

The change in your participation or contributions must be because of and consistent with the Life or Career Event and must meet all IRS requirements for changing your election. You may not change from one health plan option to another at any time other than the annual Open Enrollment Period.

Normally, when you experience a Life or Career Event, you have 30 days from the date of your life or career event to submit your request to make a change to your benefit plan enrollment, and generally the effective date of the change is retroactive to the date of the life or career event, except as otherwise required by law.

In response to the novel coronavirus outbreak (COVID-19), the federal government had previously extended deadlines for taking certain actions under the employee benefit plans sponsored by the University. This extension applied to the 30-day deadline for changing your election under the Health Plan as the result of: the loss of other health coverage, addition of a new spouse or dependent by birth, marriage, adoptions, or placement for adoption, the loss of Medicaid or CHIP coverage, and new eligibility for state premium assistance through Medicaid or CHIP. The announced end of National Emergency took affect May 2023. Therefore, these provisions are no longer available.

Tax Advantages of the Program

The Flexible Benefits Program provides an opportunity for you to pay eligible health and dependent care expenses on a before-tax basis.

- **Advantages for Dependent Care Expenses** Under the Internal Revenue Code, you can obtain a tax advantage for dependent care expenses by paying for them with the tax-free dollars you put into your FSA— Dependent Care or by claiming them as a tax credit on your federal income tax return forms.

You Cannot Use Both Methods for the Same Expenses The amount you contribute to a FSA —Dependent Care will reduce, dollar-for-dollar, the amount you may claim as a tax credit. Consult a tax advisor for details.

If You Pay Federal Income Taxes, Social Security Taxes, and Massachusetts State Income Taxes In some cases, the FSA— Dependent Care will be more advantageous than the federal dependent care tax credit, depending upon income level and number of dependents.

We encourage you to talk to a tax advisor to help you determine whether the FSA— Dependent Care or the federal dependent care tax credit is more advantageous to you.

- **Advantages for Health Care Expenses** The FSA—Health Care may be appropriate for you if you expect to have eligible uninsured medical expenses below 7.5% of your adjusted gross income in the coming calendar year. Expenses below this level are not deductible for federal income tax purposes. As a result, the FSA—Health Care may offer you an advantage which you cannot duplicate on your tax return.

Of course, your own tax situation will dictate exactly what the Flexible Spending Accounts can do for you. For more specific information about how these Flexible Spending Accounts may apply to you, we encourage you to talk to a tax advisor.

Potential Impact on Your Social Security Income

Your participation in the Flexible Benefits Program will have the effect of reducing your Social Security taxable wages by the value of your designated salary reduction amount. This results in an immediate tax savings to you. It could also serve to reduce your future Social Security benefits.

How Flexible Spending Accounts Work

- You estimate what your uninsured medical and/or dependent care expenses will be for the coming year and designate that amount on the appropriate enrollment form.
- The amount you elect to contribute will come out of your paycheck in equal installments for the remaining pay periods of the calendar year.
- The portion of your salary that is credited to an account will not count as taxable income, so you have an immediate tax savings.
- When you have an eligible expense, you file a claim to get reimbursed. You are responsible for paying providers; reimbursement checks will be made out in your name.
- Under federal law, if you make contributions to a Flexible Spending Account which are not used to pay for eligible expenses incurred during that plan year, you will forfeit the unused balance after the end of the plan year. An expense is “incurred” when the services relating to that expense are provided.
- If you are considered to be a Non-Resident Alien for tax purposes, you are generally eligible to use the Flexible Spending Accounts as an

individual. However, expenses for your spouse and children may not be claimed for reimbursement unless they can be claimed as a dependent when you file your taxes. To be considered a dependent for tax purposes, your spouse and/or dependent child must be a citizen, national, or resident of the United States, Canada, or Mexico. We encourage you to speak to a tax advisor regarding your eligibility for tax savings in a Flexible Spending Account.

- Also, as a general rule, expenses incurred before your participation commences or after you cease participation cannot be reimbursed.

Filing Claims with P&A Group

Claims for reimbursement may be filed at any time during the claims period, from January 1st of the current plan year through March 31st of the following year.

For the Dependent Care FSA, the claims must represent expenses incurred during the current plan year (January 1st to December 31st) while you were participating in the Plan. For the Health Care FSA, the claims must represent expenses incurred during the current plan year plus the grace period (January 1 of the current plan year through March 15 of the following year) while you were participating in the Plan. Expenses incurred before you enroll cannot be reimbursed. A claim or expense is “incurred” when the services relating to that claim or expense were provided.

For FSA Dependent Care Claims Only—
You must submit a

Dependent Care Documentation Form each year for each of the Dependent Care providers you use. Once this form is on file with P&A Group, claims submitted with receipts that include the dates of service will suffice for reimbursement.

The Flexible Spending Account Claim Form can be found in the Forms & Documents section under Quick Links at www.bu.edu/hr. When you complete a claim form, include any information required for the verification of health or dependent care expenses. You must include an itemized invoice or receipt indicating the dates of service, the services performed, and the cost.

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

How to Register with P&A Group and Submit Claims

Register with P&A Group

You can register to set up an online account with P&A Group. Among other things, registering will allow you to submit your claims online and use the website to check account balances and the status of claims.

- Go to the P&A Group website at www.padmin.com and select the tab for Employee Participants.
- On the right-hand side of the web page there will be a section titled, “Account Login.” Select the link “First time logging in, click here.”
- When prompted to enter your Social Security #, you should provide your University ID# instead. Then follow the instructions to set

up your account and your preferences.

Submitting Claims Use your Benefits Card as a debit card purchase wherever MasterCard® is accepted. The money is automatically transferred from your Health FSA account to the merchant.

- **QuikClaim Mobile Feature** Submit a claim and supporting documentation of your eligible expense directly from your smartphone. Go to www.padmin.com on your smartphone and log into your account.
- **Online Claim Upload** After making a purchase, log in to your My Benefits account at www.padmin.com and fill out the online reimbursement form.
- **Fax** Submit a claim form via tollfree fax: 877-855-7105.
- **Mail** Mail a claim form to P&A Group, 17 Court St., Suite 500, Buffalo, NY 14202.

When submitting a claim, you must include a receipt/proof of purchase or insurance statement. To receive reimbursement faster, sign up for direct deposit to have your money directly deposited into your designated checking or savings account.

How do I receive my reimbursement money?

The quickest way to receive your money is by direct deposit to your personal checking or savings account. Direct deposit enrollment forms are available at www.padmin.com. Once enrolled in a direct deposit, all deposits are made via direct deposit until P&A is otherwise notified. You can also receive your money via a check mailed to your home.

How do I get up-to-date account information? Access your account balance and other information anytime, anywhere with the text message feature. Simply update your P&A account profile with your mobile number. Text “BAL” to the number 70626 and receive a text message with your account balance. You can also text “CLM” to the number 70626 to receive the status of your claims.

You can also log in to your P&A account to access your real-time account information or call the customer service department at 800-688-2611 for your latest account information. This system is available in English and Spanish.

- **For dependent care expenses**, you will be reimbursed up to the remaining balance in your account at the time your claim is submitted. Your account balance is reduced by any reimbursements you receive, up to the remaining balance in your account. If the expenses you submit are greater than your account balance, you will be reimbursed up to your account balance. Qualified expenses that were submitted but not paid will be carried over to the next month, and an additional payment will be issued to you during the next regular processing cycle.
- **For health care expenses**, you can be reimbursed up to the amount you choose to contribute (reduced by any prior reimbursements for the plan year).

Treatment of Year-End Expenses You have until March 31 following the end of a given plan year to submit claims for reimbursement of expenses incurred during that plan year.

Account balances remaining after that date will, by law, be forfeited. (You may not use current plan year account balances to pay for expenses incurred in a prior plan year. Prior plan year expenses must be paid with prior plan year account balances. Also, unused amounts cannot be carried over and used to reimburse expenses incurred in a later year.)

If You Should Leave Boston University:

- **FSA—Dependent Care** You may continue to submit claims for reimbursement of eligible dependent care expenses incurred through the last day of your employment at Boston University, up to the remaining balance in your account. Such claims must be submitted no later than March 31 following the end of that calendar year. Any account balances remaining after that date will, by law, be forfeited.
- **FSA—Health Care** In certain circumstances, you may elect to continue your participation in your account through federal health care coverage continuation provisions under COBRA but only to the extent required by COBRA. If you elect to continue your participation, your contributions will be made with after-tax dollars.

If you elect to discontinue your participation, your account balance will be frozen as of the date your employment ends. You may continue to submit claims for reimbursement of expenses incurred through the last day of your employment. Such claims must be submitted no later than March 31 following the end of that calendar year. Any account balance

remaining after that date will, by law, be forfeited.

If You Should Become Totally Disabled or Die

You or your survivors may continue to submit claims for expenses incurred before the time of total disability or death, up to the remaining balance in your account. Such claims must generally be submitted no later than March 31 following the end of that calendar year and account balances remaining after that date will, generally, be forfeited.

Use of Forfeitures

Forfeited account balances will remain part of the University's assets. Under no circumstances may any forfeitures be used to directly benefit any individual plan participant.

Information to Remember

Flexible Spending Accounts have some limitations. These limitations are based on federal regulations required because of the tax-exempt feature of the accounts. For example:

- You must re-enroll in the accounts during each annual open enrollment period. You do this by completing new enrollment forms. If you do not complete a new enrollment, your participation in the accounts will cease at the end of the plan year, and you will not be able to enroll again until the next open enrollment period unless you experience a Life or Career Event or you are requesting a change during the 2020 or 2021 Plan Year (see the "Special Temporary COVID-19 Relief for 2020 and 2021" section above for more information).

- Flexible Spending Accounts can be used only for the purposes for which they are set up—that is, dependent care expenses or health care expenses, respectively.
- Your decisions regarding how much money you will contribute to the accounts for the plan year are fixed (unless there is a Life or Career Event). You cannot choose to stop, reduce, or increase your contributions during the plan year.
- If the full values of the accounts are not used up during the plan year, including the grace period for the FSA-Health Care, you forfeit the remaining balances..

Because of the requirement to forfeit any unused account balances, Flexible Spending Accounts should be used only for predictable expenses. You should, therefore, estimate conservatively.

Following are specific details concerning the Dependent and Health Care Flexible Spending Accounts.

Flexible Spending Account—Dependent Care

The FSA—Dependent Care is designed to help you pay for the cost of eligible expenses for the care of qualified dependents incurred in the calendar year during which and while you participate in this plan. An expense is "incurred" when the services relating to that expense were provided.

Because your individual situation determines whether or not the account is appropriate for you, we urge you to consult a tax advisor before enrolling in an FSA Dependent Care.

Eligible Expenses cover Qualifying Services to Qualifying Individuals.

Qualifying Services are work-related dependent care services performed in order for you and your spouse, if you are married, to remain employed or look for work. Qualifying Services can be provided:

- In your home
- Outside of your home, provided the dependent regularly spends at least eight hours per day in your household, or the dependent is under 13 years of age
- By a dependent care center or facility if it provides care to six or more individuals (excluding residents of the center) and receives a fee, payment, or grant for the services. These services qualify only if the center complies with all the applicable state and municipal laws and regulations.

You must make payments for child and dependent care to someone you (and your spouse) cannot claim as a dependent. If you make payments to your child, he or she cannot be your dependent and must be age 19 or older by the end of the year. You cannot make payments to:

- a. Your spouse
- b. The parent of your qualifying individual if your qualifying individual is your child and under age 13

Child and dependent care expenses must be work-related to qualify. Expenses are considered work-related only if both of the following are true:

- They allow you (and your spouse if you are married) to work or look for work.

- They are for a qualifying individual's care.

Qualifying nursery school expenses can be reimbursed, but kindergarten and grade school tuition expenses and the cost of overnight camp cannot be.

If qualifying care is provided in your home, the provider could be a housekeeper, nanny, live-in, or other individual, as long as his or her primary job is to provide qualifying dependent care services.

Qualifying Individuals are:

1. Your qualifying child who is your dependent and who was under age 13 when the care was provided (see the "Special Temporary COVID-19 Relief for 2020 and 2021" section above for a special exception to the under age 13 requirement),
2. Your spouse who was not physically or mentally able to care for himself or herself and lived with you for more than half the year; or
3. A person who was not physically or mentally able to care for himself or herself, lived with you for more than half the year, and either:
 - a. Was your dependent, or
 - b. Would have been your dependent except that:
 - i. He or she received gross income of \$4,300 (2020 limit) or more,
 - ii. He or she filed a joint return, or
 - iii. You, or your spouse if filing jointly, could be claimed as a dependent on someone else's income tax return.

If You Are Divorced or Separated If you are divorced or legally separated, or if you and your spouse lived apart for

the last six months of the calendar year, your children under the age of 13 will generally be considered your dependents if you had custody of them for the greater portion of that calendar year. Consult your own tax advisor for more information.

Maximum Contributions

Federal tax laws place limitations on the amount you can contribute to an FSA—Dependent Care each plan year.

If you are:	Your maximum contribution is:
Single or married filing jointly	\$5,000
Married filing separately	\$2,500

The University elected to implement the increases allowed under the American Rescue Plan Act (ARPA) from \$5,000 to \$10,500 (for employees who are married and filing jointly) and from \$2,500 to \$5,250 (for employees who are married and filing separately for 2021). See the "Special Temporary COVID-19 Relief for 2020 and 2021" section above for special limits that apply in 2021.

Other Contribution Limitations

1. If you are married, your contributions are limited to the least of the following:
 - Your earned income (after reductions in pay for contributions to other benefit plans) for the plan year; or your spouse's earned income for the plan year.

Under federal law, if your spouse is not employed during a month that you incur eligible dependent care expenses,

because he/she is a full-time student or is totally incapacitated, your spouse's earned income for that month will be treated as being either:

- \$250 if you incurred eligible expenses for one Qualifying Individual, or
- \$500 if you incurred eligible expenses for two or more Qualifying Individuals.

2. If you are single, your contributions may not be in excess of your earned income (after reductions in taxable pay for contributions to other benefit plans) for the plan year.
3. The federal maximum contribution limit applies to contributions made to this and other dependent care reimbursement accounts you or your spouse participate in during a given year. For example, if your spouse is contributing \$5,000 under the FSA—Dependent Care of his or her employer in 2025, you would not be eligible to make any contribution under this FSA—Dependent Care. Therefore, if you start working at Boston University after the beginning of the plan year and would like to participate in the Dependent Care Reimbursement Account, you must consider any contributions made to your previous employer's dependent care plan when determining your maximum contribution limit for this account.

Filing Claims

You can be reimbursed from your account by filing a claim with P&A Group.

You do not have to pay for eligible dependent care expenses before being reimbursed for them, but those expenses must be incurred by you. However, P&A Group may ask you to verify your claims and can withhold payment if you do not forward the requested information.

Note: IRS regulations require substantiation of claim.

When you file claims for eligible dependent care expenses, you must include a Taxpayer Identification Number (TIN) for each provider. An individual's TIN is typically his or her Social Security number. Also, when you file your tax return, you will have to include a special form that will include the name(s) and TIN(s) of your caregiver(s). For additional information concerning TINs, contact Human Resources.

You must submit a Dependent Care Documentation Form each year for each of the Dependent Care providers you use. Once this form is on file with P&A Group, claims submitted with receipts including dates of service will suffice for reimbursement.

If you file a claim and it is denied, in whole or in part, you have a right to appeal the denial. Information about a denial of benefits is included in the "Administrative Information" section of this handbook. ERISA does not apply to the FSA— Dependent Care.

Flexible Spending Account— Health Care

The FSA—Health Care is designed to help you pay for eligible health care expenses incurred by you and your dependents in the plan year during which and while you participate in this plan. A claim is "incurred" when the services relating to that claim were provided.

Eligible Health Care Expenses

Before opening an FSA—Health Care, you should be reasonably certain you will have eligible health care expenses during the year. As a guideline for the amount you should budget, you may wish to consider your health plan deductibles and the out-of-pocket expenses you might have to pay during the year.

Eligible expenses are those that are medically necessary and that are not covered by insurance; these generally include:

- Acupuncture
- Chiropractor services
- Convalescent home expenses for medical treatment
- Deductibles and coinsurance
- Drug treatment center expenses
- Feminine Products
- Hearing aids and hearing care expenses
- Institutional care required for a health condition (not custodial care only)

- Kidney donor expenses
- Laboratory examinations and tests
- Medical equipment
- Nursing care
- Organ transplants
- Orthodontic treatment
- Osteopath services
- Over-the-counter medications
- Podiatry services
- Prescription drugs
- Routine physical exams
- Seeing Eye dog expenses
- Special expenses for physically and mentally handicapped children
- Unreimbursed dental care expenses
- Vision care expenses, including eyeglasses and exams

In addition, other health care expenses considered tax deductible under Section 213 of the Internal Revenue Code may be eligible for reimbursement through your account (but health insurance premiums are not eligible for reimbursement). However, any health care expenses you have deducted or intend to deduct on your income tax return cannot be submitted for reimbursement.

Maximum Contributions

You may elect to set aside any amount in your FSA—Health Care up to \$3,300 in the 2025 plan year.

Filing Claims

You can be reimbursed from your account by filing a claim with P&A Group.

Note: *IRS regulations require substantiation of claim.* If you file a claim and it is denied in whole or in part, you have a right to appeal the denial. Information about appealing a denial of benefits is included in the “Administrative Information” section of this handbook.

Leaves of Absence

If you leave work for any reason for a prolonged period of time, you should always contact Human Resources to ask what effect your absence may have on your participation in this and other University sponsored benefit plans.

- **Leave of Absence with Pay** If you are granted a leave of absence with pay, your participation will continue, provided your usual payroll deductions continue.
- **Leave of Absence Without Pay** If you are granted a leave of absence without pay, you may continue your participation during your leave with limitations. Human Resources will provide you with the necessary information and forms to either continue or discontinue participation in this program during an unpaid leave of absence.

When Your Program Participation Ends

Your participation in the Flexible Benefits Program ends the day your employment with the University terminates. It will also end when your status as a regular employee ends or, for the reimbursement accounts, if you do not re-enroll during the annual open enrollment period.

At that time, you can be reimbursed for eligible expenses that were incurred before your date of

termination of employment or other termination of participation.

Closing Thoughts

The Flexible Benefits Program can be a valuable tool in your financial planning. You can realize significant tax savings by paying for eligible benefit expenses with before-tax dollars.

Every effort will be made to help you identify eligible expenses for reimbursement; however, Boston University cannot provide you with legal or tax advice. Also, the University will not be responsible if the treatment of a reimbursement amount is later challenged by the IRS.

The Flexible Benefits Program is intended to qualify under Section 125 of the Internal Revenue Code and other applicable Code Sections. Boston University reserves the right to modify or terminate the program at any time (including a change in the applicable tax laws).

Administrative Information

Sponsor for This Plan

This plan is sponsored by the employer, Boston University, Boston, Massachusetts, which is also the Plan Administrator. Eligibility for the benefit plan described in this handbook applies to those University employees on the US payroll.

Boston University’s Employer Identification Number

For identification purposes, the Internal Revenue Service has assigned number 04-2103547 to Boston University. You will need to know this number if you write to a government agency about

any of the plans.

Type of Plan, Plan Number, and Plan Year

In addition to the University’s Employer Identification Number, you need to know the following information:

- **Type of Plan:** The Flexible Benefits Plan is characterized by the federal government as a Welfare Plan.
- **Plan Number:** Boston University has assigned Plan Number 702 to The Flexible Benefits Plan.
- **Plan Year** The financial records of this plan are kept on a Plan Year basis. The Plan Year for The Flexible Benefits Plan is January 1 to December 31.

Administrator for This Plan

The day-to-day administration of this plan is handled by Human Resources. However, if you have a question or a problem that cannot be resolved by Human Resources, you should contact the Plan Administrator.

The Plan Administrator can be reached by contacting:

Plan Administrator
The Trustees of Boston University
25 Buick Street Boston, MA 02215
Phone: 617-353-4489

Boston University pays the entire cost of many of the benefit plans described in this handbook. In some cases, you and the University share the cost. In others, you pay the entire cost.

Funding and Administration of the Plan

Dependent Care and Health Care Flexible Spending Account claims are processed by P&A Group through a contract it has with the University. The address and telephone number of P&A Group are:

P&A Group
17 Court Street, Suite 500
Buffalo, NY 14202-3204
1-800-688-2611

Agent of Legal Service

The agent for the service of legal process for this plan is:

University Counsel
125 Bay State Road
Boston, MA 02215

Legal process may be served on the Plan Administrator.

Fraudulent Claims

Submission of a claim for benefits under any of the plans described in this handbook includes a representation that the claim is bona fide and, to the best knowledge of the employee, dependent, or other claimant, proper for payment. Submission of a fraudulent or knowingly false claim by an employee or an employee's dependent participating in a plan will be grounds for disciplinary action against the employee, including termination of participation by the employee and/or covered dependent(s) under the plan.

Claims for Benefits/Appealing a Denial of Claims for Benefits

Claims Determinations

Flexible Spending Account - Dependent Care

If your claim under the FSA – Dependent Care is denied in whole or in part, you or your beneficiary will receive a written notice providing:

- the specific reason or reasons for the denial;
- reference to the specific provisions of the plan on which the denial was based;
- a description of any additional information needed to process the claim; and
- an explanation of the claims review (appeals) procedure and the time limits applicable to such procedure, including your right to bring a civil action under Section 502(a) of ERISA if your claim is denied on review.

The notice will be furnished to you within 90 days after receiving your claim. However, if special circumstances require more time for processing your claim, you will be notified in writing before the initial 90 days is up. The notice will explain why an extension is necessary and the date a decision is expected. In no event will an extension go beyond 90 days after the end of the initial 90 days.

Flexible Spending Account – Health Care

If your claim under the FSA- Health Care is denied in whole or in part, the following procedures will apply, depending upon the type of claim:

Post-Service Claims are those claims that are filed for payment of benefits after medical care has been received. Claims for benefits under the FSA – Health Care will always be Post-Service Claims. If your Post-Service Claim is denied, you will receive a written notice from P&A Group within 30 days of receipt of the claim, so long as all

necessary information was provided with the claim. If circumstances beyond the control of the Plan require more time for processing your claim, federal law permits one extension of up to 15 days. You will be notified of any extension before the initial 30 days are up. The notice will explain why an extension is necessary and the date a decision is expected.

If an extension of the decision period is necessary because additional information is needed to decide your claim, then the notice of extension will specifically describe the required information and you will have 45 days to provide it. If all needed information is received within the 45-day time frame, P&A Group will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

If your claim is denied in whole or in part, you will receive written notice of:

- the specific reason or reasons for the denial;
- specific reference to the plan provisions on which the denial is based;
- if a plan rule or guideline was relied on in making the initial benefit decision, either the specific plan rule or a statement that a copy of the rule will be provided to you free upon request;
- the additional information, if any, needed to approve your claim and an explanation of why such information is necessary;
- the plan claims review procedure, including a statement of your right to bring an action under Section

502(a) of ERISA, following an adverse determination appeal; and

- if the initial benefit decision was based on a plan exclusion or limit (such as medical necessity or experimental treatment), either an explanation of the basis for the determination or a statement that such explanation will be provided to you free upon request.

How to Appeal a Claim Determination

If you disagree with a claim determination, you can contact P&A Group in writing to formally request an appeal. Your first appeal request must be submitted to P&A Group within 60 days after you receive the claim denial. In the case of a FSA- Dependent Care claim and within 180 days after you receive the claim denial in the case of a FSA – Health Care claim.

Appeal Process

An appropriate, named plan fiduciary who did not make the initial decision and who is not a subordinate of the individual who made the initial decision will decide the appeal. The review will show no deference to the initial decision. As part of the review, you or your authorized representative may submit written comments, documents, records, or other information relating to the claim for benefits, and, upon request and free of charge, you or your authorized representative will be provided reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits. You may also request the identity of any medical experts consulted by the plan in connection with the initial benefit decision. The Plan fiduciary who considers your appeal will take into account all

information you submit, regardless of whether it was submitted or considered in the initial decision. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. P&A Group and the Plan Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process.

Appeals Determinations

Flexible Spending Account – Dependent Care

P&A Group will notify you of its decision on review not later than 60 days after receiving your request for review. If special circumstances require more time to reach a decision, it will be made as soon as possible, but not later than 120 days after receiving your request. If an extension of time is necessary, you will receive a written notice explaining why an extension is necessary and the date by which a decision is expected. A denial on review will be in writing and include:

- the specific reason or reasons for the denial;
- reference to the specific Plan provisions on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your claim for benefits; and
- a statement of your right to bring a civil action under Section 502(a) of ERISA.

Flexible Spending Account – Health Care

You will be provided written or electronic notification of decision on your appeal within 60 days for the appeal of a Post-Service Claims. Prior to receiving a final adverse benefit determination based on new or additional evidence or rationale, you will be provided with any new or additional evidence considered, relied upon, or generated in connection with your claim, and any new or additional rationale, and you will have an opportunity to respond prior to the date the final adverse benefit determination is due. If the appeal is denied, you will receive a notice providing -

- the specific reason or reasons for the denial;
- specific reference to the Plan provisions on which the denial is based;
- if a plan rule or guideline was relied on in making the initial benefit decision, either the specific plan rule or a statement that a copy of the rule will be provided to you free upon request;
- the additional information, if any, needed to approve your claim and an explanation of why such information is necessary;
- the Plan claims review procedure, including a statement of your right to bring an action under Section 502(a) of ERISA, following an adverse determination appeal;
- if the benefit decision was based on a Plan exclusion or limit (such as medical necessity or experimental treatment), either an explanation of the basis for the determination or a statement that

- such explanation will be provide to you free upon request; and
- the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Exhausting Administrative Remedies

If your claim is denied on review, then you may bring a civil action in federal or state court. You may not commence such an action, however, until you have exhausted your administrative remedies under the Plan. Unless otherwise expressly stated in the plan document for the applicable plan, you must initiate any civil action on a claim for benefits under the Flexible Benefits Program within 12 months after exhaustion of your administrative remedies under the Plan.

Documents and Laws Governing This Plan

The plan description contained in this handbook was written from the documents that legally govern how the plan works.

In the event of any discrepancy between the plan description in this handbook and the controlling contracts or plan documents, the language in the controlling contracts or plan documents will govern. If you would like a copy of any of these documents, please contact Human Resources.

The plan is also regulated by applicable provisions of applicable laws, which will govern in the event of any conflict between the law and the terms of the plan as described in either the

documents or in this summary plan description.

Equal Opportunity/Affirmative Action Policy

Since its founding in 1839, Boston University has been dedicated to equal opportunity and has opened its doors to students without regard to race, sex, creed, or other irrelevant criteria. Consistent with this tradition, it is the policy of Boston University to promote equal opportunity in educational programs and employment through practices designed to extend opportunities to all individuals on the basis of individual merit and qualifications, and to help ensure the full realization of equal opportunity for students, employees, and applicants for admission and employment. The University is committed to maintaining an environment that is welcoming and respectful to all.

Boston University prohibits discrimination against any individual on the basis of race, color, religion, sex, age, national origin, physical or mental disability, sexual orientation, genetic information, military service, or because of marital, parental, or veteran status. This policy extends to all rights, privileges, programs, and activities, including admissions, financial assistance, educational and athletic programs, housing, employment, compensation, employee benefits, and the providing of, or access to, University services or facilities. Boston University recognizes that that equal opportunity is a reality. Accordingly, the University will continue to take affirmative action to achieve equal opportunity through

recruitment, outreach, and internal reviews of policies and practices.

The coordination and implementation of this policy is the responsibility of the Director of Equal Opportunity. The officers of the University and all deans, directors, department heads, and managers are responsible for the proper implementation of equal opportunity and affirmative action in their respective areas, and they are expected to exercise leadership toward their achievement. It is expected that every employee of Boston University will share this commitment and cooperate fully in helping the University meet its equal opportunity and affirmative action objectives.

Boston University has developed detailed procedures, described in its *Complaint Procedures in Cases of Alleged Unlawful Discrimination or Harassment* (www.bu.edu/eeo/policies-procedures/complaint), by which individuals may bring forward concerns or complaints of discrimination and harassment. Retaliation against any individual who brings forward such a complaint or who cooperates or assists with an investigation of such a complaint is both unlawful and strictly prohibited by Boston University.

Inquiries regarding this policy or its application should be addressed to the Director of Equal Opportunity, Equal Opportunity Office, 888 Commonwealth Avenue, Suite 303, Boston, MA 02215, or call 617-358-1796.

Amendment or Termination of the Plan

Boston University intends to continue maintaining the plan described in this

handbook for the exclusive benefit of its employees.

However, the University reserves the right to change or discontinue it, and to implement changes as required by federal, state, or local laws.

You will be informed of any material changes that are made to the plans. If a plan is terminated, your rights, on the date of the termination, would be governed by the provisions of the plan document.

Your Rights Under ERISA

The FSA – Health Care benefit is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides the participants in these plans with certain rights and protections. The following statement is included here so that you will be aware of your rights under the law.

Under ERISA:

You may examine, without charge, at Human Resources and at other specified locations, during normal business hours, all plan documents relating to the plans in which you participate. The documents that must be available for your review include insurance contracts, plan and trust documents, collective bargaining agreements, and all documents filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration, for example, detailed annual reports.

If you wish, you may request your own copies of these plan documents by writing to Human Resources. Where permitted by law, you may have to pay

a reasonable charge to cover the costs of copying.

You will receive summaries of the plans' annual financial reports each year, free of charge. The administrator for the plans is required by law to furnish each participant with a copy of these summary annual reports.

Continue Health Coverage

You may continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Flexible Benefits Plan as a result of a qualifying event. You or your dependents will have to pay for such coverage. Review this handbook and the documents governing the Flexible Benefits Plan - Health Care on the rules governing your COBRA continuation coverage rights.

Plan Fiduciaries

Besides giving you certain rights as a participant, ERISA places certain duties upon the people who are responsible for the management of the above-mentioned plans. These people are called "fiduciaries" under the law, and they have the duty to act prudently and in your best interests.

Under ERISA, no one may fire you or discriminate against you to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Enforcing Your Rights

If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to obtain copies, without charge, of documents relating to the decision, and to appeal any denial all within certain time schedules.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 for each day's delay until you receive the materials, unless the materials were not sent for reasons beyond the administrator's control. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with a plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse plan money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or file suit in a federal court.

In a lawsuit, the court normally decides who pays the court costs and legal fees. If you are successful, the other party might have to pay. But, if you lose, the court might order you to pay these costs and fees, especially if the court finds your claim to be frivolous.

Assistance with Questions

If you have any questions about this statement of your rights under ERISA, contact Human Resources. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. You

may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

A Final Note

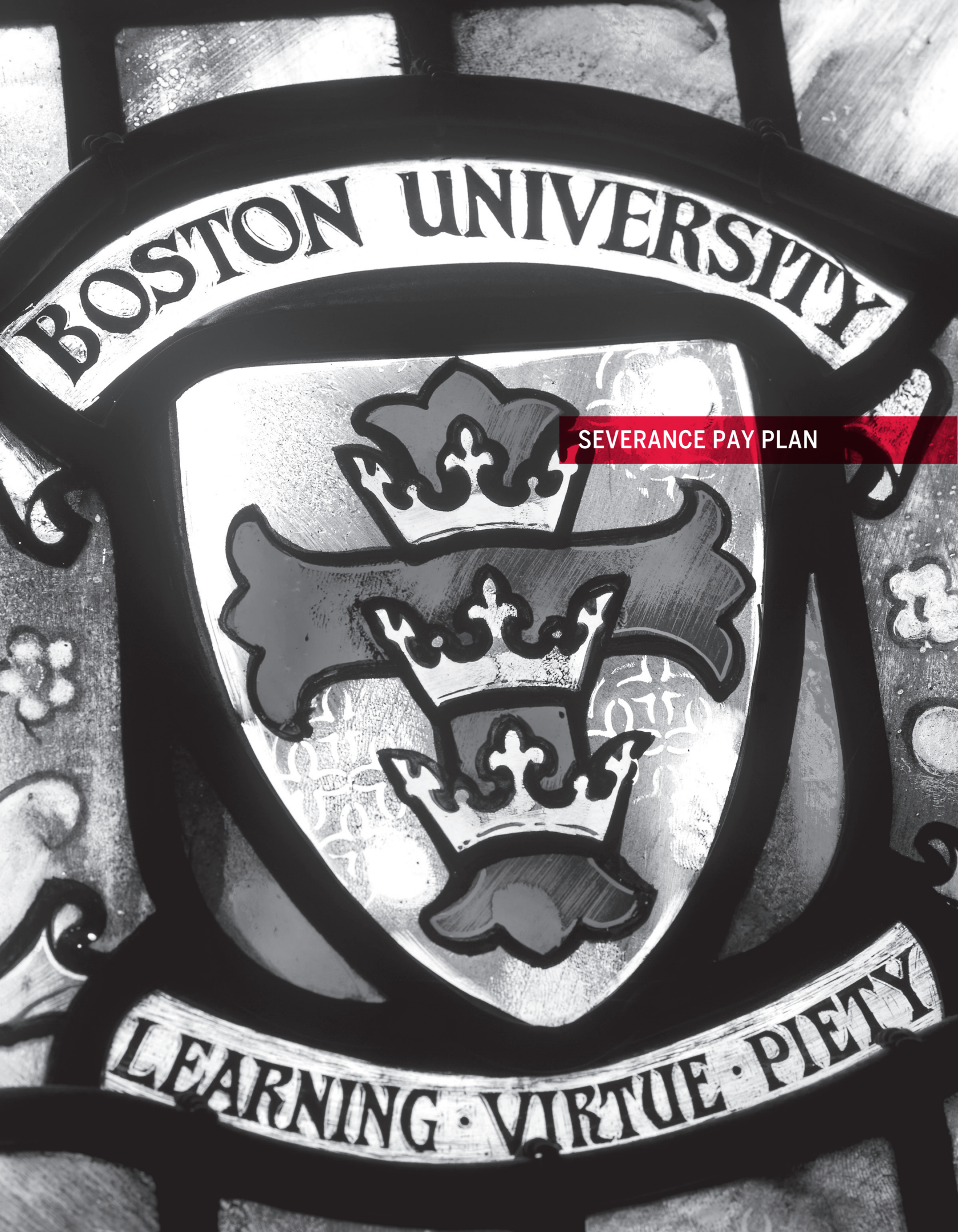
This handbook presents a summary of Boston University's benefits for faculty and staff and is intended to serve as the summary plan description for the

FSA- Health Care Plan. It is designed as a quick reference source and is not intended to cover every point of policy. In certain instances, the University may exercise discretion, with respect to the administration of the plans described in this handbook. For more in-depth information, contact Human Resources.

Periodically, the University may make changes in policy that may not be reflected immediately in this handbook.

Again, for complete and up-to-date information about any policy or benefit, you should contact Human Resources.

Please note: The policies described in this handbook are not intended to create an employment contract between Boston University and its employees. Therefore, they do not alter the University's rights regarding discharges and layoffs.



SEVERANCE PAY PLAN

Eligibility

If you are classified by the University as a regular staff employee (non-faculty) and have completed three months of continuous service, you are automatically covered by the Severance Pay Plan.

Cost

The University provides and pays the entire cost of the Severance Pay Plan. You are not required to make a contribution for this coverage.

Notification of Layoff

If it is necessary for Boston University to lay off an employee, the employee will be notified of the effective date of the layoff as far in advance as is practical. Such notice will normally be given at least one (1) month in advance of the effective date of the layoff.

Plan Benefits

Should the University find it necessary to reduce its workforce by eliminating filled positions, affected employees will be laid off. Employees whose positions have been eliminated and who have completed three months of continuous service are eligible for severance pay. Severance pay is based on the employee's most recent date of hire and is pro-rated for a partial year. Severance pay is calculated at the rate of one (1) week's pay for each full year of continuous service at Boston University.

Tax Considerations

Under current laws, severance pay is taxable as income in the year received by the laid off employee.

When Plan Membership Ends

Your membership in this plan will end when you terminate your employment with the University or when your status as a regular employee ends.

Administrative Information About the Plan

Sponsor for the Plans

The Severance Pay Plan is sponsored by the employer, Boston University, Boston, Massachusetts, which is also the Plan Administrator. Eligibility for the benefit plan described in this handbook applies to those University employees on the US payroll.

Boston University's Employer Identification Number

For identification purposes, the Internal Revenue Service has assigned number 04-2103547 to Boston University. You will need to know this number if you write to a government agency about any of the plans.

Type of Plan, Plan Number, and Plan Year

In addition to the University's Employer Identification Number, you need to know the following information:

- **Types of Plans** The plan described in this handbook is characterized by the federal government as a Welfare Plan.
- **Plan Numbers** Boston University has assigned Plan Number 704 to the Severance Pay Plan.

- **Plan Years** The financial records of this plan are kept on a Plan Year basis. The Plan Year for this plan is January 1 – December 31.

Administrator for the Plan

The day-to-day administration of the plan is handled by Human Resources. However, if you have a question or a problem that cannot be resolved by Human Resources, you should contact the Plan Administrator.

The Plan Administrator for the plan can be reached by contacting:

Plan Administrator
The Trustees of Boston University
25 Buick Street Boston, MA 02215
Phone: 617-353-4489

Funding and Administration of the Plan

Severance Pay Plan benefits are paid out of the general assets of Boston University.

Agent of Legal Service

The agent for the service of legal process for the plan is:

University Counsel
125 Bay State Road
Boston, MA 02215

Legal process may be served on the Plan Administrator.

Fraudulent Claims

Submission of a claim for benefits under the plan described in this handbook includes a representation that the claim is bona fide and, to the best knowledge of the employee, dependent, or other claimant, proper for payment.

Submission of a fraudulent or knowingly false claim by an employee or an employee's dependent participating in a plan will be grounds for disciplinary action against the employee, including termination of participation by the employee and/or covered dependent(s) under the plan.

Claims for Benefits/Appealing a Denial of Claims for Benefits

When you apply for benefits, there are time periods within which you must receive a decision on your claim for benefits. If you or your beneficiary applies for benefits and either part or all of the request is denied, you have the right to appeal that decision, provided the appeal is made in accordance with the provisions of the plan and applicable laws (e.g., appeals must be filed within required time periods).

Claims and Appeals to the University

For the Severance Pay Plan, appeals regarding benefits or other issues affecting plan participants or other persons should be made to the Office of the Senior Vice President for Operations.

Documents and Laws Governing the Plan

The plan description contained in this handbook was written from the documents that legally govern how the plans work.

In the event of any discrepancy between the plan description in this handbook and the controlling contracts or plan documents, the language in the controlling contracts or plan documents will govern. If

you would like a copy of any of these documents, please contact Human Resources.

The plan is also regulated by applicable provisions of applicable laws, which will govern in the event of any conflict between the law and the terms of the plan as described in either the documents or in the summary plan description.

Equal Opportunity/Affirmative Action Policy

Since its founding in 1869, Boston University has been dedicated to equal opportunity and has opened its doors to students without regard to race, sex, creed, or other irrelevant criteria. Consistent with this tradition, it is the policy of Boston University to promote equal opportunity in educational programs and employment through practices designed to extend opportunities to all individuals on the basis of individual merit and qualifications, and to help ensure the full realization of equal opportunity for students, employees, and applicants for admission and employment. The University is committed to maintaining an environment that is welcoming and respectful to all.

Boston University prohibits discrimination against any individual on the basis of race, color, religion, sex, age, national origin, physical or mental disability, sexual orientation, genetic information, military service, or because of marital, parental, or veteran status. This policy extends to all rights, privileges, programs, and activities, including admissions, financial assistance, educational and athletic programs, housing, employment, compensation, employee benefits, and the providing of, or access to, University services or facilities. Boston

University recognizes that that equal opportunity is a reality. Accordingly, the University will continue to take affirmative action to achieve equal opportunity through recruitment, outreach, and internal reviews of policies and practices.

The coordination and implementation of this policy is the responsibility of the Director of Equal Opportunity. The officers of the University and all deans, directors, department heads, and managers are responsible for the proper implementation of equal opportunity and affirmative action in their respective areas, and they are expected to exercise leadership toward their achievement. It is expected that every employee of Boston University will share this commitment and cooperate fully in helping the University meet its equal opportunity and affirmative action objectives.

Boston University has developed detailed procedures, described in its *Complaint Procedures in Cases of Alleged Unlawful Discrimination or Harassment* (www.bu.edu/eoo/policies-procedures/complaint), by which individuals may bring forward concerns or complaints of discrimination and harassment. Retaliation against any individual who brings forward such a complaint or who cooperates or assists with an investigation of such a complaint is both unlawful and strictly prohibited by Boston University.

Inquiries regarding this policy or its application should be addressed to the Director of Equal Opportunity, Equal Opportunity Office, 888 Commonwealth Avenue, Suite 303, Boston, MA 02215, or call 617-358-1796.

Amendment of Termination of the Plan

Boston University intends to continue maintaining the plan described in this handbook for the exclusive benefit of its employees.

However, the University reserves the right to change or discontinue it, and to implement changes as required by federal, state, or local laws.

You will be informed of any material changes that are made to the plan. If a plan is terminated, your rights, on the date of the termination, would be governed by the provisions of the plan document.

A Final Note

This handbook presents a summary of Boston University's Severance Pay Plan for faculty and staff. It is designed as a quick reference source and is not intended to cover every point of policy. In certain instances, the University may exercise discretion, with respect to the administration of the plan described in this handbook. For more in-depth information, contact Human Resources.

Periodically, the University may make changes in policy that may not be reflected immediately in this handbook.

Again, for complete and up-to-date information about any policy or benefit, you should contact Human Resources.

Please note: The policy described in this handbook is not intended to create an employment contract between Boston University and its employees. Therefore, it does not alter the University's rights regarding discharges and layoffs.

An aerial, black and white photograph of a university campus. A large, leafy tree is in the upper left. A brick path winds through the scene, intersecting several grassy areas. In the lower right, a building with a large, arched window and a decorative roof is visible. A red banner with the text "OTHER BENEFITS" is overlaid on the right side of the image.

OTHER BENEFITS



You have a variety of other benefits available as an employee of Boston University. These include:

- BU Employee Wellness
- Child Care Facilities
- Faculty/Staff Assistance Office
- Family Resources Office
- Financial Planning Software
- Fitness & Recreation Center
- Income Solutions[®]
- Personal Insurance Program
- Real Estate Services
- Bright Horizons Back- Up Care

These benefits are provided to help you and your family live life to its fullest, both personally and professionally.

Finally, the University contributes toward additional benefits that have been established under state and federal statutes. These statutory benefits include Social Security, Unemployment Compensation, and Workers' Compensation.

BU Employee Wellness

Employee Wellness is an initiative of Boston University to provide faculty and staff with resources, both on campus and off, to assist you in enhancing your overall wellness.

The departments supporting this initiative are:

- Fitness & Recreation Center
- Human Resources
- Faculty & Staff Assistance Office
- Family Resources
- Occupational Health
- Sargent Choice Nutrition Center

BU Employee Wellness offers a variety of programs designed to improve the health and well-being

of BU faculty and staff.

In addition, the website (www.bu.edu/wellness) provides extensive information about wellness related resources both on campus and off campus.

Contact BU Employee Wellness at bewell@bu.edu.

Child Care and Preschool Education Programs

Boston University offers two child care and preschool education program:

- The Boston University Children's Center has full-time and part-time programs for children from infant to five years of age. For additional information and application

forms, view the website at www.bu.edu/childrens-center.

- Little Sprouts at BUMC is a full-time program for children ages four weeks through five years old. For additional information please call 1-877-977-7688 or go to their website. [Little Sprouts: Award-Winning Early Education, Child Care, Day Care](#)

Space in the program is limited. If you are interested in The Children's Center, we encourage you to talk to the director as early as possible.

Maximize My Social Security

Maximize My Social Security helps you decide when and how to collect retiree, spousal, survivor, divorcee, parent, and child benefits to achieve the highest lifetime benefits. Features included: web-based platform, side-by-side comparison of chosen and optimal strategy, one-year license.

Developed by Laurence Kotlikoff, Professor of Economics at Boston University, Maximize My Social Security incorporates all Social Security provisions and options for singles and married couples. View a video demo at <http://maximizemysocialsecurity.com/content/quick-demo>. BU is providing faculty and staff with a coupon equal to the purchase price—(\$50 value)—of the software. All you pay is the sales tax. To purchase Maximize My Social Security, contact BU Human Resources at hr@bu.edu for your coupon code. Go to www.maximizemysocialsecurity.com and select Maximize My Social Security. Enter the coupon code in your shopping cart and proceed to checkout. You will need to pay the sales tax using your credit card.

MaxiFi Standard

MaxiFi Standard (formerly MaxiFi Planner) is a full, lifetime financial planning tool that determines how much to spend and save each year as well as how much life insurance to hold each year to ensure your family has the most stable possible living standard without putting you into debt. MaxiFi Standard also robo-optimizes your plan. It suggests Social Security benefit collection, retirement account benefit withdrawal, and retirement account annuitization strategies to maximize

your lifetime spending. You can also use the tool to consider other safe ways to raise your lifetime income including contributing more to retirement accounts, downsizing your home, switching jobs, or getting an advanced degree.

MaxiFi Premium

MaxiFi Premium includes all of MaxiFi's features, but also has fully precise Monte Carlo living standard simulations that show you your average living standard level and the risk to your living standard of investing as well as spending aggressively.

Developed by Boston University Professor Laurence Kotlikoff, MaxiFi software is powered by the patented Economic Security Computation Engine, and it allows you to build a lifetime financial road map using all your financial data.

To purchase either version of MaxiFi, contact BU Human Resources for your coupon code. Go to MaxiFi and select 'Add to cart'. You must use your Boston University email account, otherwise the coupon will not work. Enter your coupon code to cover the purchase price of the software and proceed to checkout.

You will receive a login link at the email address that you use during the checkout process just like their paying customers do.

Faculty & Staff Assistance Office

The Boston University Faculty & Staff Assistance Office provides confidential services. It is available to you and your family members if you are experiencing personal, family, or work-related problems. Services are available without

charge and include:

- Consultation
- Problem assessment
- Short-term psychotherapy
- Referral resource information

If you have a problem and are in doubt about the wisest course of action, we encourage you to contact the program. In response to your call, a counselor will meet with you to discuss your problems and consider solutions. If additional specialized counseling proves necessary, a referral will be made. Inquiries are confidential; no one will know you have used the Faculty & Staff Assistance Office unless you tell them.

For additional information or to schedule an appointment, call 617-353-5381 or visit their website at www.bu.edu/fsao. Appointments are generally scheduled between 9 a.m. and 5 p.m., Monday through Friday. After-hours appointments may be arranged upon request.

Family Resources

Family Resources is committed to helping Boston University faculty and staff become knowledgeable and informed about child care and elder care by providing a resource and referral service. For further information, contact the director at 617-353-5954 or visit their website at <http://www.bu.edu/childrens-center/family-resources/>.

Fitness & Recreation Center

The Fitness & Recreation Center has membership plans and programming designed specifically for faculty and staff. Come work out, learn a new skill, recreate with your

family, and enjoy over six acres of world-class fitness and recreation under one roof, including:

- Faculty/staff locker rooms and saunas
- Competition and recreation pools
- 8,000-square-foot fitness center
- Dance theater
- Elevated jogging track
- Racquetball and squash courts
- Seven courts of gymnasium
- 35-foot climbing wall
- Juice bar and lounge with wireless internet access
- Hundreds of recreational classes (at a significantly reduced rate if you are a member) in yoga, fitness, dance, martial arts, cycling, swimming, and much, much more.

The Fitness & Recreation Center offers highly competitive membership plans for faculty and staff, as well as spouses and dependents.

The Fitness & Recreation Center is located on BU's premises at 915 Commonwealth Avenue. Contacts: 617-353-3740, www.bu.edu/fitrec.

Income Solutions

Income Solutions® is an income annuity purchase program. This is not a benefits program sponsored by Boston University. It is part of the Hueler Companies, which is a leading technology and research firm located in Minneapolis, Minnesota.

How Can Income Solutions Help You? When you are ready to begin receiving your retirement income, an income annuity is one option you may want to explore. Income

Solutions provides you with the tools necessary to easily convert all or a portion of your retirement assets into an annuity which provides a steady income stream you cannot outlive.

Through Income Solutions, you are able to purchase income annuities at a group discount or wholesale prices compared to some of those offered in the retail marketplace. Such an annuity is not part of any Boston University retirement plan.

An annuity is a long-term contract between an annuitant and an insurance company in which the annuitant receives income payments at regular intervals from a fixed date for a specific fixed period of time and/or until death in return for the premium that the annuitant pays to the insurance company. There are advantages and disadvantages associated with annuities which you should carefully consider. You may wish to consult your own financial advisor, at your own expense, as to whether an annuity is appropriate for you.

Use the Annuity Income Calculator

By accessing Income Solutions through Boston University's website, you will be able to use the income calculator. After you answer several questions, estimates for each of the immediate fixed income annuity options available through Income Solutions will be provided along with a definition of each type. You may want to try calculating several scenarios before determining which best meets your personal circumstances. Once you have an idea of what your needs are and which annuity option(s) may make sense for you, you may request quotes.

Request Quotes Income Solutions provides you with a platform in

which you can receive quotes from a broad group of high-quality insurance companies that participate in the Income Solutions program. Every quote request is competitively bid across the participating insurance companies to ensure that retirees receive competitive annuity quotes. All annuity quotes are provided on equal terms, ensuring comparison.

There is no cost to you to use the annuity income calculator; however, if you purchase an annuity through Income Solutions, Hueler Companies will receive a specified fee which is disclosed at the Income Solutions site.

How to Access Income Solutions For more information, log on to www.bu.edu/hr/finances/financial-planning-tools/income-solutions.

You will need to log on with your BU Kerberos password.

If you have any questions, please contact Human Resources at HR@bu.edu or call 617-353-2380.

Personal Insurance

This program offers a special discount on the cost of automobile and homeowners insurance for Massachusetts residents. It is currently underwritten by Liberty Mutual. You are eligible to participate in the program if you are a Massachusetts resident, provided you have not failed to pay an automobile insurance premium during the past 12 months. Enrollment is completely voluntary and is handled directly by Liberty Mutual.

Coverage includes:

- Automobile coverage through a group discount plan
- Homeowners and renter's insurance

- Umbrella coverage
- Premium payment by payroll deduction or monthly home billing (premium payments are on an after-tax basis)

For more information, contact Liberty Mutual at 1-888-480-4566 or go to www.libertymutual.com/buemployee.

Real Estate Services

- Assistance with home finding and selling
- Mortgage services
- Relocation and moving services

For more information, contact the Real Estate Advantage Program at 1-800-396-0960. Visit their website at www.realestate-advantage.net/reabu/index.html.

Bright Horizons Back-Up Care

Boston University has partnered with Bright Horizons to provide you with Back-Up Care for children, adults and elders for planned as well as last-minute circumstances.

Back-Up Care is designed to provide occasional alternative care when your regular care plan is disrupted. This benefit provides you with a national network of vetted childcare centers and in-home caregivers through Bright Horizons for both children and adults. You have 24/7 access to book these services either online, through a mobile app, or by phone. Bookings can be made up to 30 days in advance for anticipated disruptions or on the same day for unexpected needs.

The annual benefit limit is 10 days per employee.

Details about this benefit can be found on the Family Resources webpage.

<https://www.bu.edu/childrens-center/family-resources/types-of-care/backup-care/>

Additional Benefits

In addition to your Boston University benefits, federal and state laws require employers to provide you with certain other benefits. These statutory benefits include Social Security, Unemployment Compensation, and Workers' Compensation.

Boston University pays the entire cost of Unemployment Compensation and Workers' Compensation and also contributes to the cost of your Social Security benefits.

Statutory benefits may provide you and your family with financial assistance, in addition to University-sponsored benefits, when you are injured on the job, become disabled, retire, or die.

Social Security

The Social Security Act provides a range of programs to afford you a basic level of benefits in the event of your retirement, death, or disability. Most of these benefits are financed by payroll taxes.

Your Social Security benefits include:

- Retirement insurance
- Survivors' insurance
- Disability insurance
- Medicare
- Supplemental security income

Social Security benefits are adjusted frequently, and the rules and regulations change. You should contact your local Social Security office to obtain the latest information about the benefits to which you may be entitled.

Unemployment Compensation

The University pays the Commonwealth of Massachusetts the cost of your unemployment compensation.

You may be eligible to receive unemployment compensation benefits if you lose your job through no fault of your own. Unemployment compensation is coordinated through the Massachusetts Division of Unemployment Assistance, which determines your eligibility.

Workers' Compensation

Massachusetts Workers' Compensation laws prescribe certain medical, hospital, disability compensation, rehabilitation, and death benefits to be paid in the event of injury or death due to work-related accidents or illnesses. Boston University pays the full cost of insurance to cover these benefits. You are automatically covered by this insurance while you are employed by the University.

If you are injured while you are at work, report the injury to your supervisor immediately. Remember, minor injuries (which at the time may seem trivial, may later require medical attention) may also be covered, provided they are reported when they occur. Please also report any BU work-related injury or illness to Conduent at 833-951-2415.