



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, see www.bu.edu/hr. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at bluecrossma.org/sbcglossary or call 1-800-814-4371 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$500 member / \$1,000 family in-network Boston Medical Center and Other PPO <u>Providers</u> ; \$1,000 member / \$2,000 family out-of-network.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. In-network preventive and prenatal care, most office visits, mental health visits, therapy visits; emergency room.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	\$3,000 member / \$6,000 family in-network Boston Medical Center and Other PPO <u>Providers</u> ; \$6,000 member / \$12,000 family out-of-network.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of <u>network providers</u> .	You pay the least if you use a <u>provider</u> in-network (lowest <u>cost share</u>). You pay more if you use a <u>provider</u> in-network (highest <u>cost share</u>). You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		In-Network Lowest Cost Share (You will pay the least)	In-Network Highest Cost Share	Out-of-Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 / visit	\$35 / visit	30% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; a telehealth <u>cost share</u> may be applicable
	<u>Specialist</u> visit	\$15 / visit; \$35 / chiropractor visit; \$15 / acupuncture visit	\$35 / visit; \$35 / chiropractor visit; \$35 / acupuncture visit	30% <u>coinsurance</u> ; 30% <u>coinsurance</u> / chiropractor visit; 30% <u>coinsurance</u> / acupuncture visit	<u>Deductible</u> applies first for out-of-network; limited to 20 chiropractor visits per calendar year; limited to 12 acupuncture visits per calendar year; a telehealth <u>cost share</u> may be applicable
	<u>Preventive care/screening/immunization</u>	No charge	No charge	30% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; limited to age-based schedule and / or frequency; <u>cost share</u> waived for at least one mental health wellness exam per calendar year; a telehealth <u>cost share</u> may be applicable. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	20% <u>coinsurance</u> for x-rays and lab tests for certain hospitals; 12% <u>coinsurance</u> for other <u>providers</u>	30% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> may be required
	Imaging (CT/PET scans, MRIs)	No charge	20% <u>coinsurance</u> for	30% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> may be required

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		In-Network Lowest Cost Share (You will pay the least)	In-Network Highest Cost Share	Out-of-Network (You will pay the most)	
			certain hospitals; 12% <u>coinsurance</u> for other providers		
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.OptumRX.com	Generic drugs	\$10 copay for retail; \$20 copay for mail-order	\$10 copay for retail; \$20 copay for mail-order	Not Covered	30 day supply limit at retail; 90 day supply limit at mail-order or CVS retail
	Preferred brand drugs	20% coinsurance; Min \$45 and max \$65 for retail; Min \$90 and max \$130 for mail-order	20% coinsurance; Min \$45 and max \$65 for retail; Min \$90 and max \$130 for mail-order	Not Covered	30 day supply limit at retail; 90 day supply limit at mail-order or CVS retail
	Non-preferred brand drugs	30% coinsurance; Min \$65 and max \$85 for retail; Min \$130 and max \$170 for mail-order	30% coinsurance; Min \$65 and max \$85 for retail; Min \$130 and max \$170 for mail-order	Not Covered	30 day supply limit at retail; 90 day supply limit at mail-order or CVS retail
	<u>Specialty drugs</u>	Covered at same levels as other drugs	Covered at same levels as other drugs	Not Covered	30 day supply limit for specialty drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% <u>coinsurance</u> for certain hospitals; 12%	30% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		In-Network Lowest Cost Share (You will pay the least)	In-Network Highest Cost Share	Out-of-Network (You will pay the most)	
			<u>coinsurance</u> for other <u>providers</u>		
	Physician/surgeon fees	No charge	12% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
If you need immediate medical attention	<u>Emergency room care</u>	\$150 / visit; <u>deductible</u> does not apply	\$150 / visit; <u>deductible</u> does not apply	\$150 / visit; <u>deductible</u> does not apply	<u>Copayment</u> waived if admitted or for observation stay
	<u>Emergency medical transportation</u>	12% <u>coinsurance</u>	12% <u>coinsurance</u>	12% <u>coinsurance</u>	In-network <u>deductible</u> applies first for in-network and out-of-network services
	<u>Urgent care</u>	\$15 / visit	\$35 / visit	30% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; a telehealth <u>cost share</u> may be applicable

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		In-Network Lowest Cost Share (You will pay the least)	In-Network Highest Cost Share	Out-of-Network (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% <u>coinsurance</u> for certain hospitals; 12% <u>coinsurance</u> for other <u>providers</u>	30% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services
	Physician/surgeon fees	No charge	12% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 / visit	\$35 / visit	30% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	Inpatient services	No charge	20% <u>coinsurance</u> for certain hospitals; No charge for other <u>providers</u>	30% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> / authorization required for certain services
If you are pregnant	Office visits	No charge	No charge for prenatal care; 12% <u>coinsurance</u> for postnatal care	30% <u>coinsurance</u>	<u>Deductible</u> applies first except for in-network prenatal care; <u>cost sharing</u> does not apply for in-network <u>preventive services</u> ; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth <u>cost share</u> may be applicable
	Childbirth/delivery professional services	No charge	12% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	No charge	20% <u>coinsurance</u> for certain hospitals; 12% <u>coinsurance</u> for other <u>providers</u>	30% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		In-Network Lowest Cost Share (You will pay the least)	In-Network Highest Cost Share	Out-of-Network (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	12% <u>coinsurance</u>	12% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services
	<u>Rehabilitation services</u>	\$15 / visit for outpatient services; 12% <u>coinsurance</u> for inpatient services	\$35 / visit for outpatient services; 12% <u>coinsurance</u> for inpatient services	30% <u>coinsurance</u> for outpatient services; 30% <u>coinsurance</u> for inpatient services	<u>Deductible</u> applies first except for in-network outpatient services; limited to 60 outpatient visits per calendar year (other than for <u>home health care</u> and speech therapy); <u>copayment</u> waived for physical therapy visits at the Trustees of Boston University rehabilitation facility; limited to 100 days per calendar year for inpatient admissions; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	<u>Habilitation services</u>	\$15 / visit	\$35 / visit	30% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; outpatient rehabilitation therapy coverage limits apply; coverage limits waived for early intervention services for eligible children; a telehealth <u>cost share</u> may be applicable
	<u>Skilled nursing care</u>	12% <u>coinsurance</u>	12% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Deductible</u> applies first; limited to 100 days per calendar year; <u>pre-authorization</u> required
	<u>Durable medical equipment</u>	12% <u>coinsurance</u>	12% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Deductible</u> applies first; in-network <u>cost share</u> waived for one breast pump per birth, including supplies
	<u>Hospice services</u>	12% <u>coinsurance</u>	12% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		In-Network Lowest Cost Share (You will pay the least)	In-Network Highest Cost Share	Out-of-Network (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	No charge	30% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of-network; limited to one exam every 12 months
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	No charge for members with a cleft palate / cleft lip condition	No charge for members with a cleft palate / cleft lip condition	30% <u>coinsurance</u> for members with a cleft palate / cleft lip condition	<u>Deductible</u> applies first for out-of-network; limited to members under age 18

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> Children's glasses Cosmetic surgery 	<ul style="list-style-type: none"> Dental care (Adult) Long-term care 	<ul style="list-style-type: none"> Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> Acupuncture (12 visits per calendar year) Bariatric surgery Chiropractic care (20 visits per calendar year) Hearing aids (\$2,000 per ear every three calendar years) 	<ul style="list-style-type: none"> Infertility treatment Non-emergency care when traveling outside the U.S. Routine eye care - adult (one exam every 12 months) 	<ul style="list-style-type: none"> Routine foot care (only for patients with systemic circulatory disease) Weight loss programs (\$150 per calendar year per policy)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccio.cms.gov. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through a state exchange, you can contact your state's [marketplace](#), if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact your [plan](#) sponsor. (A [plan](#) sponsor is usually the member's employer or organization that provides group health coverage to the member.)

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, call 1-800-814-4371 or contact your [plan](#) sponsor. (A [plan](#) sponsor is usually the member's employer or organization that provides group health coverage to the member.)

Does this [plan](#) provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this [plan](#) meet the Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

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

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network prenatal care and a hospital delivery)

■ <u>The plan's overall deductible</u>	\$500
■ <u>Delivery fee copay</u>	\$0
■ <u>Facility fee copay</u>	\$0
■ <u>Diagnostic tests copay</u>	\$0

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$70
The total Peg would pay is	\$570

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ <u>The plan's overall deductible</u>	\$500
■ <u>Specialist visit copay</u>	\$15
■ <u>Primary care visit copay</u>	\$15
■ <u>Diagnostic tests copay</u>	\$0

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$500
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In this example, Joe would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Joe would pay is	\$200

Mia's Simple Fracture

(in-network emergency room visit and follow-up care)

■ <u>The plan's overall deductible</u>	\$500
■ <u>Specialist visit copay</u>	\$15
■ <u>Emergency room copay</u>	\$150
■ <u>Ambulance services coinsurance</u>	12%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$100
<u>What isn't covered</u>	
Limits or exclusions	\$10
The total Mia would pay is	\$810

The plan would be responsible for the other costs of these EXAMPLE covered services.