

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. 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.
3. 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.
4. 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	\$250	\$500
\$70,000– \$100,000	\$125	\$250
> \$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.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.

BU Health Savings Plan

How BU Health Savings Plan Works

The BU Health Savings Plan is a high deductible health plan (HDHP) administered by Blue Cross Blue Shield of Massachusetts and 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)
- 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 2026, the limits are \$4,400 for employee only and \$8,750 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 \$3,900 (\$4,400-\$500). If you are age 55 or older in 2026, you may make additional pre-tax “catch-up” contributions, up to \$1,000 per year.

2026	Individual	Family
Annual HSA Contribution` Limits	\$4,400	\$8,750
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 \$90-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 participation in the Health Plan at the same contribution rate as for active employees for up to five years from the start date of your Long Term Disability benefits as long as you continue to receive benefits under the Long Term Disability plan. Human Resources will explain this feature to you upon notification of your disability.

For the first 24 months of your disability, your Health Plan 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 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

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

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
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				
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/\$2,000 per family	\$2,000 employee only/4,000 per family	\$4,000 employee only/\$8,000 per 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
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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		Not covered	12% coinsurance after deductible	Not covered
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 30-Day Supply				
Generic Medications \$20 copayment				
Preferred Brand Name				

20% coinsurance (minimum cost \$90; maximum cost \$130 /prescription			
Non-preferred Brand Name 30% coinsurance (minimum cost \$130; maximum cost \$170 /prescription			