

# Massachusetts Institute of Technology Affiliate Health Insurance Waiver Form

Appointment dates

Affiliate's last name

first name

middle initial

date of birth (month/day/year)

MIT ID or Soc. Sec. number

department

MIT office

MIT telephone

## Before You Waive!

Your insurance must meet the minimum standards listed on the back of this waiver form

Complete this form if you already have hospital insurance and do **not** want to be enrolled in the MIT Affiliate Health Plan. Incomplete forms are not accepted.

**Waivers should be submitted to the MIT Affiliate Health Plan (E23-308) within 30 days after your appointment start date.**

Waive the MIT Affiliate Extended Insurance Plan *only*

Waive the MIT Affiliate Extended Insurance Plan *and* the MIT Affiliate Medical Plan

Beginning date of waiver

month/day/year

My insurance is automatically or annually renewed.  Yes  No

My insurance expires . Please enroll me in the MIT Affiliate Health Plan.

month/day/year

Information about your health insurance program

This section must be filled out completely

MIT Medical requests that you attach a copy of your insurance card (front and back).

Name of insurance company

street address of insurance company

city, state, country

Name of employer, if provider of insurance

street address of employer

city, state, country

Name of policyholder

policy number

your relationship to policyholder

Non-U.S. citizens must submit a copy of their equivalent insurance policy together with this waiver request to the MIT Affiliate Health Plan (E23-308). Your insurance policy is the document which describes covered services and amounts of coverage.

Waiver certification:

**In waiving coverage, I certify that I have compared my health insurance policy with the MIT Affiliate Health Plan and have determined that the benefits are comparable. If I am on a J-1 visa, I certify that my coverage also meets the United States Department of State requirements. I understand that I am responsible for all medical expenses resulting from services that are not covered by my health insurance program and that neither MIT nor MIT Medical will be responsible for these expenses. If my current insurance expires for any reason during the term of my appointment at MIT, I understand that I must either subscribe to the MIT Affiliate Health Plan or submit a new waiver with information about my new outside insurance coverage.**

## Signature Required:

Affiliate's signature

date

address

Return this form to the MIT Affiliate Health Plan (E23-308).

---

## **SUGGESTED MINIMUM STANDARDS FOR AFFILIATE HEALTH PLAN**

The minimum standards for health insurance for affiliates are comparable to the Massachusetts minimum standards for students. Any affiliate at MIT has the option to waive the MIT Affiliate Medical Plan if the affiliate is covered under another health insurance plan which is comparable to the minimum standards.

### **J-1 VISA HOLDERS ONLY**

Affiliates with J-1 visas under MIT visa sponsorship must also meet United States Department of State regulations for themselves and their spouses and children who accompany them:

- 1 Medical benefits of at least \$50,000 per accident or illness
- 2 In case of death, repatriation of remains in the amount of \$7,500
- 3 In case of serious illness or injury, payment of expenses associated with the medical evacuation of the affiliate to his/her home country in the amount of \$10,000
- 4 A deductible not to exceed \$500 per accident or illness

Please carefully review the standards listed below. Your insurance does not need to satisfy each of the specific requirements set forth below; however, your insurance must provide reasonable comprehensive coverage for hospital and physician services.

---

### **General Requirements**

Coverage must include all benefits mandated by state insurance law, including (but not limited to) coverage for: mental and nervous conditions (60 inpatient days per year); alcohol and drug abuse; and maternity health care.

Maximum coverage for all benefits towards each illness or accident must be at least \$25,000.

Coverage must include the services of Christian Science practitioners subject to the same exclusions, limitations and benefit levels as other services.

Coverage may not exclude benefits for any pre-existing injury, illness, or condition.

---

### **Inpatient Hospitalization**

Hospital charges for inpatient admissions must be covered in a semi-private or intensive care unit at 80% of covered charges for each illness or accident.

Physician fees (excluding surgery) must be covered at 80% of covered charges for each illness or accident.

Surgical services must be covered at 80% of covered charges for expenses actually incurred for surgery, up to a maximum of \$5,000 for each surgical procedure; plus coverage for anesthetist or assistant surgeon services up to 30% of the amount reimbursed under the surgical coverage. The coverage requirement for outpatient surgical services is the same as noted above for inpatient services.

---

### **Outpatient Services**

Basic benefits for expenses actually incurred in a physician's office, hospital outpatient department or emergency room, clinical lab, radiological facility licensed by the state, at 80% of covered charges, up to a maximum of \$1,500 for each illness or accident. A deductible or copayment may be charged for each visit in accordance with the following schedule:

\$100 for each hospital emergency room visit that does not result in an admission;  
\$ 50 per visit to hospital outpatient departments;  
\$ 25 per visit to a physician's office.

Surgical services are covered at the same rate as listed above for inpatient surgery.

High cost procedures (those over \$200) must be covered at 80% of covered charges up to a maximum benefit of \$2,000 per illness or injury.

Outpatient mental health services must have a minimum benefit of \$500 per calendar year.

---

### **Ambulance Services**

Coverage for the use of an ambulance in an emergency, subject to a \$25 deductible, up to a maximum of \$125 per illness or injury.