## Important Questions

### What is the overall deductible?

$0$ in-network; $500$ member out-of-network. Does not apply to outpatient mental health visits, emergency room, emergency transportation.

You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.

### Are there other deductibles for specific services?

Yes. Pediatric Dental -$50 per eligible member, not to exceed $150 per family membership. There are no other specific deductibles.

You must pay all of the costs for these services up to the specified **deductible** amount before this plan begins to pay for these services.

### Is there an out-of-pocket limit on my expenses?

Yes. For medical benefits, $4,000 member / $8,000 family in-network; $4,000 member / $8,000 family out-of-network, and for prescription drug benefits, $1,000 member / $2,000 family.

The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

### What is not included in the out-of-pocket limit?

Premiums, balance-billed charges, and health care this plan doesn't cover.

Even though you pay these expenses, they don’t count toward the **out-of-pocket limit**.

### Does this plan use a network of providers?

Yes. See [www.bluecrossma.com/findadoctor](http://www.bluecrossma.com/findadoctor) or call 1-800-821-1388 for a list of preferred providers.

If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

### Do I need a referral to see a specialist?

No.

You can see the **specialist** you choose without permission from this plan.

### Are there services this plan doesn't cover?

Yes.

Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.
- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.

- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven’t met your **deductible**.

- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)

- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your cost if you use MIT Medical</th>
<th>Your cost if you use an In-Network Provider</th>
<th>Your cost if you use an Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>No charge</td>
<td>$25 / visit</td>
<td>20% coinsurance</td>
<td>Deductible applies first for out-of-network; limited to 12 visits per calendar year; visit limit does not apply to medication management services or services at MIT Medical</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>No charge</td>
<td>$25 / visit</td>
<td>20% coinsurance</td>
<td>Deductible applies first for out-of-network; limited to 12 visits per calendar year; visit limit does not apply to medication management services or services at MIT Medical</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>Not covered</td>
<td>$25 / chiropractor visit</td>
<td>20% coinsurance / chiropractor visit</td>
<td>Deductible applies first for out-of-network; limited to 12 visits per calendar year</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Not covered</td>
<td>20% coinsurance</td>
<td>Deductible applies first for out-of-network; limited to age-based schedule and/or frequency from birth through age 5; benefits for physicals and routine tests for individuals age 6 and older only available at MIT Medical</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>Deductible applies first for out-of-network</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Not covered</td>
<td>$50/test</td>
<td>20% coinsurance</td>
<td>Deductible applies first for out-of-network</td>
</tr>
<tr>
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</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$10 / prescription</td>
<td>$20 / prescription at retail pharmacy</td>
<td>Not covered</td>
<td>Up to 30-day retail supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs; coverage may be denied if preauthorization is not obtained; $20,000 annual benefit limit at retail pharmacies</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$20 / prescription</td>
<td>$30 / prescription at retail pharmacy</td>
<td>Not covered</td>
<td>Up to 30-day retail supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs; coverage may be denied if preauthorization is not obtained; $20,000 annual benefit limit at retail pharmacies</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$30 / prescription</td>
<td>$40 / prescription at retail pharmacy</td>
<td>Not covered</td>
<td>Up to 30-day retail supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs; coverage may be denied if preauthorization is not obtained; $20,000 annual benefit limit at retail pharmacies</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>$30 / prescription</td>
<td>$40 / prescription at retail pharmacy</td>
<td>Not covered</td>
<td>When obtained from a designated specialty pharmacy; pre-authorization required for certain drugs; coverage may be denied if preauthorization is not obtained; $20,000 annual benefit limit at retail pharmacies</td>
</tr>
</tbody>
</table>

More information about [prescription drug coverage](https://www.bluecrossma.com) is available at [www.bluecrossma.com](http://www.bluecrossma.com).
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<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Not covered</td>
<td>No charge; 10% coinsurance for infertility technologies</td>
<td>20% coinsurance</td>
<td>Limited services available at MIT Medical. Deductible applies first for out-of-network</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Not covered</td>
<td>No charge; 10% coinsurance for infertility technologies</td>
<td>20% coinsurance</td>
<td>Deductible applies first for out-of-network</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>Not covered</td>
<td>$50 / visit</td>
<td>$50 / visit</td>
<td>Copayment waived if admitted as an inpatient</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>Not covered</td>
<td>No charge</td>
<td>No charge</td>
<td>—— none ——</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>No charge</td>
<td>$25 / visit</td>
<td>20% coinsurance</td>
<td>Deductible applies first for out-of-network</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>Not covered</td>
<td>$100 / admission; 10% coinsurance for infertility technologies</td>
<td>20% coinsurance</td>
<td>Deductible applies first for out-of-network; pre-authorization required; coverage may be denied if preauthorization is not obtained</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>Not covered</td>
<td>No charge; 10% coinsurance for infertility technologies</td>
<td>20% coinsurance</td>
<td>Deductible applies first for out-of-network; pre-authorization required; coverage may be denied if preauthorization is not obtained</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>No charge</td>
<td>No charge for visits 1-12; $25 / visit for remaining visits</td>
<td>No charge for visits 1-12; 20% coinsurance for remaining visits</td>
<td>—— none ——</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>Not covered</td>
<td>$100 / admission</td>
<td>20% coinsurance</td>
<td>Deductible applies first for out-of-network; pre-authorization required; coverage may be denied if preauthorization is not obtained</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>No charge</td>
<td>No charge for visits 1-12; $25 / visit for remaining visits</td>
<td>No charge for visits 1-12; 20% coinsurance for remaining visits</td>
<td>—— none ——</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>Not covered</td>
<td>$100 / admission</td>
<td>20% coinsurance</td>
<td>Deductible applies first for out-of-network; pre-authorization required; coverage may be denied if preauthorization is not obtained</td>
</tr>
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<td>---------------------------</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>No charge</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>Deductible applies first for out-of-network</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>Not covered</td>
<td>$100 / admission and no charge for delivery</td>
<td>20% coinsurance</td>
<td>Deductible applies first for out-of-network</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>Not covered</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>Deductible applies first for out-of-network; pre-authorization required; coverage may be denied if preauthorization is not obtained</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>Not covered</td>
<td>$25 / visit</td>
<td>20% coinsurance</td>
<td>Deductible applies first for out-of-network; limited to 60 visits per calendar year (other than for autism, home health care, and speech therapy)</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not covered</td>
<td>$25 / visit</td>
<td>20% coinsurance</td>
<td>Deductible applies first for out-of-network; rehabilitation therapy coverage limits apply; coverage limits waived for early intervention services for eligible children</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>Not covered</td>
<td>$100 / admission</td>
<td>20% coinsurance</td>
<td>Deductible applies first for out-of-network; limited to 100 days per calendar year; pre-authorization required; coverage may be denied if preauthorization is not obtained</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>Not covered</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
<td>Deductible applies first for out-of-network; in-network cost share waived for one breast pump per birth</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>Not covered</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>Deductible applies first for out-of-network; pre-authorization required for certain services; coverage may be denied if preauthorization is not obtained</td>
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</tbody>
</table>
### Common Medical Event

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye exam</td>
<td>No charge</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>Deductible applies first for out-of-network; limited to one exam every 12 months; benefits for individuals age 6 and older only available at MIT Medical</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>—— none ——</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not covered</td>
<td>No charge</td>
<td>Not covered</td>
<td>Limited to members under age 19; twice in 12 months</td>
</tr>
</tbody>
</table>

### Excluded Services & Other Covered Services:

#### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Children's glasses
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Private-duty nursing
- Weight loss programs

#### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care (only for patients with systemic circulatory disease)

### Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep health coverage as long as you pay your premium, and meet the eligibility requirements as an MIT student, affiliate or covered family member. There are exceptions, however, such as if:

- You commit fraud
- The Institute stops offering insurance to students or affiliates

For more information or questions please call 1-617-253-5979.
Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact 1-800-782-3675.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-782-3675.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3675.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-782-3675.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-782-3675.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.
About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $7,240
- **Patient pays:** $300

#### Sample care costs:

- Hospital charges (mother) $2,700
- Routine obstetric care $2,100
- Hospital charges (baby) $900
- Anesthesia $900
- Laboratory tests $500
- Prescriptions $200
- Radiology $200
- Vaccines, other preventive $40

**Total:** $7,540

**Patient pays:**

- **Deductibles** $0
- **Copays** $100
- **Coinsurance** $0
- **Limits or exclusions** $200

**Total:** $300

### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,500
- **Patient pays:** $900

#### Sample care costs:

- Prescriptions $2,900
- Medical Equipment and Supplies $1,300
- Office Visits and Procedures $700
- Education $300
- Laboratory tests $100
- Vaccines, other preventive $100

**Total:** $5,400

**Patient pays:**

- **Deductibles** $0
- **Copays** $700
- **Coinsurance** $100
- **Limits or exclusions** $100

**Total:** $900
Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don’t include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ No. Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✔ Yes. When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✔ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you’ll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.