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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$100** member in-network; **$500** member out-of-network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network preventive and prenatal care, prescription drugs; emergency room, emergency transportation, mental health visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Pediatric Dental, **$50** per eligible member, not to exceed **$150** per family membership.	There is a separate deductible for pediatric dental services. 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. There are no other specific deductibles.
What is the out-of-pocket limit for this plan?	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 in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
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.
Will you pay less if you use a network provider?	Yes. See www.bluecrossma.com/findadoctor or call 1-800-821-1388 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Your Cost at MIT Medical	In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	$25 / visit	20% coinsurance	Deductible applies first; limited to 12 visits per calendar year; visit limit does not apply to medication management services or services at MIT Medical.
	Specialist visit	No charge	$25 / visit; $25 / chiropractor visit; $25 / acupuncture visit	20% coinsurance; 20% coinsurance / chiropractor visit; $25 / acupuncture visit	Deductible applies first except for acupuncture services; limited to 12 visits per calendar year; visit limit does not apply to medication management services; limited to 12 visits per calendar year for chiropractic services; limited to 20 visits per calendar year for acupuncture services
	Preventive care/screening/immunization	No charge	Not Covered	Not Covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	20% coinsurance	Deductible applies first
	Imaging (CT/PET scans, MRIs)	Not covered	$50 / test	20% coinsurance	Deductible applies first; copayment applies per category of test / day; pre-authorization may be required
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bluecrossma.com/medications	Generic drugs	$10 / prescription	$20 / prescription	Not covered	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
	Preferred brand drugs	$20 / prescription	$30 / prescription	Not covered	
	Non-preferred brand drugs	$30 / prescription	$40 / prescription	Not covered	
	Specialty drugs	$30 / prescription	Applicable cost share (generic, preferred, non-preferred)	Not covered	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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Your Cost at MIT Medical	In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	No charge; 10% coinsurance for infertility technologies	20% coinsurance	Deductible applies first; limited services available at MIT Medical
	Physician/surgeon fees	Not covered	No charge; 10% coinsurance for infertility technologies	20% coinsurance	Deductible applies first

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Your Cost at MIT Medical	In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need immediate medical attention	Emergency room care	Not covered	$100 / visit	$100 / visit	Copayment waived if admitted as an inpatient
	Emergency medical transportation	Not covered	No charge	No charge	None
	Urgent care	No charge	$50 / visit	20% coinsurance	Deductible applies first; limited to 12 visits per calendar year
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	$100 / admission; 10% coinsurance for infertility technologies	20% coinsurance	Deductible applies first for out-of-network; preauthorization required; coverage may be denied if preauthorization is not obtained
	Physician/surgeon fees	Not covered	No charge; 10% coinsurance for infertility technologies	20% coinsurance	Deductible applies first for out-of-network; preauthorization required; coverage may be denied if preauthorization is not obtained
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	No charge for visits 1-12, then $25 / visit for remaining visits	No charge for visits 1-12, then 20% coinsurance for remaining visits	Pre-authorization required for certain services
	Inpatient services	No covered	$100 / admission	20% coinsurance	Deductible applies first for out-of-network; preauthorization required; coverage may be denied if preauthorization is not obtained
If you are pregnant	Office visits	No charge	No charge	20% coinsurance	Deductible applies first except for in-network prenatal care; cost sharing does not apply for in-network preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery professional services	No charge	No charge	20% coinsurance	
	Childbirth/delivery facility services	Not covered	$100 / admission	20% coinsurance	

Common Medical Event	Services You May Need	Your Cost at MIT Medical	What You Will Pay		Limitations, Exceptions, & Other Important Information
			In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	Not covered	No charge	20% coinsurance	Deductible applies first; pre-authorization required; coverage may be denied if preauthorization is not obtained
	Rehabilitation services	Not covered	$25 / visit	20% coinsurance	Deductible applies first; limited to 60 visits per calendar year (other than for autism, home health care, and speech therapy)
	Habilitation services	Not covered	$25 / visit	20% coinsurance	Deductible applies first; rehabilitation therapy coverage limits apply; coverage limits waived for early intervention services for eligible children
	Skilled nursing care	Not covered	$100 / admission	20% coinsurance	Deductible applies first; limited to 100 days per calendar year; pre-authorization required; coverage may be denied if preauthorization is not obtained
	Durable medical equipment	Not covered	10% coinsurance	20% coinsurance	Deductible applies first; In-network cost share waived for one breast pump per birth
	Hospice services	Not covered	No charge	20% coinsurance	Deductible applies first; pre-authorization required for certain Services; coverage may be denied if preauthorization is not obtained

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Your Cost at MIT Medical	In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	No charge	20% coinsurance	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
	Children's glasses	50% coinsurance	50% coinsurance	50% coinsurance	Deductible applies first; limited to one set of prescription lenses and / or frames or contact lenses per calendar year until the end of the month a member turns age 18
	Children's dental check-up		No charge	Not covered	Limited to twice per calendar year until the end of the month a member turns age 19

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Private-duty nursing
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (20 visits per calendar year)
- Bariatric surgery
- Chiropractic care
- Children's glasses
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine foot care (only for patients with systemic circulatory disease)
- Routine eye care – adult

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through the state marketplace, please contact the Massachusetts Health Connector at www.mahealthconnector.org. For more information on your rights to continue coverage, you can contact the Member Service number listed on your ID card or call 1-800-262-BLUE (2583).

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

Does this plan provide Minimum Essential Coverage? [Yes]
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

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

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

About these Coverage Examples:

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

Peg is Having a Baby
(9 months of in-network prenatal care and a hospital delivery)

The plan's overall deductible	**$100**
Delivery fee copay	**$0**
Facility fee copay	**$100**
Diagnostic tests copay	**$0**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,713**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$118
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$278**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$100**
Specialist visit copay	**$25**
Primary care visit copay	**$25**
Diagnostic tests copay	**$0**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,355**

Jacquie's Simple Fracture
(in-network emergency room visit and follow-up care)

The plan's overall deductible	**$100**
Specialist visit copay	**$25**
Emergency room copay	**$100**
Ambulance services copay	**$0**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,925**

In this example, Jacquie would pay:

Cost Sharing	
Deductibles	$100
Copayments	$225
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Jacquie would pay is	**$325**

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

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