ADDENDUM TO THE BLUE CROSS BLUE SHIELD BENEFIT DESCRIPTION

Blue Care Elect Preferred

A preferred provider plan administered jointly with Blue Cross and Blue Shield of Massachusetts, Inc.
Welcome to MIT Student/Affiliate
Extended Insurance Plan

This booklet provides you with a description of benefits that are available while you are enrolled under the Student Extended Insurance Plan offered by Massachusetts Institute of Technology (MIT) and administered by Blue Cross and Blue Shield. You should read this booklet to familiarize yourself with this health plan’s main provisions and keep it handy for reference.

Blue Cross and Blue Shield has been designated by MIT to provide administrative services to this health plan, such as claims processing, case management and other related services, and to arrange for a network of health care providers whose services are covered by this health plan. The Blue Cross and Blue Shield customer service office can help you understand the terms of this health plan and what you need to do to get your maximum benefits.

Blue Cross and Blue Shield of Massachusetts, Inc. (Blue Cross and Blue Shield) is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the “Association”) permitting Blue Cross and Blue Shield to use the Blue Cross and Blue Shield Service Marks in the Commonwealth of Massachusetts. Blue Cross and Blue Shield has entered into a contract with MIT on its own behalf and not as the agent of the Association.

Some benefits are administered by Blue Cross and Blue Shield of Massachusetts on behalf of the MIT Student Extended Insurance Plan while others are directly administered by The MIT Health Plans. This document describes the benefits administered by the MIT Health Plan. This booklet is an Addendum to the Benefit Description published by Blue Cross and Blue Shield of Massachusetts. The MIT Health Plans Claims and Member Services Office (617-253-5979 or mservices@med.mit.edu) can help you understand the terms of this health plan and what you need to do to get your maximum benefits.

NOTE: Affiliates are offered the same insurance options as students; only eligibility and rates are different from the student offering. Although we call this product offering to affiliates the Affiliate Health Plan the benefits are exactly the same as those offered to students. For simplicity we refer to the Student Medical Plan and the Student Extended Insurance Plan throughout this document, however all information also applies to the Affiliate Medical Plan and the Affiliate Extended Insurance Plan.
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OR ADMINISTERED BY MIT HEALTH PLANS

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REMEMBER – this document addresses the services covered under the MIT Student Extended Insurance Plan and administered by the MIT Health Plan only. Please refer to the Benefit Description published by Blue Cross and Blue Shield of MA for additional information on benefits available through the MIT Student Extended Insurance Plan. Information regarding the MIT Medical Plan is also available separately. Please refer to the appropriate document.
Introduction

You are covered under the MIT Student Extended Insurance Plan. This health plan is a noninsured self-funded benefits plan and is financed by contributions by its enrollees and/or Massachusetts Institute of Technology (MIT). An organization has been designated by MIT to provide administrative services to this health plan, such as claims processing, case management and other related services, and to arrange for a network of health care providers whose services are covered by this health plan. The name and address of this organization is:

Blue Cross and Blue Shield of Massachusetts, Inc.
Landmark Center
401 Park Drive
Boston, Massachusetts 02215-3326

These benefits are provided by MIT on a self-funded basis. Blue Cross and Blue Shield is not an underwriter or insurer of the benefits provided by this health plan.

This booklet describes the benefits administered by the MIT Health Plan. This booklet is an Addendum to the Benefit Description published by Blue Cross and Blue Shield of Massachusetts. Together, these benefit booklets provide you with a complete description of your benefits while you are enrolled in this health plan. They explain your benefits and the terms of your coverage under this health plan. You should read these benefit booklets to become familiar with the key points. Keep it handy so that you can refer to it. The words in italics have special meanings and are described in Part 2 of the Benefit Description. MIT or Blue Cross and Blue Shield may change the terms of this health plan. If this is the case, the change is described in a rider. MIT can supply you with any riders that apply to your benefits under this health plan. Keep any riders with this booklet for easy reference.

Blue Care Elect is a preferred provider organization (PPO) health care plan. This means that you determine the amount of your benefits each time you obtain a health care service. You will receive the highest level of benefits provided by this health plan when you use providers in your preferred provider network to furnish covered services. These are called your “in-network benefits.” (When you obtain covered services from a covered non-preferred provider, you will usually receive a lower level of benefits. If this is the case, your out-of-pocket expenses will be more. These are called your “out-of-network benefits.”

Before using your benefits, you should remember there are limitations and exclusions. Limitations or restrictions and exclusions on your benefits may be found on page 12 of this document and in Parts 3, 4, 5, 6 and 7 of the Benefits Description.

Note: The MIT Student Medical Plan may provide additional benefits that are administered by MIT Medical. Please refer to the Benefit Description for the MIT Student/Affiliate Medical Plan, or contact MIT Medical Claims and Member Services for information about these benefits.
Part 1

Member Services

Your Primary Care Provider
Primary care services are covered only at MIT Medical, with the exception of limited coverage for children under five years of age. As a member of this health plan, you are not required to choose a primary care provider to coordinate the health care benefits described in this benefit booklet. You may choose any covered provider to furnish your health care services and supplies. But, your choice is important because it will impact the costs that you pay for your health care services and supplies. Your costs will be less when you use health care providers who participate in your PPO health care network to furnish your covered services. These are called your “in-network benefits.” If you choose to use covered health care providers who do not participate in your PPO health care network, you will usually receive a lower level of benefits. In this case, your out-of-pocket costs will be more. These are called your “out-of-network benefits.”

Your Health Care Network
This health plan consists of two benefit levels: one for in-network benefits; and one for out-of-network benefits. The costs that you pay for covered services will differ based on the benefit level. To receive the highest benefit level (your in-network benefits), you must obtain your health care services and supplies from providers who participate in your PPO health care network. These health care providers are referred to as “preferred providers.” (See “covered providers” in Part 2.) If you choose to obtain your health care services and supplies from a covered provider who does not participate in this PPO health care network, you will usually receive the lowest benefit level (your out-of-network benefits). See Part 8 of the Benefit Description for the times when in-network benefits will be provided if you receive covered services from a covered provider who is not a preferred provider.

When You Need Help to Find a Health Care Provider. There are a few ways for you to find a health care provider who participates in your health care network. At the time you enroll in this health plan, a directory of health care providers for your health plan will be made available to you at no additional cost. To find out if a health care provider participates in your health care network, you can:

- Call or visit MIT Medical Claims and Member Services at 617-253-5979, located on the first floor of the MIT Medical building, E23.
- Call the Blue Cross and Blue Shield customer service office. The toll free phone number to call is shown on your ID card. They will tell you if a provider is in your health care network. Or, they can help you find a covered provider who is in your local area.
- Call the Blue Cross and Blue Shield Physician Selection Service at 1-800-821-1388.
- Use the Blue Cross and Blue Shield online physician directory (Find a Doctor). To do this,
log on to www.bluecrossma.com. This online provider directory will provide you with the most current list of health care providers who participate in your health care network.

If you or your physician cannot find a provider in your health care network who can furnish a medically necessary covered service for you, you can ask Blue Cross and Blue Shield for help. To ask for this help, you can call the Blue Cross and Blue Shield customer service office. They will help you find providers in your health care network who can furnish the covered service.

When You Are Living or Traveling Outside of Massachusetts. If you live or are traveling outside of Massachusetts, you can get help to find a health care provider. Just call 1-800-810-BLUE. You can call this phone number 24 hours a day for help to find a health care provider. When you call, you should have your ID card ready. You must be sure to let the representative know that you are looking for health care providers that participate with the BlueCard PPO program. Or, you can also use the internet. To use the online “Blue National Doctor & Hospital Finder,” log on to www.bcbs.com. (For some types of covered providers, a local Blue Cross and/or Blue Shield Plan may not have, in the opinion of Blue Cross and Blue Shield, established an adequate PPO health care network. If this is the case and you obtain covered services from this type of covered provider, the in-network benefit level will be provided for these covered services. See Part 8 of the Benefit Description.)

Health Plan Identification Cards
ID Cards. After you enroll in this health plan, the subscriber will receive a PPO health plan identification card. This card is for identification purposes only. While you are a member, you must show your health plan identification card to the health care provider before you receive covered services.

Lost Your ID Card? If your PPO health plan identification card is lost or stolen, you should contact the Blue Cross and Blue Shield customer service office. They will send you a new PPO health plan identification card. Or, you may also use the online Member Self Service option that is located on the Blue Cross and Blue Shield internet website at www.blucrossma.com.

Making Inquiries and/or Resolving Claim Problems
Calling Member Services. For help to understand your benefits or to resolve a problem or concern, you may call MIT Claims & Member Services at 617-253-5979, or the Blue Cross and Blue Shield customer service office at the toll-free telephone number shown on your PPO health plan identification card. (Or, the TTD telephone number is 1-800-522-1254. To use this telephone number requires that you have special phone equipment.) A customer service representative will work with you to help you understand your benefits or resolve your problem or concern as quickly as possible.

You can call the MIT Health Plans Claims and Member Services Office Monday through Friday from 8:30 a.m. to 5:00 p.m. Or, you can write to:

MIT Health Plans
Claims and Member Services Office
Building E23, Room 191
Part 1: Member Services

Administered by MIT Health Plans

77 Massachusetts Ave
Cambridge, MA 02139
E-mail address: mservice@med.mit.edu

You can also call the Blue Cross and Blue Shield customer service office Monday through Friday from 8:00 a.m. to 6:00 p.m. at 1-800-882-1093. Or, you can write to:

Blue Cross and Blue Shield of Massachusetts, Inc.
Member Services
P.O. Box 9134
North Quincy, Massachusetts 02171-9134

Requesting Medical Policy Information.

To receive your health plan coverage, your health care services and supplies must meet the criteria for coverage that are defined in each Blue Cross and Blue Shield medical policy that applies. The policies and criteria that will apply are those that are in effect at the time you receive the health care service or supply. To check for a Blue Cross and Blue Shield medical policy, you can go online and log on to the Blue Cross and Blue Shield Web site at www.bluecrossma.com. (Your health care provider can also access a policy by using the Blue Cross and Blue Shield provider Web site.) Or, you can call the Blue Cross and Blue Shield customer service office. You can ask them to mail a copy to you.

Review and Grievance Procedures. See Part 6 for more information about the claim review and grievance process.

Translation Services

Need a Language Translator? If you or a family member needs translation services while at MIT Medical, please tell us when you make an appointment. With advance notice, we can usually arrange for foreign language or sign language interpreters at our Cambridge and Lexington centers. Some of our physicians and nurse practitioners speak other languages, and all have access to the Cyracom telephone translation service.

A language translator service is available when you call the Blue Cross and Blue Shield customer service office at the toll-free telephone number shown on your PPO health plan identification card. This service provides you with access to interpreters who are able to translate over 140 different languages. If you need these translation services, just tell the customer service representative when you call. Then during your call, Blue Cross and Blue Shield will use the language line service to access an interpreter who will assist in answering your questions or helping you to understand Blue Cross and Blue Shield procedures. (This interpreter is not an employee or designee of Blue Cross and Blue Shield.)
Part 2

Covered Services at MIT Medical

Under the MIT Student Extended Insurance Plan, you have the right to the benefits described in this section, except as limited or excluded in other sections of this Benefit Description. (For a list of benefit limitations and exclusions for the MIT Student Extended Insurance Plan see Part 4, page 12 of this document, and Parts 3, 4, 5, 6 and 7 of the Blue Cross and Blue Shield of Massachusetts Benefits Description).

Important Facts to Remember About Your Benefits

The benefits described in this Benefit Description are provided only when:

- Your treatment is furnished by a covered provider.
- Your treatment is medically necessary for you.
- Your treatment conforms with Blue Cross and Blue Shield medical policy guidelines that are in effect at the time the services or supplies are furnished. If you have access to a FAX machine, you may request medical policy information by calling the Medical Policy on Demand toll-free service at 1-888-MED-POLI. Or, you may call the Blue Cross and Blue Shield customer service office to request a copy of the information.

Allergy

Allergy serum is covered at 100% when obtained and administered at MIT Medical

Birth Control

<table>
<thead>
<tr>
<th>Birth Control</th>
<th>In-Network, you pay</th>
<th>Out-of-Network, you pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>One copayment for each up to 30 day supply; up to the benefit limit per member per calendar year combined benefits for pharmacy.</td>
<td>One copayment for each up to 30 day supply (except as noted below).</td>
<td>Coverage for devices limited to device only, office visit not covered.</td>
</tr>
</tbody>
</table>

This health plan’s benefit provides benefits for the following birth control devices under the yearly pharmacy benefit with the described limitations and cost sharing:

- Birth control pills are covered for an up to 30 day supply with a copayment based upon the tier in which the birth control pill used is assigned.
- Copayments are waived for Tier 1 generic birth control prescription drugs and devices.
- Diaphragm – The purchase of a diaphragm is covered with a copayment based upon the tier to which the diaphragm used is assigned. The visit to fit the diaphragm and the over the counter gel used in conjunction with the diaphragm are not covered (see Student Medical Plan document).
• Inter-uterine devices (IUD) – the purchase of an IUD is covered with no copayment. The IUD must be obtained through MIT Medical. The visit to insert the IUD is not covered under this Plan (see Student Medical Plan document).

• Depo Provera injections are covered with a three month copayment per injection. One injection provides 3 months of birth control prevention. The visit to administer the Depo Provera injection is not covered (see Student Medical Plan document).

• Transdermal patches for an up to 30 day supply with a copayment based upon the tier in which the transdermal patch used is assigned.

• Intra-vaginal contraceptive medication devices for an up to 30 day supply with a copayment based upon the appropriate tier.

Note: Over-the-counter birth control preparations (condoms, birth control foams, jellies, and sponges, etc.) are not covered.

### Childbirth Class

<table>
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<th>Childbirth Classes</th>
<th>In-Network, you pay</th>
<th>Out-of-Network, you pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit limited to one childbirth class per contract per pregnancy, maximum benefit $100 per class.</td>
<td>Nothing</td>
<td>No coverage</td>
</tr>
<tr>
<td></td>
<td>At MIT Medical or Mount Auburn Hospital only.</td>
<td></td>
</tr>
</tbody>
</table>

This plan provides coverage for childbirth class under the following guidelines:

• Class must be taken at either the MIT Medical Department or Mount Auburn Hospital.

• Coverage is limited to one class per pregnancy.

Note: There is no coverage for childbirth class performed at locations other than the MIT Medical Department or Mount Auburn Hospital.

### Gardasil

This health plan provides coverage for Gardasil under the following guidelines:

• The vaccine must be administered at the MIT Medical Department.

• The cost for the vaccine will go against the member’s calendar year pharmacy maximum.

Note: This coverage is for the injection only. The office visit to administer the vaccine is not covered under the MIT Student Extended Insurance Plan. The office visit is covered under The Student Medical Plan.
Inpatient Mental Health/Substance Abuse Admissions

<table>
<thead>
<tr>
<th>Inpatient Mental Health/Substance Abuse Admissions</th>
<th>In-Network, you pay</th>
<th>Out-of-Network, you pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>In a mental health hospital, general hospital or alcohol or drug treatment facility. <em>(Benefit limit of 120 total inpatient days per member per calendar year).</em></td>
<td>• Hospital and other covered facility inpatient services.</td>
<td>Nothing after $100 per admission inpatient deductible.</td>
</tr>
<tr>
<td></td>
<td>• Physician and other covered professional provider inpatient services.</td>
<td>Nothing. Must be referred by MIT Medical.</td>
</tr>
</tbody>
</table>

This health plan provides benefits when you are admitted for a mental or substance abuse condition to a *Blue Cross and Blue Shield* participating general hospital, a *Blue Cross and Blue Shield* cooperating mental health hospital, a Massachusetts participating detoxification facility, or a *Blue Cross and Blue Shield* participating alcohol or drug treatment facility under the following guidelines:

- $100 copayment per admission for hospital charges
- Facilities must participate with Blue Cross/Blue Shield or be contracted with The MIT Health Plan
- Must be referred by an MIT Medical mental health service provider

Maternity Support Services

<table>
<thead>
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<th>Maternity Support Services</th>
<th>In-Network, you pay</th>
<th>Out-of-Network, you pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(Benefit limited to one home care visit per delivery).</em></td>
<td>Nothing</td>
<td>No coverage</td>
</tr>
<tr>
<td></td>
<td>Limited to CareGroup Home Care.</td>
<td></td>
</tr>
</tbody>
</table>

This health plan provides coverage for one home health visit postpartum under the following guidelines:

- *Member* must be under the care of an MIT Medical physician during pregnancy
- Delivery must occur at the Mount Auburn Hospital
- Visit must be performed by CareGroup Home Care
- Benefit limited to one home care visit per delivery

For additional maternity benefits, see Part II, Section I – benefits administered by *Blue Cross and Blue Shield of Massachusetts*. 

Effective 9/1/2012 · Words in italics are defined in Part 2 of the Benefit Description issued by BCBSMA
Routine Eye Exam

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<th>In-Network, you pay</th>
<th>Out-of-Network, you pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit limited to one routine eye exam per member per 12 month period.</td>
<td>Nothing</td>
<td>No coverage</td>
</tr>
<tr>
<td></td>
<td>At MIT Medical eye service only.</td>
<td></td>
</tr>
</tbody>
</table>

This health plan provides coverage for a routine eye exam under the following guidelines:

- Eye exam must be performed at the MIT Medical Eye Service
- Coverage is limited to one (1) eye exam per calendar year

Note: There is no coverage for routine eye exams performed at offices other than the MIT Medical Eye Service, except for children under five years of age.
Part 3

Prescription drugs obtained through MIT Pharmacy

*Members are encouraged to fill prescriptions at the MIT Pharmacy unless the prescription is for a newly diagnosed urgent condition and the MIT Pharmacy is closed. Any refills should be filled at the MIT Pharmacy. Obtaining your prescriptions through the MIT Pharmacy allows better clinical coordination and has a lower out of pocket expense for the *member*. (Please the Benefit Description for more information about pharmacy benefits administered by Blue Cross and Blue Shield of Massachusetts.)

This chart details copays and limitations for the MIT Pharmacy and participating Express Scripts pharmacies:

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<th>MIT Pharmacy copay and limitations</th>
<th>Express Scripts pharmacy copay and limitations</th>
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</thead>
<tbody>
<tr>
<td>Tier 1 copay*</td>
<td>$5 for up to a 30-day supply</td>
<td>$15 for up to a 30-day supply</td>
</tr>
<tr>
<td>Tier 2 copay</td>
<td>$15 for up to a 30-day supply</td>
<td>$25 for up to a 30-day supply</td>
</tr>
<tr>
<td>Tier 3 copay</td>
<td>$25 for up to a 30-day supply</td>
<td>$35 for up to a 30-day supply</td>
</tr>
<tr>
<td>Supply limit</td>
<td>For many drugs, up to a 90-day supply; copay applies for each for double the 30-day copayment</td>
<td>Limited to a 30-day supply per fill at a retail pharmacy</td>
</tr>
<tr>
<td>Prescribing physician</td>
<td>Prescription must be written by an MIT clinician or by a provider to whom <em>member</em> was referred by an MIT clinician</td>
<td>No restrictions</td>
</tr>
<tr>
<td>Mental health prescriptions</td>
<td><em>Member</em> must notify MIT Medical so a referral can be entered before prescription can be filled</td>
<td>No restrictions</td>
</tr>
<tr>
<td>Mail order</td>
<td>Available through MIT Pharmacy; request can be submitted through Patient Online</td>
<td>Not available</td>
</tr>
<tr>
<td>Annual benefit limit</td>
<td>$100,000 per <em>member</em> per calendar year</td>
<td>$10,000 per <em>member</em> per calendar year</td>
</tr>
</tbody>
</table>

*Copay waived for Tier 1 contraceptives.

This health plan provides benefits for *covered prescription drugs* under the following guidelines:

- Coverage is for up to 30 day supply with a copayment based upon the tier in which the drug is classified.
Part 3: Prescription Drugs

- For many prescription drugs, members may purchase an up to 90 day supply at one time at the MIT Pharmacy only with the corresponding copayment calculated on the tier and number of days supply (For example, at MIT Pharmacy a tier 2 medication would cost: 1-30 days $15; 31-60 days $30; 61-90 days $45).

- The medication must be on the drug formulary. The formulary (the list of drugs for which a health plan provides coverage) used by Express Scripts is different than the formulary used by MIT Medical and the MIT Health Plans. MIT Medical has a customized formulary based on our experience with our students, affiliates and employees. Medications not on the Express Scripts formulary must be obtained through the MIT Pharmacy. You can check the Blue Cross formulary on-line at: http://www.bluecrossma.com/pharmacy

Drug coverage limits have been established for specific drugs or drug classifications. The following are included in these restrictions:

- All newly prescribed medications, when necessary to assess tolerance and dosage.
- Perishable drugs fills limited to one (1) up to 30 day supply in a 30 day period.
- Fertility drugs (Fertinex, Progesterone Suppositories, Progesterone Injection, Human Chorionic Gonadotropin, Profasi, Gonal, Follistim and clomiphene) fills limited to one (1) up to 30 day supply in a 30 day period. Prior approval must be obtained for coverage.
- Dental Prophylaxis (Amoxicillin, Erythromycin, other antibiotics) fills limited to a maximum of sixteen (16) capsules per month.
- Viagra (and other erectile dyfunction drugs) coverage limited to male members. Limit of up to four (4) tablets per 30 day period.

Note: Members may obtain a three month supply (12 tablets) of Viagra, or similar medications, at one time, with the 3 month copay. Members filling prescriptions for Viagra at the MIT Medical Pharmacay may purchase an additional 10 tablets per month on a cash basis (not covered by health plan).

- Toradol fills limited to a maximum five (5) day supply
- Triptans (migrane medication- Imitrex, Amerge, Maxalt, Zomig) limited to up to 30 day supply per fill; one (1) fill per 30 day period. Imitrex is limited to twelve (12) tablets per fill or six (6) injections (3 boxes with 2 shots per box) or one (1) box nasal spray (1 box contains six (6) doses). Amerge, Maxalt, Zomig are limited to twelve (12) tablets per fill.
- Biologicals (e.g. Enbrel, Avonex, Rebif, Copaxone, Pegasys, Intron, Procrit, Epogen and Neupogen) - fills limited to one (1) up to 30 day supply in a 30 day period.
- Schedule II drugs - fills limited to one (1) up to 30 day supply in a 30 day period.
- Schedule III drugs - fills limited to one (1) up to 30 day supply in a 30 day period.
- Drugs for intermittent therapies (e.g. antibiotics). Fills limited to one (1) up to 30 day supply in a 30 day period.

Drugs not recommended for long term use. Prescriptions limited to current prescribing guidelines (see provider or pharmacist for prescribing guidelines).
Part 3: Prescription Drugs

- Drugs prescribed on “as needed” basis. Fills limited to one (1) up to 30 day supply in a 30 day period.
- Vivitrol, Rebetol, Aldara, Chantix, Tazorac, Differin and Protopic. Fills limited to one (1) up to 30 day supply in a 30 day period.

Conditionally covered drugs - This health plan may provide coverage for certain non-covered prescription drugs on an individual consideration basis after review by the MIT Health Plans and MIT Medical providers:

- Diet Drugs (Meridia, Zenical, Phentermine, Ionamin, Adipex P) are not routinely covered. Coverage may be considered for patients meeting the clinical criteria established by MIT Medical for pharmaceutical weight loss treatment (BMI with corresponding obesity diagnosis; demonstrated continual weight loss). Patients approved for treatment are limited to an up to 30 day supply per fill; one (1) fill per 30 day period.
- Retin A for members over 25 years of age is covered for acne therapy only. A letter of medical necessity from the member’s physician must be submitted for coverage consideration.
- Renova for members over 25 years of age is covered for acne therapy only. A letter of medical necessity from the member’s physician must be submitted for coverage consideration.
- Onychomycosis (nail fungal infection – Lamasil, Diflucan, oral tablets) are not routinely covered. Coverage may be considered for patients meeting the clinical criteria established by MIT Medical for nail fungal infection treatment (drug is documented as medically necessary; in the presence of a positive KOH culture; multinail involvement; soft tissue involvement).
- Emla Cream (topical anesthetic) when used in children prior to an injection.
- Dental prescriptions are covered only if prescribed as a result of a covered dental procedure or to prevent infection (e.g. antibiotics).

Note: Insulin and basic diabetic supplies (test strips, lancets, etc), while classified as an over the counter medication, are covered under the pharmacy benefit subject to the maximum pharmacy benefit amount per calendar year.

Note: There is a combined benefit limit of $100,000 for all services covered under the Prescription Drug benefit, including Insulin and basic diabetic supplies, birth control pills or devices requiring a prescription, co-pay immunizations and medications requiring a prescription.
Limitations and Exclusions

In addition to those services listed as limited and excluded in the Benefit Description, the benefits described in this Addendum are limited or excluded as follows:

**Acupuncture**

**Air Ambulance**

**Birth Control**
This health plan does not provide coverage for over-the-counter birth control preparations (birth control foams, jellies, sponges, etc.).

**Durable Medical Equipment**
This health plan does not provide coverage for the durable medical equipment listed below. See Section 1, Benefits administered by Blue Cross Blue Shield for additional coverage information.

Durable medical equipment not specifically listed as either covered or not covered is presumed to be non covered. Members requesting a coverage decision for durable medical equipment not specified on either the covered or non covered list should submit their request to the health plan for individual consideration.

- Air conditioners
- Air purifiers
- Arch supports or orthotics
- Bed wedge (foam)
- Bed wetting devices or alarms
- Bras for breast prosthesis
- Breast pumps (manual or electric)
- Chair car services
- Chairs with electric seat lifts
- Communication or learning boards (electronic)
- Contact lens (see covered durable medical equipment for exception)
- Corrective shoes (see covered durable medical equipment for exception)
- Dehumidifiers
- Dental appliances/night guards (see covered durable medical equipment for exception)
- Disposables (gloves, masks, tape, swabs, gauze pads, diapers, etc.)
- Elevators
- Ergonomically designed chairs
- Exercycles
- Eyeglasses (see covered durable medical equipment for exception)
– Grab bars
– Hearing aids
– Heating pads
– Humidifiers
– Jacuzzis
– Over the toilet chairs
– Ovulation kits
– Personal comfort items (telephone, radio, TV, personal care services, etc.)
– Pregnancy test kits
– Prone board
– Pulse monitors
– Urinal suspensory (male) appliances
– Whirlpools

**Pharmacy**

This health plan does not provide coverage for certain drugs and pharmaceuticals including but not limited to the following:

– Non-sedating antihistamines
– Dental prescriptions when prescribed for a non-covered procedure
– Drugs that are available in the same strength as an over-the-counter product
– Drugs not approved by the Federal Drug Administration (FDA)
– Drugs prescribed for a cosmetic reason
– Diet Drugs Meridia, Xenical, Phentermine, Ionamin, Adipex P (see covered pharmacy benefit for exception guidelines)
– Hair Loss drugs Propecia, Minoxidil, Loniten, Proscar when prescribed for treatment of hair loss
– Retin A for members over 25 years of age (see covered pharmacy benefit for exception guidelines)
– Renova for members over 25 years of age (see covered pharmacy benefit for exception guidelines)
– Onychomycosis drugs (Lamisil, Diflucan oral tablets) (see covered pharmacy benefit for exception guidelines)
– Over the counter medications
– Emla Cream (topical anesthetic) when used for cosmetic or non-covered procedures and services. (See covered pharmacy benefit for exception guidelines).
– Viagra (and other drugs for impotency) for female members
– Vitamins (prescription or over the counter)
– Zyrtec


Part 5

Filing a Claim for Benefits Directly Administered by The MIT Health Plans

You should file a claim to the Claims and Member Services office of the MIT Health Plans for covered services directly administered by the MIT Health Plans. For Childbirth Classes, the MIT Health Plans will reimburse you, and it is up to you to pay your provider. For other covered services, providers may be paid by the MIT Health Plans after submission of the required supporting documentation. To file a claim for payment, you must:

- Fill out a claim form;
- Attach an itemized bill(s);
- Mail or drop of the claim form and attached bill to Claims and Member Services, The MIT Health Plans, E23-191, 77 Massachusetts Avenue, Cambridge, MA 02139.

You can get claim forms from the MIT Health Plans, Claims and Member Services office at E23-191 or via the MIT Health Plans web site at http://medweb.mit.edu. Forms are listed on the web-site under “About MIT Medical; Forms and Publications”.

Upon receipt of a claim, you will be sent a check to the extent of your benefits as described in this Addendum, Benefits Administered by The MIT Health Plans. Or, you will be sent a notice in writing as to why your claim is not being paid or what other information or records The MIT Health Plans needs to decide if your claim should be paid.

You must file a claim within one year of the date you received the covered service. The MIT Health Plans does not have to honor claims submitted after this one year period.

You have the right to a review when you disagree with a decision by The MIT Health Plans to deny payment for services.
Part 6

Resolving Issues

Making an Inquiry and/or Resolving Claim Problems or Concerns
Most problems or concerns can be handled with just one phone call. For help resolving a problem or concern, you should first call the Claims & Member Services Office at (617) 253-5979 or mser-vices@med.mit.edu. A customer service representative will work with you to help you understand your benefits or resolve your problem or concern as quickly as possible.

When resolving a problem or concern, The MIT Health Plans will consider all aspects of the particular case, including the terms of your benefits as described in this Benefit Description, The MIT Health Plans policies and procedures that support the administration of these benefits, the provider’s input, as well as your understanding and expectation of benefits. The MIT Health Plans will use every opportunity to be reasonable in finding a solution that makes sense for all parties and may use an individual case management approach when it is judged to be appropriate. The MIT Health Plans will follow its standard business practices guidelines when resolving your problem or concern.

If you disagree with the decision given to you by the customer service representative, you may request a review through the internal review program as described below.

Internal Review by The MIT Health Plans
To request a formal review from The MIT Health Plan, for benefits administered by the MIT Health Plan, send a written request to:

Administrator, Claims & Member Services
The MIT Health Plans
E23-305
77 Massachusetts Avenue
Cambridge, MA 02139

Once your request is received, The MIT Health Plans will research the case in detail and ask for more information as needed. When the review is completed, The MIT Health Plans will notify you of the decision or the outcome of the review.

All requests for a review must be received by The MIT Health Plans within one year of the date of treatment, event or circumstance, such as the date you were told of the service denial or claim denial. Your request for a formal review from The MIT Health Plans should include: the name and Blue Cross and Blue Shield identification number of the member asking for the review; a description of the problem; all relevant dates; names of health care providers or administrative staff involved; and details, as well as any supporting documentation, of the attempt that has been made to resolve the problem including any correspondence with or decisions by any other MIT Department or staff.
Final Grievance Review by The MIT Health Plans

For all grievances, you must first go through the formal internal review process as described above. Services denied by Blue Cross and Blue Shield must go through the Blue Cross and Blue Shield Grievance Program prior to direct appeal to The MIT Health Plans. If all or part of your grievance remains denied after review by Blue Cross and Blue Shield or formal review by The MIT Health Plans, you are then entitled to a final grievance review by The MIT Health Plans. You are not required to pursue a final grievance review and your decision whether to pursue it will not affect your other benefits. You may request a final grievance review by submitting a written request to:

Manager, MIT Health Plans
E23-305
77 Massachusetts Avenue
Cambridge, MA 02139

Include in your correspondence all steps previously taken as well as the reasons for further appeal. A final grievance review will be conducted by The MIT Health Plans Benefit Appeal Board. Within 20 working days of receiving all necessary information, the manager will notify you in writing of The MIT Health Plans Benefit Appeal Board’s decision.

For more information about your rights for a final grievance review, contact The MIT Health Plans Claims and Member Services Office at (617) 253-5979 or mservices@med.mit.edu
Part 7

Eligibility for Coverage

Who Is Eligible to Enroll

Student Enrollment
A regular, registered student (or a student taking 27 or more units) at Massachusetts Institute of Technology (MIT) is eligible for enrollment as a *subscriber* in the MIT Student Extended Insurance Plan. For details about enrollment in this health plan, contact MIT.

Affiliate Enrollment
MIT affiliates are eligible to enroll in the MIT Affiliate Extended Insurance Plan provided they:
1) have an appointment at MIT for 3 months or longer, 2) have an appointment at MIT for more than 50% of their time, 3) are not be paid by MIT funds, 4) are not eligible for MIT employee health insurance, and 5) are either on the Lab for Nuclear Science sponsored research staff or have one of the following 11 job titles: Visiting Scientist, Visiting Engineer, Visiting Scholar, Visiting Economist, Visiting Research Associate, Visiting Professor (including Assistant and Associate), Fellow, Bantrell Fellow, Research Fellow, Postdoctoral Fellow, or Research Affiliate.

Note: In order to enroll in the MIT Affiliate Extended Insurance Plan you must be enrolled in the Affiliate Medical Plan. You may not enroll in the Affiliate Extended Insurance Plan alone.

Eligible Dependents
A student or affiliate may enroll eligible dependents under his or her membership in this health plan. Eligible dependents must be enrolled in the Student/Affiliate Medical Plan in order to be eligible for the Student/Affiliate Extended Insurance plan. “Eligible dependents” include the *subscriber’s*:

- **Legal spouse.**
- **Domestic partner.** A domestic partner is defined as a person of the either sex with whom the subscriber has entered into an exclusive relationship. Both the student and the domestic partner must be at least 18 years of age and not married to anyone, share a mutually-exclusive enduring relationship, have shared a common residence and intend to do so indefinitely, consider themselves life partners, share joint responsibility for their common welfare and be financially interdependent, and otherwise meet all the eligibility requirements of the MIT Student Extended Insurance Plan.
- **Dependent children under age 26.** These include the *subscriber’s* or legal spouse’s dependent children who: live with the *subscriber* or the spouse on a regular basis; or qualify as dependents for federal tax purposes; or are the subjects of a court order that requires the *subscriber* to provide health insurance for the children.
Note: Eligibility for membership under this health plan also includes the subscriber’s children who are recognized under a Qualified Medical Child Support Order as having the right to enroll for group coverage.

- **Newborn dependent children.** The plan year of coverage for a newborn child will be the date of birth provided that the child is enrolled under the subscriber’s membership within the time period required to make family status changes (refer to page 62).

- **Unmarried adoptive dependent children under age 26.** The plan year of coverage for an adoptive child will be the date of placement with the subscriber for the purpose of adoption. The plan year of coverage for an adoptive child who has been living with the subscriber and for whom the subscriber has been getting foster care payments will be the date the petition to adopt is filed.

Note: If the adoptive parent is enrolled under a family membership as of the date he or she assumes custody of a child for the purpose of adoption, the child’s health care services will be covered from the date of custody (without a waiting period or pre-existing condition restriction). But, benefits for these services are subject to all the provisions described in this Benefit Description.

- **Disabled dependent children age 26 or older.** A disabled dependent child may continue coverage under the subscriber’s membership. But, the child must be either mentally or physically handicapped so as not to be able to earn his or her own living on the date he or she would normally lose eligibility under the subscriber’s membership. In this case, the subscriber must make arrangements with Blue Cross and Blue Shield through MIT within the time period required to make family status changes (refer to page 62). Also, Blue Cross and Blue Shield must be given any medical or other information that it may need to determine if the child can maintain coverage under the subscriber’s membership. From time to time, Blue Cross and Blue Shield may conduct reviews that will require a statement from the attending physician. This is to confirm that the child is still an eligible disabled dependent.

- **Unmarried children of enrolled unmarried dependent children.**

- **Former Spouse.** In the event of divorce or legal separation, the person who was the spouse of the subscriber prior to the divorce or legal separation will remain eligible for coverage under the subscriber’s membership, whether or not the judgment was entered prior to the plan year of this health plan. The former spouse will remain eligible for this coverage only until the subscriber is no longer required by the judgment to provide health insurance for the former spouse or the subscriber or former spouse remarries, whichever comes first. (In these situations, Blue Cross and Blue Shield must be notified within 30 days of a change to the former spouse's address. Otherwise, Blue Cross and Blue Shield will not be liable for any acts or omissions due to having the former spouse's incorrect address on file.)
Enrollment in MIT Student Extended Insurance Plan

All eligible students are automatically enrolled in the MIT Student Extended Insurance Plan. To waive coverage in the MIT Student Extended Insurance Plan, the student must complete and return a Waiver Form to MIT by September 15 for the fall term and by February 15 for the spring term. For more enrollment information or details about waiving coverage, see the Waiver FAQs on http://medweb.mit.edu/healthplans/student/waiver.html.

Enrollment in MIT Affiliate Extended Insurance Plan

To enroll in the MIT Affiliate Extended Insurance Plan:

1. Obtain the DS-2019 form or a letter from your department administrator stating your status as an affiliate.

2. Schedule and attend an affiliate orientation session at MIT Medical. Orientations are scheduled on Tuesday and Thursday mornings at 10AM. Bring the MIT appointment letter from your department with you, or a copy of your DS-2019 form. If you waive both the MIT Affiliate Medical Plan and the MIT Affiliate Extended Insurance Plan (see below), you do not need to attend an orientation. To schedule an orientation, call 617-253-4371.

3. At the orientation, you will complete and sign an enrollment form. In order to enroll in the MIT Affiliate Extended Insurance Plan you must enroll yourself, and your dependents, in the Affiliate Medical Plan. You will also need to choose whether you are billed quarterly, semi-annually, or annually for your insurance. If you need to later enroll any family members, you will need to complete another enrollment form at that time. About three weeks after you enroll, you will receive a Blue Cross Blue Shield card in the mail.


Eligible affiliates who have an appointment for 5 months or longer and are neither a Visiting Professor (including Assistant or Associate) nor a Bantrell Fellow are required by MIT to purchase health insurance. If you are required to purchase health insurance, you must either purchase both the MIT Affiliate Medical Plan and the MIT Affiliate Extended Insurance Plan, or you must file a waiver with the MIT Affiliate Health Plan Office (E23-308, 617-253-4371).

You may enroll in this health plan as of your initial eligibility date (the beginning of your appointment), or at the beginning of an academic semester (February 1 and September 1), or at the beginning of a reappointment. You must complete enrollment during the first month of your MIT appointment, or the first month of the academic semester.

Note: Affiliates who are required to enroll in health insurance must complete this enrollment during the initial eligibility month. The minimum coverage period is three months. If your MIT affiliate appointment is extended beyond the date your coverage ends, you will need to contact the MIT Affiliate Health Plan office to renew or extend your insurance coverage. Additional information is available at the MIT Affiliate Health Plans Office, E23-308.
To waive, your insurance must be comparable to the MIT Affiliate Medical Plan and the MIT Affiliate Extended Insurance Plan (combined). You can find the waiver form at web.mit.edu/medical/p-affiliate.html. Complete insurance information is required on all waiver forms. For enrollment information or details about waiving coverage, contact the MIT Health Plans Office at 617-253-4371 or affplan@med.mit.edu. If you are in the United States on a US Visa you must also adhere to all of the requirements issued by the U.S. State Department.

Enrolling Dependents

To enroll your dependents, you must complete an enrollment form and submit it at the same time you enroll, or at the beginning of an academic semester. If you arrive at MIT from another country before your family members arrive, you may wait to enroll your family members when they arrive, however, you must enroll these family members within 30 days of their arrival in this country. In addition to a completed enrollment form, you will need to provide proof of their arrival (e.g., stamped visa or airline ticket). You will be required to provide proof of family relationship or eligibility to enroll family members.

Note: Students must complete an enrollment form at the beginning of each traditional academic year or term. Your completed enrollment form must be received by September 15 for the fall term or by February 15 for the spring term. Forms are available at web.mit.edu/medical/p-student.html or in the Health Plans Office at E23-303.

Making Membership Changes

Generally, you may make membership changes (for example, change from an individual membership to a family membership) only if you have a change in family status such as:

- Marriage or divorce.
- Birth, adoption or change in custody of a child.
- Death of an enrolled spouse or dependent child.
- The loss of an enrolled dependent’s eligibility under the subscriber’s membership. For example, when a dependent child or a full-time student dependent reaches the maximum dependent age to be covered under this health plan, his or her coverage ends under the subscriber’s membership.

If you want to ask for a membership change or you need to change your name or mailing address, you should call or write MIT at MIT Health Plans Enrollment, Offices E23-308, 77 Massachusetts Avenue, Cambridge, MA 02139, or (617) 253-1322. MIT will send you any special forms you may need. You must request the membership change within the time period required by MIT. If you do not make the change within the required time period, you will have to wait until the group’s next enrollment period to make the change. All membership changes or any additions are allowed only when they comply with the eligibility and enrollment rules set by MIT for your group health care benefits and the conditions outlined in this Benefit Description.
**Special Situations**

Sometimes, students are determined by their academic dean to be medically unable to register. These students are given the option to continue coverage in the MIT Student Health Plan. Eligible students who choose this option are charged on their Student Account Statement for combined enrollment in the MIT Student Medical Plan, and the MIT Student Extended Insurance Plan.

Students medically unable to register must enroll in both plans. The insurance charges will appear on their student account statements, and any non-covered charges provided at The MIT Medical Department will be billed to them through the MIT general accounts system. Any dependents who are covered during the semester the student withdraws for medical reasons may continue coverage for the remainder of the term. However, they will not be eligible to reenroll if you are determined by your academic dean to be medically unable to register for subsequent term(s).