

2008 HEALTH PLANS

MIT Medical Health Plans			
	Traditional MIT Health Plan (HMO)	Flexible MIT Health Plan (Point of Service (POS) Plan)	
	At MIT Medical or when authorized in advance by MITHP Physician	In-Network: At MIT Medical or when authorized in advance by MITHP physician	Out-of-Network: At any Blue Cross Blue Shield Provider without the authorization of MITHP physician
PLAN PROVISIONS			
Annual deductible	None	None	For covered hospital, surgical, and medical expenses: \$1,000 per member per calendar year, \$2,000 per family per plan year.
Plan share/ participant share of covered expenses (out-of-pocket limit)	Plan pays 100% of authorized expenses from affiliated providers. Participants pay nothing for office visits at MIT Medical. No charge for covered hospital services at plan-affiliated hospitals or at other hospitals when referred by MITHP physician.	Plan pays 100% of authorized expenses from affiliated providers. Participants pay nothing for office visits at MIT Medical. No charge for covered hospital services at plan-affiliated hospitals or at other hospitals when referred by MITHP physician.	For covered hospital, surgical, and medical expenses: After deductible, plan pays 80%, participant pays 20% up to out-of-pocket limit of \$3,000 per person, \$6,000 per family per plan per year, including deductible.
Doctor's office visits: For specific treatment (including specialists)	Fully covered at MIT Medical or when referred by MITHP to a BCBSMA participating provider. For emergency coverage, see below.	Fully covered at MIT Medical or when referred by MITHP to a BCBSMA participating provider. For emergency coverage, see below.	After your deductible is met, the plan covers 80% of approved charges until the out-of-pocket limit is met, and 100% of approved charges thereafter. For emergency coverage, see below.
Routine visits	Routine visits: Fully covered at MIT Medical. There is a \$25 co-pay for some vaccines and immunizations.	Routine visits: Fully covered at MIT Medical. There is a \$25 co-pay for some vaccines and immunizations.	Routine visits: No coverage, except for limited pediatric visits.
INPATIENT COVERED SERVICES			
Semi-private room and hospital services	Fully covered at designated hospitals when arranged by MITHP physician. For emergency coverage, see below.	Fully covered at designated hospitals when arranged by MITHP physician. For emergency coverage, see below.	80% after deductible, 100% after out-of-pocket limit. Covered at participating hospitals. For emergency coverage, see below.
Inpatient care by physician	Fully covered	Fully covered	80% after deductible, 100% after out-of-pocket limit. Covered at participating hospitals. For emergency coverage, see below.
EMERGENCY CARE			
In or outside of plan network	You pay a \$50 co-payment when you visit a hospital emergency room for sudden onset of a life-threatening condition; you must notify MITHP within 24 hours. The co-payment is waived if you are admitted as an inpatient. For urgent and emergency care services outside of MA you must notify BCBSMA within 48 hours of seeking care.	You pay a \$50 co-payment when you visit a hospital emergency room for sudden onset of a life-threatening condition; you must notify MITHP within 24 hours. The co-payment is waived if you are admitted as an inpatient. For urgent and emergency care services outside of MA you must notify BCBSMA within 48 hours of seeking care.	In-network: If the services meet BCBS' criteria for emergency care the service will be covered as an in-network service; if not it will be processed as an out-of-network service. Out-of-network: 80% after deductible, 100% after out-of-pocket limit for treatment of "sudden and serious" illness or accidental injury if treated within 72 hours of accident. For urgent and emergency care services outside of MA you must notify BCBSMA within 48 hours of seeking care.
OUTPATIENT COVERED SERVICES			
Drugs that require a prescription by law, insulin, and syringes	For up to a 30-day supply when filled at MIT Pharmacy or participating Express Scripts pharmacy. Co-pays vary by tier. At MIT Pharmacy you pay \$8 for tier 1; \$25 for tier 2 and \$40 for tier 3. You may obtain a 3-month supply for most drugs for a 2-month co-pay when filled at the MIT Pharmacy. At participating Express Scripts pharmacies you pay \$25 for tier 1; \$40 for tier 2 and \$50 for tier 3. Limited to a 30-day supply per fill.	For up to a 30-day supply when filled at MIT Pharmacy or participating Express Scripts pharmacy. Co-pays vary by tier. At MIT Pharmacy you pay \$8 for tier 1; \$25 for tier 2 and \$40 for tier 3. You may obtain a 3-month supply for most drugs for a 2-month co-pay when filled at the MIT Pharmacy. At participating Express Scripts pharmacies you pay \$25 for tier 1; \$40 for tier 2 and \$50 for tier 3. Limited to a 30-day supply per fill.	At participating Express Scripts pharmacies you pay \$25 for tier 1; \$40 for tier 2 and \$50 for tier 3. Limited to a 30 day supply per fill.
Outpatient mental health care; psychotherapy, diagnostic, or evaluation services	For up to 50 visits per calendar year. When you see a provider who is participating with the BCBSMA Managed Care Behavioral Health Network* you pay a \$20 co-payment per visit. When you see a provider who is not participating with the BCBSMA Managed Care Behavioral Health Network you are reimbursed 50% of the reasonable and customary fee, not to exceed \$60 per visit. You may be responsible for the difference between the allowed amount and the provider's actual charge.	For up to 50 visits per calendar year. In-network: When you see a provider who is participating with the BCBSMA Managed Care Behavioral Health Network you pay a \$20 co-payment per visit. Out-of-network: When you see a provider who is not participating with the BCBSMA Managed Care Behavioral Health Network you are reimbursed 50% of the reasonable and customary fee, not to exceed \$60 per visit. You may be responsible for the difference between the allowed amount and the provider's actual charge.	For up to 50 visits per calendar year. In-network: When you see a provider who is participating with the BCBSMA Managed Care Behavioral Health Network you pay a \$20 co-payment per visit. Out-of-network: When you see a provider who is not participating with the BCBSMA Managed Care Behavioral Health Network you are reimbursed 50% of the reasonable and customary fee, not to exceed \$60 per visit. You may be responsible for the difference between the allowed amount and the provider's actual charge.
Allergy testing and treatment	Testing, treatment and allergy antigens fully covered at MIT Medical only.	Testing, treatment and allergy antigens fully covered at MIT Medical only.	After your deductible is met, the plan covers 80% of authorized charges until the out-of-pocket limit is met, and 100% of authorized charges thereafter.
Chiropractor's office visits for specific treatment	Not covered	Not covered	Not covered
	http://web.mit.edu/medical/	http://web.mit.edu/medical/	

This comparison is not a legal document. It reflects limited plan coverage information as of January 2008. The plan document for each health plan governs in all questions of coverage.

If you have any questions about a particular plan or about other benefits offered at MIT, please visit <http://hrweb.mit.edu/benefits/>

*Effective Jan. 1, 2008, MIT Medical will move the administration of mental and substance abuse benefits from Value Options to BCBSMA Managed Care Behavioral Health Network. All members will receive a letter with more information. Please review the letter carefully and contact Health Plan Claims & Member Services if you have any questions.

Other MIT Health Plans

COMPARISON CHART

Tufts Health Plan EPO (Exclusive Provider Organization)	Network Blue New England (Blue Cross Blue Shield HMO)	Blue Care Elect Blue Cross Blue Shield Preferred Provider Organization (PPO)	
		In Network	Out-of-Network
None	None	None	\$250 per member per calendar year; \$500 per family per calendar year
Plan pays 100% of authorized expenses from affiliated providers. Participants pay nothing or a small fee when they receive care. No charge for covered hospital services at plan-affiliated hospitals or at other hospitals when referred by THP physician.	Plan pays 100% of authorized expenses from affiliated providers. Participants pay nothing or a small fee when they receive care. No charge for covered hospital services at plan-affiliated hospitals or at other hospitals when referred by Network Blue New England physician.	Plan pays 100% of authorized expenses from affiliated providers. Participants pay nothing or a small fee when they receive care.	For covered hospital, surgical and medical expenses: After deductible, plan pays 80%, participant pays 20% up to out-of-pocket limit of \$1,000 per person, \$2,000 per family per plan year.
You pay \$10 per visit at THP physician's office or when referred by THP physician. For emergency coverage, see below. Routine visits: You pay \$10 per office visit.	You pay \$10 per visit when provided or referred by PCP. For emergency coverage, see below. Routine visits: You pay \$10 per office visit.	You pay \$10 per visit. Routine visits: You pay \$10 per office visit.	After your deductible is met, plan covers 80% of authorized charges until the out-of-pocket limit is met, and 100% of authorized charges thereafter.
Fully covered at designated hospitals when arranged by THP physician. For emergency coverage and out-of-area coverage, see below.	Fully covered at designated hospitals when arranged by Network Blue New England physician. For emergency coverage and out-of-area coverage, see below.	Fully covered at hospital when authorized by the plan.	After your deductible is met, plan covers 80% of authorized charges until the out-of-pocket limit is met, and 100% of authorized charges thereafter.
Fully covered	Fully covered	Fully covered at hospital when authorized by the plan.	After your deductible is met, plan covers 80% of authorized charges until the out-of-pocket limit is met, and 100% of authorized charges thereafter.
You pay a \$50 per visit at an emergency room unless admitted to the hospital for the sudden onset of a life-threatening illness or injury. You must notify THP or your physician within 48 hours.	Within service area: Prior authorization is required except in life threatening situations. You pay \$50 per visit at an emergency room unless admitted to the hospital. You must notify Network Blue New England or your PCP within 48 hours if you are hospitalized. Outside the plan network: You pay \$50 per visit unless admitted to the hospital for unforeseen illness or injury. No prior authorization required. You must notify Network Blue New England or your PCP within 48 hours.	You pay \$50 emergency room co-payment—waived if admitted or observation stay. You must notify your PCP by the next business day. It is not subject to the deductible and coinsurance.	After your deductible is met, plan covers 80% of authorized charges until the out-of-pocket limit is met, and 100% of authorized charges thereafter.
When prescribed by THP, you pay \$8 for generic, \$25 for preferred brand name, and \$40 for a non-preferred brand-name prescription or refill for a 30-day supply at a participating pharmacy. Maintenance medications available through the Managed Mail Service: For a 90-day supply, you pay \$16 for generic, \$50 for brand name, and \$80 for non-formulary brand-name drugs. *See note below on policy for prescription drugs.	Covered up to a 30-day supply at participating pharmacies. You pay \$8 for generic, \$25 for preferred brand name, and \$40 for a non-preferred brand-name prescription. Mail order offers 90-day supply at the same cost. You pay \$16 for generic, \$50 for brand name, and \$80 for non-formulary brand-name drugs. *See note below on policy for prescription drugs.	At participating retail pharmacies, you pay \$8 for generic, \$25 for brand name, and \$40 for a non-preferred brand-name prescription. Mail order offers 90-day supply at the same cost. You pay \$16 for generic, \$50 for brand name, and \$80 for non-formulary brand-name drugs. *See note below on policy for prescription drugs.	At participating retail pharmacies, you pay \$8 for generic, \$25 for brand name, and \$40 for a non-preferred brand-name prescription. Mail order offers 90-day supply at the same cost. You pay \$16 for generic, \$50 for brand name, and \$80 for non-formulary brand-name drugs. *See note below on policy for prescription drugs.
When authorized by THP physician, you pay \$10 per visit for 24 visits maximum. For outpatient substance abuse rehabilitation, you pay \$10 per visit. Mental Health: unlimited coverage for specified biologically-based illness.	Biologically based condition: \$10 co-pay per visit (no visit limit). Non-biologically based condition: \$10 co-pay per visit (limit 24 visits per member per calendar year).	You pay \$10 per visit.	80% after deductible; coverage up to 24 visits per calendar year less any benefits provided in-network.
You pay \$10 per visit.	You pay \$10 per visit. Allergy antigens fully covered.	You pay \$10 per visit.	After your deductible is met, plan covers 80% of authorized charges until the out-of-pocket limit is met, and 100% of authorized charges thereafter.
You pay \$10 per visit. Coverage for up to 12 visits per year with a participating provider for manual spinal manipulation only.	You pay \$10 per visit. No annual limit.	You pay \$10 per visit.	After your deductible is met, plan covers 80% of authorized charges until the out-of-pocket limit is met, and 100% of authorized charges thereafter.
http://www.tuftshealthplan.com	http://www.bcbsma.com	http://www.bcbsma.com	

***Prescription drugs**—For Blue Cross Blue Shield and Tufts Health Plan members, the pharmacy benefits are administered and managed by Express Scripts, Inc. For more information on the pharmacy benefits administered by Express Scripts, Inc., visit <http://hrweb.mit.edu/benefits/>.