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 http://hrweb.mit.edu/benefits.
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 **1-800-882-1093** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0** PCP / Plan Approved or when you select an MIT primary care provider (PCP); **$500** member / **$1,000** family Self-Referred.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Emergency room, emergency transportation, preventive care.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$2,500** member / **$5,000** family for PCP / Plan-Approved or when you select an MIT primary care provider (PCP); **$2,500** member / **$5,000** family Self-Referred.	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.	You pay the least if you use a provider in-network (lowest cost share). You pay more if you use a provider in-network (highest cost share). 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?	Yes, PCP / Plan-Approved level of benefits only.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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
		MIT Medical PCP (You will pay the least)	PCP / Plan-Approved	Self-Referred (You will pay the most)	
	Primary care visit to treat an injury or illness	$10 / visit	$20 / visit	25% coinsurance	Deductible applies first for Self-Referred
	Specialist visit	$10 / visit; $10 / chiropractor visit	$20 / visit; $20 / chiropractor visit	25% coinsurance; 25% coinsurance / chiropractor visit; $10 / acupuncture visit when you have MIT medical PCP; $20 / acupuncture visit when you have another PCP	Deductible applies first for Self-Referred except for acupuncture services; limited to 20 visits per calendar year for acupuncture services
	Preventive care/screening/immunization	No charge	No charge	No charge	GYN exam limited to one exam per calendar year. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	Diagnostic test (x-ray, blood work)	No charge	No charge	25% coinsurance	Deductible applies first for Self-Referred
	Imaging (CT/PET scans, MRIs)	$50; no charge at Shields Health Care Group	$50; no charge at Shields Health Care Group	25% coinsurance	Deductible applies first for Self-Referred; copayment applies per category of test / day; pre-authorization required for certain services

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		MIT Medical PCP (You will pay the least)	PCP / Plan-Approved	Self-Referred (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	$5 MIT Pharmacy, $8 retail supply or $16 mail service supply	$8 retail supply or $16 mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; cost share waived for birth control; pre-authorization required for certain drugs
	Preferred brand drugs	$15 MIT Pharmacy, $25 retail supply or $50 mail service supply	$25 retail supply or $50 mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; pre-authorization required for certain drugs
	Non-preferred brand drugs	$40 MIT Pharmacy, and retail supply or $80 mail service supply	$40 retail supply or $80 mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; pre-authorization required for certain drugs
	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	25% coinsurance	Deductible applies first for Self-Referred; pre-authorization required for certain services
	Physician/surgeon fees	No charge	No charge	25% coinsurance	Deductible applies first for Self-Referred; pre-authorization required for certain services
	Emergency room care	$100 / visit	$100 / visit	$100 / visit	Copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	No charge	None
	Urgent care	$10 / visit	$20 / visit	25% coinsurance	Deductible applies first for Self-Referred
	Facility fee (e.g., hospital room)	No charge	No charge	25% coinsurance	Deductible applies first for Self-Referred; pre-authorization required

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		MIT Medical PCP (You will pay the least)	PCP / Plan-Approved	Self-Referred (You will pay the most)	
	Physician/surgeon fees	No charge	No charge	25% coinsurance	Deductible applies first for Self-Referred; pre-authorization required
	Outpatient services	$10 / visit	$20 / visit	25% coinsurance	Deductible applies first for Self-Referred; pre-authorization required for certain services
	Inpatient services	No charge	No charge	25% coinsurance	Deductible applies first for Self-Referred; pre-authorization required for certain services

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		MIT Medical PCP (You will pay the least)	PCP / Plan-Approved	Self-Referred (You will pay the most)	
If you are pregnant	Office visits	No charge	No charge	25% coinsurance	Deductible applies first for Self-Referred; cost sharing does not apply MIT Medical PCP or PCP / Plan-Approved 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	25% coinsurance	
	Childbirth/delivery facility services	No charge	No charge	25% coinsurance	
	Home health care	No charge	No charge	25% coinsurance	Deductible applies first for Self-Referred; pre-authorization required
	Rehabilitation services	$10 / visit	$20 / visit	25% coinsurance	Deductible applies first for Self-Referred; limited to 60 visits per calendar year (other than for home health care and speech therapy); pre-authorization required for certain services
	Habilitation services	$10 / visit	$20 / visit	25% coinsurance	Deductible applies first for Self-Referred; rehabilitation therapy coverage limits apply; pre-authorization required for certain services
	Skilled nursing care	No charge	No charge	25% coinsurance	Deductible applies first for Self-Referred; limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	10% coinsurance	10% coinsurance	25% coinsurance	Deductible applies first for Self-Referred; MIT Medical PCP and PCP / Plan-Approved cost share waived for one breast pump per birth
	Hospice services	No charge	No charge	25% coinsurance	Deductible applies first for Self-Referred; pre-authorization required for certain services

<table>
<tr><th rowspan="2">Common Medical Event</th><th rowspan="2">Services You May Need</th><th colspan="3">What You Will Pay</th><th rowspan="2">Limitations, Exceptions, & Other Important Information</th></tr>
<tr><th>MIT Medical PCP (You will pay the least)</th><th>PCP / Plan-Approved</th><th>Self-Referred (You will pay the most)</th></tr>
<tr><td rowspan="3">If your child needs dental or eye care</td><td>Children's eye exam</td><td>$10 / visit</td><td>$20 / visit</td><td>25% coinsurance</td><td>Deductible applies first for Self-Referred; limited to one exam every 12 months</td></tr>
<tr><td>Children's glasses</td><td>Not covered</td><td>Not covered</td><td>Not covered</td><td>None</td></tr>
<tr><td>Children's dental check-up</td><td>No charge for members with a cleft palate / cleft lip condition</td><td>No charge for members with a cleft palate / cleft lip condition</td><td>No charge for members with a cleft palate / cleft lip condition</td><td>Limited to members under age 18</td></tr>
</table>

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.)

- Children's glasses
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Private-duty nursing

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
- Hearing aids ($2,500 per calendar year for members age 19 or younger)
- Infertility treatment
- Applied Behavioral Analysis Therapy (ages 3 through 6)
- Routine eye care - adult (one exam every 12 months)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss and fitness reimbursement program ($150 per program per calendar year per policy)

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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x6156 or www.cciio.cms.gov. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact 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 a state exchange, you can contact your state's marketplace, if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

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.)

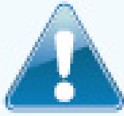
Does this plan provide Minimum Essential Coverage? [Yes]
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? [No]
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	$0
■ Delivery fee copay	$0
■ Facility fee copay	$0
■ 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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$78
The total Peg would pay is	$78

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

■ The plan's overall deductible	$0
■ Specialist visit copay	$10
■ Primary care visit copay	$10
■ 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	$0
Copayments	$80
Coinsurance	$0
What isn't covered	
Limits or exclusions	$500
The total Joe would pay is	$580

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

■ The plan's overall deductible	$0
■ Specialist visit copay	$10
■ 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	$0
Copayments	$150
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Jacquie would pay is	$150

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