



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 <u>deductible</u> ?	\$1,500 individual contract / \$3,000 family contract in-network; \$1,500 individual contract / \$3,000 family contract out-of-network.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. In-network prenatal care; preventive care.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$3,000 member / \$6,000 family in-network; \$3,000 member / \$6,000 family out-of-network.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.bluecrossma.com/findadoctor or call 1-800-821-1388 for a list of network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
	Primary care visit to treat an injury or illness	10% coinsurance; No charge at MIT Medical	25% coinsurance	Deductible applies first
	<u>Specialist</u> visit	10% coinsurance; No charge at MIT Medical; 10% coinsurance / chiropractor visit; 10% coinsurance / acupuncture visit	25% coinsurance; 25% coinsurance / chiropractor visit; 10% coinsurance / acupuncture visit	Deductible applies first; limited to 20 visits per calendar year for acupuncture services
	<u>Preventive care/screening/immunization</u>	No charge	25% coinsurance	Deductible applies first for out-of-network; limited to age-based schedule and / or frequency. 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.
	<u>Diagnostic test</u> (x-ray, blood work)	10% coinsurance; No charge at MIT Medical	25% coinsurance	Deductible applies first
	Imaging (CT/PET scans, MRIs)	10% coinsurance	25% coinsurance	Deductible applies first; pre-authorization may be required

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
<p>If you need drugs to treat your illness or condition <u>More information about prescription drug coverage is available at www.express-scripts.com</u></p>	Generic drugs	After deductible: \$5 MIT Pharmacy, \$8 retail supply or \$16 mail service supply	After deductible and copay, the difference between the total cost and the "allowed amount".	Deductible applies first; up to 30-day retail (90-day mail service) supply. Deductible waived for preventive medications; pre-authorization required for certain drugs
	Preferred brand drugs	After deductible: \$15 MIT Pharmacy, \$25 retail supply or \$50 mail service supply	After deductible and copay, the difference between the total cost and the "allowed amount".	Deductible applies first; up to 30-day retail (90-day mail service) supply. Deductible waived for preventive medications; pre-authorization required for certain drugs
	Non-preferred brand drugs	After deductible: \$40 MIT Pharmacy, and retail supply or \$80 mail service supply	After deductible and copay, the difference between the total cost and the "allowed amount".	Deductible applies first; up to 30-day retail (90-day mail service) supply. Deductible waived for preventive medications; pre-authorization required for certain drugs
	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	25% coinsurance	Deductible applies first
	Physician/surgeon fees	10% coinsurance	25% coinsurance	Deductible applies first

Common Medical Event	Services You May Need	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 immediate medical attention	<u>Emergency room care</u>	10% coinsurance	10% coinsurance	In-network deductible applies first for in-network and out-of-network services
	<u>Emergency medical transportation</u>	10% coinsurance	10% coinsurance	In-network deductible applies first for in-network and out-of-network services
	<u>Urgent care</u>	10% coinsurance; No charge / MIT Medical provider	25% coinsurance	Deductible applies first
	Facility fee (e.g., hospital room)	10% coinsurance	25% coinsurance	Deductible applies first; pre-authorization required
	Physician/surgeon fees	10% coinsurance	25% coinsurance	Deductible applies first; pre-authorization required
	Outpatient services	10% coinsurance	25% coinsurance	Deductible applies first; pre-authorization required for certain services
	Inpatient services	10% coinsurance	25% coinsurance	Deductible applies first; pre-authorization required for certain services
	Office visits	No charge for prenatal care; 10% coinsurance for postnatal care; No charge for postnatal care at MIT Medical provider	25% coinsurance	
	Childbirth/delivery professional services	10% coinsurance	25% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	25% coinsurance	

Common Medical Event	Services You May Need	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	<u>Home health care</u>	10% coinsurance	25% coinsurance	Deductible applies first; pre-authorization required
	<u>Rehabilitation services</u>	10% coinsurance	25% coinsurance	Deductible applies first; limited to 60 visits per calendar year (other than for home health care and speech therapy)
	<u>Habilitation services</u>	10% coinsurance	25% coinsurance	Deductible applies first; rehabilitation therapy coverage limits apply
	<u>Skilled nursing care</u>	10% coinsurance	25% coinsurance	Deductible applies first; limited to 100 days per calendar year; pre-authorization required
	<u>Durable medical equipment</u>	10% coinsurance	25% coinsurance	Deductible applies first; in-network cost share waived for one breast pump per birth
	<u>Hospice services</u>	10% coinsurance	25% coinsurance	Deductible applies first; pre-authorization required for certain services
	Children's eye exam	No charge	25% coinsurance	Deductible applies first for out-of-network; limited to one exam every 12 months
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge for members with a cleft palate / cleft lip condition	25% coinsurance for members with a cleft palate / cleft lip condition	Limited to members under age 18; deductible applies first for out-of-network

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 programs (\$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.) You may also contact The Office of Patient Protection at 1-800-436-7757 or www.mass.gov/hpc/opp.

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 \$1,500
- Delivery fee coinsurance 10%
- Facility fee coinsurance 10%
- Diagnostic tests coinsurance 10%

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:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$1,121
<i>What isn't covered</i>	
Limits or exclusions	\$78
The total Peg would pay is	\$2,699

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

- The plan's overall deductible \$1,500
- Specialist visit coinsurance 10%
- Primary care visit coinsurance 10%
- Diagnostic tests coinsurance 10%

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:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$589
<i>What isn't covered</i>	
Limits or exclusions	\$500
The total Joe would pay is	\$2,589

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

- The plan's overall deductible \$1,500
- Specialist visit coinsurance 10%
- Emergency room coinsurance 10%
- Ambulance services coinsurance 10%

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:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$43
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Jacquie would pay is	\$1,543

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