

SUMMARY PLAN DESCRIPTION

Blue Care Elect Preferred

A preferred provider plan administered by
Blue Cross and Blue Shield of Massachusetts, Inc.

MIT Affiliate Extended Insurance Plan

Academic Year 2009–2010



Welcome to MIT Affiliate Extended Insurance Plan

This booklet provides you with a description of benefits that are available while you are enrolled under the Affiliate 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 Affiliate Extended Insurance Plan while others are directly administered by The MIT Health Plans (See MIT Affiliate Extended Insurance Plan Section II-Supplemental). The MIT Health Plans Claims and Member Services Office (617-253-5979 or msservices@med.mit.edu) can help you understand the terms of this health plan and what you need to do to get your maximum benefits.

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REMEMBER – this document addresses the MIT Affiliate Extended Insurance Plan only. Information regarding the MIT Medical Plan is available separately. Please refer to the appropriate document.

Introduction

You are covered under the MIT Affiliate Extended Insurance Plan. This health plan is a non-insured self-funded benefits plan and is financed by contributions by 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 Blue Care Elect booklet provides you with a complete description of benefits that are available while you are enrolled in the MIT Affiliate Extended Insurance Plan and administered by *Blue Cross and Blue Shield*. You should read this booklet to familiarize yourself with the main provisions and keep it handy for reference. The words in italics have special meanings and are described in Part 2. 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.

Note: The MIT Affiliate Medical Plan may provide additional benefits that are administered by MIT Medical. Please refer to Section II of this document, or contact MIT Medical Claims and Member Services for information about these benefits.

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 in Parts 3, 4, 5, 6 and 7.

Part I

Member Services

Network of Health Care Providers

Provider Network. Under this health plan, you will receive the highest level of benefits when you use providers in your designated *preferred provider* health care network to furnish *covered services*. These are called your “in-network benefits.” When you obtain *covered services* from a covered health care provider that is not in the designated *preferred provider* health care network, 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.”

To find out if a health care provider is a *preferred provider*, you may call the *Blue Cross and Blue Shield* customer service toll-free telephone number that is shown on your PPO health plan identification card. You may also use the online provider directory for your designated health care network that is located on the *Blue Cross and Blue Shield* internet website at www.blucrossma.com.

Finding a Preferred Provider

Finding a Preferred Provider in Massachusetts. To find a *preferred provider* in Massachusetts, you may call the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your PPO health plan identification card. Or, you may call the Physician Selection Service at 1-800-821-1388. You may also access the online Physician Directory on the *Blue Cross and Blue Shield* internet website at www.blucrossma.com.

Finding a Preferred Provider Outside of Massachusetts. If you live or are traveling outside of Massachusetts and need health care services, you can check the status of an out-of-state provider or obtain help in finding a *preferred provider* by calling 1-800-810-BLUE. You can call this telephone number for help finding a provider 24 hours a day. Or, you may access the BlueCard® Doctor & Hospital Finder on the internet at www.bcbs.com. When you call, you should have your PPO health plan identification card ready. Be sure to let the representative know that you are looking for health care providers in the “BlueCard® PPO” program.

Note: For some types of covered health care providers, *Blue Cross and Blue Shield* or the local Blue Cross and/or Blue Shield Plan may not have (in the opinion of *Blue Cross and Blue Shield*) established an adequate *preferred provider* network. If this is the case and you obtain *covered services* from that type of non-*preferred provider*, this health plan will provide “in-network benefits” for these *covered services*.

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*.

Note: All members will be issued new ID Cards effective 9/1/2009 with a new “DMT” alpha prefix. Claims for services on or after 9/1/09 must be submitted using the new prefix. If you do not receive your new ID card please contact the MIT Health Plan office or *Blue Cross and Blue Shield* customer service.

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 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
77 Massachusetts Ave
Cambridge, MA 02139
E-mail address: msservice@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 the benefits described in this Benefit Description, your treatment must conform to *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.

Appeals and Formal Grievance Review. See Part 9 for more information about the claim appeals and formal grievance review process.

Translation Services

Need a Language Translator? 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

Definitions

The following terms are shown in italics in this Benefit Description and in any *riders* that apply to your benefits under this health plan. These terms will give you a better understanding of your benefits.

Allowed Charge

The charge that is used to calculate payment of your benefits. The *allowed charge* depends on the type of health care provider that furnishes a *covered service* to you.

- *Preferred Providers*. For providers that have a preferred payment agreement with *Blue Cross and Blue Shield* or with the local Blue Cross and/or Blue Shield Plan, the *allowed charge* is based on the provisions of that provider's preferred payment agreement. (Blue Cross and/or Blue Shield Plan means an independent corporation or affiliate operating under a license from the Blue Cross and Blue Shield Association.) **For covered services, you pay only your copayment, deductible and/or coinsurance, whichever applies.**
- **Non-Preferred Providers With a Local Payment Agreement**. For non-preferred providers outside Massachusetts that have a payment agreement with the local Blue Cross and/or Blue Shield Plan, the *allowed charge* is the "negotiated price" that the local Blue Cross and/or Blue Shield Plan passes on to *Blue Cross and Blue Shield*. In many cases, the negotiated price paid by *Blue Cross and Blue Shield* to the local Blue Cross and/or Blue Shield Plan is a discount from the provider's billed charges. However, a number of local Blue Cross and/or Blue Shield Plans can determine only an estimated price at the time your claim is paid. Any such estimated price is based on expected settlements, withholds, any other contingent payment arrangements and non-claims transactions, such as provider advances, with the provider (or with a specific group of providers) of the local Blue Cross and/or Blue Shield Plan in the area where services are received. In addition, some local Blue Cross and/or Blue Shield Plans' payment agreements with providers do not give a comparable discount for all claims. These local Blue Cross and/or Blue Shield Plans elect to smooth out the effect of their payment agreements with providers by applying an average discount to claims. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. Local Blue Cross and/or Blue Shield Plans that use these estimated or averaging methods to calculate the negotiated price may prospectively adjust their estimated or average prices to correct for overestimating or underestimating past prices. **In most cases for covered services, you pay only your copayment, deductible and/or coinsurance, whichever applies. However, the amount you pay is considered a final price.**

- **Non-Preferred Providers Without a Local Payment Agreement** For non-preferred providers that do not have a payment agreement with *Blue Cross and Blue Shield* or with the local Blue Cross and/or Blue Shield Plan, the provider's actual charges are used to calculate your benefits. For covered services, you pay only your copayment, deductible and/or coinsurance, whichever applies.

Benefit Limit

The day, visit or dollar benefit maximum that applies to certain *covered services*. See Part 5, “Covered Services” of this Benefit Description for the *benefit limit (if any) that applies for a covered service*. Once your benefits have reached the *benefit limit* described in your Benefit Description for specific *covered services*, no further benefits are provided by this health plan for those health care services or supplies. When this is the case, you must pay all charges that are in excess of the *benefit limit* for those health care services or supplies.

Note: Any benefits you have already received under prior *Blue Cross and Blue Shield* plan(s) or plan(s) administered by *Blue Cross and Blue Shield* for a specific *covered service* will count toward the *benefit limit* for the same *covered services* under this health plan.

Blue Cross and Blue Shield

Blue Cross and Blue Shield of Massachusetts, Inc., the organization that 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. This includes an employee or designee of *Blue Cross and Blue Shield* (including a Blue Cross and/or Blue Shield Plan) who is authorized to make decisions or take action called for as described in this Benefit Description.

Coinsurance

The amount that you must pay for a certain *covered service*. See Part 5, “Covered Services” of this Benefit Description for the *percentage amount of your coinsurance and which covered services are subject to coinsurance*. Your *coinsurance* is a percentage of:

- The provider's actual charge or the *allowed charge*, whichever is less (unless otherwise required by law) when you receive *covered services* from a *preferred provider* or a *non-preferred provider* who has a payment agreement with a local Blue Cross and/or Blue Shield Plan.
- The provider's actual charge when you receive *covered services* from a *non-preferred provider* who does not have a payment agreement with *Blue Cross and Blue Shield* or the local Blue Cross and/or Blue Shield Plan.

Copayment

The amount that you must pay for a certain *covered service*. Your *copayment* is usually a fixed dollar amount. In most cases, a *preferred provider* will collect the *copayment* from you at the time he or she furnishes the *covered service*. However, when the provider's actual charge at the time of providing the *covered service* is less than your *copayment*, you pay only that provider's actual charge or the *allowed charge*, whichever is less. Any later charge adjustment—up or down—will not affect your *copayment* (or the amount you were charged at the time of the service if it was less than the *copayment*). See Part 5, “Covered Services” of this Benefit Description for the amount of your *copayment* and which *covered services* are subject to a *copayment*. (In some cases when a *copayment* would normally apply, your *copayment* is waived. This Benefit Description describes the situations when your *copayment* is waived.)

Covered Services

Health care services or supplies for which this health plan provides benefits as described in this Benefit Description. In order to receive the highest level of benefits provided by this health plan (referred to as “in-network benefits”), *covered services* must be furnished by *preferred providers*. A lower level of benefits (referred to as “out-of-network benefits”) will usually be provided when you obtain *covered services* from a covered non-*preferred provider*. (See Part 10 for situations when in-network benefits may be provided for *covered services* furnished by non-*preferred providers*.)

Deductible

The amount that you must pay before benefits are provided for certain *covered services*. The amount that is put toward your *deductible* is calculated based on:

- The provider's actual charge or the *allowed charge*, whichever is less (unless otherwise required by law) when you receive *covered services* from a *preferred provider* or a non-*preferred provider* who has a payment agreement with the local Blue Cross and/or Blue Shield Plan.
- The provider's actual charge when you receive *covered services* from a non-*preferred provider* who does not have a payment agreement with *Blue Cross and Blue Shield* or the local Blue Cross and/or Blue Shield Plan.

Your Overall Deductible Amounts	In-Network Benefits	Out-of-Network Benefits
See Part 5, “Covered Services” for a description of <i>covered services</i> that are subject to a <i>deductible</i> .	None	Overall <i>Deductible</i>
		\$250 per <i>member</i> per calendar year

There are amounts you pay that do not count toward your *deductible(s)*. These include: any *copayments* and/or *coinsurance* amounts; any amount you pay when your benefits are reduced or denied because you did not follow the requirements of the *utilization review* program (see Part 4); and any amount you pay that is more than the *allowed charge*.

Diagnostic Lab Tests

The examination or analysis of tissues, liquids or wastes from the body. This also includes: the taking and interpretation of 12-lead electrocardiograms; all standard electroencephalograms; and glycosylated hemoglobin (HgbA1C) tests, urinary protein/microalbumin tests and lipid profiles to diagnose and treat diabetes.

Diagnostic X-Ray and Other Imaging Tests

Fluoroscopic tests and their interpretation; and the taking and interpretation of roentgenograms and other imaging studies that are recorded as a permanent picture, such as film. Some examples of imaging tests include magnetic resonance imaging (MRI) and computerized axial tomography (CT scans). These types of tests also include diagnostic tests that require the use of radioactive drugs.

Effective Date

The date on which your membership in this health plan begins.

Emergency Medical Care

Medical, surgical or psychiatric care that you need immediately due to the sudden onset of a condition manifesting itself by acute symptoms, including severe pain, which are severe enough that the lack of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing your health or the health of another (including an unborn child) in serious jeopardy, serious impairment of bodily functions or serious dysfunction of any bodily organ or part. Some examples of conditions that require *emergency medical care* are suspected heart attacks, strokes, poisoning, loss of consciousness, convulsions and suicide attempts. This also includes treatment of *mental conditions* when: you are admitted as an *inpatient* as required under Massachusetts General Laws, Chapter 123, Section 12; you seem very likely to endanger yourself as shown by a serious suicide attempt, a plan to commit suicide or behavior that shows that you are not able to care for yourself; or you seem very likely to endanger others as shown by an action against another person that could cause serious physical injury or death or by a plan to harm another person.

Group

The corporation, partnership, individual proprietorship or other organization that has entered into an agreement under which *Blue Cross and Blue Shield* provides administrative services for the *group's* self-insured benefits plan.

Inpatient

A registered bed patient in a facility. (A patient who is kept overnight in a hospital solely for observation is not considered a registered *inpatient*. This is true even though the patient uses a bed. In this case, the patient is considered an *outpatient*.)

Medical Technology Assessment Guidelines

The guidelines that *Blue Cross and Blue Shield* uses to assess whether a technology improves health outcomes such as length of life or ability to function. These guidelines include the following five criteria:

- The technology must have final approval from the appropriate government regulatory bodies. This criterion applies to drugs, biological products, devices (such as durable medical equipment) and diagnostic services. A drug, biological product or device must have final approval from the Food and Drug Administration (FDA). Any approval granted as an interim step in the FDA regulatory process is not sufficient. Except as required by law, this health plan may limit benefits for drugs, biological products and devices to those specific indications, conditions and methods of use approved by the FDA.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed English-language journals. The qualities of the body of studies and the consistency of the results are considered in evaluating the evidence. The evidence should demonstrate that the technology can measurably alter the physiological changes related to a disease, injury, illness or condition. In addition, there should be evidence or a convincing argument based on established medical facts that the measured alterations affect health outcomes. Opinions and evaluations by national medical associations, consensus panels and other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence upon which they are based.
- The technology must improve the net health outcome. The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
- The technology must be as beneficial as any established alternatives. The technology should improve the net outcome as much as or more than established alternatives. The technology must be as cost effective as any established alternatives that achieve a similar health outcome.
- The improvement must be attainable outside the investigational setting. When used under the usual conditions of medical practice, the technology should be reasonably expected to improve health outcomes to a degree comparable to that published in the medical literature.

Medically Necessary

All *covered services*, except routine circumcision, voluntary sterilization procedures, stem cell ("bone marrow") transplant donor suitability testing and preventive health services, must be *medically necessary* and appropriate for your specific health care needs. This means that all *covered services* must be consistent with generally accepted principals of professional medical practice. *Blue Cross and Blue Shield* decides which *covered services* are *medically necessary* and appropriate for you by using the following guidelines. All health care services must be required to diagnose or treat your illness, injury, symptom, complaint or condition and they must also be:

- Consistent with the diagnosis and treatment of your condition and in accordance with *Blue Cross and Blue Shield* medical policy and *medical technology assessment guidelines*.
- Essential to improve your net health outcome and as beneficial as any established

alternatives covered by this health plan. This means that if *Blue Cross and Blue Shield* determines that your treatment is more costly than an alternative treatment, benefits are provided for the amount that would have been provided for the least expensive alternative treatment that meets your needs. In this case, you pay the difference between the claim payment and the actual charge.

- As cost effective as any established alternatives and consistent with the level of skilled services that are furnished.
- Furnished in the least intensive type of medical care setting required by your medical condition.

It is not a service that: is furnished solely for your convenience or religious preference or the convenience of your family or health care provider; promotes athletic achievements or a desired lifestyle; improves your appearance or how you feel about your appearance; or increases or enhances your environmental or personal comfort.

Member

You, the person who has the right to the benefits described in this Benefit Description. A *member* may be the *subscriber* or his or her enrolled spouse (or former spouse, if applicable) or an enrolled dependent child (or other enrolled dependent, as applicable). In this Benefit Description, the term “you” refers to any *member* who has the right to the benefits provided by this health plan—the *subscriber* or the enrolled spouse or any other enrolled dependent.

Mental Conditions

Psychiatric illnesses or diseases. (These include drug addiction and alcoholism.) The illnesses or diseases that qualify as *mental conditions* are listed in the latest edition, at the time you receive treatment, of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders.

Mental Health Provider

A provider that may furnish *covered services* to *members* for the treatment of *mental conditions*. These providers include:

- Alcohol and drug treatment facilities.
- Clinical specialists in psychiatric and mental health nursing.
- Community health centers (that are a part of a general hospital).
- Day care centers.
- Detoxification facilities.
- General hospitals.
- Licensed independent clinical social workers.
- Licensed mental health counselors.
- Mental health centers.

- Mental hospitals.
- Physicians.
- Psychologists.
- Any other mental health provider designated by Blue Cross and Blue Shield.

Out-of-Pocket Maximum

The maximum amount you pay in a calendar year for certain *covered services*. When the *deductible* and *coinsurance* amounts you have paid in a calendar year add up to the *out-of-pocket maximum* amount, full benefits will be provided based on the *allowed charge* if you continue to receive these *covered services* during the rest of that calendar year.

Your Out-of-Pocket Maximum Amount	In-Network Benefits	Out-of-Network Benefits
(Note: the out-of-pocket maximum includes out-of-network deductible and coinsurance amounts.)	<i>Out-of-Pocket Maximum</i>	
	\$1,000 per <i>subscriber</i> per calendar year \$500 per enrolled dependent per calendar year	

There are amounts you pay that do not count toward your *out-of-pocket maximum*. These include: any *copayments*; any amount you pay when your benefits are reduced or denied because you did not follow the requirements of the *utilization review* program (see Part 4); and any amount you pay that is more than the *allowed charge*.

Outpatient

A patient who is not a registered bed patient in a facility. For example, a patient at a health center, provider's office, surgical day care unit or ambulatory surgical facility is considered an *outpatient*. A patient who is kept overnight in a hospital solely for observation is also considered an *outpatient*. This is true even though the patient uses a bed.

Preferred Provider

A covered health care provider that has a written preferred provider payment agreement with *Blue Cross and Blue Shield* or a local Blue Cross and/or Blue Shield Plan. (A covered health care provider that does not have a written preferred provider payment agreement with *Blue Cross and Blue Shield* or a local Blue Cross and/or Blue Shield Plan is referred to as a "non-preferred provider" in this Benefit Description.) Covered health care providers that may furnish *covered services* to you include:

- **Hospital and Other Covered Facilities.** Alcohol and drug treatment facilities; ambulatory surgical facilities; Christian Science sanatoriums; chronic disease hospitals; community health centers; day care centers; detoxification facilities; free-standing diagnostic imaging facilities; free-standing dialysis facilities; free-standing radiation therapy and chemotherapy facilities; general hospitals; independent labs; mental health centers; mental hospitals; rehabilitation hospitals; and skilled nursing facilities.

- **Physician and Other Covered Professional Providers.** Certified registered nurse anesthetists; Christian Science practitioners; clinical specialists in psychiatric and mental health nursing; dentists; licensed independent clinical social workers; licensed mental health counselors; licensed speech-language pathologists; nurse midwives; nurse practitioners; occupational therapists (effective for services furnished on and after January 1, 2004); physical therapists; physicians; and psychologists.
- **Other Covered Health Care Providers.** Ambulance services; appliance companies; coordinated home health agencies; early intervention providers; home infusion therapy providers; hospice providers; oxygen suppliers; and visiting nurse associations.

Note: To find out if a covered health care provider is a *preferred provider*, you may look on-line at bluecrossma.com. Or, you may call the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your PPO health plan identification card.

Rider

An amendment that changes the terms described in this Benefit Description. MIT or *Blue Cross and Blue Shield* may change the terms of this health plan. For example, a *rider* may change the amount you must pay for certain services such as the amount of your *deductible* or *copayment*, or it may add or limit the benefits provided by this health plan. The *rider* describes the change that is made to this Benefit Description. MIT will supply you with any *riders* that apply to your benefits under this health plan. You should keep any *riders* with this booklet.

Room and Board

Your room, meals and general nursing services while you are an *inpatient*. This includes hospital services furnished in an intensive care or similar unit.

Special Services

The services and supplies that a facility ordinarily furnishes to its patients for diagnosis or treatment while the patient is in the facility. *Special services* include such things as:

- The use of special rooms. These include: operating rooms; and treatment rooms.
- Tests and exams.
- The use of special equipment in the facility. Also, the services of the people hired by the facility to run the equipment.
- Drugs, medications, solutions, biological preparations and medical and surgical supplies used while you are in the facility.
- Administration of infusions and transfusions and blood processing fees. These do not include the cost of: whole blood; packed red blood cells; blood donor fees; or blood storage fees.
- Internal prostheses (artificial replacements of parts of the body) that are part of an operation. These include things such as: hip joints; skull plates; intraocular lenses; and pacemakers. They do not include things such as: ostomy bags; artificial limbs or eyes; hearing aids; or airplane splints.

Subscriber

The eligible person who signs the enrollment form at the time of enrollment in this health plan. In most cases, this is the individual who is a registered Affiliate at MIT.

Utilization Review

The approach that *Blue Cross and Blue Shield* uses to evaluate the necessity and appropriateness of many different services. This approach employs a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. These techniques include pre-admission review, concurrent review, discharge planning, pre-authorization of selected *outpatient* services, post-payment review and individual case management. *Blue Cross and Blue Shield's* utilization management policies are designed to encourage appropriate care and services (not less care). *Blue Cross and Blue Shield* understands the need for special concern about underutilization, and shares this concern with *members* and providers. *Blue Cross and Blue Shield* does not compensate individuals who conduct *utilization review* activities based on denials. It also does not offer incentives to providers to encourage inappropriate denials of care and services.

Blue Cross and Blue Shield applies *medical technology assessment guidelines* to develop its clinical guidelines and *utilization review* criteria. In developing these, *Blue Cross and Blue Shield* carefully assesses a treatment to determine that it is:

- Consistent with generally accepted principals of professional medical practice; and
- Required to diagnose or treat your illness, injury, symptom, complaint or condition; and
- Essential to improve your net health outcome and as beneficial as any established alternatives covered by this health plan; and
- As cost effective as any established alternatives and consistent with the level of skilled services that are furnished; and
- Furnished in the least intensive type of medical care setting required by your medical condition.

Blue Cross and Blue Shield reviews clinical guidelines and *utilization review* criteria periodically to reflect new treatments, applications and technologies. As new drugs are approved by the Food and Drug Administration (FDA), *Blue Cross and Blue Shield* reviews their safety, effectiveness and overall value on an ongoing basis. While a new drug is being reviewed, it will not be covered by this health plan.

Part 3

Emergency Medical Services

Obtaining Emergency Medical Services

This health plan provides benefits for worldwide emergency medical services. These emergency medical services may include *inpatient* or *outpatient* services by providers qualified to furnish *emergency medical care* and that are needed to evaluate or stabilize your emergency medical condition.

Call 911. At the onset of an emergency medical condition that in your judgment requires *emergency medical care*, you should go to the nearest emergency room. For assistance, call your local emergency medical service system by dialing the emergency telephone access number 911, or the local emergency telephone number. You will not be denied benefits for medical and transportation services described in this Benefit Description that you incur as a result of your emergency medical condition.

You usually need emergency medical services because of the sudden onset of a condition with acute symptoms, including severe pain, which are severe enough that the lack of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing your health or the health of another (including an unborn child) in serious jeopardy, serious impairment of bodily functions or serious dysfunction of any bodily organ or part. Some examples of conditions that require *emergency medical care* are suspected heart attacks, strokes, poisoning, loss of consciousness, convulsions and suicide attempts.

Note: When you receive emergency medical services from an emergency room at a non-preferred hospital, this health plan will provide the same benefits that you would normally receive if a preferred hospital had furnished the services.

Post-Stabilization Care

After your emergency medical condition has been evaluated and stabilized in the hospital emergency room, you may be ready to go home or you may require further care.

Admission From the Emergency Room. Your condition may require that you be admitted directly from the emergency room for *inpatient emergency medical care* in that hospital. If this is the case, you, the facility or someone on your behalf must notify *Blue Cross and Blue Shield* within 48 hours of the admission. (In Massachusetts, the preferred hospital will call *Blue Cross and Blue Shield* for you.) This notification to *Blue Cross and Blue Shield* must include the patient's name, the patient's identification number, the name of the facility, the date of admission and the condition for which the patient is receiving treatment. *Blue Cross and Blue Shield* will monitor and evaluate the clinical necessity and appropriateness of the health care services you are receiving in order to make sure you continue to need *inpatient* coverage in that facility. (For more information about Concurrent Review, see Part 4, "Utilization Review Requirements.")

Transfer to Another *Inpatient* Facility. Your emergency room provider may recommend transfer for *inpatient* care to another facility. If this is the case, you or the admitting facility must call *Blue Cross and Blue Shield* within 48 hours of the admission so that *Blue Cross and Blue Shield* can evaluate the appropriateness of the health care services you are receiving in order to make sure you need *inpatient* coverage in that facility. (In Massachusetts, the preferred facility will call *Blue Cross and Blue Shield* for you.)

Outpatient Follow-up Care. Your emergency room provider may recommend *outpatient* follow-up care. If this is the case, this health plan will provide benefits for *covered services*. These services must be coordinated with the clinicians at MIT Medical.

Filing a Claim for Emergency Medical Services

You do not have to file a claim when you receive *covered services* from a *preferred provider* or a provider outside of Massachusetts who has a payment agreement with the local Blue Cross and/or Blue Shield Plan. The provider will file the claim for you. Just tell the provider that you are a *member* and show him or her your PPO health plan identification card. *Blue Cross and Blue Shield* will pay the provider directly for *covered services*.

But, you may have to file your claim when you receive *covered services* from a *non-preferred provider* in Massachusetts or a *non-preferred provider* outside of Massachusetts who does not have a payment agreement with the local Blue Cross and/or Blue Shield Plan. The provider may ask you to pay the entire charge at the time of the visit. It is up to you to pay your provider. After you have filed your claim, you will be repaid less the amount you normally pay for *covered services*. See Part 8 for more information about filing a claim for repayment of *covered services*.

Part 4

Utilization Review Requirements

To receive all the benefits described in this Benefit Description, you must follow the requirements of this *utilization review* program. This program applies anywhere in the United States. **Your benefits may be reduced or denied if you do not follow the requirements of this program.** This section describes how the *utilization review* program works. To check on the status or outcome of a *utilization review* decision, you may call the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your PPO health plan identification card.

Note: Your provider will be considered your authorized representative for the prior approval process. *Blue Cross and Blue Shield* will tell your provider if a proposed service has been approved or may ask your provider for more information if it is needed to make a decision. (See Part 10 for more information about authorized representatives.)

Prior Authorization Requirements

All *inpatient* admissions must be approved in advance by *Blue Cross and Blue Shield* to receive in-network benefits or out-of-network benefits as described in this Benefit Description. In some situations, you will need to start the process described in this section for obtaining approval from *Blue Cross and Blue Shield*. Otherwise, your benefits may be reduced or denied. (The requirements of this program do not apply to *covered services* when Medicare is the primary coverage.)

Pre-Admission Review

Before you enter a facility for *inpatient* care, prior approval must be obtained from *Blue Cross and Blue Shield* in order for the care to be covered by this health plan. (This pre-approval is not required when your *inpatient* admission is for *emergency medical care* or maternity services.) For proposed admissions in a preferred facility, the facility may start this pre-admission review process for you. A *preferred provider* can tell you if you must start this process. **You must start the pre-admission review process if the preferred facility does not start this process or if your proposed admission is to a non-preferred facility.** To start the pre-admission review process, you must call the *Blue Cross and Blue Shield utilization review* unit at the toll-free telephone number shown on your PPO health plan identification card.

Blue Cross and Blue Shield will get in touch with your physician about the proposed admission if more information is needed. In some situations, *Blue Cross and Blue Shield* may arrange an evaluation (usually face to face) with an assessment provider who will assess your specific need and determine if the health care setting is suitable to treat your condition. Within two working days of receiving all necessary information, *Blue Cross and Blue Shield* will determine if the health care setting is suitable to treat your condition. If necessary information is missing or more information is needed, *Blue Cross and Blue Shield* will request the necessary information or records within 15 calendar days of receiving the pre-admission review request. The requested information or records must be provided within 45 calendar days of *Blue Cross and Blue Shield's* request. If the requested

information or records are not provided to *Blue Cross and Blue Shield* within 45 calendar days of the request, the proposed *inpatient* coverage will be denied.

Coverage Approval. If *Blue Cross and Blue Shield* determines that the proposed setting for your care is suitable, *Blue Cross and Blue Shield* will call the facility within 24 hours of the determination to let the facility know the status of the pre-admission review. *Blue Cross and Blue Shield* will also send a written (or electronic) confirmation of the coverage approval to you and the facility within two working days of the phone call to the facility.

Coverage Denial. If *Blue Cross and Blue Shield* determines that the proposed setting is not *medically necessary* for your condition, *Blue Cross and Blue Shield* will call the facility within 24 hours of the determination to let the facility know of the denial of coverage and to recommend alternative treatment. *Blue Cross and Blue Shield* will also send a written (or electronic) explanation of the coverage decision to you and the facility within one working day of the phone call to the facility. (This explanation will describe the reasons for the denial, the applicable terms of your *group* benefits as described in this Benefit Description, any applicable *Blue Cross and Blue Shield* medical policy guidelines used and how to obtain a free copy, any additional information needed, the review process and your right to pursue legal action.)

Reconsideration of Adverse Determination. When *Blue Cross and Blue Shield* determines that *inpatient* coverage is not *medically necessary* for your condition, your health care provider may ask that *Blue Cross and Blue Shield* arrange a reconsideration of that decision from a clinical peer reviewer. This reconsideration will be conducted between your provider and the clinical peer reviewer within one working day of the request for a reconsideration. If the initial determination is not reversed, you (or the health care provider on your behalf) may request a formal review as described in Part 9 of this Benefit Description. (You may request a formal review even though your health care provider has not followed this reconsideration process.)

If Pre-Approval Requirements Are Not Followed. If you do not call for pre-admission review prior to being admitted as an *inpatient*, you must pay the first \$1,000 of otherwise covered facility charges for each admission that *Blue Cross and Blue Shield* determines is *medically necessary*. You must pay this amount as well as any costs that you would normally be required to pay for *covered services*.

Note: If you do not call for pre-admission review and *Blue Cross and Blue Shield* determines your admission is not *medically necessary* (or if you choose to be admitted after the pre-admission review determined that *inpatient* coverage was not *medically necessary*), you must pay the entire amount for facility and physician (or other professional provider) services for the admission.

Concurrent Review and Discharge Planning

Concurrent Review means that while you are an *inpatient*, *Blue Cross and Blue Shield* will monitor and evaluate the clinical necessity and appropriateness of the health care services you are receiving and to make sure you still need *inpatient* coverage in that facility. In some cases, *Blue Cross and Blue Shield* may determine that you will need to continue *inpatient* coverage in that facility beyond the number of days initially thought to be required for your condition. *Blue Cross and Blue Shield* will make this determination within one working day of receiving all necessary information. When this is the case, *Blue Cross and Blue Shield* will call the facility within one working day of the coverage determination to let the facility know the approval status of the review. *Blue Cross and Blue Shield* will also send a written (or electronic) explanation of the decision to you and the facility within one working day of the phone call to the facility. This written (or electronic) explanation will include the number of additional days that are being approved for coverage (or the next review date), the new total number of approved days or services and the date the approved services will begin.

In other cases, based on *medical necessity* determination, *Blue Cross and Blue Shield* may determine that you no longer need *inpatient* coverage in that facility. Or, you may no longer need *inpatient* coverage at all. *Blue Cross and Blue Shield* will make this coverage determination within one working day of receiving all necessary information. When this is the case, *Blue Cross and Blue Shield* will call the facility within 24 hours of the coverage determination to let the facility know of the decision and to discuss plans for continued coverage in a health care setting that better meets your needs. For example, your condition may no longer require *inpatient* coverage in a hospital, but still may require skilled nursing coverage. If this is the case, your physician may decide to transfer you to an appropriate skilled nursing facility. Any proposed plans will be discussed with you by your physician. All arrangements for discharge planning will be confirmed in writing with you.

If you choose to stay in the facility after you have been notified by your provider or *Blue Cross and Blue Shield* that *inpatient* coverage is no longer medically necessary, no further benefits will be provided by this health plan. You must pay all charges for the rest of that *inpatient* stay, starting from the date the written notification is sent to you.

Reconsideration of Adverse Determination. When *Blue Cross and Blue Shield* determines that continued *inpatient* coverage is not *medically necessary* for your condition, your health care provider may ask that *Blue Cross and Blue Shield* arrange a reconsideration of that decision from a clinical peer reviewer. This reconsideration will be conducted between your health care provider and the clinical peer reviewer within one working day of the request for a reconsideration. If the initial determination is not reversed, you (or the health care provider on your behalf) may request a formal review as described in Part 9 of this Benefit Description. (You may request a formal review even though your health care provider has not followed this reconsideration process.)

Prior Approval for Home Health Care Services

Before you receive home health care, approval must be obtained from *Blue Cross and Blue Shield* in order for the care to be covered by this health plan. If you are planning to obtain home health care from a *preferred provider*, the provider may start the approval process for you. A *preferred provider* can tell you if you must start this process. **You must start the pre-approval process if the preferred provider does not start this process or if you are planning to obtain these services from a non-preferred provider.**

To start this pre-approval process, you must call the *Blue Cross and Blue Shield utilization review* unit at the toll-free telephone number shown on your PPO health plan identification card. When prior approval is requested, *Blue Cross and Blue Shield* will determine within two working days of receiving all necessary information if the proposed services should be covered as *medically necessary* for your condition. (If necessary information is missing or more information is needed, *Blue Cross and Blue Shield* will request the necessary information or records within 15 calendar days of receiving the request. The requested information or records must be provided within 45 calendar days of *Blue Cross and Blue Shield's* request. If the requested information or records is not provided to *Blue Cross and Blue Shield* within 45 calendar days of the request, the proposed *outpatient* coverage will be denied. (If you have been receiving *inpatient* care, *Blue Cross and Blue Shield* may approve these services through Discharge Planning.)

Coverage Approval. If *Blue Cross and Blue Shield* determines that the proposed course of treatment should be covered as *medically necessary* for your condition, *Blue Cross and Blue Shield* will call the health care provider within 24 hours of the determination to let the provider know the approval status of the review. *Blue Cross and Blue Shield* will also send a written (or electronic) confirmation of the approval to you and the provider within two working days of the phone call to the provider.

Coverage Denial. If *Blue Cross and Blue Shield* determines that the proposed course of treatment should not be covered as not *medically necessary* for your condition, *Blue Cross and Blue Shield* will call the health care provider within 24 hours of the determination to let the provider know of the denial of coverage and to recommend alternative treatment. *Blue Cross and Blue Shield* will also send a written (or electronic) explanation of the decision to you and the provider within one working day of the phone call to the provider. (This explanation will describe the reasons for the denial, the applicable terms of your *group* benefits as described in this Benefit Description, any applicable *Blue Cross and Blue Shield* medical policy guidelines used and how to obtain a free copy, any additional information needed, the review process and your right to pursue legal action.)

Reconsideration of Adverse Determination. When *Blue Cross and Blue Shield* determines that the proposed course of treatment will not be covered as *medically necessary* for your condition, your health care provider may ask that *Blue Cross and Blue Shield* arrange a reconsideration of that decision from a clinical peer reviewer. This reconsideration will be conducted between your provider and the clinical peer reviewer within one working day of the request for a reconsideration. If the initial review determination is not reversed, you (or the health care provider on your behalf) may request a formal review as described in Part 9 of this Benefit Description. (You may request a formal review even though your health care provider has not followed this reconsideration process.)

If Pre-Approval Requirements Are Not Followed. If you do follow this prior approval process, you must pay the first \$1,000 of otherwise covered charges for each course of treatment that *Blue Cross and Blue Shield* determines is *medically necessary*. You must pay this amount as well as any costs that you would normally be required to pay for *covered services*.

Individual Case Management

Individual Case Management is a flexible program for managing your benefits in some situations. Through this program, *Blue Cross and Blue Shield* works with your health care providers to make sure that you get *medically necessary* services in the least intensive setting that meets your needs. Individual Case Management is for a *member* whose condition may otherwise require *inpatient* hospital care. Under Individual Case Management, coverage for services in addition to those described in this Benefit Description may be approved to:

- Shorten an *inpatient* stay by sending a *member* home or to a less intensive setting to continue treatment;
- Direct a *member* to a less costly setting when an *inpatient* admission has been proposed; or
- Prevent future inpatient stays by providing outpatient benefits instead.

Blue Cross and Blue Shield may, in some situations, present a specific alternative treatment plan to you and your attending physician. This treatment plan will be one that is *medically necessary* for you. *Blue Cross and Blue Shield* will need the full cooperation of everyone involved: the patient (or guardian); the hospital; the attending physician; and the proposed setting or health care provider. Also, there must be a written agreement between the patient (or family or guardian) and *Blue Cross and Blue Shield*, and between the provider and *Blue Cross and Blue Shield* to furnish the services approved through this alternative treatment plan.

Part 5

Covered Services

There are two levels of benefits under this health plan. You will receive the highest level of benefits when you obtain *covered services* from a *preferred provider*. These are called your “in-network benefits.” When you obtain *covered services* from a covered health care provider that is not a *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.”

You have the right to the benefits described in this section, except as otherwise limited or excluded in this Benefit Description. **Be sure to read this section along with Part 4 for the requirements you must follow to receive benefits and the limitations and exclusions in Part 6, as well as all sections of this Benefit Description. Pay close attention to all *benefit limits* described in this section. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply. When this occurs, you must pay all charges.**

Admissions for *Inpatient Medical and Surgical Care*

Inpatient Medical and Surgical Services	In-Network, you pay	Out-of-Network, you pay
In a general, chronic disease or rehabilitation hospital, skilled nursing facility or Christian Science sanatorium (<i>benefit limit of 120 total inpatient days per member per calendar year</i>)	<ul style="list-style-type: none"> Hospital and other covered facility inpatient services 	
	Nothing after \$100 per admission inpatient copayment	40% coinsurance after \$250 overall deductible
	<ul style="list-style-type: none"> Physician and other covered professional provider inpatient services 	
	Nothing	40% coinsurance after \$250 overall deductible
	(See also “Maternity Services and Well Newborn <i>Inpatient Care</i> .”)	

This health plan provides benefits based on the *allowed charge* for *medically necessary inpatient* admissions in a general, chronic disease or rehabilitation hospital, skilled nursing facility or Christian Science sanatorium. These benefits include:

- Semiprivate *room and board* and *special services*.
- Surgery furnished by a physician, or nurse practitioner and services of an assistant surgeon (physician) when *Blue Cross and Blue Shield* decides an assistant is needed. These surgical services include (but are not limited to):
 - Reconstructive surgery. This non-dental surgery is meant to improve or give back bodily function or correct a functional physical impairment that was caused by a birth defect, a prior surgical procedure or disease or an accidental injury. This also includes surgery to correct a deformity or disfigurement that was caused by an accidental injury.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

This includes reconstructive surgery for a *member* who is receiving benefits for a mastectomy and who elects breast reconstruction in connection with the mastectomy. This health plan provides benefits for: reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas. These services will be furnished in a manner determined in consultation with the attending physician and the patient.

- Human organ and stem cell (“bone marrow”) transplants furnished in accordance with *Blue Cross and Blue Shield* medical policy and *medical technology assessment guidelines*. This includes one or more stem cell transplants for a *member* who has been diagnosed with breast cancer that has spread. For covered transplants, benefits also include the harvesting of the donor’s organ or stem cells when the recipient is a *member* (“harvesting” includes the surgical removal of the donor’s organ or stem cells and related *medically necessary* services and/or tests that are required to perform the transplant itself) and drug therapy during the transplant procedure to prevent rejection of the transplanted organ/tissue or stem cells. (See “Lab Tests, X-Rays and Other Tests” for benefits for transplant donor suitability testing.) No benefits are provided for the harvesting of the donor’s organ or stem cells when the recipient is not a *member*.
- Oral surgery. This includes: reduction of a dislocation or fracture of the jaw or facial bone; excision of a benign or malignant tumor of the jaw; and orthognathic surgery that you need to correct a significant functional impairment that cannot be adequately corrected with orthodontic services but only if you have a serious medical condition that requires that you be admitted to a hospital as an *inpatient* in order for the surgery to be safely performed. (No benefits are provided for orthognathic surgery when it is performed primarily for cosmetic reasons. This surgery must be performed along with orthodontic services. If it is not, the oral surgeon must send a letter to *Blue Cross and Blue Shield* asking for approval for the surgery. But, no benefits are provided for the orthodontic services.)

Covered oral surgery also includes removal of impacted teeth that are fully or partially imbedded in the bone.

- Voluntary sterilization procedures.
- Anesthesia services furnished by a physician other than the attending physician or by a certified registered nurse anesthetist, when the anesthesia is related to covered surgery.
- Radiation and x-ray therapy furnished by a physician. This includes: radiation therapy using isotopes, radium, radon or other ionizing radiation; and x-ray therapy for cancer or when used in place of surgery.
- Chemotherapy (drug therapy for cancer) furnished by a physician.
- Interpretation of *diagnostic x-ray and other imaging tests, diagnostic lab tests* and diagnostic machine tests furnished by a physician, when these tests are not furnished by a hospital-based radiologist or pathologist.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

- Medical care furnished by a physician, nurse practitioner or Christian Science practitioner and medical care by a physician other than the attending physician to treat an uncommon aspect or complication of your illness or injury. This health plan provides benefits for medical care by two or more physicians at the same time only when *Blue Cross and Blue Shield* decides that the care is needed to treat a critically ill patient. The second physician must be an expert in a different medical sub-specialty than the attending physician. If the second physician is an expert in the same medical sub-specialty as the attending physician, this health plan provides benefits only for the services of the attending physician.
- Monitoring services related to dialysis when furnished by a covered health care provider.
- Consultations furnished by a physician other than the attending physician. The consultation must be needed to diagnose or treat the condition for which you were admitted. Or, it must be for a complication that develops after you are an *inpatient*. The attending physician must order the consultation. The physician who furnishes it must send a written report to *Blue Cross and Blue Shield* if it asks for one. The physician who furnishes this consultation for you must be an expert in a different medical sub-specialty than the attending physician. If the consultant is an expert in the same medical sub-specialty as the attending physician, this health plan provides benefits only for the services of the attending physician.
- Intensive care services furnished by a physician other than the attending physician or by a nurse practitioner. This means services that are needed for only a limited number of hours to treat an uncommon aspect or complication of your illness or injury.
- Emergency admission services furnished by a physician or nurse practitioner. This means a complete history and physical exam of a *member* who is admitted as an *inpatient* for *emergency medical care*, when the treatment is taken over immediately by another physician.
- Pediatric specialty care furnished by covered health care providers with recognized expertise in specialty pediatrics.
- Second surgical opinions furnished by a physician. This includes a third surgical opinion when the second surgical opinion differs from the first.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

Ambulance Services

Emergency and Other Medically Necessary Ambulance Transport	In-Network, you pay	Out-of-Network, you pay
	<ul style="list-style-type: none"> <li data-bbox="542 499 873 531">Air ambulance transport 	
	20% <i>coinsurance</i>	40% <i>coinsurance</i> after <i>deductible</i>
	<ul style="list-style-type: none"> <li data-bbox="542 604 1382 699">Ground ambulance transport (emergency and other <i>medically necessary</i> ambulance transport) up \$1,200 <i>benefit limit</i> per day per <i>member</i> 	
	All amounts in excess of the \$1,200 <i>benefit limit</i>	All amounts in excess of the \$1,200 <i>benefit limit</i> (<i>deductible</i> does not apply)

This health plan provides benefits based on the *allowed charge* for:

- Emergency Ambulance Transport.** These benefits include ambulance transport to an emergency medical facility for *emergency medical care*. For example, covered ambulance services include transport from an accident scene or to a hospital due to symptoms of a heart attack. These benefits include air ambulance transport to take you to a hospital when your emergency medical condition requires the use of an air ambulance rather than a ground ambulance. **If you need assistance at the onset of an emergency medical condition that in your judgment requires *emergency medical care*, call your local emergency medical service system by dialing the emergency telephone access number 911, or the local emergency telephone number.**
- Other Medically Necessary Ambulance Transport.** These benefits include other *medically necessary* ambulance transport furnished by an ambulance service to take you to or from the nearest hospital (or another covered facility). This includes ambulance transport that is needed for a *mental condition*.

No benefits are provided for taxi or chair car service or to transport the *member* to or from medical appointments.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

Chiropractic Services

Chiropractic Service	In-Network, you pay	Out-of-Network, you pay
(\$1,500 <i>benefit limit</i> per member per calendar year).	20% <i>coinsurance</i> after a \$25 per visit deductible.	No coverage

This health plan provides benefits for chiropractic services under the following conditions:

- The services are rendered by a licensed Blue Cross and Blue Shield provider.
- You are responsible for a \$25 copayment, plus a 20% coinsurance per visit.
- The maximum benefit available is \$1500 in actual charges per illness or accident. This maximum applies to the full charge for the visit(s) and not the reimbursement made by the health plan for the visit(s).

Note: No reimbursement is available for services rendered by providers not licensed by Blue Cross and Blue Shield.

Dialysis Services

Outpatient Dialysis Services and Home Dialysis	In-Network, you pay	Out-of-Network, you pay
(\$300 <i>benefit limit</i> for home dialysis installation)	Nothing	40% <i>coinsurance</i> after <i>deductible</i>

This health plan provides benefits based on the *allowed charge* for:

- *Outpatient* dialysis furnished by a general or chronic disease hospital, community health center, free-standing dialysis facility or physician.
- Home dialysis that is under the direction of a general or chronic disease hospital or free-standing dialysis facility. These benefits include: non-durable medical supplies such as dialysis membrane and solution, tubing and drugs needed during dialysis; and the cost to maintain or fix dialysis equipment. *Blue Cross and Blue Shield* will decide whether to rent or to buy the dialysis equipment. If the dialysis equipment is bought, this health plan keeps ownership rights to this equipment. It does not become your property. No benefits are provided for: costs to get or supply power, water or waste disposal systems; costs of a person to help with the dialysis procedure; and costs not needed to run the dialysis equipment.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

Durable Medical Equipment

Durable Medical Equipment Bought or Rented for Home Use	In-Network, you pay	Out-of-Network, you pay
(\$5,000 <i>benefit limit</i> per <i>member</i> per calendar year combined with benefits for prosthetic devices).	20% <i>coinsurance</i>	40% <i>coinsurance</i> after <i>deductible</i>
	(The <i>benefit limit</i> does not apply when durable medical equipment is furnished as part of covered home dialysis, home health care or hospice services.)	

This health plan provides benefits based on the *allowed charge* for durable medical equipment you buy or rent from an appliance company. These benefits include equipment that: can stand repeated use; serves a medical purpose; is medically necessary for you; is not useful if you are not ill or injured; and can be used in the home. Some examples of covered durable medical equipment include (but are not limited to):

- Hospital beds; wheelchairs; crutches; and walkers.
- Knee and back braces.
- Orthopedic and corrective shoes that are part of a leg brace.
- Glucometers that are *medically necessary* due to the patient's type of diabetic condition.
- Visual magnifying aids and voice-synthesizers for a legally blind *member* who has insulin dependent, insulin using, gestational or non-insulin dependent diabetes.
- Insulin injection pens.

***Blue Cross and Blue Shield* will decide whether to rent or buy the durable medical equipment.**

If *Blue Cross and Blue Shield* decides to rent the equipment, benefits will not be more than the amount that would have been paid if the equipment were bought. If the equipment is bought, this health plan keeps ownership rights to the equipment. It does not become your property.

This health plan provides these benefits for the least expensive equipment of its type that meets your needs. If *Blue Cross and Blue Shield* determines that you chose durable medical equipment that costs more than what you need for your medical condition, this health plan will provide benefits only for those charges that would have been paid for the least expensive equipment that meets your needs. In this case, you pay the provider's charges that are more than the claim payment.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

Early Intervention Services

Outpatient Early Intervention Services	In-Network, you pay	Out-of-Network, you pay
(\$5,200 <i>benefit limit</i> per eligible child per calendar year; \$15,600 lifetime)	20% <i>coinsurance</i>	40% <i>coinsurance</i> after <i>deductible</i>

This health plan provides benefits based on the *allowed charge* for early intervention services furnished by an early intervention provider for enrolled dependent children from birth through age two (until the child turns three years old). These benefits include: physical, speech/language and occupational therapy; nursing care; and psychological counseling.

Emergency Room Services

Outpatient Emergency and Accident Medical Treatment	In-Network, you pay	Out-of-Network, you pay
	\$100 <i>copayment</i> per visit for facility services	\$100 <i>copayment</i> per visit for facility services (<i>deductible</i> does not apply)
	(The emergency room <i>copayment</i> is waived when your visit is for an overnight observation stay or if you are admitted as an <i>inpatient</i> .)	

This health plan provides benefits based on the *allowed charge* for *outpatient emergency medical care* furnished at an emergency room of a general hospital. **At the onset of an emergency medical condition that in your judgment requires *emergency medical care*, you should go to the nearest emergency room. For assistance, call your local emergency medical service system by dialing the emergency telephone access number 911, or the local emergency telephone number.** (See Part 3 for more information about your benefits for emergency medical services.)

Home Health Care

Medically Necessary Home Health Care	In-Network, you pay	Out-of-Network, you pay
By a visiting nurse association, coordinated home health agency or home infusion therapy provider (no <i>benefit limit</i>)	20% <i>coinsurance</i>	40% <i>coinsurance</i> after <i>deductible</i>
	(The short-term rehabilitation therapy <i>benefit limit</i> does not apply when physical, speech and/or occupational therapy services are furnished as part of a covered home health care program.)	

This health plan provides benefits based on the *allowed charge* for *medically necessary* home

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific covered service, no more benefits are provided for the specific service or supply.

health care. These benefits include:

- Part-time skilled nursing visits and physical therapy furnished by a visiting nurse association.
- Part-time skilled nursing visits, physical therapy, speech/language therapy, occupational therapy, medical social work, nutrition counseling, home health aide services, medical supplies, durable medical equipment, enteral infusion therapy and basic hydration therapy furnished by a coordinated home health agency.
- Home infusion therapy, including the infusion solution, preparation of the solution and equipment for its administration and necessary part-time nursing furnished by a home infusion therapy provider.

This health plan provides these benefits only when you are expected to reach a defined medical goal set by your attending physician and, for medical reasons, you are not reasonably able to travel to another treatment site where medically appropriate care can be furnished for your condition.

No benefits are provided for: meals, personal comfort items and housekeeping services; custodial care; treatment of *mental conditions*; and home infusion therapy, including the infusion solution, when furnished by a pharmacy or other provider that is not a home infusion therapy provider (except for enteral infusion therapy and basic hydration therapy by a coordinated home health agency).

Note: You must obtain prior approval as specified under Part 4: Utilization Review Requirements on page 19.

Hospice Services

Inpatient and/or Outpatient Hospice Services	In-Network, you pay	Out-of-Network, you pay
(includes respite care and bereavement services)	Nothing	Nothing (<i>deductible</i> does not apply)

This health plan provides benefits based on the *allowed charge* for hospice services furnished by a hospice provider. These benefits include:

- Services arranged by the hospice provider such as home health aide visits, drugs, durable medical equipment and skilled nursing visits.
- Respite care. This care is furnished to the hospice patient in order to relieve the family or primary care person from care giving functions.
- Bereavement services. These services are provided to the family or primary care person after the death of the hospice patient. They can include contacts, counseling, communication and correspondence.

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This health plan provides these benefits only when: the patient has a terminal illness and is expected to live six months or less (as certified by a physician); the patient and attending physician have agreed to a plan of care that stresses pain control and symptom relief rather than curative treatment; an adult is the primary care person in the home; and the patient lives in the service area of the hospice provider.

Infertility Services

Tests and Surgical Services to Diagnose and/or Treat Infertility	In-Network, you pay	Out-of-Network, you pay
(limited to infertility providers designated by Blue Cross and Blue Shield subject to the annual <i>benefit limit</i> .)	• Outpatient lab tests and x-rays	
	10% <i>coinsurance</i>	40% <i>coinsurance</i> after <i>deductible</i>
	• Outpatient surgical services (includes related anesthesia)	
	Nothing	40% <i>coinsurance</i> after <i>deductible</i>
	• Outpatient medical care services	
	\$25 copayment per visit then 20% <i>coinsurance</i>	40% <i>coinsurance</i> after <i>deductible</i>
(See also “Admissions for <i>Inpatient</i> Medical and Surgical Care.”)		

Note: this coverage is limited to a \$5,000 *benefit limit* per *member* per calendar year for all Infertility Services. You are responsible for all charges in excess of the \$5,000 *benefit limit*.

This health plan provides benefits based on the *allowed charge* for *diagnostic lab tests, diagnostic x-rays and other imaging tests* and surgical services to diagnose and treat infertility for a healthy *member* who is unable to conceive or produce conception during a period of one year. These benefits include: artificial insemination; sperm, egg and/or inseminated egg procurement and processing; banking of sperm or inseminated eggs (provided these charges are not covered by the donor’s health plan); and infertility technologies (such as in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer, natural oocyte retrieval intravaginal fertilization, intracytoplasmic sperm injection and assisted embryo hatching). **All services must be furnished in accordance with Blue Cross and Blue Shield medical policy and medical technology assessment guidelines.**

All covered services must be medically necessary for you and furnished by an infertility provider designated by Blue Cross and Blue Shield. If Blue Cross and Blue Shield determines that infertility services are not medically necessary for you or you receive services from an infertility provider not designated by Blue Cross and Blue Shield, no benefits will be provided for these services.

No benefits are provided for: *outpatient* long term sperm or egg preservation or long term cryopreservation not associated with active infertility treatment; costs that are associated with achieving pregnancy through surrogacy (gestational carrier); and infertility treatment that is needed as

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a result of a prior sterilization or unsuccessful sterilization reversal procedure. (This health plan will provide benefits for *medically necessary* infertility treatment that is needed after a sterilization reversal procedure that is successful as determined by appropriate diagnostic tests.)

Lab Tests, X-Rays and Other Tests

Outpatient Diagnostic Tests, Including Preoperative Tests	In-Network, you pay	Out-of-Network, you pay
	10% <i>coinsurance</i>	40% <i>coinsurance</i> after <i>deductible</i>

Diagnostic Tests

This health plan provides benefits based on the *allowed charge* for:

- *Diagnostic lab tests* furnished by a general, chronic disease, rehabilitation or mental hospital, surgical day care unit, ambulatory surgical facility, community health center, independent lab, physician or nurse practitioner. These tests also include diagnostic machine tests (such as pulmonary function tests and holter monitoring).
- *Diagnostic x-ray and other imaging tests* furnished by a general, chronic disease, rehabilitation or mental hospital, surgical day care unit, ambulatory surgical facility, community health center or physician. These tests also include diagnostic imaging tests by a free-standing diagnostic imaging facility.
- Preoperative tests furnished by a general hospital or community health center (that is part of a hospital). These tests must be performed before a scheduled *inpatient* or surgical day care unit admission for surgery. And, they must not be repeated during the admission. These tests include: *diagnostic lab tests*; *diagnostic x-ray and other imaging tests*; and diagnostic machine tests (such as pulmonary function tests).
- Human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to establish stem cell (“bone marrow”) transplant donor suitability when the tests are furnished to a *member* by a covered health care provider. This includes testing for A, B or DR antigens or any combination.

Routine Pap Smear Tests

Annual Routine Pap Smear Tests	In-Network, you pay	Out-of-Network, you pay
(<i>benefit limit</i> of one test per <i>member</i> per calendar year).	10% <i>coinsurance</i>	40% <i>coinsurance</i> after <i>deductible</i>

This health plan provides benefits based on the *allowed charge* for routine Pap smear tests furnished by a general hospital, community health center, independent lab, physician, nurse midwife or nurse practitioner. (See “Diagnostic Tests” above for your benefits for *diagnostic lab tests*.)

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Maternity Services and Well Newborn *Inpatient* Care

Obstetrical Care	In-Network, you pay	Out-of-Network, you pay
(inpatient and outpatient services related to pregnancy and childbirth, including prenatal and postnatal care and delivery))	<ul style="list-style-type: none"> <i>Inpatient</i> maternity admissions (See “Admissions for <i>Inpatient</i> Medical and Surgical Care” for <i>inpatient benefit limit</i>) 	
	Nothing after \$100 <i>inpatient copayment</i>	40% <i>coinsurance</i> after <i>deductible</i>
	<ul style="list-style-type: none"> <i>Outpatient</i> obstetrical services (includes prenatal and postnatal care) 	
	Nothing*	40% <i>coinsurance</i> after <i>deductible</i>
	*The benefits for prenatal and postnatal care furnished by a physician or nurse midwife are included in the payment for the delivery. You may be responsible for 20% <i>coinsurance</i> for services billed separately from the all inclusive, global physicians’ fee.	

Maternity Services

This health plan provides benefits based on the *allowed charge* for all medical care related to pregnancy and childbirth (or miscarriage) for any female *member*. These benefits include:

- Semiprivate *room and board* and *special services* when the enrolled mother is an *inpatient* in a general hospital. Nursery charges for a well newborn are included with the benefits for the mother’s maternity admission. The mother’s (and newborn child’s) *inpatient* stay will be no less than 48 hours following a vaginal delivery or 96 hours following a Caesarian section unless the mother and her attending physician decide otherwise as provided by law. If the mother chooses to be discharged earlier, this health plan provides benefits for one home visit by a physician, registered nurse, nurse midwife or nurse practitioner within 48 hours of discharge. This visit may include: parent education; assistance and training in breast or bottle feeding; and appropriate tests. This health plan will provide benefits for more visits by a covered health care provider only if *Blue Cross and Blue Shield* determines they are needed.
- Delivery of one or more than one baby, including prenatal and postnatal medical care by a physician or nurse midwife. Your benefits for prenatal and postnatal medical care by a physician or nurse midwife are included in the payment for the delivery. The benefits that are available for these obstetrical services will be those that are in effect on the date of delivery. But, when a physician or nurse midwife furnishes only prenatal and/or postnatal care, benefits are those that are available on the date the care is received.

These benefits also include prenatal and postnatal medical care exams and lab tests by a general hospital or community health center. The benefits that are available for these services are those that are available on the date the care is received.

- Standby attendance furnished by a pediatrician, when a known or suspected complication

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threatening the health of the mother or child requires the presence of a pediatrician during the delivery.

All expectant mothers enrolled in this health plan may take part in a program that provides support and education for expectant mothers. Through this program, *members* receive outreach and education that add to the care the *member* gets from her obstetrician or nurse midwife. You may call the *Blue Cross and Blue Shield* customer service office for more information.

No benefits are provided for childbirth classes.

Well Newborn Inpatient Care

Well Newborn Care During the Mother's Maternity Admission	In-Network, you pay	Out-of-Network, you pay
(See "Maternity Services" above your benefits for nursery room charges.)	Nothing	40% <i>coinsurance</i> after <i>deductible</i>

This health plan provides benefits based on the *allowed charge* for well newborn care furnished during the enrolled mother's *inpatient* maternity stay. These benefits include:

- Pediatric care furnished by a physician (who is a pediatrician) or nurse practitioner for a well newborn. (These visits are counted toward the *benefit limit* that applies for subsequent visits for *outpatient* routine pediatric care received during the first year of life.)
- Routine circumcision furnished by a physician.
- Newborn hearing screening tests performed by a covered health care provider before the newborn child (an infant under three months of age) is discharged from the hospital to the care of the parent or guardian.

Note: See "Admissions for *Inpatient* Medical and Surgical Care" for benefits when an enrolled newborn child requires *medically necessary inpatient* care.

Medical Formulas

Medically Necessary Formulas and Foods for Certain Conditions	In-Network, you pay	Out-of-Network, you pay
(<i>benefit limit</i> applies for food products modified to be low protein)	Nothing	Nothing (<i>deductible</i> does not apply)

This health plan provides benefits based on the *allowed charge* for:

- Special medical formulas that are *medically necessary* to treat: homocystinuria; maple

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syrup urine disease; phenylketonuria; propionic acidemia; methylmalonic acidemia; and tyrosinemia.

- Enteral formulas for home use that are *medically necessary* to treat malabsorption caused by: Crohn's disease; chronic intestinal pseudo-obstruction; gastroesophageal reflux; gastrointestinal motility; ulcerative colitis; and inherited diseases of amino acids and organic acids.
- Food products modified to be low protein that are *medically necessary* to treat inherited diseases of amino acids and organic acids for up to a \$5,000 *benefit limit* for each *member* in each calendar year. You may buy these food products directly from a distributor.

Medication Management of Psychiatric Drugs

Outpatient Medication Management Visits	In-Network, you pay	Out-of-Network, you pay
(<i>benefit limit</i> of 4 <i>outpatient</i> visits per member per calendar year)	Nothing	Nothing (<i>deductible</i> does not apply)

This health plan provides benefits based on the *allowed charge* for *outpatient* monitoring and medication management for *members* taking psychiatric drugs, when these services are furnished by a general, chronic disease or rehabilitation hospital, community health center, physician, nurse practitioner or *mental health provider*. This benefit is separate from the benefit for outpatient medical care.

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Mental Health/Substance Abuse Outpatient Visits

Outpatient Visits for Treatment of Mental Conditions, Including Drug Addiction and Alcoholism	In-Network, you pay	Out-of-Network, you pay
(benefit limit of 1 visit per week up to 24 visits per member per calendar year)	• Visits 1 through 12 each calendar year	
	Nothing	Nothing (deductible does not apply)
	• Visits 13 through 24 each calendar year	
	20% coinsurance	20% coinsurance (deductible does not apply)
	(The <i>benefit limit</i> does not apply to electric shock therapy.)	

When you need *outpatient* services to diagnose or treat a *mental condition* (including drug addiction and alcoholism), this health plan provides benefits based on the *allowed charge* for psychiatric services furnished by a *mental health provider*. These benefits include:

- Services to diagnose or treat a biologically-based *mental condition*. “Biologically-based *mental conditions*” means: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder; delirium and dementia; affective disorders; and any biologically-based *mental conditions* appearing in the most recent edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders that are scientifically recognized and approved by the Commissioner of the Department of Mental Health in consultation with the Commissioner of the Division of Insurance.
- Treatment of rape-related mental or emotional disorders for victims of a rape or victims of an assault with intent to rape.
- Services to diagnose or treat non-biologically-based *mental conditions* (including drug addiction and alcoholism).

No benefits are provided for: *inpatient* admissions for mental health and/or substance abuse treatment other than electric shock treatment; and psychiatric services for a condition that is not a *mental condition*.

Note: The benefits described in this Benefit Description do not include *inpatient* services for mental health and/or substance abuse treatment, except for electric shock therapy. For these *covered services*, your *inpatient* benefits are the same as those described for *inpatient* medical care except that benefits may also be provided for admissions in a mental hospital or substance abuse treatment facility. See “Admissions for *Inpatient* Medical and Surgical Care” for more information. Please see Section II, Benefits Administered by MIT Health Plans, for additional information on *Inpatient* Mental Health/Substance Abuse Admissions.

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Outpatient Medical Care

Outpatient Medical Care	In-Network, you pay	Out-of-Network, you pay
(There is a 4 visit/year <i>benefit limit</i> , combined in-network and out-of-network. This <i>benefit limit</i> is combined with Podiatry Care.)	\$25 <i>copayment</i> , then 20% <i>coinsurance</i>	40% <i>coinsurance</i> after <i>deductible</i>

This benefit is for medically necessary urgent care. No coverage is available for routine services which must be provided at MIT Medical and are covered under the MIT Affiliate Medical Plan. Covered services include:

- Medically necessary provided in an office, health center, or hospital clinic or outpatient department
- Outpatient medical care services to diagnose or treat your illness or injury
- Second and third surgical opinions
- Specialty consultations
- Follow-up care related to an accidental injury or emergency medical condition
- Injections (non allergy)
- Diabetes self-management training and education
- Outpatient medical exams and contact lenses (plus the fitting of contact lenses) to treat keratoconus.

Oxygen and Equipment

Oxygen for Home Use	In-Network, you pay	Out-of-Network, you pay
	20% <i>coinsurance</i>	40% <i>coinsurance</i> after <i>deductible</i>

This health plan provides benefits based on the *allowed charge* for oxygen and the equipment to administer it for use in the home when obtained from an oxygen supplier. This includes oxygen concentrators.

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Pediatric Care for a Well Child

Routine Pediatric Care Through Age 5	In-Network, you pay	Out-of-Network, you pay
(<i>benefit limit</i> applies based on age-based schedule—see below)	20% <i>coinsurance</i>	40% <i>coinsurance</i> after <i>deductible</i>

This health plan provides benefits based on the *allowed charge* for routine pediatric care through age 5, when these services are furnished by a general hospital, community health center, independent lab, physician or nurse practitioner. These benefits include:

- Routine medical exams and related routine services furnished in accordance with *Blue Cross and Blue Shield* medical policy guidelines.
- Hereditary and metabolic screening at birth.
- Appropriate immunizations (including flu shots and travel immunizations).
- Tuberculin tests.
- Hematocrit, hemoglobin and other appropriate blood tests.
- Urinalysis.
- Blood tests to screen for lead poisoning.

These benefits are limited to the following age-based schedule: ten visits during the first year of life (birth to age one), less any *inpatient* pediatric visits for a well newborn; three visits during the second year of life (age one to age two); and one visit each calendar year from age two through age 5.

For an enrolled dependent child who gets benefits for hepatitis B vaccine from a state agency, this health plan provides benefits only to administer the vaccine. Otherwise, this health plan also provides benefits for the hepatitis B vaccine when the child is at high risk for getting the disease.

No benefits are provided for: exams that are needed to take part in school, camp and sports activities or by third parties (except when these exams are furnished as part of a covered routine exam); and routine services and tests for a *member* age 6 or older.

Pharmacy Services and Supplies

This health plan covers certain drugs and supplies that you buy from a network pharmacy. This coverage is provided **only** when all of the following criteria are met.

- The drug or supply that you buy is listed on the *Blue Cross and Blue Shield* Drug Formulary as a covered drug or supply.
- The drug or supply that you buy is prescribed for your use out of the hospital or another health care facility.
- The drug or supply that you buy is purchased from a network pharmacy that is approved

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by *Blue Cross and Blue Shield* for payment for the specific covered drug and/or supply. This means that for most covered drugs and supplies, you may buy your drug or supply from any network retail pharmacy. However, for a select number of covered drugs and supplies, you may need to buy your drug or supply from certain network pharmacies that specialize in treating specific diseases and that have been approved by *Blue Cross and Blue Shield* for payment for that specific covered drug or supply.

Drug Formulary. The *Blue Cross and Blue Shield* Drug Formulary is a list of *Blue Cross and Blue Shield* approved drugs and supplies. Under its agreement with the plan sponsor, *Blue Cross and Blue Shield* has the right to update its Drug Formulary from time to time. In this case, your coverage for certain drugs and supplies may change. For example, a drug may be added to or excluded from the Drug Formulary; or a drug may change from one member cost-share level to another member cost-share level. For the list of drugs that are not included on the *Blue Cross and Blue Shield* Drug Formulary, you may access this information on-line at www.bluecrossma.com/pharmacy. You may check for updates or obtain more information about the *Blue Cross and Blue Shield* Drug Formulary, including which drugs are not included on the formulary, by calling the *Blue Cross and Blue Shield* customer service office. The toll-free phone number is shown on the back of your health plan ID card. You may also go online and log on to the *Blue Cross and Blue Shield* internet website at www.bluecrossma.com.

Drug Formulary Exception Process. Prescriptions for non-formulary medications must be obtained through the MIT Pharmacy. The MIT Pharmacy will obtain the medication from another pharmacy. Medications obtained in this manner will be subject to the MIT Pharmacy *copayment* amount.

Blue Cross and Blue Shield also includes a Drug Formulary Exception Process for medications obtained from a network pharmacy. This process allows your prescribing health care provider to ask for an exception from *Blue Cross and Blue Shield*. This exception is to ask for coverage for a drug (or supply) that is not on the *Blue Cross and Blue Shield* Drug Formulary. *Blue Cross and Blue Shield* will consider a Drug Formulary exception request if there is a medical basis for your not being able to take, for your condition, any of the covered drugs or an over-the-counter drug. If the Drug Formulary exception request is approved by *Blue Cross and Blue Shield*, you will receive coverage for the drug (or supply) that is not on the *Blue Cross and Blue Shield* Drug Formulary. For this drug (or supply), you will pay the highest *member* cost-share amount.

Buying Covered Drugs and Supplies. For questions regarding your pharmacy coverage contact Claims and Member Services at 617-253-5979. For help to obtain your pharmacy coverage at a Network pharmacy, you may call the *Blue Cross and Blue Shield* customer service office. The toll-free phone number is shown on the back of your health plan ID card. A *Blue Cross and Blue Shield* customer service representative can help you find a pharmacy where you may buy a specific drug or supply. They can also help you find out which *member* cost-share level you will pay for a specific covered drug or supply. Or, you may also go online and log on to the *Blue Cross and Blue Shield* internet website at www.bluecrossma.com.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

Pharmacy Benefits		MIT Pharmacy copay and limitations	Express Scripts copay and limitations
Members can choose to obtain their prescription medications through the MIT Pharmacy or from a network pharmacy. There are benefit differences and may be differences in the Formulary	Rx copay	\$15/ up to a 30-day supply	\$25/ up to a 30-day supply
	Supply limit	For many drugs, up to a 90-day supply for double the 30-day copayment	Limited to a 30-day supply per fill
	Annual benefit limit	\$3,500 per member per year, combined with Express Scripts claims	\$1,000 per member per year
	Prescribing physician	Prescription must be written by an MIT clinician or by a provider to whom member was referred by an MIT clinician	No restrictions
	Mental health prescriptions	Member must notify MIT Medical, so a referral can be entered before prescription can be filled	No restrictions
	Mail order	Available through MIT Pharmacy; request can be submitted through Patient Online.	Not available
	Note: Members of the MIT Student Extended Insurance Plan must fill all prescriptions at the MIT Pharmacy or a participating Express Scripts pharmacy. There is no reimbursement for prescriptions filled at a non-participating pharmacy		

(When you buy your drug or supply, the pharmacist will give you a generic equivalent of the prescribed drug whenever it is allowed.)

Covered Drugs and Supplies. This pharmacy coverage is provided for:

- Drugs that require a prescription by law and are furnished in accordance with *Blue Cross and Blue Shield medical technology assessment guidelines*. These include: birth control drugs; oral diabetes medication that influences blood sugar levels; hormone replacement therapy drugs for peri- and post-menopausal women; and certain drugs used on an off-label basis (such as: drugs used to treat cancer; and drugs used to treat HIV/AIDS).
- Injectable insulin and disposable syringes and needles needed for its administration, whether or not a prescription is required. (When a *copayment* applies to your pharmacy coverage, if insulin, syringes and needles are bought at the same time, you pay two *copayments*: one for the insulin; and one for the syringes and needles.)
- Materials to test for the presence of sugar when they are ordered for you by a physician for home use. These include: blood glucose monitoring strips; ketone strips; lancets; urine glucose testing strips; normal, low and high calibrator solution/chips; and dextrostik or glucose test strips. (See “Durable Medical Equipment” for your coverage for glucometers.)
- Insulin injection pens.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

- Insulin infusion pumps and related pump supplies. (You will obtain the insulin infusion pump from an appliance company instead of a pharmacy. For the insulin infusion pump itself, the cost you would normally pay for covered drugs and supplies will be waived.)
- Syringes and needles when *medically necessary* for you.
- Drugs that do not require a prescription by law (“over-the-counter” drugs), if any, that are listed on the *Blue Cross and Blue Shield* Drug Formulary as a covered drug. Your Pharmacy Program booklet will list the over-the-counter drugs that are covered, if there are any. Or, you may go online and log on to the *Blue Cross and Blue Shield* internet website at www.bluecrossma.com.
- Diaphragms and other prescription birth control devices that have been approved by the U.S. Food and Drug Administration (FDA). For these, you pay the cost of the lowest *member* cost-share level.
- Prescription prenatal vitamins and pediatric vitamins with fluoride.
- Nicotine gum or nicotine patches (or other smoking cessation aids that require a prescription by law) when they are prescribed by a physician. This health plan limits this coverage to three 30-day supply for each member in each calendar year.

Non-Covered Drugs and Supplies. No pharmacy benefits are provided for:

- Anorexiant.
- Pharmaceuticals that you can buy without a prescription, except as described above.
- Medical supplies such as dressings and antiseptics.
- The cost of delivering drugs to you.
- Combination vitamins that require a prescription, except for: prescription prenatal vitamins; and pediatric vitamins with fluoride.
- Dental topical fluoride, rinses and gels that require a prescription.
- Immunizing agents; toxoids; blood; and blood products.
- Drugs and supplies that you buy from a non-network retail pharmacy. The only exception is when you are traveling outside of the *service area* and a network retail pharmacy is not reasonably available to you. In this case, you may fill your prescription at any retail pharmacy. But, you must pay all charges at the time you buy your drug. Then, you should call the *Blue Cross and Blue Shield* customer service office for a claim form to file your claim. *Blue Cross and Blue Shield* will repay you, less the amount you would normally pay for covered drugs and supplies.
- Drugs and supplies that you buy from a non-designated retail or mail service pharmacy.
- Drugs and supplies that you buy from a pharmacy that has not been approved by *Blue Cross and Blue Shield* for payment for the specific covered drug or supply.
- Non-sedating antihistamines.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

- Drugs and supplies that are dispensed or administered by health care providers, when they are supplied by the provider during the visit. This includes health care providers such as: physician assistants; home health care providers; and visiting nurses.

Physical Therapy

See short-term rehabilitation therapy.

Podiatry Care

Outpatient Medically Necessary Foot Care	In-Network, you pay	Out-of-Network, you pay
(There is a 4 visit/year <i>benefit limit</i> , combined in-network and out-of-network. This <i>benefit limit</i> is combined with Outpatient medical care.)	<ul style="list-style-type: none"> • Outpatient lab tests and x-rays 	
	10% <i>coinsurance</i>	40% <i>coinsurance</i> after <i>deductible</i>
	<ul style="list-style-type: none"> • Outpatient surgical services (includes related anesthesia) 	
	Nothing	40% <i>coinsurance</i> after <i>deductible</i>
	<ul style="list-style-type: none"> • <i>Outpatient</i> medical care (subject to annual <i>benefit limit</i> for outpatient medical care) 	
	\$25 copayment, then 20% <i>coinsurance</i>	40% <i>coinsurance</i> after <i>deductible</i>
(See also “Admissions for <i>Inpatient</i> Medical and Surgical Care.”)		

This health plan provides benefits based on the *allowed charge* for non-routine podiatry (foot) care furnished by a general hospital, surgical day care unit, ambulatory surgical facility, community health center or physician. These benefits include and are limited to *diagnostic lab tests*; diagnostic x-rays; and surgical services (including related anesthesia).

No benefits are provided for: certain foot care supplies such as foot orthotics, arch supports, shoe (foot) inserts, orthopedic and corrective shoes that are not part of a leg brace (except as described in this Benefit Description for “Prosthetic Devices”) and fittings, castings and other services related to devices for the feet. See “Outpatient Medical Care” for coverage of medical care provided by a Podiatrist or other provider.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

Prosthetic Devices

Prosthetic Devices	In-Network, you pay	Out-of-Network, you pay
(\$5,000 <i>benefit limit</i> per member per calendar year combined with benefits for durable medical equipment)	20% <i>coinsurance</i>	40% <i>coinsurance</i> after <i>deductible</i>

This health plan provides benefits based on the *allowed charge* for prosthetic devices you get from an appliance company. These benefits include devices that are: used to replace the function of a missing body part; made to be fitted to your body as an external substitute; and not useful when you are not ill or injured. Some examples of prosthetic devices include (but are not limited to):

- Artificial arms, legs and eyes.
- Ostomy supplies.
- Urinary catheters.
- Breast prostheses, including mastectomy bras.
- Wigs (scalp hair prostheses) for up to a *benefit limit* of \$500 for each *member* in each calendar year when hair loss is due to chemotherapy, radiation therapy, infections, burns, traumatic injury, congenital baldness and medical conditions resulting in alopecia areata or alopecia totalis (capitus). (No benefits are provided for wigs when hair loss is due to: male pattern baldness; female pattern baldness; or natural or premature aging.)
- Insulin infusion pumps and related pump supplies.
- Therapeutic/molded shoes and shoe inserts for a *member* with severe diabetic foot disease.

This health plan provides these benefits for the least expensive prosthesis of its type that meets your needs. If *Blue Cross and Blue Shield* determines that you chose a prosthesis that costs more than what you need for your medical condition, this health plan will provide benefits only for those charges that would have been paid for the least expensive prosthesis that meets your needs. In this case, you pay the provider's charges that are more than the claim payment.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

Qualified Clinical Trials for Treatment of Cancer

Covered Services Furnished in a Qualified Clinical Trials	In-Network, you pay	Out-of-Network, you pay
(For <i>inpatient</i> admissions, see “Admissions for <i>Inpatient</i> Medical and Surgical Care.”)	These benefits are provided to the same extent as they would have been provided if the patient did not participate in a trial. (For your cost, refer to the applicable <i>covered services</i> sections of Part 5.)	

This health plan provides benefits for health care services received by a *member* who is enrolled in a qualified clinical trial (for treatment of cancer). These benefits are provided for health care services that are consistent with the standard of care for someone with the patient’s diagnosis, consistent with the study protocol, and that would be covered if the patient did not participate in the trial. This includes investigational drugs and devices that have been approved for use as part of the trial. These benefits are provided to the same extent as they would have been provided if the patient did not participate in a trial.

No benefits are provided for:

- Investigational drugs and devices that have not been approved for use in the trial.
- Investigational drugs and devices that are paid for by the manufacturer, distributor or provider of the drug or device, whether or not the drug or device has been approved for use in the trial.
- *Non-covered services* under this health plan.
- Costs associated with managing the research for the trial.
- Items, services or costs that are reimbursed or otherwise furnished by the sponsor of the trial.
- Costs that are inconsistent with widely accepted and established national and regional standards of care.
- Costs for clinical trials that are not “qualified trials” as defined by law.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

Radiation Therapy and Chemotherapy

Outpatient Radiation Therapy and/or Chemotherapy Services	In-Network, you pay	Out-of-Network, you pay
	Nothing	Nothing (<i>deductible</i> does not apply)

This health plan provides benefits based on the *allowed charge* for radiation and x-ray therapy and chemotherapy furnished by a general, chronic disease or rehabilitation hospital, community health center, free-standing radiation therapy and chemotherapy facility, physician, nurse practitioner or other covered health care provider with a recognized expertise in specialty pediatrics. These benefits include:

- Radiation therapy using isotopes, radium, radon or other ionizing radiation.
- X-ray therapy for cancer or when used in place of surgery.
- Drug therapy for cancer (chemotherapy).

Short-Term Rehabilitation Therapy

Outpatient Physical, Speech and/or Occupational Therapy	In-Network, you pay	Out-of-Network, you pay
	<ul style="list-style-type: none"> • Physical therapy (24-visit <i>benefit limit</i> per member per calendar year) 	
	Visits 1-16 each year, 20% <i>coinsurance</i> ; and for visits 17-24 each year, 50% <i>coinsurance</i>	
	<ul style="list-style-type: none"> • Speech/language therapy (24-visit <i>benefit limit</i> per member per calendar year) 	
	Visits 1-16 each year, 20% <i>coinsurance</i> ; and for visits 17-24 each year, 50% <i>coinsurance</i>	
	<ul style="list-style-type: none"> • Occupational therapy (24-visit <i>benefit limit</i> per member per calendar year) 	
	Visits 1-16 each year, 20% <i>coinsurance</i> ; and for visits 17-24 each year, 50% <i>coinsurance</i>	

This health plan provides benefits based on the *allowed charge* for *medically necessary* short-term rehabilitation therapy furnished by a general, chronic disease or rehabilitation hospital, community health center, physical therapist, licensed speech-language pathologist or other covered health care provider with a recognized expertise in specialty pediatrics or, for *covered services* furnished on and after January 1, 2004, an occupational therapist. These benefits include: physical therapy;

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

speech/language therapy; occupational therapy; or an organized program of these combined services.

Note: When physical, speech/language and/or occupational therapy services are furnished as part of an approved home health care program, the *benefit limit* that applies to short-term rehabilitation therapy does not apply. (See “Home Health Care.”)

Speech, Hearing and Language Disorder Treatment

Outpatient Diagnostic Tests and Speech Therapy for Speech, Hearing and Language Disorders	In-Network, you pay	Out-of-Network, you pay
(Note: <i>covered services</i> do not include <i>outpatient</i> medical care services.)	<ul style="list-style-type: none"> Diagnostic tests 	
	10% <i>coinsurance</i>	40% <i>coinsurance</i> after <i>deductible</i>
	<ul style="list-style-type: none"> Speech/language therapy 	
	(See “Short-Term Rehabilitation Therapy.”)	

This health plan provides benefits based on the *allowed charge* for *medically necessary* services to diagnose and treat speech, hearing and language disorders when the services are furnished by a general, chronic disease or rehabilitation hospital, community health center, licensed speech-language pathologist or other covered health care provider with a recognized expertise in specialty pediatrics. These benefits include and are limited to: diagnostic tests; and speech/language therapy (see “Short-Term Rehabilitation Therapy” for your benefits for these *covered services*).

No benefits are provided for *outpatient* medical care services or when these services are furnished in a school-based setting.

Surgery as an Outpatient

Outpatient Surgical Services, Including Related Anesthesia	In-Network, you pay	Out-of-Network, you pay
	Nothing	40% <i>coinsurance</i> after <i>deductible</i>

This health plan provides benefits based on the *allowed charge* for *outpatient* surgical services by a surgical day care unit, ambulatory surgical facility, general, chronic disease or rehabilitation hospital, community health center, physician, nurse practitioner or other covered health care provider with a recognized expertise in specialty pediatrics. These benefits include:

- Routine circumcision.
- Voluntary sterilization procedures.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

- Endoscopic procedures.
- Surgical procedures (including emergency and scheduled surgery). These surgical services include (but are not limited to):
 - Reconstructive surgery. This non-dental surgery is meant to improve or give back bodily function or correct a functional physical impairment that was caused by a birth defect, a prior surgical procedure or disease or an accidental injury. This also includes surgery to correct a deformity or disfigurement that was caused by an accidental injury.

This includes reconstructive surgery for a *member* who is receiving coverage for a mastectomy and who elects breast reconstruction in connection with the mastectomy. As required by federal law, this health plan provides benefits for: reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas. These services will be furnished in a manner determined in consultation with the attending physician and the patient.

- Human organ and stem cell (“bone marrow”) transplants furnished in accordance with *Blue Cross and Blue Shield* medical policy and *medical technology assessment guidelines*. This includes one or more stem cell transplants for a *member* who has been diagnosed with breast cancer that has spread. For covered transplants, benefits also include the harvesting of the donor’s organ or stem cells when the recipient is a *member* (“harvesting” includes the surgical removal of the donor’s organ or stem cells and related *medically necessary* services and/or tests that are required to perform the transplant itself) and drug therapy during the transplant procedure to prevent rejection of the transplanted organ/tissue or stem cells. (See “Lab Tests, X-Rays and Other Tests” for benefits for transplant donor suitability testing.) No benefits are provided for harvesting of the donor’s organ or stem cells when the recipient is not a *member*.
- Oral surgery. This includes: reduction of a dislocation or fracture of the jaw or facial bone; excision of a benign or malignant tumor of the jaw; and orthognathic surgery that you need to correct a significant functional impairment that cannot be adequately corrected with orthodontic services when the surgery is furnished at a hospital provided that you have a serious medical condition that requires that you be admitted to a surgical day care unit of a hospital or to an ambulatory surgical facility in order for the surgery to be safely performed. These benefits are also provided when the surgery is furnished at an oral surgeon’s office. (Orthognathic surgery is not covered when it is performed primarily for cosmetic reasons. This surgery must be performed along with orthodontic services. If it is not, the oral surgeon must send a letter to *Blue Cross* and *Blue Shield* asking for approval for the surgery. No benefits are provided for the orthodontic services.)

Covered oral surgery also includes removal of impacted teeth that are fully or partially imbedded in the bone when you have a serious medical or dental condition that requires that you be admitted to a surgical day care unit of a hospital or to an ambulatory surgical facility in order for the surgery to be safely performed.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

- Non-dental surgery and necessary postoperative care, when billed as part of the global surgery *allowed charge*, by a dentist (see Part 6, “Dental Care”).
- Necessary postoperative care, when billed as part of the global surgery *allowed charge*, after covered *inpatient* or *outpatient* surgery.
- Anesthesia services related to covered surgery, including anesthesia administered by a physician other than the attending physician or by a certified registered nurse anesthetist.

TMJ Disorder Treatment

Outpatient Diagnostic X-Rays, Surgery and Physical Therapy for TMJ Disorders	In-Network, you pay	Out-of-Network, you pay
(Note: <i>covered services</i> do not include <i>outpatient</i> medical care services.)	• Outpatient surgical services (includes related anesthesia)	
	Nothing	40% <i>coinsurance</i> after <i>deductible</i>
	• Diagnostic x-rays	
	10% <i>coinsurance</i>	40% <i>coinsurance</i> after <i>deductible</i>
	• Physical therapy	
	(See “Short-Term Rehabilitation Therapy.”)	

This health plan provides benefits based on the *allowed charge* for temporomandibular joint (TMJ) disorder treatment furnished by a general, chronic disease or rehabilitation hospital, community health center, surgical day care unit, ambulatory surgical facility, physician, dentist or physical therapist. These benefits are limited to services that are required to treat TMJ disorders that are caused by or result in a specific medical condition such as degenerative arthritis and jaw fractures or dislocations. The medical condition must be proven to exist by means of diagnostic x-ray tests or other generally accepted diagnostic procedures. These benefits include and are limited to: surgical repair or intervention; diagnostic x-rays; and physical therapy (see “Short-Term Rehabilitation Therapy” for your benefits for these *covered services*).

No benefits are provided for: TMJ disorders that are not proven to be caused by or to result in a specific medical condition; *outpatient* medical care services, including splint therapy; appliances, other than a mandibular orthopedic repositioning appliance (MORA); and services, supplies or procedures to change the height of teeth or otherwise restore occlusion (such as bridges, crowns or braces).

Part 6

Limitations and Exclusions

The benefits described in this Benefit Description are limited or excluded as described in this section. (Other limitations or restrictions and exclusions on your benefits may be found in Parts 3, 4, 5 and 7. You should be sure to read all provisions described in this Benefit Description.)

Note: There are additional benefits covered under this Plan are administered by MIT Health Plan. Some of the services listed below may be covered services when administered by MIT Health Plan. Please refer to Section II of this document for information about these benefits.

Admissions Before Effective Date

The benefits described in this Benefit Description are provided only for *covered services* furnished on or after your *effective date*. If you are already an *inpatient* in a hospital (or another covered health care facility) on your *effective date*, this health plan will provide benefits starting on your *effective date*. But, these benefits are subject to all the provisions described in this Benefit Description.

Benefits From Other Sources

No benefits are provided for health care services and supplies to treat an illness or injury for which you have the right to benefits under government programs. These include the Veterans Administration for an illness or injury connected to military service. They also include programs set up by other local, state, federal or foreign laws or regulations that provide or pay for health care services and supplies or that require care or treatment to be furnished in a public facility. No benefits are provided if you could have received governmental benefits by applying for them on time. (This exclusion does not include Medicaid or Medicare. See Part 7 for more information if you are eligible for Medicare benefits.)

Birth Control

No benefits are provided for: family planning services; birth control drugs and devices; and over-the-counter birth control preparations (for example, condoms, birth control foams, jellies and sponges). See Section II of this document, Benefits Administered by MIT, as well as the benefit description for the MIT Affiliate Medical Plan.

Blood and Related Fees

No benefits are provided for: whole blood; packed red blood cells; blood donor fees; and blood storage fees.

Cosmetic Services and Procedures

No benefits are provided for cosmetic services that are performed solely for the purpose of making you look better, whether or not these services are meant to make you feel better about yourself or treat a *mental condition*. For example, no benefits are provided for: acne related services such as the removal of acne cysts, injections to raise acne scars, cosmetic surgery and dermabrasion or other procedures to plane the skin; electrolysis; hair removal or restoration (except as described in Part 5 for scalp hair prostheses); and liposuction. (See Part 5 for your benefits for reconstructive surgery.)

Custodial Care

No benefits are provided for custodial care. This is care that is furnished mainly to help a person in the activities of daily living. It does not require day to day attention by medically-trained persons. It may consist, for example, of: *room and board*; routine nursing; services to help in personal hygiene and self-care for a *member* who is mentally and/or physically disabled but who does not require the regular attention of medically-licensed staff; or services to a *member* whose condition is not likely to improve, even if the *member* receives the regular attention of medically-licensed staff. Also, no benefits are provided for services to observe or reassure a *member*.

Dental Care

Unless otherwise described in Part 5, no benefits are provided for services that *Blue Cross and Blue Shield* determines to be for dental care, even when the dental condition is related to or caused by a medical condition or medical treatment. However, benefits are provided for facility charges when you have a serious medical condition that requires that you be admitted to a hospital as an *inpatient* or to a surgical day care unit of a hospital or to an ambulatory surgical facility in order for dental surgery to be safely performed. Some examples of serious medical conditions are hemophilia and heart disease.

Educational Testing and Evaluations

No benefits are provided for exams, evaluations or services that are performed solely for educational or developmental purposes. The only exceptions are for: early intervention services when covered by this health plan; treatment of *mental conditions* for children with serious behavioral or emotional disorders when covered by this health plan; and *covered services* to diagnose and/or treat speech, hearing and language disorders. (See Part 5.)

Exams/Treatment Required by a Third Party

No benefits are provided for physical, psychiatric and psychological exams, treatments and related services that are required by third parties. Some examples of non-*covered services* are: exams and tests required for recreational activities, employment, insurance and school; and court-ordered exams and services, except for *medically necessary* services. (But, certain exams may be covered when they are furnished as part of a covered routine physical exam.)

Experimental Services and Procedures

The benefits described in this Benefit Description are provided only when *covered services* are furnished in accordance with *Blue Cross and Blue Shield medical technology assessment guidelines*. No benefits are provided for health care charges that are received for or related to care that *Blue Cross and Blue Shield* considers to be experimental services or procedures. The fact that a treatment is offered as a last resort does not mean that benefits will be provided for it. There are two exceptions to this exclusion. This health plan does provide benefits for:

- One or more bone marrow transplants for a *member* who has been diagnosed with breast cancer that has spread.
- Certain drugs used on an off-label basis. Some examples are: drugs used to treat cancer; and drugs used to treat HIV/AIDS.

Eye Exams and Eyewear

No benefits are provided for eye exams and eyeglasses and contact lenses or exams to prescribe, fit or change them. There is one exception to this exclusion. This health plan does provide benefits for intraocular lenses that are implanted after covered corneal transplant, cataract surgery or other covered eye surgery when the natural eye lens is replaced.

Hearing Exams and Hearing Aids

No benefits are provided for routine hearing exams and hearing aids or exams to prescribe, fit or change them.

Home Birth

No benefits are provided for home births, except when the delivery in the home is an emergency or unplanned.

Lifetime Benefit Maximum

The benefits described in this Benefit Description are not subject to an overall lifetime benefit maximum. However, there are lifetime *benefit limits* or restrictions that apply for certain *covered services* (for example, early intervention services) See Part 5, “*Covered Services*” for information about *benefit limits* that apply to specific services and supplies.

Medical Devices, Appliances, Materials and Supplies

No benefits are provided for medical devices, appliances, materials and supplies, except as otherwise described in Part 5. Some examples of non-covered items are:

- Devices such as: air conditioners; air purifiers; arch supports; bath seats; bed pans; bath tub grip bars; chair lifts; computers; computerized communication devices; computer software; dehumidifiers; dentures; elevators; foot orthotics; heating pads; hot water bottles; humidifiers; orthopedic and corrective shoes that are not part of a leg brace; raised toilet seats; and shoe (foot) inserts.

- Special clothing, except for gradient pressure support aids for lymphedema or venous disease and clothing needed to wear a covered device (for example, mastectomy bras and stump socks).
- Self-monitoring devices, except for certain devices that *Blue Cross and Blue Shield* decides would give a *member* having particular symptoms the ability to detect or stop the onset of a sudden life-threatening condition.

Missed Appointments

No benefits are provided for charges for appointments that you do not keep. Physicians and other providers may charge you for failing to keep your scheduled appointments. They may do so if you do not give reasonable notice to the office. You must pay for these charges. Appointments that you do not keep are not counted against any visit or dollar limits for benefits described in this Benefit Description.

Non-Covered Providers

No benefits are provided for any services and supplies furnished by the kinds of health care providers that are not covered by this health plan. For each *covered service*, this Benefit Description specifies the kinds of health care providers that are covered. (See Part 2, “Definitions.” The definition of “*preferred provider*” describes those types of health care providers covered by this health plan.)

Non-Covered Services

No benefits are provided for:

- A service or supply that is not described as a *covered service* in this Benefit Description. (There is one exception to this exclusion. As other services and supplies are approved by the United States Food and Drug Administration (FDA) for the diagnosis and treatment of insulin dependent, insulin using, gestational or non-insulin dependent diabetes, your benefits will be changed to include those services and supplies as long as they can be classified under categories of services or supplies that are already covered under this Benefit Description and are in accordance with *Blue Cross and Blue Shield medical technology assessment guidelines*.)
- Acupuncture.
- *Outpatient* medical care services to diagnose or treat your illness or injury beyond the annual 4 visit maximum.
- *Outpatient* nutrition counseling services.
- *Outpatient* hormone replacement therapy.
- Allergy testing (such as PRIST, RAST and scratch tests).
- Injections (such as allergy shots).
- Services that do not conform to *Blue Cross and Blue Shield* medical policy guidelines.
- Services or supplies that you received when you were not enrolled in this health plan. There

is one exception to this exclusion. This health plan does provide benefits for routine nursery charges. But, to ensure benefits for all *covered services* for the newborn child, you must remember to enroll the newborn under the *subscriber's* membership within the time period required to make family status changes (see Part 11).

- Any service or supply furnished along with a *non-covered service*.
- Services and supplies that are not considered *medically necessary* by *Blue Cross and Blue Shield*, except as otherwise described in this Benefit Description.
- Services that are furnished to someone other than the patient, except as described in this Benefit Description for: hospice services; and harvesting of a donor's organ or stem cells (which includes the surgical removal of the donor's organ or stem cells and related *medically necessary* services and/or tests that are required to perform the transplant itself) when the recipient is a *member*.
- Services that are furnished to all patients due to a facility's routine admission requirements.
- Services and supplies that are related to sex change surgery or to the reversal of a sex change.
- A provider's charge for shipping and handling, taxes or interest (finance charges).
- A provider's charge to file a claim. Also, a provider's charge to transcribe or copy your medical records.
- A separate fee for services by interns, residents, fellows or other physicians who are salaried employees of the hospital or other facility.
- Expenses that you have when you choose to stay in a hospital or other health care facility beyond the discharge time determined by *Blue Cross and Blue Shield*.

Note: Many of these services are covered under the MIT Affiliate Medical Plan, when services are provided at MIT Medical. In addition, see Section II of this document, Benefits Administered by MIT, for additional coverage through the MIT Affiliate Extended Insurance Plan.

Personal Comfort Items

No benefits are provided for items or services that are furnished for your personal care or convenience or for the convenience of your family. Some examples of non-covered items or services are: telephones; radios; televisions; and personal care services.

Private Room Charges

For covered *room and board*, the benefits described in this Benefit Description are provided based on the semiprivate room rate. If a private room is used, you must pay for any charges that are more than the semiprivate room rate.

Refractive Eye Surgery

No benefits are provided for refractive eye surgery for conditions that can be corrected by means other than surgery. This type of surgery includes radial keratotomy.

Reversal of Voluntary Sterilization

No benefits are provided for the reversal of sterilization.

Services and Supplies After Termination Date

No benefits are provided for services and supplies furnished after your termination date in this health plan. There is one exception to this exclusion. The benefits described in this Benefit Description will continue to be provided for *inpatient* services, but only if you are receiving covered *inpatient* care on your termination date. In this case, benefits will continue to be provided until all the benefits allowed by this health plan have been used up or the date of discharge, whichever comes first. This does not apply if your membership in this health plan is canceled for misrepresentation or fraud.

Services Furnished to Immediate Family

No benefits are provided for a *covered service* furnished by a provider to himself or herself or to a member of his or her immediate family. The only exception is for drugs for which this health plan provides benefits when used by a physician or dentist while furnishing a *covered service*. “Immediate family” means any of the following members of a provider’s family:

- Spouse or spousal equivalent.
- Parent, child, brother or sister (by birth or adoption).
- Stepparent, stepchild, stepbrother or stepsister.
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law or sister-in-law. (For purposes of providing *covered services*, an in-law relationship does not exist between the provider and the spouse of his or her wife’s (or husband’s) brother or sister.)
- Grandparent or grandchild.

Note: For the purposes of this exclusion, the immediate family members listed above will still be considered immediate family after the marriage which created the relationship is ended (by divorce or death).

Surrogate Pregnancy

No benefits are provided for services related to achieving pregnancy through a surrogate (gestational carrier).

Part 7

Other Party Liability

Other Health Coverage

If you are covered under other hospital, medical, dental, health or other plans, the benefits provided by the MIT Affiliate Extended Insurance Plan will be reduced by the benefits provided by those plan(s). This means that the benefits available under this health plan are secondary to or in excess of the benefits provided by other plan(s). Other plans include: personal injury insurance; automobile insurance, including medical payments coverage; homeowner's insurance; or other plans that cover hospital or medical expenses.

You must include information on your enrollment forms about other health plans under which you are covered. Once you are enrolled in this health plan, you must notify *Blue Cross and Blue Shield* if you add or change health plan coverage. Upon request, you must also supply *Blue Cross and Blue Shield* with information about other plans that may provide you with coverage for health care services.

Medicare Program

When you are eligible for the Medicare program and Medicare is allowed by federal law to be the primary payor, the benefits provided by this health plan will be reduced by the amount of benefits allowed under Medicare for the same *covered services*. This reduction will be made whether or not you actually receive the benefits from Medicare. It is our responsibility to notify the Health Plan of your Medicare eligibility status and effective date of Medicare A and B.

Plan Rights to Recover Benefit Payments

Subrogation and Reimbursement of Benefit Payments

If you are injured by any act or omission of another person, the benefits under this health plan will be subrogated. This means that this health plan and *Blue Cross and Blue Shield*, as this health plan's representative, may use your right to recover money from the person(s) who caused the injury or from any insurance company or other party. If you recover money, this health plan is entitled to recover up to the amount of the benefit payments that it has made. This is true no matter where or by whom the recovered money is held or how it is designated and even if you do not recover the total amount of your claim against the other person(s). This is also true if the payment you receive is described as payment for other than health care expenses. The amount you must reimburse this health plan will not be reduced by any attorney's fees or expenses you incur.

Member Cooperation

You must give *Blue Cross and Blue Shield*, as this health plan's representative, information and help. This means you must complete and sign all necessary documents to help *Blue Cross and Blue Shield* get this money back on behalf of this health plan. This also means that you must give *Blue*

Cross and Blue Shield timely notice of all significant steps during the negotiation, litigation or settlement with any third party (such as filing a claim or lawsuit, initiation of settlement discussions, agreement to a settlement in principle, etc.) and before settling any claim arising out of injuries you sustained by an act or omission of another person(s) for which this health plan paid benefits. You must not do anything that might limit this health plan's right to full reimbursement.

Workers' Compensation

No benefits are provided for health care services and supplies to treat an illness or injury for which you have the right to benefits under any workers' compensation act or equivalent employer liability or indemnification law. All employers provide their employees with workers' compensation insurance. This is done to protect employees in case of work related illness or injury. All medical claims related to the illness or injury must be billed to the employer's workers' compensation carrier. It is up to you to use workers' compensation insurance. If this health plan provides or pays for *covered services* that are covered by workers' compensation, *Blue Cross and Blue Shield* on behalf of this health plan has the right to get paid back from the party that legally must pay for the health care services.

If you have recovered the value of services from workers' compensation or another employer liability program, you will have to pay the amount recovered for medical services that were paid by this health plan. If *Blue Cross and Blue Shield* is billed in error for these services, you must promptly call or write the *Blue Cross and Blue Shield* customer service office.

Part 8

Filing a Claim

When the Provider Files a Claim

Your provider will file a claim for you when you receive a *covered service* from a *preferred provider* or a provider outside of Massachusetts that has a payment agreement with the local Blue Cross and/or Blue Shield Plan. Just tell the provider that you are a *member* and show him or her your PPO health plan identification card. Also, be sure to give the provider any other information that is needed to file your claim. You must properly inform your provider within 30 days after you receive the *covered service*. If you do not, benefits will not have to be provided. The provider will be paid directly for *covered services*.

When a Member Files a Claim

You may have to file your claim when you receive a *covered service* from a *non-preferred provider* in Massachusetts or a *non-preferred provider* outside of Massachusetts that does not have a payment agreement with the local Blue Cross and/or Blue Shield Plan. The provider may ask you to pay the entire charge at the time of the visit. It is up to you to pay your provider. To file a claim for repayment, you must:

- Fill out a claim form;
- Attach your original itemized bills; and
- Mail the claim to the *Blue Cross and Blue Shield* customer service office.

You can get claim forms from the *Blue Cross and Blue Shield* customer service office. *Blue Cross and Blue Shield* will mail to you all applicable forms within 15 days after receiving notice that you obtained some service or supply for which you may be paid.

Note: When you receive *covered services* outside the United States, you must file your claim to the BlueCard® Worldwide Service Center. (The BlueCard Worldwide International Claim Form you receive from *Blue Cross and Blue Shield* will include the address to mail your claim.) The service center will prepare your claim, including the conversion to U.S. currency and forward it to *Blue Cross and Blue Shield* for repayment to you.

You must file a claim within one year of the date you received the *covered service*. This health plan does not have to honor claims submitted after this one-year period.

Timeliness of Claim Payments

Within 30 calendar days after *Blue Cross and Blue Shield* receives a completed request for benefits or payment, a decision will be made and, where appropriate, payment will be made to the provider (or to you if you sent in the claim) for your claim to the extent of your benefits described in this Benefit Description. Or, you and/or the provider will be sent a notice in writing of why your claim is not being paid in full or in part.

Missing Information Received Within 45 Days. If the request for benefits or payment is not complete or if more information is needed to make a final determination for the claim, *Blue Cross and Blue Shield* will ask for the information or records it needs within 30 calendar days of receiving the request for benefits or payment. This additional information must be provided to *Blue Cross and Blue Shield* within 45 calendar days of this request.

Missing Information Not Received Within 45 Days. If the additional information is provided to *Blue Cross and Blue Shield* within 45 calendar days of the request, a decision will be made within the time remaining in the original 30-day claim determination period or within 15 calendar days of the date the additional information is received, whichever is later.

If the additional information is not provided to *Blue Cross and Blue Shield* within 45 calendar days of the request, the claim for benefits or payment will be denied. If the additional information is submitted after this 45 days, then it may be viewed as a new claim for benefits or payment. In this case, a decision will be made within 30 days as described previously in this section.

Part 9

Grievance Program

You have the right to a review when you disagree with a decision by *Blue Cross and Blue Shield* to deny payment for services, or if you have a complaint about the care or service you received from *Blue Cross and Blue Shield* or a *preferred provider*.

Making an Inquiry or Resolving Claim Problems

Most problems or concerns can be handled with just one phone call. (See page 3 for more information about *Member Services*.) For help resolving a problem or concern, you should first call the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your PPO health plan identification card. 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, *Blue Cross and Blue Shield* will consider all aspects of the particular case, including the terms of your *group* benefits as described in this Benefit Description, *Blue Cross and Blue Shield* policies and procedures that support the administration of these benefits, the provider's input, as well as your understanding and expectation of benefits. *Blue Cross and Blue Shield* 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. *Blue Cross and Blue Shield* 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 formal internal grievance program as described below.

Internal Formal Grievance Review

How to Request a Grievance Review

To request a formal review from the internal Grievance Program, you (or your authorized representative) have three options.

- **Write or Fax.** The preferred option is for you to send your grievance in writing to: Grievance Program, Blue Cross and Blue Shield of Massachusetts, Inc., Landmark Center, 401 Park Drive, 01/08, Boston, Massachusetts 02215-3326; or Fax to: 1-617-246-3616. *Blue Cross and Blue Shield* will let you know that your request was received by sending you a written confirmation within 15 calendar days.
- **E-mail.** Or, you may send your grievance to the Grievance Program internet address grievances@bcbsma.com. *Blue Cross and Blue Shield* will let you know that your request was received by sending you a confirmation immediately by e-mail.
- **Telephone Call.** Or, you may call the *Blue Cross and Blue Shield* Grievance Program at 1-800-462-5601 (extension 63605) to request a formal grievance review.

Once your request is received, *Blue Cross and Blue Shield* will research the case in detail and ask for more information as needed. When the review is completed, *Blue Cross and Blue Shield* will let you know in writing of the decision or the outcome of the review.

All grievances must be received by *Blue Cross and Blue Shield* 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.

What to Include in a Grievance Review Request

Your request for a formal grievance review should include: the name and health plan 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; details of the attempt that has been made to resolve the problem; and any comments, documents, records and other information to support your grievance. If *Blue Cross and Blue Shield* needs to review the medical records and treatment information that relate to your grievance, *Blue Cross and Blue Shield* will promptly send you an authorization form to sign if needed. You must return this signed form to *Blue Cross and Blue Shield*. It will allow for the release of your medical records. You also have the right to look at and get copies (free of charge) of records and criteria that *Blue Cross and Blue Shield* has and that are relevant to your grievance, including the identity of any experts who may have been consulted.

Authorized Representative

You may choose to have another person act on your behalf during the grievance review process. You must designate this person in writing to *Blue Cross and Blue Shield*. Or, if you are not able to do this, a person such as a conservator, a person with power of attorney or a family member may be your authorized representative.

Who Handles the Grievance Review

All grievances are reviewed by individuals who are knowledgeable about *Blue Cross and Blue Shield* and the issues involved in the grievance. The individuals who will review your grievance will be those who did not participate in any of *Blue Cross and Blue Shield's* prior decisions regarding the subject of your grievance, nor do they work for anyone who did. When a grievance is related to a *medical necessity* denial, at least one grievance reviewer is an individual who is an actively practicing health care professional in the same or similar specialty that usually treats the medical condition, performs the procedure or provides treatment that is the subject of your grievance.

Response Time

The review and response for *Blue Cross and Blue Shield's* formal internal grievance review will be completed within 30 calendar days. Every reasonable effort will be made to speed up the review of grievances that involve health care services that are soon to be obtained by the *member*. (When the grievance review is for services you have already obtained and it requires a review of your medical records, the 30-day response time will not include the days from when *Blue Cross and Blue Shield* sends you the authorization form to sign until it receives your signed authorization form if needed. If *Blue Cross and Blue Shield* does not receive your authorization within 30 calendar days after you are asked for it, *Blue Cross and Blue Shield* may make a final decision about your grievance without that medical information.)

Note: If your grievance review began after an inquiry, the 30-day response time will begin on the day you tell *Blue Cross and Blue Shield* that you disagree with *Blue Cross and Blue Shield's* answer and would like a formal grievance review.

Blue Cross and Blue Shield may extend the time frame to complete a grievance review, with your permission, in cases when *Blue Cross and Blue Shield* and the *member* agree that additional time is required to fully investigate and respond to the grievance.

Response

Once the grievance review is completed, *Blue Cross and Blue Shield* will let you know of the decision or the outcome of the review. If *Blue Cross and Blue Shield* continues to deny coverage for all or part of a health care service or supply, *Blue Cross and Blue Shield's* response will explain the reasons. It will give you the specific medical and scientific reasons for the denial and a description of alternative treatment, health care services and supplies that would be covered and information about requesting an external review.

Grievance Records

Blue Cross and Blue Shield will maintain a record of all formal grievances, including the response for each grievance review, for up to seven years.

Expedited Review for Immediate or Urgently-Needed Services

In place of the formal grievance review described above, you have the right to request an “expedited” review right away when your grievance review concerns medical care or treatment for which waiting for a response under the grievance review timeframes described above would seriously jeopardize your life or health or your ability to regain maximum function as determined by *Blue Cross and Blue Shield* or your physician, or if your physician says that you will have severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance review. If you request an expedited review, *Blue Cross and Blue Shield* will review your grievance and notify you of the decision within 72 hours after your request is received.

Appeals for Rhode Island Residents or Services

The following provisions apply only to:

- A *member* who lives in Rhode Island and is planning to obtain services that *Blue Cross and Blue Shield* has determined are not *medically necessary*.
- A *member* who lives outside Rhode Island and is planning to obtain services in Rhode Island that *Blue Cross and Blue Shield* has determined are not *medically necessary*.

Blue Cross and Blue Shield decides which services are *medically necessary* by using its *medical necessity* guidelines. Some of the services that are described in this Benefit Description may not be *medically necessary* for you. If *Blue Cross and Blue Shield* has determined that services are not *medically necessary* for you, you have the right to the following appeals process:

Reconsideration

Reconsideration is the first step in this appeals process. If you receive a letter denying payment for

your health care services, you may request that *Blue Cross and Blue Shield* reconsider its decision by writing to: Grievance Program, Blue Cross and Blue Shield of Massachusetts, Inc., Landmark Center, 401 Park Drive, Boston, Massachusetts 02215-3326. You must submit your reconsideration request within 180 days of the adverse decision. Along with your letter, you should include any information that supports your request. *Blue Cross and Blue Shield* will review your request and let you know the outcome of your reconsideration request within 15 calendar days after receipt of all necessary information.

Appeal

An appeal is the second step in this process. If *Blue Cross and Blue Shield* continues to deny benefits for all or part of the original service, you may request an appeal within 60 days of receiving the reconsideration denial letter. Your appeal request should include any information that supports your appeal. You may also inspect and add information to your *Blue Cross and Blue Shield* case file to prepare your appeal. In accordance with Rhode Island state law, if you wish to review the information in your *Blue Cross and Blue Shield* case file, you must make your request in writing and include the name of a physician who may review your file on your behalf. Your physician may review, interpret and disclose any or all of that information to you. Once received by *Blue Cross and Blue Shield*, your appeal will be reviewed by a provider in the same specialty as your attending provider. *Blue Cross and Blue Shield* will notify you of the outcome of your appeal within 15 calendar days of receiving all necessary information.

External Appeal

If your appeal is denied, you have the right to present your case to an appeals agency that is designated by Rhode Island and not affiliated with *Blue Cross and Blue Shield*. If you request this voluntary external appeal, Rhode Island requires you be responsible for half of the cost of the appeal. Your *group* will be responsible for the remaining half. To file an external appeal, you must make your request in writing to Grievance Program, Blue Cross and Blue Shield of Massachusetts, Inc., Landmark Center, 401 Park Drive, Boston, Massachusetts 02215-3326. Along with your request, you must state your reason(s) for your disagreement with *Blue Cross and Blue Shield's* decision and enclose a check payable to one of the following external appeals agencies: MassPRO (your fee is \$147.50) or the Center for Health Dispute Resolution (your fee is \$144.20). (If your service denial is for treatment of *mental conditions*, your fee is: \$237.50 for MassPRO and \$144.20 for the Center for Health Dispute Resolution.)

Within five calendar days after the receipt of your written request and payment for the appeal, *Blue Cross and Blue Shield* will forward your request to the external appeals agency along with your *group's* portion of the fee and your entire *Blue Cross and Blue Shield* case file. The external appeals agency will notify you in writing of the decision within ten working days of receiving all necessary information.

Expedited Appeal

If your situation is an emergency, you have the right to an expedited appeal at all three levels of appeal as stated above. An emergency is defined as the sudden onset of a medical or *mental condition* that in the absence of immediate medical attention could reasonably be expected to result in placing your health or your ability to regain maximum function in serious jeopardy or, in your physician's opinion, would result in severe pain. You may request an expedited reconsideration or appeal by contacting *Blue Cross and Blue Shield* at the telephone number shown in your letter. *Blue Cross and Blue Shield* will notify you of the result of your expedited appeal within 72 hours of its receipt. To request an expedited voluntary external appeal, you must send your request in writing to: Grievance Program, Blue Cross and Blue Shield of Massachusetts, Inc., Landmark Center, 401 Park Drive, Boston, Massachusetts 02215-3326. Your request should state your reason(s) for your disagreement with the decision and include signed documentation from your provider that describes the emergency nature of your treatment. In addition, Rhode Island requires you be responsible for half of the cost of the appeal. Your request for an expedited appeal must also include a check payable to one of the following external appeals agencies: MassPRO (your fee is \$172.50) or the Center for Health Dispute Resolution (your fee is \$144.20). (If your service denial is for treatment of *mental conditions*, your fee is: \$237.50 for MassPRO and \$144.20 for the Center for Health Dispute Resolution.)

Within two working days after the receipt of your written request and payment for the appeal, *Blue Cross and Blue Shield* will forward your request to the external appeals agency along with your *group's* portion of the fee and your entire *Blue Cross and Blue Shield* case file. The external appeals agency will notify you in writing of the decision within 72 hours of receiving your request for a review.

External Appeal Final Decision

If the external appeals agency upholds the original decision of *Blue Cross and Blue Shield*, this completes the appeals process for your case. But, if the external appeals agency reverses *Blue Cross and Blue Shield's* decision, the claim in dispute will be reprocessed by *Blue Cross and Blue Shield* upon receipt of the notice of the final appeal decision. In addition, *Blue Cross and Blue Shield* will repay you for your share of the cost for the external appeal within 60 days of the receipt of the notice of the final appeal decision.

Final Grievance Review

For all grievances, you must first go through the formal internal grievance process as described above. If all or part of your grievance remains denied, you are then entitled to a final grievance review by Massachusetts of Technology (MIT). You are not required to pursue a final grievance review and your decision whether to pursue it will not affect your other benefits. If you receive a denial letter from *Blue Cross and Blue Shield*, the letter will tell you what steps you should take to file a request for a final grievance review by MIT. For more information about your rights for a final grievance review, contact MIT.

Part 10

Other Plan Provisions

Access to and Confidentiality of Medical Records

Blue Cross and Blue Shield and *preferred providers* may, in accordance with applicable law, have access to all medical records and related information needed by *Blue Cross and Blue Shield* or *preferred providers*. *Blue Cross and Blue Shield* may collect information from health care providers, other insurance companies or MIT to help them administer the benefits described in this Benefit Description and to get facts on the quality of care provided under this and other health care contracts. In accordance with law, *Blue Cross and Blue Shield* and *preferred providers* may use this information, and may disclose it to necessary persons and entities as follows:

- For administering benefits (including coordination of benefits with other insurance plans); disease management programs; managing care; quality assurance; utilization management; the prescription drug history program; grievance and claims review activities; or other specific business, professional or insurance functions for *Blue Cross and Blue Shield*.
- For bona fide medical research according to the regulations of the U.S. Department of Health and Human Services and the Food and Drug Administration for the protection of human subjects.
- As required by law or valid court order.
- As required by government or regulatory agencies.
- As required by the subscriber's group or its auditors.
- For the purpose of processing a claim, medical information may be released to your group's reinsurance carrier.

To obtain a copy of *Blue Cross and Blue Shield's* Commitment to Confidentiality statement, call the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your PPO health plan identification card.

Blue Cross and Blue Shield will not share information about you with the Medical Information Bureau (MIB). Except as described above, *Blue Cross and Blue Shield* will keep all information confidential and not disclose it without your consent.

You have the right to get the information *Blue Cross and Blue Shield* collects. You may also ask *Blue Cross and Blue Shield* to correct any information that you believe is not correct. *Blue Cross and Blue Shield* may charge a reasonable fee for copying records.

Acts of Providers

Blue Cross and Blue Shield is not liable for the acts or omissions by any individuals or institutions that furnish care or services to you. In addition, *Blue Cross and Blue Shield* will not interfere with the relationship between providers and their patients. You are free to select or discharge any

provider. It is not up to *Blue Cross and Blue Shield* to find a provider for you. *Blue Cross and Blue Shield* is not responsible if a provider refuses to furnish services to you. *Blue Cross and Blue Shield* does not guarantee that you will be admitted to any facility or that you will get a special type of room or service. If you are admitted to a facility, you will be subject to all of its requirements. This includes its requirements on admission, discharge and the availability of services.

Assignment of Benefits

You cannot assign any benefit or monies due under this health plan to any person, corporation or other organization without MIT's and *Blue Cross and Blue Shield's* written consent. Any assignment by you will be void. Assignment means the transfer of your rights to the benefits provided under this health plan to another person or organization. There is one exception to this rule. If Medicaid has already paid the provider, you can assign your benefits to Medicaid.

Authorized Representative

You may choose to have another person act on your behalf concerning your benefits under this health care plan. You must designate this person in writing to *Blue Cross and Blue Shield*. Or, if you are not able to do this, a person such as a conservator, a person with power of attorney or a family member may be your authorized representative. You can get a form to designate an authorized representative from the *Blue Cross and Blue Shield* customer service office.

In certain situations, *Blue Cross and Blue Shield* may consider your health care facility or your physician to be your authorized representative. For example, *Blue Cross and Blue Shield* may tell your hospital that a proposed *inpatient* admission has been approved or may ask your physician for more information if more is needed to make a decision. Or, *Blue Cross and Blue Shield* will consider the provider to be your authorized representative for *emergency medical care* services. *Blue Cross and Blue Shield* will continue to send benefit payments and written communications regarding health care coverage in accordance with *Blue Cross and Blue Shield's* standard practices, unless specifically requested to do otherwise.

Benefits for Services By Non-Preferred Providers

There are two levels of benefits under this health plan. You will usually receive the highest level of benefits ("in-network benefits") provided by this health plan only when you obtain *covered services* from a *preferred provider*. But, this health plan will provide "in-network benefits" for *covered services* furnished by *non-preferred providers* in the following situations:

- You receive ambulance transport to an emergency medical facility for *emergency medical care*.
- You receive *inpatient emergency medical care* as described in Parts 5.
- You receive *covered services* in an emergency room of a hospital (or you receive emergency medical services from any other type of *non-preferred provider* as described in Part 5 when a *preferred provider* is not reasonably available).
- You receive *covered services* that are not reasonably available from a *preferred provider* and you had prior approval from *Blue Cross and Blue Shield* to obtain those services.

- You receive *covered services* from a covered type of provider for which *Blue Cross and Blue Shield* or the local Blue Cross and/or Blue Shield Plan has not, in the opinion of *Blue Cross and Blue Shield*, established an adequate *preferred provider* network.

Otherwise, when you obtain *covered services* from a *non-preferred provider*, this health plan will provide 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.

Changes to This Health Plan

MIT or *Blue Cross and Blue Shield* may change the benefits described in this Benefit Description. For example, a change may be made to the amount you must pay for certain services. MIT is responsible for sending you a notice of any change. The notice will describe the change being made. It will also give the effective date of the change. When a change is made to your benefits, you can get the actual language of the change from MIT. The change will apply to all benefits for services you receive on or after its effective date.

Note: If you are already an *inpatient* on the effective date of the change, the change will not apply until you are discharged from that *inpatient* stay.

Time Limit for Legal Action

Before pursuing a legal action against *Blue Cross and Blue Shield* for any claim under this health plan, you must complete a formal internal grievance review as described in Part 9 of this Benefit Description. You may, but do not need to, pursue an external review prior to pursuing a legal action.

If, after completing the grievance review, you choose to bring legal action against *Blue Cross and Blue Shield*, this action must be brought within two years after the cause of action arises. For example, if you are filing a legal action because you were denied a service or a claim for benefits under this health plan, you will lose your right to bring a legal action against *Blue Cross and Blue Shield* unless you file your action within two years after the date you were first sent a notice of the service or claim denial. Going through the internal formal grievance process does not extend the two-year limit for filing a lawsuit. However, if you choose to pursue a voluntary external review, the days from the date your request is received by the external reviewer until the date you receive the response are not counted toward the two-year limit. If the two-year limit described in this section is less than that allowed by applicable law, this two-year filing limit is extended to the minimum time allowed by such law.

Part II

Eligibility for Coverage

Who Is Eligible to Enroll

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

An affiliate may enroll eligible dependents under his or her membership in this health plan.

“Eligible dependents” include the *subscriber’s*:

- Legal spouse.
- Domestic partner. A domestic partner is defined as a person of the same sex or opposite sex with whom the affiliate has entered into an exclusive relationship. Both the affiliate 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 Affiliate Extended Insurance Plan.
- Unmarried dependent children under age 25. 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 *effective date* 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.

- Unmarried adoptive dependent children under age 25. The *effective date* of coverage for an adoptive child will be the date of placement with the *subscriber* for the purpose of adoption. The *effective date* 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 Summary Plan Description.

- Unmarried disabled dependent children age 25 or older. An unmarried 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. Also, *Blue Cross and Blue Shield* and/or The MIT Health Plans 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* or The MIT Health Plans 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 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 *effective date* of this health plan. This coverage is provided with no additional cost.

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, The MIT Health Plans and *Blue Cross and Blue Shield* must be notified within 30 days of a change to the former spouse's address. Otherwise, The MIT Health Plans and *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.)

In the event the *subscriber* remarries, the former spouse may continue coverage under a separate membership with the *subscriber's group*, provided the divorce judgment requires that the *subscriber* provide health insurance for the former spouse. This is true even if the *subscriber's* new spouse is not enrolled under the *subscriber's* membership.

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.
4. Choose a Primary Care Physician at MIT Medical. Visit web.mit.edu/medical/service/g-choosing.html to make your selection.

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).

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.

Enrollment Periods

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. Further information is available at the MIT Affiliate Health Plans Office, E23-308.

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).

Your dependents must enroll in the MIT Affiliate Medical Plan in order to enroll in the MIT Affiliate Extended Insurance Plan.

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 an unmarried 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 visit the MIT Affiliate Health Plans Office (E23-308, 617-253-4371) or write affplan@med.mit.edu. 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 Summary Plan Description.

SECTION II.

Supplemental Plan Provisions Administered by The MIT Health Plans

MIT Affiliate Extended Insurance Plan



Part I

Covered Services

Under the MIT Affiliate 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 Affiliate Extended Insurance Plan see Section I – Benefits Administered by *Blue Cross and Blue Shield* of Massachusetts, page 42 and Section II Supplemental – Benefits Administered by The MIT Health Plans, page 73).

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. (For more information, see Section I Part 9.)
- 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; or your treatment has been preapproved by The MIT Health Plans.

Acupuncture

Acupuncture	In-Network, you pay	Out-of-Network, you pay
<i>(Benefit limit of 12 visits per calendar year).</i>	Nothing	No coverage

This health plan provides benefits for acupuncture visits for pain management under the following conditions:

- A referral from an MIT Medical provider must be obtained prior to services being rendered.
- Services must be rendered at the New England School of Acupuncture.

Note: No reimbursement is available for services rendered by providers other than those practising at the New England School of Acupuncture.

Air Ambulance

Air Ambulance	In-Network, you pay	Out-of-Network, you pay
<i>(Benefit limited, a maximum of \$10,000 per episode of care).</i>	Nothing for the first \$10,000, 100% for allowed amount in excess of \$10,000	No coverage

This health plan provides benefits for an air ambulance to transport you when your emergency medical condition requires the use of an air ambulance rather than ground ambulance transportation under the following conditions:

- The air ambulance must be medically necessary and approved and coordinated by an MIT Medical provider prior to services being rendered.
- Patient must be airlifted by air ambulance from one acute facility to an acute facility in our network of hospitals.

Note: there is a \$10,000 benefit limit per accident or illness for air ambulance services.

Birth Control

Birth Control	In-Network, you pay	Out-of-Network, you pay
(\$15 <i>copayment</i> for each up to 30 day supply; \$3,500 <i>benefit limit</i> per member per calendar year combined benefits for pharmacy).	\$15 copayment for each up to 30 day supply (except as noted below).	
	Coverage for devices limited to device only, office visit not covered.	

This health plans 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 \$15 copayment. Members may purchase an up to 90 day supply at one time (with the corresponding copayment calculated on the number of days supply - 1–30 days \$15; 31–60 days \$30; 61–90 days \$45).
- Diaphragm - the purchase of a diaphragm is covered with a \$15 copayment. The visit to fit the diaphragm and the over the counter gel used in conjunction with the diaphragm are not covered.
- Inter-uterine devices (IUD) - the purchase of an IUD is covered with a \$45 copayment. The IUD must be obtained through MIT Medical. The visit to insert the IUD is not covered under this Plan (see Affiliate Medical Plan document).
- Depo Provera injections are covered with a \$45 copayment per injection. One injection provides 3 months of birth control protection. The visit to administer the Depo Provera injection is not covered.
- Transdermal patches for an up to 30 day supply with a \$15 copayment.

- Intra-vaginal contraceptive medication devices for an up to 30 day supply with a \$15 copayment. The visit to insert the device (if needed) is not covered.

Note: This coverage is for the actual birth control device only. The office visit to insert, fit or administer the birth control device is not covered under the MIT Affiliate Extended Insurance Plan. Members must purchase the Affiliate Medical Plan in order for the office visit at MIT Medical to be covered (see MIT Affiliate Medical Plan, Page 11 for coverage guidelines). Over-the-counter birth control preparations (birth control foams, jellies and sponges, etc.) are not covered.

Childbirth Class

Childbirth Classes	In-Network, you pay	Out-of-Network, you pay
<i>(Benefit limited to one childbirth class per contract per pregnancy).</i>	Nothing	No coverage
	At MIT Medical or Mount Auburn Hospital only.	

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

Gardasil	In-Network, you pay	Out-of-Network, you pay
<i>(\$20 copayment per immunization and injectable \$3,500 benefit limit per member per calendar year combined benefits for pharmacy).</i>	\$20 <i>copayment</i> per immunization and injectable.	No coverage

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 \$3,500 per member per calendar year pharmacy maximum.
- There is a \$20 copayment for each injection

Note: This coverage is for the injection only. The office visit to administer the vaccine is not covered under the MIT Affiliate Extended Insurance Plan. The office visit is covered under The Affiliate Medical Plan.

Inpatient Mental Health/Substance Abuse Admissions

Inpatient Mental Health/ Substance Abuse Admissions	In-Network, you pay	Out-of-Network, you pay
In general a mental health hospital, general hospital or alcohol or drug treatment facility. (<i>Benefit limit</i> of 60 total inpatient days per member per calendar year).	<ul style="list-style-type: none"> Hospital and other covered facility inpatient services. 	
	Nothing after \$100 per admission inpatient deductible.	
	<ul style="list-style-type: none"> Physician and other covered professional provider inpatient services. 	
	Nothing. Must be referred by MIT Medical.	

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 Plans
- Must be referred by an MIT Medical mental health service provider

Maternity Support Services

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

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

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

Pharmacy Services and Supplies

Prescription Drugs	At MIT Medical	At Retail Pharmacies using Express Scripts (BCBSMA ID card)
(\$3,500 combined <i>benefit limit</i> per <i>member</i> per calendar year). See page 36 for additional information on the pharmacy benefit administered by Blue Cross Blue Shield of MA	\$15 copayment for each up to 30 day supply (except as noted below).	\$25 copayment for each up to 30 day supply (except as noted below). Benefit limit of \$1,000 per calendar year, applied towards overall pharmacy limit.
	Copayment does not count towards calendar out-of-pocket maximum.	

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

- Up to 30 day supply with a \$15 copayment (or \$25 copayment at a retail pharmacy)
- For most 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 number of days supply (For example, at MIT Pharmacy: 1-30 days \$15; 31-60 days \$30; 61-90 days \$45).

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

- Perishable drugs fills limited to one (1) up to 30 day supply in a 30 day period.
- Infertility drugs (Fertinex, Progesterone Suppositories, Progesterone Injection, Human Chorionic Gonadotropin, Profasi, Follistim) 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 coverage limited to male members. Limit of up to 4 tablets per 30 day period. Members filling prescriptions for Viagra at the MIT Medical Pharmacy may purchase an additional 10 tablets per month on a cash basis (not covered by the health plan).
- Toradol fills limited to a maximum 5 day supply
- Triptans (migraine 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 nine (9) tablets per fill or 6 injections (3 boxes with 2 shots per box) or one (1) box nasal spray (1 box contains six (6) doses). Amerge, Maxalt and Zomig are limited to nine (9) tablets per fill.
- 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).

- Drugs prescribed on an “as needed” basis. 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 continued 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 - Lamisil, 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; prescribed by a dermatologist in the presence of a positive KOH culture; multinail involvement; soft tissue involvement). Patients approved for treatment are limited to an up to 30 day supply per fill; one (1) fill per 30 day period.
- 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.

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 \$3,500 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.

Routine Eye Exam

Routine Eye Exam	In-Network, you pay	Out-of-Network, you pay
<i>(Benefit limited to one routine eye exam per member per 12 month period).</i>	Nothing	No coverage
	At MIT Medical eye service only.	

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.

Part 2

Limitations and Exclusions

In addition to those services listed as limited and excluded in Section I, Benefits Administered by *Blue Cross and Blue Shield*, the benefits described in the part of the benefit description are limited or excluded as follows:

Allergy Serum

This health plan does not provide coverage (either as a separate benefit or as part of the prescription drug benefit) for allergy serum.

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 suspensary (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 3

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 Pharmacy, Acupuncture, Childbirth Classes, and Chiropractor, 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 web.mit.edu/medical. Forms are listed on the web site under “Basic Facts”.

Upon receipt of a claim, you will be sent a check to the extent of your benefits as described in this Benefit Description, Part II, Section II-Supplemental 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 4

Grievance Program

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 formal grievance program as described below.

Formal Grievance Review by The MIT Health Plans

To request a formal review from The MIT Health Plans under the Grievance Program, 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 let you know in writing of the decision or the outcome of the review.

All grievances 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 grievance 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 *Blue Cross and Blue Shield*.

Final Grievance Review by The MIT Health Plans

For all grievances, you must first go through the formal internal grievance 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. With 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 msservices@med.mit.edu