SUMMARY PLAN DESCRIPTION
FOR THE
HEALTH PLAN FOR EMPLOYEES (THE “PLAN”)
of Massachusetts Institute of Technology (the “Institute”)
(the “Plan Sponsor” and “Plan Administrator”)
(Plan No. 505)

ABOUT THIS SUMMARY PLAN DESCRIPTION

This document, together with the Subscriber’s Certificates, Schedule of Benefits and the Summary of Benefits for the medical benefit plan you have selected (collectively referred to in this document as the “Booklet”), constitute the Summary Plan Description for your medical and prescription drug benefits, and is intended to comply with the disclosure requirements set forth in regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act of 1974 (ERISA). You should use these materials to understand the medical benefits the Institute provides to you.

The Institute reserves the right to amend, modify or terminate the Plan or any part thereof with or without notice, at any time at its sole discretion. If there is a discrepancy between this document and the official Plan document(s), the provisions of the Plan document(s) and/or any related insurance contracts are controlling and will govern.
Effective January 1, 2014
HEALTH PLAN FOR EMPLOYEES OF MIT SUMMARY PLAN DESCRIPTION (SPD)

This document presents basic information about the medical, dental, prescription and vision benefits provided by the Plan, as of the effective date on the front cover, and your rights to such benefits as a Plan participant. This document, together with the Subscriber’s Certificate, Schedule of Benefits and the Summary of Benefits for the medical benefit plan you have selected (collectively referred to in this document as the “Booklet”), constitute the Summary Plan Description for your medical, dental, prescription drug and vision benefits.

You and any of your dependents covered under the Plan should review this entire document and the Booklet applicable to the benefit option you have selected carefully. Copies of the applicable Booklet can be obtained from the Plan Administrator free of charge.

1. **Plan Name and Type**

   This Plan is the Health Plan for Employees of Massachusetts Institute of Technology. Under ERISA, the Plan is an employee welfare benefit plan providing group medical, prescription drug and vision benefits.

2. **Employer Identification Number (“EIN”) and Address of Plan Sponsor and Plan Number**

   EIN: 04-2103594  
   Plan Number: 505  
   Name: Massachusetts Institute of Technology (the “Institute”)  
   Address: 77 Massachusetts Avenue, E19-215  
   Cambridge, MA 02139  
   Telephone Number: 617-253-6151

3. **Plan Administrator**

   The Plan Sponsor is also the Plan Administrator. The Plan Administrator’s address and telephone number are the same as those of the Plan Sponsor listed above.

4. **Agent for Service of Legal Process**

   Service of legal process may be made upon the Plan Administrator.

5. **Plan Year**

   The Plan Year is the 12 month period of January 1 to December 31 (the calendar year).
6. **Authority of Plan Administrator**

The Plan Administrator (or its delegate(s)) shall have complete discretion to interpret and construe the provisions of the plans, programs and policies described in this SPD, to determine benefit eligibility for participation and for benefits, make findings of fact, correct errors and supply omissions. All decisions and interpretations of the Plan Administrator (or its delegate(s)) made pursuant to the plans, programs and policies described in this SPD shall be final, conclusive and binding on all persons and may not be overturned unless found by a court to be arbitrary and capricious.

The Plan Administrator may also delegate any of its responsibilities under the Plan to any other person or entity. The Plan Administrator has delegated discretionary authority to interpret the Plan to the applicable claims administrator.

7. **Plan Eligibility and Benefits**

**Employee Eligibility**

To be eligible for medical, prescription and vision benefits from the Institute, an employee must satisfy the requirements for eligibility detailed in the applicable Booklet and must generally (1) work at least 50% of the normal full-time schedule in his or her department, laboratory or center at the Institute; (2) have been appointed to work at the Institute for at least three (3) months; and (3) be paid by the Institute. An Employee is also considered an Eligible Employee if he or she meets the foregoing eligibility criteria and either (i) has a visiting appointment at the Institute or (ii) has retired from the Institute and then comes back to work for the Institute as an “Active Retiree.”

The following individuals shall not be considered eligible under any circumstances:

(i) Consultants, contractors, affiliates, teaching or research assistants, honorary lecturers, post-doctoral trainees, work-study student, student program workers not working for the Institute, summer appointment, individuals paid by vouchers or MITemps and members of the armed services assigned to the Institute.

(ii) Any other individual who is in a division, department, unit, or job classification designated by the Institute as not benefit eligible, regardless of the individual’s work schedule or number of hours worked.

(iii) Independent contractors, freelancers and the like shall not be eligible even if they are subsequently determined to be common law employees for any purpose, including without limitation, for wage, labor or tax purposes by the Internal Revenue Service, the Department of Labor or any other Federal or state agency, administrative body or court. Any such determination shall be prospective only.
Dependent Eligibility for Health Benefits

An eligible employee who is enrolled for coverage under the Plan may enroll his or her eligible children, spouse or domestic partner, and the children of his or her spouse or domestic partner for such coverage, if and to the extent such coverage is available. Eligible spouses, domestic partners and dependents (including same or opposite sex domestic partners) are those individuals who meet the requirements set forth in the applicable Booklet.

Employee benefits while an individual is on Long Term Disability

If an individual is receiving long term disability payments, he/she continues to be covered in the medical and dental plan at the level of coverage in effect the date the individual began receiving long term care disability payments. The full cost of the medical and dental plan is paid by MIT during the individual’s approved long term disability period.

If the individual is awarded Social Security disability benefits, he/she will become eligible for Medicare 24 months after the effective date. Medicare will generally pay primary to the plan in that situation (assuming the individual has already received 6 months of taxable disability benefits from MIT). In addition, if the disabled individual is age 65 he/she will become eligible for Medicare on that basis. Such individual must enroll in one of the Medicare Supplemental Plans offered by MIT. Failure to enroll in Medicare will result in the loss of medical coverage. The cost of Medicare Part B is paid by the individual, the cost of the Medicare Supplemental Plan is paid by MIT.

If the individual has an eligible spouse/domestic partner who was on the plan when the disability became in effect, he/she will continue on the plan as long as he/she is not eligible for Medicare. If the spouse/domestic partner is eligible for Medicare, he/she should enroll in Medicare.

If applicable, the individual’s child(ren) will continue to be covered under the MIT medical and dental plans until 26 years of age.

Health Benefits under the Plan

The Plan offers a choice of health plan options, including health maintenance organizations (HMO) and a point-of-service (POS) plan to assist with most types of medical care. There are no pre-existing condition exclusions under these plans.
The Plan includes a benefit for certain vision expenses under the medical plans (e.g., check-ups and doctor’s office visits). However, the EyeMed Vision Care Plan will cover the cost of eyeglasses and contact lenses—the “hardware” of vision care.

The Plan offers a choice of two dental plans administered by Delta Dental: the Delta Dental MIT Comprehensive Plan and the Delta Dental MIT Basic Plan.

The benefit options available under the Plan are described in the applicable Booklet(s), which have been provided to you under separate cover. For a complete description of these benefits, please refer to the Booklet(s) provided by the applicable medical or vision plan provider. The Booklet(s) includes detailed information on any cost-sharing provisions, any annual and lifetime caps on benefits and other plan limits, coverage for preventive services, coverage for existing or new drugs, coverage for medical tests, devices and procedures, the use of and access to in and out-of-network providers, any conditions or limits on the selection of primary care or specialty care providers, any restrictions on emergency care, and any pre-authorization and utilization review procedures.

Health Maintenance Organizations (HMO)

- **MIT Traditional Health Plan**

  This plan provides care through a staff of medical professionals at MIT Medical centers in Cambridge and Lexington, MA. When you enroll, you choose a primary care physician ("PCP") on staff at MIT Medical who coordinates your medical care. You may choose a mental health provider from Managed Care Behavioral Health Network. For more information on the Traditional Health Plan visit [http://web.mit.edu/medical](http://web.mit.edu/medical).

Point of Service Plan (POS)

- **MIT Choice Plan**

  The MIT Choice Plan, a Blue Cross Blue Shield plan - provides a higher level of benefit (in-network) for employees and their dependents who live in the Blue Cross New England network and who select a PCP to manage their healthcare. "In-network" benefits are provided for employees and their dependents who select a PCP in the Blue Cross New England network or at MIT Medical. The MIT Choice Plan also provides an "out-of-network" benefit for family members who may reside outside of the Blue Cross New England network or for those who choose to receive care outside of the network.
Individuals who want to access only the "out-of-network" benefit (for example, a permanent resident of Maryland or Florida) do not have to select a PCP, but those who want to receive the "in-network" level of coverage must select a PCP. MIT Choice allows families to split their primary care relationships between MIT Medical and primary care providers in the HMO Blue New England network. If you do not select a PCP, regardless of whether you currently reside within the Blue Cross New England network, your benefits will be paid as "out-of-network" and will be subject to a deductible and coinsurance as indicated below.

Under the "out of network," benefit, members will pay for all visits to health professionals until they meet the $500 deductible, per individual; $1,000 per family. After meeting the $500 individual or $1,000 family deductible, members will also be responsible to pay 25% of any medical bills for services received by a Blue Cross Blue Shield provider until the annual out-of-pocket dollar amount is reached. This is called co-insurance. The annual out-of-pocket amounts for services received by a Blue Cross Blue Shield provider are $2,500 per individual or $5,000 per family. The $500/$1000 deductible amounts are included in these annual out-of-pocket amounts.

Preferred Provider Organization Plan (PPO)

- **Blue Care Elect Preferred (PPO) Plan**

The Blue Care Elect Preferred (PPO) Plan is offered only to employees assigned to work by the Institute outside of New England. The Blue Care Elect Preferred (PPO) Plan provides the highest level of benefits when you obtain covered services from preferred providers. You may also obtain covered services from non-preferred providers, but the out-of-pocket costs will be higher. For some covered services, you must meet a calendar-year deductible before benefits are provided. The calendar-year deductible begins on January 1 and ends on December 31 of each year.

**Vision Care**

- **EyeMed Vision Care Plan**

Although vision care will still be covered under the medical plans listed above (e.g., check-ups and doctor’s office visits), this optional plan will cover the cost of eyeglasses and contact lenses—the “hardware” of vision care. To participate in this optional plan, you need to choose it as a separate election.
The vision plan has a network of providers through EyeMed Vision Care, but out-of-network benefits are also available. For more information, contact 888-4-EYEMED.

Dental Care

- **Delta Dental MIT Comprehensive Plan**

  The MIT Comprehensive Plan provides coverage for dental services including but not limited to, diagnostic, preventive, restorative, oral surgery, periodontics, endodontics, prosthetic maintenance and emergency dental care. Participants must meet a $50 deductible that is waived for diagnostic and preventive services. The MIT Comprehensive Plan will provide benefits up to a calendar year maximum of $1,750 per person. The MIT Comprehensive Plan will provide coverage for orthodontic services at 50% of the maximum plan allowance through age 18, with a $1,750 separate lifetime maximum.

- **Delta Dental MIT Basic Plan**

  The MIT Basic Plan provides coverage for dental services including but not limited to, diagnostic, preventive, restorative, oral surgery, periodontics, endodontics, prosthetic maintenance and emergency dental care. The MIT Basic Plan will provide benefits up to a calendar year maximum of $1,750 per person.

**Circumstances That May Cause Loss of Medical Benefits**

The Plan contains some restrictions on the type and amount of medical benefits payable as well as the circumstances under which benefits are paid. Circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of any benefits are described in the separate Booklet(s). You should review the applicable Booklet(s) in order to acquaint yourself with these provisions. You may lose coverage under the Plan if the Plan Sponsor terminates the Plan or amends it to reduce or eliminate your coverage.

**Provider Directories/Listings**

Provider directories/listings for the provider networks utilized by the benefit options under the Plan will be available through the applicable plan provider via the internet. Paper copies will be made available upon request from the plan provider and the Plan Sponsor free of charge.

8. **Plan Funding and Contributions**
Medical, dental, vision and prescription drug benefits under the Plan are funded through a combination of the Plan Sponsor’s general assets and any group insurance contracts purchased by the Plan Sponsor from time to time.

**Fully Insured Benefits.** Any coverage that is fully insured provides benefits under one or more insurance policies or contracts issued to the Plan Sponsor. Insurance carriers issuing these policies are solely responsible for financing and providing the benefits under the insurance policies and contracts. The Plan Sponsor has no liability for any benefits due or alleged to be due, under any such insurance policies or contracts.

The EyeMed Vision Care Plan is provided through a fully insured group insurance contract entered into by the Plan and EyeMed Vision Care, LLC, underwritten by Combined Insurance Company of America.

The address to submit claims for EyeMed Vision Care, LLC is:

FAA/EyeMed Vision Care, LLC
Attn: OON Claims
P.O. Box 8504
Mason, Ohio 45040-7111

**Self-Funded Benefits.** Any coverage that is self-funded provides benefits under one or more administrative services arrangements. Under such arrangements, third party administrators provide claims payment and other administrative services under an administrative services contract with the Plan Sponsor but they do not assume any financial risk or obligation with respect to claims or benefits under the coverage.

The MIT Choice Plan, Blue Care Elect Preferred (PPO) Plan and the MIT Traditional Health Plan benefits are provided through a self-insured plan administered by a third party administrator, Blue Cross and Blue Shield of Massachusetts, Inc. (“Blue Cross Blue Shield”). Blue Cross Blue Shield is designated to provide administrative services, make medical claim determinations based on the Plan’s medical policy and process claims.

The address to submit claims for Blue Cross Blue Shield is:

Landmark Center
401 Park Drive
Boston, Massachusetts 02215-3326.

The Delta Dental MIT Basic Plan and the Delta Dental MIT Comprehensive Plan are provided through a self-insured plan administered by a third party administrator Delta Dental of Massachusetts (“Delta Dental”). Delta Dental is designated to provide administrative services, make medical claim determinations based on the Plan’s medical policy and process claims.
The address to submit claims for Delta Dental is:
Attention: Customer Service
Delta Dental of Massachusetts
465 Medford Street
Boston, MA 02129

9. **Internal Claims Denial and Appeal**

Claims for Fully-Insured Benefits. All claims and appeals of denied claims involving a benefit under the EyeMed Vision Care Plan shall be submitted to First American Administrators, Inc., a wholly owned subsidiary of EyeMed Vision Care, LLC, (“EyeMed”) which shall be solely responsible for administering all such claims in accordance with ERISA (including the Department of Labor Regulations thereunder) and state law, as applicable. The final determination of EyeMed on review shall in all cases be final, and the Plan Sponsor shall not have any authority to overrule any determination of the insurance carrier of a fully insured benefit under the Plan.

Claims for Self-Funded Benefits. All claims and appeals of denied claims involving a medical benefit under the MIT Choice Plan, Blue Care Elect Preferred (PPO) Plan and a medical and prescription drug benefit under the MIT Traditional Health Plan shall be submitted to Blue Cross Blue Shield, which shall be solely responsible for administering all such claims in accordance with ERISA (including Department of Labor Regulations thereunder) and state law, as applicable. You may contact Blue Cross Blue Shield for more information about claims procedures relating to your benefit option under the Plan.

Claims for Prescription Drug Benefits. All claims and appeals of denied claims involving a prescription drug benefit under the MIT Choice Plan and the Blue Care Elect Preferred (PPO) Plan shall be submitted to Express Scripts (“ESI”), which shall be solely responsible for administering all such claims in accordance with ERISA (including Department of Labor Regulations thereunder) and state law, as applicable. You may contact ESI for more information about claims procedures relating to your benefit option under the Plan.

Timing of Claims and Appeals Decisions. Under ERISA, claims and appeals must be decided within a reasonable time, subject to the certain maximum limits summarized as follows:

**Initial claims.** After receipt of the claim, the claim must be decided no later than:

- As soon as possible but no later than 72 hours for urgent care claims
- 15 days for pre-service claims
- 30 days for post-service claims (or up to 45 days in the event of special circumstances)
Claimants have 180 days to appeal a denied claim.

**Appeals of denied claims.** After receipt of the request for review, the appeal must be decided no later than:

- as soon as possible but no later than 72 hours for urgent care claims
- 30 days for pre-service claims
- 60 days for post-service claims

Claims and appeals will be decided within the period required by ERISA.

**Timely Filing Requirement.** Unless otherwise specified in the Plan, your applicable Booklet, or this Summary Plan Description, you or your dependent(s) must file an initial claim for medical, vision or prescription drug benefits within 12 months from the date of service. You or your dependent(s) must complete the claims and appeals process described in the Claims and Appeals Section of the Plan, or your applicable Booklet, before you may bring legal action or, where applicable, pursue external review. You may not file a lawsuit for benefits if the initial claim or appeal is not made within the time periods described in the Claims and Appeals section of your Plan or applicable Booklet.

You must file any lawsuit for benefits within 1 year after the final decision on appeal. You may not file suit after the 1 year period expires. You or your dependent(s) are not required to request voluntary internal review or an external review before filing a lawsuit. If you or your dependent(s) do request voluntary internal review or an external review of the decision on appeal, the time taken to appeal under the voluntary review process will not be counted against the 1 year time period in which you have to file a lawsuit.

10. **External Review**

**Standard External Review**

Individuals enrolled in the MIT Choice Plan, MIT Traditional Plan and the Blue Care Elect Preferred (PPO) Plan may have a right to external review. However, it is important to note that enrollees in the EyeMed Vision Plan, Delta Dental MIT Basic Plan and the Delta Dental MIT Comprehensive Plan will not have a right to external review as outlined below.

If the outcome of the mandatory first level appeal is adverse to you and it was based on medical judgment, you may be eligible for an independent external review pursuant to federal law.
You must submit your request for external review to the appropriate administrator: (1) Blue Cross Blue Shield for medical and prescription claims for the MIT Traditional Plan and medical claims for the MIT Choice Plan and the Blue Care Elect Preferred (PPO) Plan or (2) ESI for prescription drug claims for the MIT Choice Plan and the Blue Care Elect Preferred (PPO) Plan, within four (4) months of the notice of your final internal adverse determination. A request for external review must be in writing unless the administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to the address provided in your applicable Booklet. You do not have to resend the information that you submitted for internal appeal. However, you will have at least five business days to submit to the external reviewer any additional information that the reviewer must consider in conducting the external review. The claim will be decided within 45 days of receiving the request.

All necessary information, including the administrator’s decision, can be sent between the administrator and you by telephone, facsimile or other similar method.

**Expedited External Review**
You may be eligible for an expedited external review of your adverse benefit determination in certain situations (e.g., medical conditions for which the standard review timeframe would seriously jeopardize your life or jeopardize your ability to regain maximum function). To proceed with an Expedited External Review, you or your authorized representative must contact the administrator at the number shown on your ID card and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the provider’s name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

A final decision of your expedited external review will be provided within 72 hours after the external reviewer receives your request for review.

**Your Rights**
Your decision to seek External Review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent External Review. The External Review decision is final.

11. **Right to Subrogation and Reimbursement**

Unless otherwise stated in the applicable Booklet, any benefits under the Plan will be subject to the subrogation and reimbursement rules below. **This section applies**
to your Spouse, Domestic Partner and Eligible Dependents the same as it applies to you.

Plan’s Right to Subrogation

This section applies if another party is, or may be considered, liable for your injury, sickness, or other condition (including insurance carriers who are so financially liable).

The Plan will not cover either the reasonable value of the services to treat such injury, sickness or other condition or the treatment of such injury, sickness, or other condition. These benefits are specifically excluded.

The Plan may, however, advance moneys or provide care for such an injury, sickness or other condition, and, if so, in consideration for the advancement of benefits, the Plan is subrogated to all of your rights against any party liable for the payment for the medical treatment of such injury, sickness or other condition (including any insurance company), in the amount of benefits advanced or provided by the Plan to you. The Plan may assert this right independently of you. This right includes, but is not limited to, your rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers’ compensation coverage, or other insurance. The Plan is not obligated in any way to pursue this right independently or on your behalf, but may choose to pursue its rights to reimbursement under the Plan, at its sole discretion. If such moneys are advanced, as described in this section, you shall be considered the constructive trustee over these funds, and failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan.

You are obligated to cooperate with the Plan and its agents to protect the Plan’s subrogation rights. Cooperation means providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan’s subrogation claim, and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.

If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not prejudice, in any way, the subrogation rights of the Plan under this section. If you fail to cooperate as provided herein, including executing any documents required herein, the Plan may, in addition to remedies provided elsewhere in the Plan and/or under the law, set off from any future benefits otherwise payable under the Plan the amount of benefits advanced under this section to the extent not recovered by the Plan.

The costs of legal representation of the Plan in matters related to subrogation shall be borne solely by the Plan. The costs of legal representation of the Participant shall be borne solely by you.
Reimbursement to Plan if you Recover Payment for an Injury or Illness

This section applies if you or your legal representative, estate or heirs recover money or other property for an injury, sickness or other condition, or if you have made, or in the future may make, such a recovery, including a recovery from an insurance carrier.

The Plan will not cover either the reasonable value of the services to treat such an injury, sickness or other condition or the treatment of such an injury, sickness or other condition. These benefits are specifically excluded.

The Plan may, however, advance moneys or provide care for such an injury, sickness or other condition, and, if so, you shall promptly convey moneys or other property from any settlement, arbitration award, verdict or any insurance proceeds or monetary recovery from any party received by you to the Plan in the amount of benefits advanced or provided by the Plan to you, regardless of whether or not: 1) you have been fully compensated, or made whole for your loss; 2) liability for payment is admitted by you or any other party; or 3) your recovery is itemized or specified as a recovery for medical expenses incurred. If such moneys are advanced, you shall be considered the constructive trustee over these funds, and failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan.

If a recovery is made, the Plan shall have first priority in payment over you or any other party to receive reimbursement of the benefits advanced on your behalf. This reimbursement shall be from any recovery made by you, and includes, but is not limited to, uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers’ compensation settlement, compromises or awards, other group insurance (including student plans), and direct recoveries from liable parties. The Plan has the right to recover interest on the amount paid by the Plan because of the injury, sickness or other condition and the Plan has the right to 100 percent reimbursement in a lump sum.

To secure the rights of the Plan under this section, and because of the Plan’s advancement of benefits, you must acknowledge that the Plan shall have first priority against the proceeds of any such settlement, arbitration award, verdict, or any other amounts received by you and assign to the Plan any benefits you may have under any automobile policy or other coverage, to the extent of the Plan’s claim for reimbursement. You shall sign and deliver, at the request of the Plan or its agents, any documents needed to protect such priority or reimbursement right, or to effect such assignment of benefits. By accepting any benefits advanced by the Plan under this section, you acknowledge that any proceeds of settlement or judgment, including your claim to such proceeds held by another person, held by you or by another, are being held for the benefit of the Plan under these provisions.
You shall cooperate with the Plan and its agents, and shall sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan’s right of reimbursement, provide any relevant information, and take such actions as the Plan or its agents reasonably request to assist the Plan making a full recovery of the reasonable value of the benefits provided.

You shall not take any action that prejudices the Plan’s rights of reimbursement and consents to the right of the Plan, by and through its agent, to impress an equitable lien or constructive trust on the proceeds of any settlement to enforce the Plan’s rights under this section, and/or set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The Plan shall be responsible only for those legal fees and expenses to which it agrees in writing. You shall not incur any expenses on behalf of the Plan in pursuit of the Plan’s rights hereunder. The Plan is not responsible for any attorney’s fees, other expenses or costs that you incur without its prior written consent. Moreover, the Plan is not subject to any state laws or equitable doctrines, including but not limited to the “common fund” doctrine, which would purport to require the Plan to reduce its recovery by any portion or your attorney’s fees or costs, regardless of whether funds recovered are used to repay benefits paid by the Plan.

The Plan shall recover the full amount of benefits advanced and paid hereunder, without regard to any claim or fault on the part of any beneficiary of yours, whether under comparative negligence or otherwise.

12. **Plan Amendment or Termination**

   The Plan Sponsor hopes to continue the Plan indefinitely but the Plan may be changed or discontinued by the Plan Sponsor with respect to all or any class of employees, at any time and for any reason, without notice. Any claims or expenses incurred before the date of any Plan amendment or termination will be paid in accordance with the Plan terms in effect at the time the claim or expense was incurred, provided the claim is filed with the Plan in accordance with the applicable claims procedures and within the applicable time limits for filing such claims. No vested rights of any nature are provided under the Plan.

13. **Plan Documents**

   The documents constituting the Plan may be reviewed in the offices of the Plan Administrator.

14. **Annual Enrollment Period**
You have the opportunity to make changes to your Plan elections for the upcoming Plan Year during the annual enrollment period. At that time you may choose to make changes to your benefit elections or keep your current elections. Generally, the benefit elections you make will remain in effect for the entire Plan Year unless you experience a change in status or you qualify for the special enrollment period (described in the following sections) and you change your benefit election.

Each year, you will be notified of the annual enrollment period, enrollment procedures, coverage costs, and time frames available to enroll in or change your election for the upcoming Plan Year. The Plan Sponsor may make changes to the plans at any time, so it is important to review your annual enrollment materials carefully when you receive them.

15. **Changes in Status**

Outside of the annual enrollment period, federal law provides that you may change certain benefit elections only if you experience a change in status, and the change in your benefit election is consistent with your change in status. A change in status includes, but is not limited to, the following types of events:

- Changes in your legal marital status, as those terms are defined under federal law (marriage, divorce, death of a spouse, legal separation).

- Changes in the number of your dependents (birth, death, adoption, placement for adoption).

- Employment changes (termination or commencement of your own, your spouse's, or your eligible dependents employment, or your own, your spouse's, or your eligible dependents commencement of or return from an unpaid leave of absence).

- Work schedule changes (reduction or increase in hours by you, your spouse, or your eligible dependents).

- Changes in your dependent's eligibility (change in age, marital, student, or disability status).

As mentioned above, any requested change in coverage must be consistent with your change in status.

You must notify the Plan Sponsor within 31 days of your change in status. If you do not request a change to your benefit elections within 31 days of your change in status, you must wait until the next annual enrollment period, or until you experience another change in status, to make a change.
16. **Special Enrollment Rights under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”)**

A group health plan is required to provide special enrollment periods during which certain individuals who previously declined coverage are allowed to enroll (without having to wait until the Plan’s next open enrollment period).

Consequently, if you are declining enrollment for yourself or your dependents (including your spouse or domestic partner) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. The EyeMed Vision Plan is an excepted benefit under HIPAA, and as such is not subject to the special enrollment rights outlined above.

17. **Paying for Your Coverage**

The cost of your coverage is shared by you and the Plan Sponsor. You pay your share of the cost through regular payroll deductions. Your cost is based on a number of factors, including the benefits you select and the level of coverage you choose (for example, individual or family coverage).

When you enroll in coverage, your contributions generally are made on a pre-tax basis. This means that your share of the cost of your coverage generally is deducted from your salary before federal, Social Security, and state income taxes are withheld. As a result, your taxable income is reduced, thereby saving you money. However, it's important to note that paying for coverage or making contributions on a pre-tax basis could slightly reduce future Social Security benefits.

Special rules apply if your domestic partner and/or his or her children are covered under the Plan.

18. **Tax Consequences of Domestic Partner Benefits**

Domestic partners generally do not qualify as spouses or dependents for federal income tax purposes. Therefore, the value of Institute-provided medical, dental and vision coverage that relate to your domestic partner, or his or her children, generally will be considered imputed income and will be taxable to you on each paycheck that the benefits are maintained. This value is subject to change from year to year as the underlying benefit values change. Tax and other withholdings will be made from your paycheck and the value of those benefits will be included in your Form W-2. During any period in which domestic partner benefits that have an imputed income are maintained by you but you are not receiving a paycheck from
the Institute, the Institute reserves the right to collect the employee FICA tax liability directly from you.

The above rules will not apply if your domestic partner (and/or his or her children) satisfies the requirements to be considered your tax dependent under the Internal Revenue Code.

19. **Statement of ERISA Rights**

As a participant in the Plan you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

**Receive Information about Your Plan and Benefits**

Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

**Prudent Actions by Plan Fiduciaries**

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

**Enforce Your Rights**

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or Federal court.

In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a qualified medical child support order (“QMCSO”), you may file suit in Federal court. The Plan has adopted procedures relating to QMCSOs, and those procedures may be obtained without charge from the Plan Administrator by request.

If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

20. **COBRA Rights**

The Plan extends continuation coverage to all eligible dependents, including domestic partners and children of domestic partners. References to COBRA in this section are to the Plan’s continuation coverage and not necessarily legally required under COBRA.

The right to COBRA continuation coverage was created by a federal law, the
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

As discussed in more detail below, COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse or domestic partner, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. There may be other coverage options for you and your family. On January 1, 2014, you’ll be able to buy coverage through the Health Insurance Marketplace (“Marketplace”). In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse or domestic partner of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse or domestic partner dies;
- Your spouse’s or domestic partner’s hours of employment are reduced;
- Your spouse’s or domestic partner’s employment ends for any reason other than his or her gross misconduct; or
- You become divorced or legally separated from your spouse or your domestic partnership dissolves.

Your dependent children (and those of your spouse or domestic partner, if applicable) will become qualified beneficiaries if they lose coverage.
under the Plan because any of the following qualifying events happens:

- The employee dies;
- The employee’s hours of employment are reduced;
- The employee’s employment ends for any reason other than his or her gross misconduct;
- The parents become divorced or they terminate their domestic partnership; or
- The child stops being eligible for coverage under the Plan as a “dependent child.”

**When is COBRA Coverage Available?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction in hours of employment or the death of the employee, the employer must notify the Plan Administrator of the qualifying event.

**You Must Give Notice of Some Qualifying Events**

For the other qualifying events (the employee’s divorce or termination of domestic partnership or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Plan Administrator (see page 1 for the address and telephone number).

**How is COBRA Coverage Provided?**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses and domestic partners, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee’s divorce or termination of domestic partnership or a dependent child’s losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA
continuation coverage for his spouse or domestic partner and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage generally lasts for only up to a total 18 months.

**What is COBRA Continuation Coverage?**

Continuation coverage under COBRA is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights.

**How Long Will Continuation Coverage Last?**

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of loss of coverage due to an employee’s death, divorce or termination of domestic partnership or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement.

Continuation coverage will be terminated before the end of the maximum period if:

- Any required premium is not paid in full on time;
- A qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary;
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage; or
- The employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).
How Can You Extend the Length of COBRA Continuation Coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. As discussed below, you must notify the Plan Administrator (see page 1 for the address and telephone number) within a specified time period of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide timely notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage to the 18 month period of continuation coverage (for a total maximum of 29 months) may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation and must last at least until the end of the 18-month period of continuation coverage. You must notify the Plan within 60 days of such a determination by the Social Security Administration and before the end of the 18 month period of continuation coverage. That notice must be given to the Plan Administrator (see page 1 for the address and telephone number). Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA’s determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses, domestic partners and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or termination of domestic partnership or a dependent child’s ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage. That notice must be given to the Plan Administrator (see page 1 for the address and telephone number).

How Can You Elect COBRA Continuing Coverage?

To elect continuation coverage, you must complete the Election Form you will receive (after notice of the qualifying event has been given to the Plan Administrator, as explained above) and furnish it according to the directions on that form. Each qualified beneficiary has a separate right to elect continuation coverage.
For example, the employee’s spouse or domestic partner may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee’s spouse or domestic partner can elect continuation coverage on behalf of all the qualified beneficiaries.

Until 2014, if there is more than a 63-day gap in health coverage, other group health plans may impose pre-existing condition exclusions that would not otherwise apply. Election of COBRA coverage may help prevent such a gap. However, beginning in 2014 there are limitations on plans imposing a preexisting condition exclusion and such exclusions will become prohibited under the Affordable Care Act. You should also take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How Much Does COBRA Continuation Cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage.

When and How Must Payment for COBRA Continuation Coverage Be Made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is postmarked, if mailed). If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the Plan Administrator (see page 1 for the address and telephone number), to confirm the correct amount of your first payment.

Periodic payments for continuation coverage
After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first day of the month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break.

Grace period for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan may be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

For More Information

For more information about your rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website). For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

In order to protect you and your family’s rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information
If you have any questions about how COBRA is administered under the Plan, please contact the Plan Administrator (see page 1 for the address and telephone number).

21. **Protecting Your Privacy**

   HIPAA requires health plans to notify Plan participants about policies and practices to protect the confidentiality of your health information. The Institute issues a privacy notice to all covered employees when they enroll for coverage, and every three years. A copy is also available by contacting the Plan Administrator.

22. **The Newborns’ and Mothers’ Health Protection Act of 1996 (“NMHPA”)**

   Under NMHPA, group health plans, insurance companies and health maintenance organizations (HMOs) offering health coverage for hospital stays in connection with the birth of a child must provide health coverage for a minimum period of time. For example, NMHPA provides that coverage for a hospital stay following a normal vaginal delivery may generally not be limited to less than 48 hours for both the mother and newborn child. Health coverage for a hospital stay in connection with childbirth following a cesarean section may generally not be limited to less than 96 hours for both the mother and newborn child. However, NMHPA generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). NMHPA also provides that group health plans, insurance companies and HMOs may not require that a provider obtain authorization for prescribing a length of maternity stay not in excess of the above periods.

23. **Qualified Medical Child Support Orders**

   As required by ERISA, the Plan recognizes QMCSOs. A QMCSO is a court order or an order issued by a state administrative agency in accordance with federal and state laws that require an alternate beneficiary (for example, a child or stepchild) to be covered by a plan participant’s group health plan.

   The Plan honors QMCSOs that meet the legal requirements for such orders. It is important to note that a QMCSO cannot require a plan to provide a type or form of benefit, or an option, that is not currently available from the Plan to which the order is directed, unless receiving this benefit or option is necessary to meet the requirements of the Social Security Act, which relates to the enforcement of state child support laws and reimbursement of Medicaid.

   A QMCSO must be provided to the Plan Sponsor to determine if it meets the legal requirements for a QMCSO. If it does, the alternate beneficiary is considered a beneficiary for the purposes of ERISA and he or she is enrolled as a dependent of the employee participant. If the Plan Sponsor receives a medical child support order
that relates to you, you will be notified and then informed of the decision as to whether the order is qualified.

A copy of the Plan’s QMCSO procedures is available, free of charge, upon written request.


WHCRA provides that, in the case of a participant or beneficiary who is receiving benefits under a group health plan in connection with a mastectomy and who elects breast reconstruction, coverage under the plan will be provided in a manner determined in consultation with the attending physician and the patient, 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 the mastectomy, including lymphedemas.

Under WHCRA, coverage of breast reconstruction benefits may be subject only to deductibles and coinsurance limitations consistent with those established for other benefits under the Plan.
APPENDIX A

Health Plan for Employees of Massachusetts Institute of Technology Benefit Descriptions

- MIT Choice Plan Schedule of Benefits
- MIT Traditional Health Plan Schedule of Benefits
- Blue Care Elect Preferred (PPO) Plan Schedule of Benefits
- Delta Dental MIT Basic Plan Subscriber’s Certificate
- Delta Dental MIT Comprehensive Plan Subscriber’s Certificate
- EyeMed Vision Care Summary of Vision Care Services