BlueCross® BlueShield®

Massachusetts Institute of Technology

SUMMARY OF BENEFITS

BLUE CHOICE® NEW ENGLAND PLAN 2

MIT

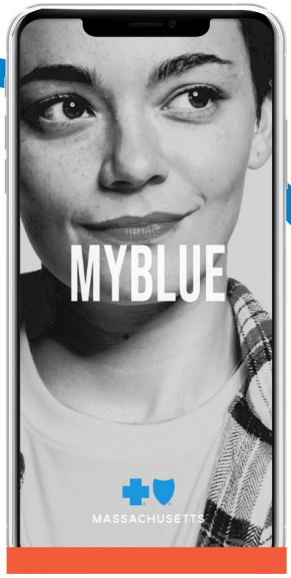
UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:

COVERAGE AND BENEFITS

CLAIMS AND BALANCES

DIGITAL ID CARD



Sign in

Download the app, or create an account at **bluecrossma.com.**

YOUR CARE

Your Primary Care Provider (PCP)
When you enroll in this health plan, you choose a primary care provider (PCP) for you and each member of your family. There are a few ways to find a PCP: visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.com/findadoctor**; consult the Provider Directory; or call the Member Service number on your ID card. If you have trouble choosing a doctor, Member Service can help. They can give you the doctor's gender, the medical school she or he attended, and whether there are languages other than English spoken in the office.

Your PCP is the first person you call when you need routine or sick care. If your PCP decides that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist who is likely affiliated with your PCP's hospital or medical group. Your provider may also work with Blue Cross Blue Shield of Massachusetts regarding the Utilization Review Requirements including Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. For detailed information about Utilization Review, see your benefit description.

When you Select an MIT Medical Primary Care Provider (PCP)
When you select an MIT Medical primary care provider as your PCP, your costs will be lower than when you select any other network PCP. For example, you will pay a lower copayment for covered services furnished by either your MIT Medical primary care provider or services furnished by a network specialist when you have an approved referral from your MIT Medical primary care provider. You may have to pay a higher copayment for the same covered services if you selected a network primary care provider who is not part of MIT Medical. For more information, go to **http://medweb.mit.edu/.**

When You Choose to Receive Care on Your Own (Self-Referred)
You have the freedom to seek care without seeing your PCP first. When you seek care on your own from a participating provider, your out-of-pocket cost will be greater. If you require hospitalization, you, or someone on your behalf, will need to call us before you're admitted to make sure that you're covered.

You must pay a calendar-year deductible before benefits are provided. The calendar-year deductible begins on January 1 and ends on December 31 of each year. The deductible is **$500** per member (or **$1,000** per family).

Your Out-of-Pocket Maximum
Your out-of-pocket maximum is the most that you could pay during a calendar year for deductible, copayments, and coinsurance for covered services. When your care is provided or arranged by your Blue Choice New England PCP or by your MIT Medical primary care provider (PCP), your out-of-pocket maximum is **$2,500** per member (or **$5,000** per family). When you choose to receive care on your own (self-referred) from a participating provider, your out-of-pocket maximum is **$2,500** per member (or **$5,000** per family).

Emergency Room Services
In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call **911** (or the local emergency phone number). You pay a copayment per visit for emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay. See the chart for your cost share.

Telehealth Services
You are covered for certain medical and mental health services for conditions that can be treated through video visits from an approved telehealth provider. Most telehealth services are available by using the Well Connection website at **wellconnection.com** on your computer, or the Well Connection app on your mobile device, when you prefer not to make an in-person visit for any reason to a doctor or therapist. Some providers offer telehealth services through their own video platforms. For a list of telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.com**, consult the Provider Directory, or call the Member Service number on your ID card.

Service Area
The plan's service area includes all cities and towns in the Commonwealth of Massachusetts, State of Rhode Island, State of Vermont, State of Connecticut, State of New Hampshire, and State of Maine.

When Outside the Service Area
If you're traveling outside the plan's service area and you need urgent or emergency care, you should go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. To receive the highest level of benefits, any additional follow-up care must be arranged by your PCP.

Dependent Benefits
This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. See your benefit description (and riders, if any) for exact coverage details.

Domestic Partner Coverage
Domestic partner coverage may be available for eligible dependents. Contact your plan sponsor for more information.

Covered Services	Your Cost for MIT Medical Primary-Care Approved Benefits	Your Cost for Other Network PCP/ Plan-Approved Benefits	Your Cost for Self-Referred/ Out-of-Network Benefits
Preventive Care			
Well-child care exams	Nothing	Nothing	Nothing, no deductible*
Routine adult physical exams, including related tests	Nothing	Nothing	Nothing, no deductible*
Routine GYN exams, including related lab tests (one per calendar year)	Nothing	Nothing	Nothing, no deductible*
Routine hearing exams, including routine tests	$10 per visit	$20 per visit	$10 per visit when you have an MIT Medical PCP or $20 per visit when you have another PCP, no deductible*
Hearing aids (up to $2,500 for one hearing aid or one set of binaural hearing aids per calendar year for a member age 19 or younger)	All charges beyond the maximum	All charges beyond the maximum	All charges beyond the maximum, no deductible*
Routine vision exam (one per calendar year)	$10 per visit	$20 per visit	$10 per visit when you have an MIT Medical PCP or $20 per visit when you have another PCP, no deductible*
Family planning services–office visits	Nothing	Nothing	Nothing, no deductible*
Outpatient Care			
Emergency room visits	$100 per visit (waived if admitted or for observation stay)	$100 per visit (waived if admitted or for observation stay)	$100 per visit, no deductible (waived if admitted or for observation stay)
Office or health center visits	$10 per visit	$20 per visit	25% coinsurance after deductible*
Mental health or substance use treatment	$10 per visit	$20 per visit	25% coinsurance after deductible*
Telehealth services for simple medical conditions or mental health	Nothing	Nothing	Not covered
Chiropractors' office visits	$10 per visit	$20 per visit	25% coinsurance after deductible*
Acupuncture visits (up to 20 visits per calendar year)	$10 per visit	$20 per visit	$10 per visit when you have an MIT Medical PCP or $20 per visit when you have another PCP, no deductible*
Short-term rehabilitation therapy–physical and, occupational (up to 60 visits per calendar year**)	$10 per visit	$20 per visit	25% coinsurance after deductible*
Speech, hearing, and language disorder treatment–speech therapy	$10 per visit	$20 per visit	25% coinsurance after deductible*
Diagnostic X-rays and lab tests	Nothing	Nothing	25% coinsurance after deductible*
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests, when performed: • Shields Health Care Group • Other covered providers	Nothing $50 per category per service date	Nothing $50 per category per service date	25% coinsurance after deductible* 25% coinsurance after deductible*
Home health care and hospice services	Nothing	Nothing	25% coinsurance after deductible*
Oxygen and equipment for its administration	Nothing	Nothing	25% coinsurance after deductible*
Durable medical equipment such as wheelchairs, crutches, hospital beds	10% coinsurance***	10% coinsurance***	25% coinsurance after deductible*
Prosthetic devices	Nothing	Nothing	25% coinsurance after deductible*
Surgery and related anesthesia	Nothing	Nothing	25% coinsurance after deductible*

* In addition to your deductible and coinsurance, you may be responsible for any balance of charges above the allowed charge.
** No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care, treatment of autism spectrum disorders, or speech therapy.
*** MIT Medical PCP and PCP/plan-approved cost share waived for one breast pump per birth.

Covered Services	Your Cost for MIT Medical Primary-Care Approved Benefits	Your Cost for Other Network PCP/ Plan-Approved Benefits	Your Cost for Self-Referred/ Out-of-Network Benefits
Inpatient Care (and maternity care)			
General or chronic disease hospital care (as many days as medically necessary)	Nothing	Nothing	25% coinsurance after deductible*
Mental hospital or substance use facility care (as many days as medically necessary)	Nothing	Nothing	25% coinsurance after deductible*
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing	Nothing	25% coinsurance after deductible*
Skilled nursing facility care (up to 100 days per calendar year)	Nothing	Nothing	25% coinsurance after deductible*

* In addition to your deductible and coinsurance, you may be responsible for any balance of charges above the allowed charge.

Get the Most from Your Plan: Visit us at bluecrossma.com or call 1-800-882-1093 to learn about discounts, savings, resources, and special programs available to you, like those listed below.	
Wellness Participation Program Fitness Reimbursement: a program that rewards participation in qualified fitness programs This fitness program applies for fees paid to: a health club with cardiovascular and strength-training equipment; a fitness studio offering instructor-led group classes for cardiovascular and strength-training; or virtual fitness memberships or classes. (See your benefit description for details.)	$150 per calendar year per policy
Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program This weight loss program applies for fees paid to: hospital-based or non-hospital-based weight loss programs that focus on eating and physical activity habits and behavioral/lifestyle counseling with certified health professionals. (See your benefit description for details.)	$150 per calendar year per policy

24/7 Nurse Line: A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583). No additional charge.

QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-882-1093, or visit us online at bluecrossma.com.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; prescription drugs for use outside of the hospital; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders. **Note:** Blue Cross and Blue Shield of Massachusetts, Inc., administers claims payment only and does not assume financial risk for claims.

000618320 (9/20) CAD

MASSACHUSETTS

NONDISCRIMINATION NOTICE

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. It does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS PROVIDES:

- Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print or other formats).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call Member Service at the number on your ID card.

If you believe that Blue Cross Blue Shield of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with the Civil Rights Coordinator by mail at Civil Rights Coordinator, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126; phone at **1-800-472-2689 (TTY: 711)**; fax at **1-617-246-3616**; or email at **civilrightscoordinator@bcbsma.com**.

If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, online at **ocrportal.hhs.gov**; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, DC 20201; by phone at **1-800-368-1019** or **1-800-537-7697 (TDD)**.

Complaint forms are available at **hhs.gov**.

000489593

55-1487 (6/20)

MASSACHUSETTS

PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES

Spanish/Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).

Portuguese/Português: ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

Chinese/简体中文: 注意：如果您讲中文，我们可向您免费提供语言协助服务。请拨打您 ID 卡上的号码联系会员服务部（TTY 号码：**711**）。

Haitian Creole/Kreyòl Ayisyen: ATANSYON: Si ou pale kreyòl ayisyen, sèvis asistans nan lang disponib pou ou gratis. Rele nimewo Sèvis Manm nan ki sou kat Idantitifkasyon w lan (Sèvis pou Malantandan TTY: **711**).

Vietnamese/Tiếng Việt: LƯU Ý: Nếu quý vị nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cung cấp cho quý vị miễn phí. Gọi cho Dịch vụ Hội viên theo số trên thẻ ID của quý vị (TTY: **711**).

Russian/Русский: ВНИМАНИЕ: если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Позвоните в отдел обслуживания клиентов по номеру, указанному в Вашей идентификационной карте (телетайп: **711**).

Arabic/ةيبر:

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هُويتك (جهاز الهاتف النصي للصم والبكم "TTY": **711**).

Mon-Khmer, Cambodian/ខ្មែរ: ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខ នៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (TTY: **711**)។

French/Français: ATTENTION : si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le Service adhérents au numéro indiqué sur votre carte d'assuré (TTY : **711**).

Italian/Italiano: ATTENZIONE: se parlate italiano, sono disponibili per voi servizi gratuiti di assistenza linguistica. Chiamate il Servizio per i membri al numero riportato sulla vostra scheda identificativa (TTY: **711**).

Korean/한국어: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드에 있는 전화번호(TTY: **711**)를 사용하여 회원 서비스에 전화하십시오.

Greek/Ελληνικά: ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε την Υπηρεσία Εξυπηρέτησης Μελών στον αριθμό της κάρτας μέλους σας (ID Card) (TTY: **711**).

Polish/Polski: UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej. Należy zadzwonić do Działu obsługi ubezpieczonych pod numer podany na identyfikatorze (TTY: **711**).

Hindi/हिंदी: ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए नि:शुल्क उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वाई.: **711**).

Gujarati/ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમને ભાષાકીય સહાયતા સેવાઓ વિના મૂલ્યે ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર આપેલા નંબર પર Member Service ને કૉલ કરો (TTY: **711**).

Tagalog/Tagalog: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tawagan ang Mga Serbisyo sa Miyembro sa numerong nasa iyong ID Card (TTY: **711**).

Japanese/日本語: お知らせ：日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。IDカードに記載の電話番号を使用してメンバーサービスまでお電話ください（TTY: **711**）。

German/Deutsch: ACHTUNG: Wenn Sie Deutsche sprechen, steht Ihnen kostenlos fremdsprachliche Unterstützung zur Verfügung. Rufen Sie den Mitgliederdienst unter der Nummer auf Ihrer ID-Karte an (TTY: **711**).

Persian/پارسیان:
توج: اگر زبان شما فارسی است، خدمات کمک زبانی ب صورت رایگان در اختیار شما قرار می گیرد. با شمار تلفن مندرج بر روی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: **711**).

Lao/ພາສາລາວ: ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: **711**).

Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'déé' nóomba biká'ígíiji' béésh bee hodíílnih (TTY: **711**).

000489691

55-1493 (6/20)