

SUMMARY PLAN DESCRIPTION
FOR THE
HEALTH AND WELFARE PLAN FOR EMPLOYEES OF MASSACHUSETTS INSTITUTE OF
TECHNOLOGY (THE “PLAN”)
(Plan No. 505)

Effective January 1, 2020

SUMMARY PLAN DESCRIPTION (SPD)
FOR THE HEALTH AND WELFARE PLAN FOR EMPLOYEES OF MASSACHUSETTS
INSTITUTE OF TECHNOLOGY (THE “PLAN”)

This document presents basic information about the medical and prescription drug, dental, vision, and health care and dependent care flexible spending accounts, life insurance and global benefits provided by the Health and Welfare Plan for Employees of Massachusetts Institute of Technology (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 Certificates, Schedule of Benefits and the Summary of Benefits for the health and welfare plans you have selected (collectively referred to in this document as the “Booklet”), constitutes the Summary Plan Description for your medical and prescription drug, dental, vision, and health care and dependent care flexible spending accounts, life insurance and global 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). An amendment to one of these documents constitutes an amendment to the Plan. You should use these materials to understand the Health and Welfare Plan benefits that Massachusetts Institute of Technology (“MIT”) provides to you.

This Summary Plan Description should be read in conjunction with any applicable insurance policy/evidence of coverage or benefit booklet/summary provided by the insurers or Claims Administrators listed at Appendix A. Unless otherwise noted, if there is a conflict between a specific provision under the Plan Document and a benefit booklet/summary, insurance policy/evidence of coverage, or this Summary Plan Description, the Plan Document controls. If the Plan Document is silent on a specific issue, then the Summary Plan Description controls on that issue, except where the Summary Plan Description refers to a benefit booklet/summary or insurance policy/evidence of coverage, in which case the benefit booklet/summary or insurance policy/evidence of coverage control. If both the Plan Document and Summary Plan Description are silent, the terms of the applicable insurance policy/evidence of coverage or benefit booklet/summary controls. However, with respect to fully insured benefits, the terms of the certificate of insurance coverage or insurance policy/evidence of coverage control when describing specific benefits that are covered or insurance-related terms. See Appendix A to determine whether a particular benefit is self-funded by the Company or fully insured by the insurer. The terms and conditions of the insurance coverage provided under the Plan, including the description of covered benefits, limitations and exclusions, coordination of benefits, subrogation, claims procedures, and pre-certification, are set forth in greater detail in the insurance policy/evidence of coverage issued in connection with the Plan. Copies of the insurance policy/evidence of coverage are available by calling MIT Benefits at 617-253-6151 or sending an email to benefits@mit.edu.

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

Massachusetts Institute of Technology (“MIT”) 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.

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I. Medical and Prescription Drug, Dental, Vision, and Health Care and Dependent Care Flexible Spending Account Benefits

1. Eligibility and Benefits

A. Employee Eligibility

To be eligible for medical and prescription drug, dental, vision, and health care and dependent care flexible spending accounts under the Plan from MIT, 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 MIT; (2) have been appointed to work at MIT for at least three (3) months; and (3) be paid by MIT. An employee is also considered an eligible employee for these benefits if they meet the foregoing eligibility criteria and either (i) has a visiting appointment at MIT, (ii) has a postdoctoral fellowship appointment of at least three months and wants to continue existing MIT health plan coverage, or (iii) has retired from MIT and then comes back to work for MIT as an “Active Retiree,” or (iv) was eligible for Retiree Welfare Benefit Plan coverage while eligible for long term disability benefit payments from MIT and then comes back to work for MIT (not including on a phased rehabilitation appointment).

The following individuals shall not be considered an eligible employee for medical and prescription drug, dental, vision, and health care and dependent care flexible spending accounts under the Plan under any circumstances:

- (i) Consultants, contractors, affiliates, teaching or research assistants, honorary lecturers, post-doctoral trainees with no existing enrollment, work-study student, student program workers not working for MIT, summer appointment, international visiting student, family member who is not employed by MIT, individuals paid by vouchers or MITemps, and members of the armed services assigned to MIT.
- (ii) Any other individual who is in a division, department, unit, or job classification designated by MIT 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.

Your enrollment in coverage provided under the Plan is subject to all limitations of the Plan and any related insurance contracts, including elimination periods, at-work requirements and hourly eligibility requirements. Enrollment in certain coverages may also be limited due to international home and/or work address.

Note: If your employment with the Plan Sponsor is governed by a collective bargaining agreement, then the availability of, and the extent of your participation in, the coverage under the Plan summarized in this Summary Plan Description (SPD) will also be governed by the terms of your collective bargaining agreement.

B. Dependent Eligibility

An eligible employee who is enrolled in medical and prescription drug, dental, and vision 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 in such coverage, if and to the extent such coverage is available. An eligible employee may only enroll him or herself in the health care flexible spending account and dependent care flexible spending account benefits, but may receive reimbursements for expenses incurred by or for the care of, respectively, certain spouses and dependents, as defined under the terms of the Cafeteria Benefit Plan of Massachusetts Institute of Technology. Please see that document for additional details.

- (i) Spouse – A “spouse” is defined as an individual who is lawfully married to an eligible employee as recognized by the state, possession, or territory of the US, or non-US country in which the marriage was entered into, regardless of domicile, and who is not legally separated. In the event of a divorce or a legal separation, the covered spouse of an eligible employee prior to the divorce or legal separation will, generally, only remain eligible for coverage under the eligible employee’s group membership through the earlier of the employee’s coverage end date or the date the decree nisi or rule nisi indicates the divorce is final. A legal separation is a qualifying event that permits, but does not require, the employee to remove the legally separated spouse from coverage. More information on divorced spouse coverage is found in Section I.4 If You Are Divorced.
- (ii) Domestic Partner – A “domestic partner” means an individual of the same or opposite gender as the eligible employee with whom the eligible employee has a relationship of commitment that meets the requirements established by the Plan Administrator and that is certified by the eligible employee to the Plan Administrator. The requirements, terms and conditions for such status shall be prescribed by the Plan Administrator and may be amended from time to time.

(iii) Children – “Children” includes the child of an eligible employee or the eligible employee’s spouse or domestic partner until the end of the calendar month in which the child turns age twenty-six (26). A child is not required to live with the eligible employee or the eligible employee’s spouse (or domestic partner), be a dependent on the eligible employee’s spouse’s (or domestic partner’s) tax return or be a full-time student to be a dependent eligible for health benefits. Eligible children may include:

1. A newborn child. The effective date of coverage for a newborn child will be the child’s date of birth provided that the eligible employee notifies the Plan within thirty-one (31) days of the date of birth.
2. An adopted child. The effective date of coverage for an adopted child will be the date of placement of the child with the eligible employee 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.
3. An eligible dependent also includes:
 - a. A person up to the age twenty-six (26) who is not the eligible employee’s child but who qualifies as a dependent under the Internal Revenue Code.
 - b. A child recognized under a Qualified Medical Child Support Order as having the right to enroll for health care coverage.
 - c. A disabled dependent child age twenty-six (26) or older. A dependent child who is certified by a licensed physician as being mentally or physically incapable of earning his or her own living, will continue to be covered after he or she would otherwise lose dependent eligibility under the Plan, so long as the child continues to be mentally or physically incapable of earning his or her own living. The requirements, terms and conditions for such status shall be prescribed by the Plan Administrator and may be amended from time to time.

C. Employee Benefits While on Long Term Disability from MIT

If an employee is eligible for long term disability benefit payments from MIT, he or she may continue to be covered in the Plan at the level of medical and prescription drug, and dental coverage in effect the date he or she became eligible for long term disability benefit payments. Effective December 10, 2020, employees eligible for long term disability benefit payments for three (3) years or more are not eligible for medical and prescription drug coverage under this Plan. Effective December 10, 2020, employees eligible for long term disability benefit payments who are or become eligible for coverage under the Retiree Welfare Benefit Plan, are

not eligible for medical and prescription drug coverage under this Plan. For eligibility for medical and prescription drug coverage after such three-year time period, or after becoming eligible for coverage under the Retiree Welfare Benefit Plan, please see the Retiree Welfare Benefit Plan.

The full cost of the medical and prescription drug, and dental plans is paid by MIT during the employee's approved long-term disability period, as long as the employee remains eligible for such benefits under this Plan. Vision, flexible spending account and dependent care assistance benefits are not available while on Long Term Disability, including when the employee has a Phased Rehabilitation appointment of at least 50%.

If the disabled employee is awarded Social Security disability benefits, he or she will generally become eligible for Medicare twenty-four (24) months after the Social Security disability effective date. In addition, if the disabled employee is age sixty-five (65) or older he or she will become eligible for Medicare on that basis. Such individual must enroll in one of the Medicare Supplement Plans offered by MIT. Medicare will pay primary to the Medicare Supplement Plan in that situation (assuming the individual under age 65 employee has already received six (6) months of taxable disability benefits from MIT). Failure to enroll in Medicare Parts A and B will result in the loss of medical coverage from MIT. The full cost of Medicare Part B is paid by the individual; the full cost of the Medicare Supplement Plan is paid by MIT.

If the disabled employee has an eligible spouse or domestic partner who was enrolled in coverage under the Plan when the employee became eligible for disability benefit payments from MIT, the spouse or domestic partner will continue on the medical and prescription drug, and dental benefits under the Plan with the full cost paid by MIT, until the earlier of: the date they are eligible for Medicare or the date the employee is eligible for coverage under the Retiree Welfare Benefit Plan, except when the employee is eligible for coverage as defined in Section 2.1 (c) of the Retiree Welfare Benefit Plan, as long as the employee remains eligible for disability benefit payments from MIT. If the spouse or domestic partner is eligible for Medicare, he or she must enroll in Medicare Parts A and B, and one of the Medicare Supplement Plans offered by MIT. Failure to enroll in Medicare will result in the loss of medical coverage from MIT. The full cost of Medicare Part B is paid by the spouse or domestic partner; the full cost of the Medicare Supplement Plan is paid by MIT. Please see the Retiree Welfare Benefit Plan for additional eligibility information.

If applicable, the disabled employee's child(ren) will continue to be covered under the Plan (medical and prescription drug, and dental) until the earlier of: twenty-six (26) years of age or the date the employee is eligible for coverage under the Retiree Welfare Benefit Plan, except when the employee is eligible for coverage as defined in Section 2.1 (c) of the Retiree

Welfare Benefit Plan, as long as the employee remains eligible for disability benefit payments from MIT, with the full cost paid by MIT. Please see the Retiree Welfare Benefit Plan document for additional eligibility information.

2. When Coverage Ends

Coverage for you and your dependents will automatically terminate on the earliest of:

- The end of the month in which your employment ends, including retirement except flexible spending account and dependent care assistance expenses that must be incurred on or before the day your employment ends
- The date the Plan or a benefit option terminates
- The last day for which required contributions are paid
- The date you or a dependent is no longer eligible for coverage
- The date the Plan Administrator determines in its sole discretion that you have made a false statement on any enrollment form or claim form or filed a fraudulent request with the Plan

3. Retirement

If you retire from MIT after age fifty-five (55) with ten (10) years of service and are eligible to enroll in retiree medical coverage from MIT, you must notify the Plan Administrator within thirty-one (31) days of the date of your retirement in order to be eligible for immediate enrollment in the MIT Retiree Welfare Benefit Plan. If you and/or your spouse or domestic partner are age sixty-five (65) or older, or otherwise eligible for Medicare when you retire from MIT, enrollment in Medicare Parts A and B are required to be eligible for enrollment in the Retiree Welfare Benefit Plan. Please see the Retiree Welfare Benefit Plan document for additional eligibility information. If you and/or your spouse are covered under the Plan, and are age sixty-five (65) or older when you retire from MIT, upon request, MIT will provide a letter to you and/or your spouse to waive any late enrollment penalty that may be assessed by Medicare if you decide to enroll in Medicare when coverage ends under the Plan. MIT cannot provide a penalty waiver letter to a retiree or spouse over age sixty-five (65) who is not covered under the Plan, or to a Domestic Partner over age sixty-five (65) even if they are covered under the Plan.

4. If You Are Divorced

You are responsible for notifying MIT of your divorce in a timely manner, but no later than 31 days from the date of the final decree nisi or rule nisi. Except as described below, a spouse who has been covered under the Plan is no longer eligible to continue coverage under the eligible employee's group membership once legally divorced. The effective date for termination of coverage will be the date stipulated in the final decree nisi or rule nisi (also known as a divorce decree). Payroll deductions for a former spouse's coverage must be paid through the end of the pay period in which the spouse's coverage ends. Any dependent child(ren) covered under your Health Plan(s) can continue to be covered under the Health Plan(s) up to twenty-six (26) years of age.

If at the time of the divorce your former spouse is under age sixty-five (65) and covered under the Plan, and the divorce decree states that you are legally required to provide continued healthcare coverage for your former spouse, the Plan will allow coverage to continue under a separate, individual coverage under the Plan at 100% of the full, unsubsidized rates. The former spouse will only be offered continuation coverage for the benefit option the former spouse was enrolled in prior to the divorce, i.e., if only enrolled in medical and prescription drug benefits, then continuation of coverage in the medical and prescription drug benefit option will be offered to the former spouse. If such coverage is waived, MIT will not offer any future opportunity to enroll in such coverage.

Your former spouse's coverage will continue until the earliest of one of the following events occurs:

- Your former spouse turns age sixty-five (65) or otherwise becomes eligible for Medicare
- Your former spouse remarries
- You are no longer eligible for benefits under the Plan for any reason, including, but not limited to: reduction in your work effort; termination of employment; you are approved for Long Term Disability from MIT; your death
- You retire
- You are no longer obligated to provide coverage per the divorce decree
- You or your former spouse, whoever is responsible for payment, fails to pay the required premiums
- MIT amends the Plan to eliminate this coverage option
- The date the Plan or a benefit option terminates
- The date the Plan Administrator determines in its sole discretion that you have made a false statement on any enrollment form or claim form or filed a fraudulent request with the Plan

If your former spouse becomes ineligible for continued coverage under the Plan, due to one of the events above, the former spouse's coverage will terminate no later than the first of the month after the event occurs and he or she will be offered COBRA continuation coverage.

Notwithstanding the above, when you fail to notify MIT of your divorce in a timely manner, and your former spouse is covered under the Plan for more than the reasonable amount of time allowed after divorce per state law, MIT has the right to cancel coverage for your former spouse retroactive to the date allowed by state law. In addition, your former spouse will not be eligible for or offered COBRA continuation coverage. Under certain circumstances, you may be responsible for imputed income tax and claim costs incurred while your former spouse was covered under the Plan.

If at the time of the divorce your former spouse is over the age of sixty-five (65) and covered under the Plan, the Plan will not allow coverage to continue for the former spouse even when the divorce decree states that you are legally required to

provide continued healthcare coverage for your former spouse. The former spouse will be removed no later than the first of the month following the date the divorce becomes finalized. COBRA continuation coverage will be offered to your former spouse for enrolled medical and prescription, dental and/or vision plans. Upon request, MIT will provide a letter to your former spouse to waive any late enrollment penalty that may be assessed by Medicare if your former spouse decides to enroll in Medicare when coverage ends under the Plan. Former spouses are not eligible to enroll in any of the Medicare Supplement Plans offered by MIT under the Retiree Welfare Benefit Plan.

5. Benefits under the Plan

The Plan offers a choice of Blue Cross Blue Shield medical plan options that all provide prescription drug benefits, including a high deductible health plan, a Health Maintenance Organization (HMO), a Point-of-Service (POS), and a Preferred Provider Organization (PPO) plan to assist with most types of medical care. There are no pre-existing condition exclusions under these plans.

The medical plan options available under the Plan also include a benefit for certain vision expenses (e.g., check-ups and doctor's office visits).

The Plan offers the EyeMed Vision Care Plan to help reduce 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 Basic Plan and the Comprehensive Plan.

The benefit options available under the Plan are described in the applicable Booklet(s), which are available to you under separate cover. For a complete description of these benefits, please refer to the Booklet(s) provided by the applicable medical, dental, 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.

Certain changes were made to the Plan during the COVID-19 pandemic, including extensions of certain claim filing deadlines and COBRA deadlines, changes in Health Care and Dependent Care Flexible Spending Account elections. View <https://hr.mit.edu/covid19/faq> on the MIT Benefits website for more information and the Cafeteria Plan of Massachusetts Institute of Technology for more information.

6. Table of Medical and Prescription Drug, Dental, Vision, and Health Care and Dependent Care Flexible Spending Account Benefits

Benefit Option	Description
Medical Benefit Options	
MIT Traditional Health Plan	<p>The MIT Traditional Health Plan provides medical coverage and prescription drug benefits administered by Blue Cross Blue Shield of MA. The primary medical care and prescription drug benefits are provided 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 will need to obtain a referral from your MIT Medical-based PCP for visits to most health care providers. When necessary, you will have access to the HMO Blue of MA provider network. You (and those you cover) will have a \$10 copay for most visits to a health care provider. You may choose a mental health provider from the Managed Care Behavioral Health Network.</p>
MIT Choice Health Plan	<p>The MIT Choice Health Plan provides medical coverage and prescription drug benefits. The medical coverage is a Blue Cross Blue Shield of MA plan and the prescription drug benefits are through Express Scripts, Inc. (“ESI”). The MIT Choice Health Plan provides a higher level of benefit (in-network) for employees and their dependents who live in the HMO Blue 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 HMO Blue New England network or at MIT Medical. The MIT Choice Health Plan also provides an “out-of-network” benefit for family members who may reside outside of the HMO Blue New England network or for those who choose to receive care outside of the network. You will need to obtain a referral from your PCP for visits to most network health care providers. You (and those you cover) will have a copay for office visits based on the location of the PCP. For an MIT Medical PCP, there is a \$10 copay. For a provider in the HMO Blue New England network, there is a \$20 copay.</p> <p>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. The MIT Choice Health Plan allows families to split their primary care relationships between primary care providers at the MIT Medical Center and in the HMO Blue New England network. If you do not select a PCP, regardless of whether you currently reside within the HMO Blue</p>

Benefit Option	Description
	<p>New England network, your benefits will be paid as “out-of-network” and will be subject to a deductible and coinsurance as indicated below.</p> <p>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 pay a co-insurance amount of 25% of any medical bills for services received by a Blue Cross Blue Shield provider until the annual out-of-pocket maximum is reached. The annual out-of-pocket maximum for services received by a Blue Cross Blue Shield provider is \$2,500 per individual or \$5,000 per family. The \$500/\$1000 deductible amounts are included in these annual out-of-pocket maximums. The calendar-year deductible begins on January 1 and ends on December 31 of each year.</p>
Blue Care Elect Preferred (PPO) Plan	<p>The Blue Care Elect Preferred (PPO) Plan provides medical coverage and prescription drug benefits. The medical coverage is a Blue Cross Blue Shield of MA plan and the prescription drug benefits are through Express Scripts, Inc. (ESI). The Blue Care Elect Preferred (PPO) Plan is offered only to employees with a U.S. home and work address that MIT has assigned to work 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 the annual calendar year deductible before benefits are provided. The calendar-year deductible begins on January 1 and ends on December 31 of each year.</p>
MIT High Deductible Health Plan	<p>The MIT High Deductible Health Plan (HDHP) provides medical coverage and prescription drug benefits. The medical coverage is a Blue Cross Blue Shield of MA plan that offers the same qualified medical services as the MIT Traditional Health Plan and the MIT Choice Health Plan, including 100% coverage of the cost of medical preventive services in-network. Prescription drug benefits are provided through Express Scripts, Inc. (ESI). Compared with the other plans, the HDHP plan has a lower premium and a higher deductible.</p> <p>Members will pay for all non-preventive services, non-preventive prescriptions, and out-of-network preventive services until they meet the \$1,500 deductible, per individual; \$3,000 per family. After meeting the \$1,500 individual or \$3,000 family deductible, members</p>

Benefit Option	Description
	<p>will also pay a co-insurance percentage of the cost of these services until the annual out-of-pocket maximum is reached. The co-insurance percentage is 10% in-network, 25% out-of-network and 0% at MIT Medical. The annual out-of-pocket maximum for non-preventive and out-of-network preventive services is \$3,000 per individual or \$6,000 per family. These out-of-pocket maximum amounts include your deductible and co-insurance.</p> <p>Preventive prescriptions have a copay, but are not subject to the deductible. The calendar-year deductible begins on January 1 and ends on December 31 of each year.</p> <p>Employees enrolled in the HDHP plan are automatically eligible to enroll in a health savings account, as described in Section II, Health Savings Account.</p>
Dental and Vision Benefit Options	
MIT Basic Dental Plan	<p>The MIT Basic Dental Plan, administered by Delta Dental, is a plan that provides a certain level of coverage for dental services including but not limited to, diagnostic and preventive (oral exams and cleanings), basic restorative (oral surgery, periodontics, endodontics, prosthetic maintenance) and emergency dental care. The MIT Basic Dental Plan will provide benefits up to a calendar year maximum of \$1,750 per person.</p>
MIT Comprehensive Dental Plan	<p>The MIT Comprehensive Dental Plan, administered by Delta Dental, is a plan that provides a certain level of coverage for dental services including but not limited to, diagnostic and preventive (oral exams and cleanings), basic restorative (oral surgery, periodontics, endodontics, prosthetic maintenance), major restorative (dentures, fixed bridges, crowns and implants) and emergency dental care. Participants must meet a \$50 deductible that is waived for diagnostic and preventive services. The MIT Comprehensive Dental Plan will provide benefits up to a calendar year maximum of \$1,750 per person. The MIT Comprehensive Dental Plan will provide coverage for orthodontic services at 50% of the maximum plan allowance through age 18, with a \$1,750 separate lifetime maximum.</p> <p>The MIT Comprehensive Dental Plan also offers a Rollover Max Program that may increase your annual maximum benefit by up to \$1,250, when you meet minimum care and maximum threshold guidelines.</p>
Vision Care Plan	<p>Although a benefit for certain vision expenses is included under the medical plans listed above (e.g., check-ups and doctor's office</p>

Benefit Option	Description
	<p>visits), this optional plan, administered by EyeMed, will help reduce 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.</p> <p>When you enroll, you can obtain services either through EyeMed’s network of providers or through an independent service provider. You will generally receive a higher reimbursement when you use in-network providers. For more information, contact 888-4-EYEMED.</p>
Flexible Spending Accounts	
<p>Health Care Flexible Spending Account</p>	<p>The Health Care Flexible Spending Account (HCFSA) allows you to set aside up to the annual limit set by federal law (current maximum is \$2,750 unless otherwise stated by the IRS) on a pre-tax basis to pay for eligible health care expenses. In most cases, this money is exempt from state and local taxes as well. You benefit by being able to pay for certain expenses with tax-free money. IRS rules prohibit employee participation in an HCFSA if the employee contributes to a Health Savings Account (HSA), or if MIT contributes to an HSA on their behalf.</p> <p>If you establish an HCFSA during the year, you are only eligible for reimbursement of expenses you incur after becoming an HCFSA participant. Additionally, you may receive reimbursements from your HCFSA only for eligible expenses incurred during the same calendar year in which you deposit money into your account. You may submit claims for reimbursement for eligible services received during that calendar year through April 30 of the next year. You may receive reimbursements for expenses incurred by spouses and dependents, as defined under the terms of the Cafeteria Benefit Plan of Massachusetts Institute of Technology. Please see that document for additional details.</p> <p>Active employees with a HCFSA who re-enroll during open enrollment and have unused funds in their account as of December 31 will be able to carry over up to \$550 (indexed annually by the IRS) into the next calendar year automatically. However, if you do not re-enroll in a Health Care FSA in subsequent years, or if IRS rules prohibit your participation in an HCFSA the following calendar year, your HCFSA account balance must be used by April 30 following the year in which the Health Care FSA was elected.</p> <p>Eligible expenses that can be reimbursed from your HCFSA are as follows: medical and prescription, dental, and vision expenses, and other expenses not paid by your medical benefit option, such as deductibles and copayments/coinsurance. Any amounts above the</p>

Benefit Option	Description
	<p>Plan's reimbursement rate for out-of-network providers may be reimbursed from your HCFSA. IRS rules specify the types of expenses eligible for reimbursement from your HCFSA.</p> <p>Employees who elect participation in an HCFSA are eligible to receive an FSA debit card.</p>
<p>Dependent Care Flexible Spending Account</p>	<p>The Dependent Care Flexible Spending Account (DCFSA) allows you to set aside funds before taxes for planned dependent care services received for dependent children under the age of thirteen (13), while you work or search for work. If you establish a DCFSA during the year, you are only eligible for reimbursement of expenses you incur after becoming a DCFSA participant. Each family may contribute up to \$5,000 per year. If each spouse contributes to a different DCFSA, the combined total of their Dependent Care FSA contributions for a calendar year must not exceed \$5,000 for a couple filing taxes jointly. Additionally, you may receive reimbursements from your DCFSA only for eligible expenses incurred during the same calendar year in which you deposit money into your account. You may continue to submit bills for eligible services you received during that calendar year through April 30 of the next year. You may receive reimbursements for expenses incurred for certain dependents, as defined under the terms of the Cafeteria Benefit Plan of Massachusetts Institute of Technology. Please see that document for additional details.</p> <p>You must re-enroll in the DCFSA each year during open enrollment if you want to participate the next calendar year.</p>

7. Internal Claims Denial and Appeal

Claims for Self-Funded Benefits

- Medical Benefits - All claims and appeals of denied claims involving a medical benefit under the MIT Choice Health Plan, Blue Care Elect Preferred (PPO) Plan, the MIT High Deductible Health Plan and a medical or a 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.
- Prescription Drug Benefits - All claims and appeals of denied claims involving a prescription drug benefit under the MIT Choice Health Plan, Blue Care Elect Preferred (PPO) Plan, and the MIT High Deductible Health

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.

- Dental Benefits - All claims and appeals of denied claims involving a dental benefit under the MIT Basic Dental Plan and the MIT Comprehensive Dental Plan shall be submitted to Delta Dental, 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 Delta Dental for more information about claims procedures relating to your benefit option under the Plan.

Claims for Fully Insured Benefits

- Vision Benefits - All claims and appeals of denied claims involving a benefit under the 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.

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 twelve (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 one (1) year after the final decision on appeal. You may not file suit after the one (1) year period expires. In no case may a suit or legal action be brought if the claim for benefits was not made within the time period prescribed in the applicable policy. This limitation for suits for benefits applies in any forum where you initiate a suit or legal action.

You or your dependent(s) are not required to request a voluntary internal review or an external review before filing a lawsuit. If you or your dependent(s) do request a 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 one (1) year time period in which you have to file a lawsuit.

8. External Review

Standard External Review

Individuals enrolled in the MIT Traditional Health Plan, MIT Choice Health Plan, MIT High Deductible Health Plan and Blue Care Elect Preferred (PPO) Plan may have a right to an external review. However, it is important to note that enrollees in the vision and dental plans will not have a right to an 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 drug claims for the MIT Traditional Health Plan and medical claims for the MIT Choice Health Plan, the Blue Care Elect Preferred (PPO) Plan and the MIT High Deductible Health Plan or (2) ESI for prescription drug claims for the MIT Choice Health Plan, the Blue Care Elect Preferred (PPO) Plan and the MIT High Deductible Health Plan, within four (4) months of the notice of your final internal adverse determination. A request for an 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 an

internal appeal. However, you will have at least five (5) 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 forty-five (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 time frame 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.

II. *Health Savings Account*

Overview

When you enroll in the MIT High Deductible Health Plan, you are eligible for a Fidelity Health Savings Account (HSA)—this account holds the money that you can use to pay for your medical services. The HSA is not sponsored or maintained by MIT. Rather, it is your own account to which you can contribute pre-tax or after-tax dollars. You can use the money in your HSA on a tax-free basis to pay for any qualified medical expenses, including your annual deductible if you choose. Furthermore, unused dollars roll over from year to year and therefore can be saved or invested and accumulate through retirement. If you use the money in your HSA to pay for any expenses that are not qualified medical expenses, the distribution is subject to income tax, and may be subject to a 20% penalty.

MIT will contribute to your HSA account with Fidelity in one lump sum, annually: \$500 for an employee and \$1,000 for an employee plus spouse or domestic partner (if a tax dependent), employee and child(ren), or family. You may elect to contribute to your HSA account to cover your deductible plus the funds needed to cover your out-of-pocket maximum; your contribution will be deducted from your paycheck, each pay period, pre-tax.

If you contribute to an HSA, Internal Revenue Service rules prohibit you from contributing to a full-purpose Health Care Flexible Spending Account (HCFSA).

Contributions

When you elect to contribute to your HSA those contributions are deducted pre-tax from your paycheck and sent to your Fidelity account. You can change your election amount anytime during the year.

The IRS sets the HSA limits, including catch-up contribution amounts for individuals age fifty-five (55) or over. These limits may increase or decrease in the future.

The amounts noted below are the maximum amounts you and MIT together can contribute to your HSA during 2020 if you are below age fifty-five (55). If you are age fifty-five (55) or over, your maximum annual contribution increases by \$1,000 (generally prorated by the number of months the year that you are age fifty-five (55) or over). You may not contribute pre-tax or after-tax dollars to your HSA above the maximum amount.

Coverage Options	2020 Maximum HSA Contributions
Employee Only	\$3,550
Employee + Covered Spouse	\$7,100
Employee + Family	\$7,100
Employee + Child(ren)	\$7,100

You determine how much to contribute on an annual basis (up to the federal allowed maximum limits). Then the total annual amount is divided by the number of paychecks you

receive in a year. The resulting dollar amount is your pre-tax payroll deduction per pay period.

For example:

- Annual HSA contribution is \$5,000
- Paid twice each month = 24 times a year
- Pre-tax payroll deduction per pay period = \$208.33

HSA Funds

You must have money in your HSA before the funds are available to pay for eligible expenses. In addition, there is no “use it or lose it” rule with an HSA. Your funds remain in your account, until you choose to withdraw them. You may enhance account growth through investment earnings such as mutual funds, money markets, or other investment type products.

Setting Up an HSA

The rules for setting up and using an HSA are determined by the Internal Revenue Service (IRS).

When you enroll in the MIT High Deductible Health Plan option you will be given the opportunity to enroll in an HSA with Fidelity. You must enroll in an HSA with Fidelity to receive the HSA contribution from MIT. You will make your HSA contributions through automated pre-tax payroll deductions as described in the contributions section above.

You do not have to open an HSA account with Fidelity. You can select another financial institution that manages HSAs. When you select another financial institution, your contributions to that HSA will not be made through automated pre-tax payroll deductions. HSA contributions made on an after-tax basis can generally be deducted on your Form 1040. Keep in mind that banking institutions offer a variety of arrangements when it comes to account fees, management and investment options.

If you are no longer enrolled in the MIT High Deductible Health Plan option, you may still access your HSA funds to pay for eligible medical expenses on a tax-free basis. You may not, however, contribute to the HSA if you are not enrolled in the MIT High Deductible Health Plan, or another HSA-compatible medical coverage, or if you are enrolled in non-high deductible health plan coverage (other than dental, vision, and certain other types of permitted coverage).

Using Your HSA Funds

After enrollment with Fidelity, you will automatically receive a health care debit card to access your HSA funds during the year. You can use your card at the point of purchase to pay for eligible medical, prescription drug, dental and vision care expenses.

At the same time you receive your card, you will receive instructions on how to access your online HSA account. When you are logged onto your account you can review your account payment history, request to be reimbursed for eligible expenses paid out-of-pocket, and learn more about how to manage your HSA.

You may need to prove to the IRS that distributions from your HSA were for eligible expenses and not otherwise reimbursed. It is an IRS requirement that participants keep all receipts when using an HSA to pay for eligible expenses. If you use your HSA to purchase non-eligible expenses, the distribution will be subject to income tax and may be subject to a 20% penalty.

Federal laws allow financial institutions to place “reasonable limits” on funds regarding the size or frequency of HSA distributions. Check with the financial institution that manages your HSA directly for details.

HSAs are subject to all the same legal and regulatory requirements and limitations as any other financial account. Employees are responsible for complying with those requirements.

HSAs are also subject to the financial institutions’ banking, processing and administrative fees associated with the establishment and maintenance of the HSAs. It is the employee’s responsibility to pay any banking fees associated with an HSA.

You do not have to pay account management fees for your HSA with Fidelity while you are an MIT employee.

Covered and Excluded Expenses

HSA Expenses	
This table contains an alphabetical list of some items that are eligible/ineligible HSA expenses. For a full list of eligible HSA expenses, see IRS Publication 969 .	
Eligible HSA Expenses	Ineligible HSA Expenses
<ul style="list-style-type: none"> • Acupuncture • Blood tests • Chiropractor • Contraceptives • Diagnostic devices (such as a blood sugar monitor) • Hearing aids • Hospital services • Insulin (including administration supplies) • Lab tests • Nursing services • Prescription medications • Wheelchairs 	<ul style="list-style-type: none"> • Athletic club memberships • Cosmetic surgery • Cosmetics, hygiene products and similar items • Premiums for life insurance, income protection, disability, loss of limbs, sight or similar benefits • Tobacco cessation programs • Weight loss programs

III. Global Benefits

1. Eligibility and Benefits

Third country nationals, key local nationals and ex-patriate employees on assignment overseas for six months or longer are eligible for medical, prescription drug, dental, vision, international Employee Assistance Program (iEAP) through Cigna Global Health and global Basic Life Insurance and Accidental Death and Dismemberment insurance benefits through Zurich Global. For more information on eligibility and benefits, please refer to the insurance certificates issued by Cigna Global Health and Zurich Global.

2. Table of Global Medical, Dental and Vision Benefits

Benefit Option	Description
Cigna Global Health Benefit Plan	Cigna Global Health Benefit Plan offers combined medical, prescription drug, dental, vision, and international Employee Assistance Program (iEAP) benefits under one plan. More information on Cigna Global Health Benefits is available on the Benefits website at: https://hr.mit.edu/benefits/cigna-global-health

3. Table of Global Life and AD&D Insurance Benefits

Benefit Option	Description
Zurich Global Life Insurance coverage for U.S. expatriates	
Basic Life Insurance	Flat \$10,000
Accidental Death & Dismemberment Insurance	Flat \$10,000
Zurich Global Life Insurance coverage for third country and local nationals	
Basic Life Insurance	2x Annual Earnings up to \$500,000. Guarantee Issue amount is up to \$200,000 with no Evidence of Insurability (EOI).
Accidental Death and Dismemberment Insurance	Flat \$100,000
More information on Zurich Global Life and AD&D Insurance benefits is available on the benefits website at: https://hr.mit.edu/benefits/zurich	

A 50% accelerated benefit is available as cash advances against the life insurance death benefit in the case of being diagnosed with a terminal illness.

The following age reductions apply to all Zurich Global Life Insurance flat or 2x calculated coverages. Age reductions are effective as of the January 1 coincident with or next following attaining the limiting age.

Age 65	66%	Age 85	20%
Age 70	44%	Age 90	16%
Age 75	34%	Age 95	12%
Age 80	26%		

4. Coverage after Retirement

Third Country and Local Nationals who retire from MIT after age fifty-five (55) and were a benefit eligible employee at MIT for at least ten (10) years after their 45th birthday, are eligible for \$50,000 (subject to age reduction of benefit starting at age sixty-five) in Basic Life insurance at the date of retirement, for twenty-four (24) months up to age seventy (70). Age reductions are effective as of the January 1 coincident with or next following attaining the limiting age. This continuation of the life insurance benefit will not include Premium Waiver, Accelerated Death Benefit or Accidental Death and Dismemberment coverage. US Expatriates are eligible for U.S Life Insurance benefits at retirement as stipulated in Section IV, Life Insurance Benefits.

IV. *Life Insurance Benefits*

1. Eligibility and Benefits

Life Insurance and Accidental Death and Dismemberment benefits are administered by Metropolitan Life Insurance Company (MetLife). To be eligible for life insurance benefits under the Plan from MIT, an employee must satisfy the requirements for eligibility as set forth in the Plan and must generally (1) work at least 50% of the normal full-time schedule in his or her department, laboratory or center at MIT; (2) have been appointed to work at MIT for at least three (3) months; and (3) be paid by MIT.

The following individuals shall not be considered Eligible Employees under any circumstances:

- (i) Visitors, consultants, contractors, affiliates, teaching or research assistants, honorary lecturers, postdoctoral fellows, postdoctoral trainees, work-study student, non-Institute student program workers, summer appointment, international visiting student, individuals paid by vouchers or MITemps, family members who are not employed by the Institute 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.

View more detailed eligibility requirements on the MIT Benefits website at <http://hrweb.mit.edu/benefits/life-other-insurance>

Employees who are eligible for life insurance benefits will automatically receive Basic Life Insurance and Accidental Death and Dismemberment coverage under the Group Life Insurance Policy (the "Policy".) Accidental Death and Dismemberment coverage is not available while on Long Term Disability except when the employee has a Phased Rehabilitation appointment of at least 50%.

Employees can supplement basic life insurance coverage with additional, optional coverage under the Policy. Optional Supplemental Life Insurance coverage is available for you and Dependent Life Insurance coverage is available for your spouse or domestic partner and your children. Optional dependent coverage is not available while on Long Term Disability including when the employee has a Phased Rehabilitation appointment of at least 50%.

You must be Actively at Work for coverage to become effective. In addition, you, your enrolled spouse or domestic partner and eligible child(ren) must not be home or hospital confined or receiving or applying to receive disability benefits from any source when coverage becomes effective.

If you are not Actively at Work on the date coverage would otherwise take effect, coverage will take effect on the day you resume active work. The coverage for your spouse or domestic partner and eligible child(ren) will take effect on the date they are no longer home or hospital confined, receiving or applying for disability benefits from any source or hospitalized, provided coverage is approved, and you notify MIT of the status change.

Your enrollment in life insurance benefits provided under the Plan is subject to all limitations of the Plan and any related insurance contracts, including elimination periods, at-work requirements and hourly eligibility requirements. Enrollment in certain coverages may also be limited due to an international home and/or work address.

2. Designate a Beneficiary or Beneficiaries

You can select any beneficiary(ies) other than your employer, and you may change your beneficiary(ies) at any time. You can also designate more than one beneficiary. It is important to officially designate - and update, as needed - the person you want to receive the benefits from your life insurance plan in the event of your death. Make sure your beneficiary knows about your MIT Life Insurance coverage. Submit your completed and signed Life Insurance Beneficiary Designation Form to MIT Benefits no more than 30 days from the date you make the designation.

3. When Coverage Ends Under the Policy

Coverage for you and your dependents will automatically terminate on the earliest of:

- The day your employment ends, except Basic Life and, if elected, enrolled Supplemental Life coverage when you are either (1) approved for the MIT Long Term Disability Plan; or (2) retired from MIT, and are under the age of seventy (70)
- The date the Plan or a benefit option terminates
- The last day for which required contributions are paid
- The date you or a dependent is no longer eligible for coverage
- The effective date MetLife, the insurance carrier, determines in its sole discretion that you have made a false statement on any enrollment form or claim form or filed a fraudulent request with the Plan

4. Coverage after Approval for the MIT Long Term Disability Plan or after Retirement

Coverage after Approval for the MIT Long Term Disability Plan

If you are eligible for benefits under the MIT Long Term Disability Plan and are under age seventy (70), your Basic Life Insurance and, in most cases, your enrolled

Supplemental Life Insurance may only continue at the level that was in effect on your last day of active employment, then decrease when you reach age sixty-five (65). You may be eligible to convert Supplemental Life insurance coverage or amounts that are lost due to age or a change in eligibility. If you remain on the MIT Long Term Disability Plan after you turn age seventy (70), all eligible life insurance will end on the June 30th after you turn age seventy (70), at which time you will have the option to convert or port your enrolled coverages.

Note: If you are eligible for benefits under the MIT Long Term Disability Plan and your last day worked was before age sixty (60), you must submit an application for Waiver of Premiums for Total Disability (Continued Protection) to MetLife to be eligible to continue your Basic Life and Supplemental Life Insurance. When you submit a complete application to MetLife, whether or not you are deemed eligible by MetLife for Waiver of Premium, your life insurance benefit will continue under the Policy based on your age and eligible coverage. Failure to submit a complete application for Waiver of Premiums to MetLife will result in cancellation of your life insurance benefit under the Policy, with no option to convert or port.

The waiver will only apply if you are deemed eligible by MetLife for Waiver of Premium and after you have satisfied a 6-month waiting period. The continuation of eligible insurance under the Waiver of Premium will end on the earliest of: date of death; date total disability ends and you are not eligible for retirement from MIT; date you fail to provide proof of total disability as required; date you refuse to be examined by a MetLife physician; or, the July 1st after you attain age seventy (70). Please note that this benefit is only available to you and, if you are enrolled in Supplemental Life Insurance, is only available after you have been enrolled in the Supplemental Life Insurance for one year. If you were not enrolled in your Supplemental Life Insurance coverage for one year when your total disability began, your coverage may continue if you take advantage of the Conversion or Portability options.

Note your eligibility for and your disability status under the MIT Long Term Disability Plan is determined by the MIT Long Term Disability Plan Administrator and is not affected by your approval or denial for Waiver of Premium.

Coverage after Retirement

If you retire from MIT after age fifty-five (55) and were a benefit eligible employee at MIT for at least ten (10) years after your 45th birthday, your Basic Life Insurance and, if elected, your Supplemental Life Insurance may only continue at the level that was in effect on your last day of active employment, then decrease when you reach age 65. You may be eligible to convert Supplemental Life coverage or amounts that are lost due to age or a change in eligibility. Coverage will end on the June 30th after you turn age seventy (70), at which time you will have the option to convert or port your enrolled coverages.

5. Conversion and Portability Options When Coverage Ends or Reduces

Conversion and Portability Options are available for your protection after your

eligibility for coverage ends or reduces under the Policy. Your Basic Life and Supplemental Life and Dependent Life insurance benefits are protected for thirty-one (31) days after your eligibility terminates in whole or in part due to your retirement, termination of employment, or a change in your employee class or age.

Conversion - You can generally convert your Basic Life and Supplemental Life and Dependent Life Insurance benefits to an **Individual Whole Life** insurance policy if your conversion application is received within the 31-day continued protection period. During the continuation protection period you will not have to provide evidence of insurability. The new policy will take effect on the 32nd day after the date you are no longer eligible for coverage.

Portability – If your Supplemental Life Insurance under the Policy terminates or reduces, you will have an opportunity to continue group term coverage (“portability”) under a different policy, subject to plan design and state availability. If your portability application is received within the 31-day continued protection period, you will not have to provide evidence of insurability. Rates may be higher than your current rates. To take advantage of this feature, you must have coverage of at least \$10,000, up to a maximum of \$1 million.

More information on conversion and portability can be viewed on the MIT Benefits website at <http://hrweb.mit.edu/benefits/life-other-insurance> or by contacting the Plan Administrator.

6. Table of Life Insurance Benefits

Benefit Option	Description
Basic Life Insurance	MIT provides Basic Life Insurance coverage under the Policy to all eligible employees with coverage up to \$50,000 (age reductions apply). Enrollment is automatic and effective on the date you are eligible, and MIT pays the full cost of coverage. In the event of your death, the Policy pays the full amount of your coverage to your designated beneficiary in a single payment.
Accidental Death and Dismemberment Insurance	MIT provides Accidental Death and Dismemberment coverage under the Policy in the amount of two (2) times your Basic Life Insurance coverage up to \$100,000 (age reductions apply) in the event of an active-at-work benefit eligible employee’s death or dismemberment in a covered loss (work-related or not). Coverage depends on age and other limitations. See Section IV. 8, What is Not Covered under the Group Policy, for exclusions. Enrollment is automatic and MIT pays the full cost of coverage. The Policy pays a calculated accidental loss coverage amount to you or your designated beneficiary in a single payment, even if you already have accident insurance. For death occurring as the direct result of an “in the line of duty” job-related injury, an additional Accidental Death Benefit may be

Benefit Option	Description
	<p>paid to MIT Campus Police officers only. Eligibility for and payment of benefits under the job-related injury coverage are subject to review and approval by MetLife based upon its underwriting rules.</p>
<p>Optional Supplemental Life Insurance (for employees)</p>	<p>Optional Supplemental Life Insurance coverage under the Policy is separate from your Basic Life Insurance coverage. You can choose a coverage level equal to 1-7x your base annual salary (regular pay, not including overtime or other premium pay) up to a maximum coverage amount of \$2 million. The cost of your Supplemental Life Insurance coverage depends on your age, and the coverage amount is based on the level you choose (age reductions may apply). Use the MetLife insurance coverage calculator located at hr.mit.edu/benefits/life/optional to estimate the amount of coverage that best suits your needs. You pay the full cost of Supplemental Life Insurance through after-tax payroll deductions each pay period. In the event of your death, the Policy pays the full amount of your coverage to your designated beneficiary in a single payment.</p> <p>Within thirty-one (31) days of your date of hire, you are eligible to enroll in the Guarantee Issue (“GI”) amount of Supplemental Life Insurance coverage, 1-3x your base annual salary, up to \$500,000, without providing Evidence of Insurability (“EOI”) to MetLife. EOI approval from MetLife is required when you request coverage above the GI. EOI approval from MetLife is also required to increase your coverage level any time after the GI window has expired.</p> <p>Supplemental Life Insurance coverage enrollment is effective no earlier than the first of the month after the date you are eligible. Active-at-work rules apply to Supplemental Life Insurance enrollment and increases.</p>
<p>Optional Dependent Life Insurance</p>	<p>Optional Dependent Life Insurance coverage under the Policy is separate from your Basic Life Insurance coverage. You have the option to enroll your spouse or domestic partner, and your eligible child(ren) in Dependent Life Insurance coverage. However, you cannot enroll a child who is already covered under the Policy by your spouse or domestic partner. In the event of the death of a dependent covered under this plan, the Policy pays the full amount of the coverage to you in a single payment.</p> <p>The initial cost of your Dependent Spouse or Domestic Partner Life Insurance depends on your age when you enroll and the coverage option you choose. The per child cost of Dependent Child Life Insurance is the same for all eligible employees. You pay the full cost of Dependent Life Insurance through after-tax</p>

Benefit Option	Description
	<p>payroll deductions each pay period.</p> <p>You can choose a coverage amount of \$50,000 or \$100,000 for a spouse or domestic partner (even if your spouse or domestic partner purchases dependent coverage for you under this same Policy). Within thirty-one (31) days of your date of hire or marriage, you can enroll your spouse or domestic partner in the Guarantee Issue (“GI”) \$50,000 coverage without providing Evidence of Insurability (“EOI”) to MetLife. EOI approval from MetLife is required when you request coverage above the GI. EOI approval from MetLife is also required to add or increase coverage during open enrollment.</p> <p>You can choose a coverage amount of \$10,000 for each unmarried biological or adopted child or stepchild from age six (6) months to age twenty-six (26) (whether or not the child is your tax dependent). The coverage amount is \$100 for a biological or adopted child or stepchild from age 15 days to six (6) months.</p> <p>Dependent Life Insurance coverage enrollment is effective no earlier than the first of the month after the date you are eligible. Dependents are subject to active-at-work, and coverage eligibility rules as they apply to Dependent Life Insurance enrollments and increases.</p>

An Accelerated Benefit Option of up to 80% of your Basic and Supplemental Life insurance proceeds to a maximum of \$40,000 for Basic and \$500,000 for Supplemental is available to you in the event that you become terminally ill and are diagnosed with less than twenty-four (24) months to live. The Accelerated Benefit Option is also available to spouses insured under Dependent Life insurance plans. This option is not available for dependent child coverage.

7. Assignment of Life Insurance Benefits

You may assign Your Life Insurance rights and benefits under the Group Policy as a gift or as a viatical assignment. You may also assign Your Accidental Death and Dismemberment Insurance rights and benefits under the Group Policy as a gift. MetLife will recognize the assignee(s) under such assignment as owner(s) of Your right, title and interest in the Group Policy if: (1) a Written form satisfactory to MetLife, affirming this assignment, has been completed; (2) the Written form has been Signed by You and the assignee(s); (3) MIT, the Policyholder, acknowledges that Your Life Insurance and Accidental Death and Dismemberment Insurance being assigned is in force on the life of the assignor; and (4) the Written form is delivered to MetLife for recording.

All other insurance under the Group Policy may not be assigned prior to a claim for benefits, except as required by law. We are not responsible for the validity of an assignment. You may have made an irrevocable assignment under a group policy that

the Group Policy replaces. In this case, MetLife will recognize the assignee(s) under such assignment as owners of Your right, title and interest under the Group Policy if: (1) a Written form satisfactory to MetLife, affirming this assignment, has been completed; (2) the Written form has been Signed by You, the assignee(s) and MIT, the Policyholder; and (3) the Written form is delivered to MetLife for recording.

8. What is Not Covered under the Group Policy

Group Policy exclusions for **suicide** are as follows:

For Supplemental Life

If You commit suicide within two (2) years* from the date Life Insurance for You takes effect, MetLife will not pay such insurance and liability will be limited as follows:

- any premium paid by You will be returned to the Beneficiary; and
- any premium paid by the Policyholder will be returned to the Policyholder

If You commit suicide within two (2) years from the date an increase in Your Life Insurance takes effect, MetLife will pay to the Beneficiary the amount of Insurance in effect on the day before the increase. Any premium You paid for the increase will be returned to the Beneficiary. Any premium paid by the Policyholder for the increase will be returned to the Policyholder.

For Dependent Life

If a Dependent commits suicide within two (2) years* from the date Life Insurance for such Dependent takes effect, MetLife will not pay such insurance and liability will be limited as follows:

- any premium paid by You will be returned to the Beneficiary; and
- any premium paid by the Policyholder will be returned to the Policyholder

If a Dependent commits suicide within two (2) years from the date an increase in Life Insurance for such Dependent takes effect, MetLife will pay to the Beneficiary the amount of Insurance in effect on the day before the increase. Any premium You paid for the increase will be returned to the Beneficiary. Any premium paid by the Policyholder for the increase will be returned to the Policyholder.

*One (1) year for Missouri and North Dakota; suicide does not apply for Washington state.

Group Policy exclusions for Accidental Death and Dismemberment are as follows:

Accidental Death & Dismemberment insurance does not include payment for any loss which is caused by or contributed to by: physical or mental illness, diagnosis of or treatment of the illness; an infection, unless caused by an external wound accidentally sustained; suicide or attempted suicide; injuring oneself on purpose; the voluntary intake or use by any means of any drug, medication or sedative, unless taken as prescribed by a doctor or an over-the-counter drug taken as directed; voluntary intake of alcohol in combination with any drug, medication or sedative; war, whether declared or undeclared, or act of war, insurrection, rebellion or riot; committing or

trying to commit a felony; any poison, fumes or gas, voluntarily taken, administered or absorbed; service in the armed forces of any country or international authority, except the United States National Guard; operating, learning to operate, or serving as a member of a crew of an aircraft; while in any aircraft for the purpose of descent from such aircraft while in flight (except for self- preservation); or operating a vehicle or device while intoxicated as defined by the laws of the jurisdiction in which the accident occurs.

9. Claims and Appeals for Fully Insured Life Insurance Benefits

Plan benefits due under the Group Life Insurance Policy (the Policy) are paid by MetLife, the insurance carrier, in accordance with applicable insurance policies. All claims, and appeals of denied claims involving a benefit under the Policy shall be submitted to MetLife, 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 MetLife on review shall in all cases be final, and MIT shall not have any authority to overrule any determination of the insurance carrier of a fully insured benefit under the Plan or Policy.

Timing of Claims and Appeals Decisions. Unless otherwise specified in the Policy, the claims procedures in this subsection will apply to claims for life insurance benefits.

Initial Determination. MetLife shall notify a claimant of the benefit claim determination within a reasonable period of time, but not later than ninety (90) days after receipt of the claim unless it determines that special circumstances require an extension of time for processing the claim. If MetLife determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the expiration of the initial 90-day period. In no event shall such extension exceed a period of ninety (90) days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the insurer expects to render the benefit determination.

Notice of Denial. If the claim is denied in whole or in part, the claimant will receive a written notice setting forth, in a manner calculated to be understood by the claimant: (a) the specific reason or reasons for the denial; (b) reference to the specific Plan or Policy provisions on which the denial is based; (c) a description of any additional information needed from the claimant in connection with the claim and the reason such information is needed; and (d) an explanation of the claims review procedure and the applicable time limits, including a statement concerning the claimant's right to bring a civil action under ERISA section 502(a)(1)(B) following an adverse determination on review.

Right to Request Review. The claimant must make a written request for review to MetLife within sixty (60) days of the initial denial of the claim. If a written request for review is not made within such 60-day period, the claimant shall forfeit his or her right to review. The claimant's written request for review may (but is not required to)

include issues, comments, documents, and other records the claimant wants considered in the review. All the information the claimant submits will be taken into account on review, even if it was not reviewed as part of the initial decision. No deference will be given to the initial decision. The claimant may ask to examine or receive free copies of all pertinent Plan and Policy documents, records, and other information relevant to the claim by asking the third-party administrator or insurer.

Decision Upon Review. MetLife shall notify a claimant of the benefit claim determination on review within a reasonable period of time, but not later than sixty (60) days after receipt of the claimant's appeal, unless it determines that special circumstances (such as a hearing) require an extension of time for processing the claim. If such an extension is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of sixty (60) days from the end of the initial period. The extension notice shall indicate the special circumstances requiring the extension and the date by which MetLife expects to render the determination on review.

Notice of Denial of Appeal. If the decision on appeal is denied, the claimant will receive a written notice setting forth, in a manner calculated to be understood by the claimant: (a) the specific reason or reasons for the denial; (b) reference to the specific Plan or Policy provisions on which the denial is based; (c) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and (d) a statement describing any voluntary appeal procedures offered by the Plan or Policy and the claimant's right to obtain the information about such procedures and a statement of the claimant's right to bring an action under ERISA section 502(a).

Unless otherwise provided in the applicable Policy, a Participant, or an authorized representative thereof may file a claim for Life and Accidental Death and Dismemberment benefits under the Plan or Policy or with respect to any other rights or claims relating to the Plan or Policy by filing a written claim, identified as a claim for benefits, with MetLife, or any delegate thereof. MetLife or any delegate thereof, may treat any writing or other communication received by it as a claim under the Plan or Policy, even if the writing or communication is not identified as a claim for benefits. When submitting claims for Life an Accidental Death and Dismemberment benefits, the claimant must submit the required Proof as described in the certificate. Claims not submitted on the appropriate MetLife claim form must be submitted in accordance with the instructions on the MetLife claim form. A claim under the Plan or Policy must be submitted within the time period specified in the applicable Policy.

You must file any lawsuit for benefits within one (1) year after the final decision on appeal. You may not file suit after the one (1) year period expires. In no case may a suit or legal action be brought if the claim for benefits was not made within the time period prescribed in the applicable policy. This limitation for suits for benefits applies in any forum where you initiate a suit or legal action.

10. Other MetLife Services

MetLife offers other services to employees eligible for life insurance benefits under the Group Life Insurance Policy.

Will Preparation Services. Like life insurance, a carefully prepared Will along with a Power of Attorney is important. With a will, you can define your most important decisions such as who will care for your children or inherit your property. By enrolling in Supplemental Life Insurance coverage, you will have access to a network of attorneys participating in the MetLife Will Preparation Services. You may take advantage of face-to-face access to a participating plan attorney to prepare or update a will, living will or powers of attorney. When you use a participating plan attorney there will be no charge for the covered services. To obtain the legal plan's toll-free number and the Institute's group access number please contact MIT Benefits. Covered services may vary by state. Tax Planning and preparation of Living Trusts are not covered by the Will Preparation Service.

MetLife Grief Counseling Services. Facing a loss is never easy, and how you cope and grieve is very personal. Your MetLife Group Term Life coverage through the Institute comes with confidential Grief Counseling. You, your dependents and your beneficiaries can have up to five (5) confidential counseling sessions per event at no extra cost, and will have access to resources that help cope with the grief and practical challenges that accompany a loss. To obtain the plan's toll-free number and the Institute's group access information please visit the MIT Benefits website at <http://hrweb.mit.edu/benefits/life-other-insurance> or contact MIT Benefits.

Additional assistance from research specialists is also available at no cost. These specialists can refer services and providers as well as offer additional information that you may find helpful. They can help you:

- Find specific types of support groups, e.g., children who have lost parents; survivors of suicide; dealing with grief – divorce, chronic illness, medical diagnosis, losing a pet; etc.
- Locate local funeral homes and identify monument vendors
- Locate back-up care for children or older adults
- Find storage facilities, estate sale planners and charities that pick up donations
- By providing information on important tasks such as notifying the Social Security Administration, banks and utilities.

This program is available to insureds, their dependents and beneficiaries who have received a serious medical diagnosis or suffered a loss. Events that *may* result in a loss are not covered under this program unless and until such loss has occurred.

MetLife Estate Resolution Services. When you are enrolled in Supplemental Life Insurance coverage, your estate representative will have access to a network of attorneys participating in the MetLife Estate Resolution Services. The attorney will consult face-to-face with your beneficiaries or by telephone regarding the probate process for your estate. The attorney will also handle the probate of your estate for your executor or administrator. This can help alleviate the financial and administrative

burden upon your loved ones in their time of need. When your estate representative uses a participating plan attorney there will be no charge for the covered services. To obtain the legal plan's toll-free number and the Institute's group access number please contact MIT Benefits. Covered services may vary by state.

The following are not covered by the Estate Resolution Service: Matters in which there is a conflict of interest between the executor, administrator, any beneficiary or heir and the estate; any disputes with the Policyholder, Employer, Plan Attorneys, MetLife and/or any of its affiliates; any disputes involving statutory benefits; Will contests or litigation outside Probate Court; Appeals; Court costs, filing fees, recording fees, transcripts, witness fees, expenses to a third party, judgments or fines; and frivolous or unethical matters.

MetLife's Center for Special Needs Planning is a service that works with families who have dependents with special needs. To help them prepare for the complex financial, social, emotional, and educational issues facing them, MetLife's Center for Special Needs Planning helps families with financial planning strategies.

V. ***General Plan Information***

1. Plan Name and Type

This Plan is the Health and Welfare Plan for Employees of Massachusetts Institute of Technology (the “Plan”). Under ERISA, the Plan is an employee welfare benefit plan providing group medical and prescription drug, dental, vision, and health care and dependent care flexible spending accounts, life and accidental death and dismemberment insurance benefits. The Plan also provides global medical and prescription drug, dental, vision, international Employee Assistance Program (iEAP), global Basic Life Insurance and Accidental Death and Dismemberment Insurance benefits, for those who meet the eligibility requirements for these global plans.

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

EIN: 04-2103594
Plan Number: 505
Name: Massachusetts Institute of Technology (“MIT”)
Address: 77 Massachusetts Avenue, NE49-5000
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 Summary Plan Description (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 Funding and Contributions

Medical and prescription drug, dental, basic and accidental death and dismemberment life insurance, and global 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. Information on the funding of the Plan's benefit options is outlined in the chart in Appendix A.

- 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.
- 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. Third-party administrators provide administrative services, make medical claim determinations based on the Plan's medical policy and process claims.

8. 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.

9. Assignment of Benefits

No benefit, right or interest of any covered person under the Plan shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, including any liability for, or subject to, the debts, liabilities or other obligations of such person; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, garnish, execute or levy upon, or otherwise dispose of any right to benefits payable hereunder or legal causes of action, shall be void.

Notwithstanding the foregoing, the Plan may choose to remit payments directly to health care providers with respect to covered services, if authorized by the Covered

Person, but only as a convenience to Covered Persons. Health care providers are not, and shall not be construed as, either “participants” or “beneficiaries” under this Plan and have no rights to receive benefits from the Plan or to pursue legal causes of action on behalf of (or in place of) Covered Persons under any circumstances. See Section IV.7, Assignment of Life Insurance Benefits, for information regarding assignment of life insurance benefits.

10. 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.

11. Plan Documents

The documents constituting the Plan may be provided upon request or reviewed in the offices of the Plan Administrator.

12. 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.

13. Qualified Life Events and 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)

- Change in your domestic partnership status (adding a domestic partner, terminating a domestic partnership or marriage to domestic partner as noted above)
- 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)
- Dependent satisfies or ceases to satisfy eligibility requirements for coverage (change in age, marital, student, or disability status)
- Receipt of a judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody, including a qualified medical child support order QMCSO that requires medical coverage for an employee's child
- Entitlement of an employee, spouse or dependent to Medicaid, Children's Health Insurance Program (CHIP), a subsidy (State Premium Assistance Program), or Part A or B of Medicare or loss of entitlement to benefits under those programs
- Employee unpaid leave under Family and Medical Leave Act (FMLA)
- You and/or your dependent(s) do not initially enroll in coverage because you and/or your dependent are covered under another medical plan, and that coverage is lost as the result of an event described below (See "Loss of Coverage" below for more details)

If any of these qualified life events occur, you may change your election during the calendar year, provided that the change is consistent with a qualified life event that affects eligibility for coverage (e.g., change from employee-only to employee-plus-one due to marriage). You must notify the Plan Administrator within thirty-one (31) days of your change in status. The Plan Administrator will then notify the claims administrator. If you do not request a change to your benefit elections within thirty-one (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.

14. 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 thirty-one (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 thirty-one (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.

15. Loss of Coverage

Loss of coverage means you or your dependent lose coverage under a health plan for any of the following reasons: termination of employment; reduction in hours worked; your spouse dies; you and your spouse divorce or legally separate; your dependent loses dependent status; you or your dependent’s plan stops offering coverage to a group of similarly situated individuals; employer contributions for the coverage were terminated; the other coverage was COBRA continuation, and you or your dependent reaches the maximum length of time for COBRA continuation; or the other plan terminates. Loss of coverage does not include loss of coverage due to failure to pay premiums on a timely basis, termination of coverage for cause (such as making a fraudulent claim), or you or your Dependent(s) voluntarily dropping coverage.

Except for making an enrollment change pursuant to a QMCSO (as described above) or a change in entitlement under Medicaid or CHIP, you must elect coverage, or change your coverage election, within thirty-one (31) days of the occurrence of a Qualified Life Event.

If you or a dependent is no longer eligible under Medicaid or CHIP, or you or a Dependent becomes eligible for assistance for Plan coverage under Medicaid or CHIP, you must request enrollment within sixty (60) days of the prior coverage terminating or becoming eligible for assistance.

16. 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 one hundred (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.

17. Missing Persons and Uncashed Checks

If the Plan Administrator, insurer or claims administrator (as applicable) cannot locate an individual covered under the Plan, after making a reasonably diligent effort, including by giving written notice addressed to the individual's last known address as shown by the records of the Plan, the amount payable to the individual is forfeited. Additionally, if a check for benefits under the Plan remains uncashed for ninety (90) days after issue, amounts attributable to such check shall be forfeited to the Plan. In such event, you shall have no further claim to such amount for any reason. See Section IV.9, Claims and Appeals for Fully Insured Life Insurance Benefits, for information regarding timing and payment of life insurance claims.

18. No Guarantee of Employment

Being a Plan participant is not an employment contract, and your membership in the Plan does not give you the right to keep your job with MIT.

19. Applicable Law

The Plan and all rights hereunder are governed by and construed, administered, and regulated in accordance with the provisions of ERISA, HIPAA, and the Code to the extent applicable, and to the extent not preempted by ERISA, the laws of the Commonwealth of Massachusetts, without giving effect to its conflicts of laws

provision. The Plan may not be interpreted to require any person to take any action, or fail to take any action, if to do so would violate any applicable law.

20. Merger or Consolidation

In the event of any dissolution, merger, consolidation, or reorganization of MIT in which MIT is not the survivor, the Plan shall terminate with respect to MIT and its eligible employees unless the Plan is continued by the successor to MIT and such successor agrees to be bound by the terms and conditions of the Plan.

21. The Plan's Right to Recover Overpayment

Payments are made in accordance with the provisions of the Plan. If it is determined that payment was made for an ineligible charge or that other insurance was considered primary, the Plan has the right to recover the overpayment. The Plan (or the third-party administrator) will try to collect the overpayment from the party to whom the payment was made. However, the Plan reserves the right to seek overpayment from any participant, beneficiary or dependent. In addition, the Plan has the right to engage an outside collection agency to recover overpayments on the Plan's behalf if the Plan's collection effort is not successful. The Plan may also bring a lawsuit to enforce its rights to recover overpayments.

If the overpayment is made to a provider, the Plan (or any third-party administrator) may reduce or deny benefits, in the amount of the overpayment, for otherwise covered services for current and/or future claims with the provider on behalf of any participant, beneficiary or dependent in the Plan. If a provider to whom an overpayment was made has patients who are participants in other health and welfare plans administered by the third-party Administrator, the third-party administrator may reduce payments otherwise owed to the provider from such other health plans by the amount of the overpayment.

22. 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.

23. 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 MIT-provided medical, prescription drug, dental and vision coverages that relates 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 MIT, MIT 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.

24. 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 thirty (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 Plan 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.

25. 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. Beginning 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 thirty (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 sixty (60) days after the qualifying event occurs. You must provide this notice to the Plan Administrator (see Section V, General Plan Information, 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 thirty-six

(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 eighteen (18) months before the qualifying event, COBRA continuation for qualified beneficiaries other than the employee lasts until thirty-six (36) months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight (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 thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (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 eighteen 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 eighteen (18) months. In the case of a 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 thirty-six (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 eighteen (18) months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until thirty-six (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 Section V, General Plan Information, 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 twenty-nine (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 sixty (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 Section V, General Plan Information, 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 thirty (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 eighteen (18) months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is thirty-six (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 sixty (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 Section V, General Plan Information, 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.

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 thirty (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 forty-five (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 no later than forty-five (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 Section V, General Plan Information, 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 thirty (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 <http://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 Section V, General Plan Information, for the address and telephone number.

26. Protecting Your Privacy

HIPAA requires health plans to notify Plan participants about policies and practices to protect the confidentiality of your health information. MIT 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.

27. 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 forty-eight (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 ninety-six (96) hours for both the mother and new born 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 forty-eight (48) hours (or ninety-six (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.

28. 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.

29. Women's Health and Cancer Rights Acts of 1998 ("WHCRA")

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 and Welfare Plan for Employees of Massachusetts Institute of Technology Benefit Descriptions

Benefit Option	Funding	Enrollment Required/ Automatic Enrollment	Administrator/Insurer	Contact Information	Description of Benefits/ Benefit Booklet
Medical and Prescription Drug Benefit Options					
MIT Traditional Health Plan (with prescription drug coverage)	Self-Funded	Enrollment Required	Blue Cross and Blue Shield of Massachusetts, Inc. (“Blue Cross Blue Shield”)	One Enterprise Drive Quincy, MA 02171-2126	MIT Traditional Health Plan Summary of Benefits
MIT Choice Health Plan (1)	Self-Funded	Enrollment Required	Blue Cross and Blue Shield of Massachusetts, Inc.	One Enterprise Drive Quincy, MA 02171-2126	MIT Choice Health Plan Summary of Benefits
Blue Care Elect Preferred (PPO) Plan (1)	Self-Funded	Enrollment Required	Blue Cross and Blue Shield of Massachusetts, Inc.	One Enterprise Drive Quincy, MA 02171-2126	Blue Care Elect PPO Plan Summary of Benefits
MIT High Deductible Health Plan (1) (2)	Self-Funded	Enrollment Required	Blue Cross and Blue Shield of Massachusetts, Inc.	One Enterprise Drive Quincy, MA 02171-2126	MIT High Deductible Health Plan Summary of Benefits
(2) Health Savings Account (HSA)	Self-Funded	Enrollment Required after enrollment in HDHP	Fidelity	Phone: 1-800-544-3716 Netbenefits.com	N/A
(1) Prescription Drug Benefit	Self-Funded	Automatic enrollment with noted medical benefit options	Express Scripts, Inc. (“ESI”)	Phone: 1-866-454-7118 express-scripts.com	Prescription drug benefit options, tiers and costs at: hr.mit.edu/benefits/prescriptions

Benefit Option	Funding	Enrollment Required/ Automatic Enrollment	Administrator/Insurer	Contact Information	Description of Benefits/ Benefit Booklet
Dental and Vision Benefit Options					
Vision Care Plan	Fully insured	Enrollment Required	EyeMed Vision Care, LLC, underwritten by Combined Insurance Company of America.	Submit claims for EyeMed Vision Care, LLC to: FAA/EyeMed Vision Care, LLC Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111	Vision Plan Summary of Benefits
MIT Basic and Comprehensive Dental Plans	Self-Funded	Enrollment Required	Delta Dental of Massachusetts	Submit dental claims to: Delta Dental of Massachusetts Attention: Customer Service 465 Medford Street Boston, MA 02129	Basic Dental Plan Subscriber's Certificate; Comprehensive Dental Plan Subscriber's Certificate
Global Benefit Options					
Global Health Benefit Plan	Fully Insured	Enrollment Required	Cigna Global Health Options	Phone: 1-800-441-2668 www.cignaenvoy.com Cigna Global Health Benefits PO Box 15050 Wilmington, DE 19850	Cigna Global Health Benefit Certificate of Insurance
Global Basic Life and Accidental Death and Dismemberment Insurance	Fully Insured	Enrollment Required	Zurich	Phone: 1-800-206-8826 Life Claims P.O. Box 1705 Grand Rapids, MI 49501	Zurich American Life Insurance Company Group Certificate of Coverage

Benefit Option	Funding	Enrollment Required/ Automatic Enrollment	Administrator/Insurer	Contact Information	Description of Benefits/ Benefit Booklet
Group Life Insurance Benefits					
Basic Life Insurance and Accidental Death and Dismemberment Insurance	Fully Insured	Automatic Enrollment	Metropolitan Life Insurance Company	Metropolitan Life Insurance Company 200 Park Avenue, New York, NY 10166	MetLife Insurance Certificate of Insurance
Optional Employee Life Insurance, Dependent Life Insurance	Fully Insured	Enrollment Required	Metropolitan Life Insurance Company	Metropolitan Life Insurance Company 200 Park Avenue, New York, NY 10166	MetLife Insurance Certificate of Insurance