Schedule of Medical Benefits
Medicare Supplement

Purpose of Medicare Supplement Option
The purpose of the Medicare Supplement option is to provide the participant and his/her dependent(s) with protection against those expenses which are not reimbursed under the Federal Medicare Program. Please see Summary Plan Description for more details and consult Medicare Handbook for frequency limits that apply to Preventive Services and other information.

Features that Add Value
- MIT Health Benefits Trust and your employer have chosen MedCost Benefit Services to administer their health plan benefits. With over a decade of experience in the health care industry, MedCost is a leader in benefits administration because of our outstanding service, respect for your personal health information, and our commitment to offering products and services that are important to you.
- At MedCost, we recognize that affordable health care is vital to your wellbeing and that of your family. We are dedicated to educating our members about the health care options available to them and helping them to become more informed health care consumers. We offer several interactive online tools so you can easily access the most up-to-date information regarding your health benefits.

Customer Service and Emergency Care
- No matter where you travel, you are covered for emergency care. In case of emergency, seek medical care immediately. Go directly to the nearest emergency room or call 911. Call your doctor as soon as possible for follow-up care. You must contact MedCost Benefit Services Customer Service at 800-795-1023 within 48 hours of receiving emergency treatment.
- Call for assistance for required approval for precertification before admittance to a hospital. If you have questions about claim status, benefits, or other general questions, you may contact MedCost Benefit Services Customer Service department at (800) 795-1023 or mbscs@medcost.com. Please include your Member ID number in the body of the email.

Quality Service Is Part of Quality Care
- Service is at the heart of everything we do. Our goal is to give you: fast, accurate answers; responsive, courteous and professional assistance; and ease and convenience in finding the information you need to manage your health.
- www.medcost.com – For access to information 24/7, go to Member login to visit your personalized member website. You will need your ID card with your Member and Group ID numbers to create an account.
- If you have questions about claim status, benefits, or other general questions, you may contact MedCost Benefit Services Customer Service department at (800) 795-1023 or mbscs@medcost.com. Please include your Member ID number in the body of the email.

Health & Wellness Toolkit
Start now taking the first step toward building a healthier you! Studies show that by making healthy choices part of your lifestyle, you are more likely to continue with them. We offer you an online Health & Wellness Toolkit to show you how to make those changes. This toolkit is separated into four main sections, each very different but equally important:
- Fitness will guide you through implementing a walking exercise plan and stretching routine to improve your overall health and flexibility. You’ll also find tips on how to increase your physical activity at work.
- Nutrition is based on the USDA Food Pyramid and will guide you through the food groups, serving sizes and healthy food and beverage choices. Find healthy recipes, too!
- Health covers conversations to have with your doctor and provides basic information on common health concerns and preventive screenings.
- Lifestyle discusses tobacco cessation, stress relief, sleep habits, and germs to help you change bad habits into healthy ones.

It’s Your Choice
There is no listing of physicians. No referrals are needed; however, you may have to pay for services received and file a claim for reimbursement.
SCHEDULE OF BENEFITS
Medicare Supplement
2015

For access to information 24/7, go to www.medcost.com and go to Member Login to visit the personalized website; use ID card with Member and Group ID numbers to create an account. For questions about claim status, benefits or other general questions, contact MedCost Benefit Services Customer Service at (800) 795-1023 or mbscs@medcost.com; please include Member ID in body of email.

This Schedule of Benefits is an outline of benefits of the Medicare Supplement Option provided by MIT.

### Waiting Period
Effective on date deemed by the governmental unit

### Spousal Definition
The term “Spouse” means the person of the opposite gender or same gender who is legally recognized as the husband or wife under the laws of the state where the marriage took place. The Employer may require documentation proving a legal marital relationship.

### Dependent Children
To limiting age of 26 years

### Pre-Existing Conditions
This Plan does not apply a Pre-Existing Conditions Exclusion Period.

### Benefit Maxima / Deductibles / Out-of-Pocket

<table>
<thead>
<tr>
<th>Benefit Year is January 1st through December 31st.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifetime Maximum per Person</strong></td>
</tr>
<tr>
<td><strong>Benefit Year Maximum - Medical</strong></td>
</tr>
<tr>
<td>$25,000</td>
</tr>
<tr>
<td><strong>Benefit Year Maximum - Prescriptions</strong></td>
</tr>
<tr>
<td>$25,000</td>
</tr>
<tr>
<td><strong>Deductible / Out-of-Pocket</strong></td>
</tr>
<tr>
<td>Not Applicable</td>
</tr>
<tr>
<td><strong>Carryover Deductible</strong></td>
</tr>
<tr>
<td>No. See Master Summary Plan Description.</td>
</tr>
</tbody>
</table>

### Medicare Part A Services - Medicare Part A Deductible: $1,260

In general, Part A covers:
- Inpatient care in hospitals (such as critical access hospitals, inpatient rehabilitation facilities and long-term care hospitals)
- Inpatient care in a skilled nursing facility (not custodial or long term care)
- Hospice care services
- Home health care services
- Inpatient care in a religious non-medical health care institution

<table>
<thead>
<tr>
<th>Inpatient Facility: Day 0-90</th>
<th>100% of Medicare deductible, charges over Medicare allowable expenses and Medicare copay for days 61-90</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicare Copay for days 61-90</strong></td>
<td>$315 per day</td>
</tr>
<tr>
<td>Inpatient Facility: Day 91-150</td>
<td>100% of daily Medicare coinsurance if Patient elects to use Lifetime reserve 100% limited to 30 days if Patient elects not to use Lifetime reserve</td>
</tr>
<tr>
<td><strong>Medicare Copay for days 91+</strong></td>
<td>$630 per day</td>
</tr>
<tr>
<td>Skilled Nursing / Extended Care Facility: Day 0-100</td>
<td>100% of daily Medicare copay</td>
</tr>
<tr>
<td><strong>No copay for days 1-20. Medicare copay for days 21-100 - $157.50 per day</strong></td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing / Extended Care Facility: Day 100+</td>
<td>100% of the Extended Care Facility’s charge (semi-private rate) 60 additional days</td>
</tr>
<tr>
<td>Home Health Care:</td>
<td>100% of Medicare coinsurance for Durable Medical Equipment Other Home Health Care paid at 100% by Medicare</td>
</tr>
<tr>
<td>Hospice:</td>
<td>100% of daily Medicare copay</td>
</tr>
<tr>
<td>Blood given at hospital if not replaced:</td>
<td>100% of first 3 pints in a Benefit Year, not covered by Medicare 100% of 3 pint deductible if the blood is not replaced</td>
</tr>
</tbody>
</table>
**Medicare Part B Services**

*Medicare Part B (Medical Insurance) is an insurance option for people who qualify for Medicare.*

Its purpose is to cover Medically Necessary services like doctors' services, outpatient care, home health services and other medical services. Part B also covers certain preventive services.

Part B provides coverage for doctors' services outside the hospital setting and other medical services that Part A doesn’t cover.

**Additional services covered include:**

- Doctor visits received as an inpatient at a hospital or at a hospital or at a doctor’s office, or as an outpatient at a hospital or other health care facility.
- Medically Necessary services or supplies that are needed for the diagnosis or treatment of your medical condition and meet accepted standards of medical practice (for example, laboratory tests, X-rays, physical therapy or rehabilitation services, etc.)
- Ambulance services
- Some home health care
- **Preventive services** to prevent illness or detect it at an early stage, when treatment is most likely to work best (for example, pap tests, flu shots and colorectal cancer screenings)

**Preventive services** include Physical or Gynecological exam, well child care, laboratory services, X-ray services, immunizations / vaccines / flu shots, health history, developmental assessment, colorectal screening, diabetes screening and education, pap smear, ovarian cancer screenings, PSAs, bone mass measurements, and family planning / contraceptive management (Includes FDA approved contraceptive methods / devices and sterilization procedures (other than surgical sterilization) and education and counseling for women, including devices, injectables and implants, excluding over-the-counter products. Includes injectable contraceptives administered in the physician's office. Oral contraceptives and patches are covered under the Prescription Drug benefit.) Gynecologists may perform the Gynecological exam and pap smear, with the balance of the physical exam performed by another Physician. There will be no duplication of services.

*Includes Mammograms and Colonoscopies other than inpatient. Includes polyp removal during routine colonoscopy when billed properly by the provider.*

*Medical Nutritional Counseling* is covered when rendered by a licensed health care provider, in-network when available, as required to provide appropriate guidance and education for diet related conditions or risk factors, including but not limited to diabetes, obesity, high cholesterol and high blood pressure. Includes up to 3 visits in a Benefit Year.

The Patient Protection and Affordable Care Act (PPACA), as part of Health Care Reform, contains a provision that requires your health plan to provide certain preventive care services with no cost-sharing, i.e., not subject to copays, coinsurance, or deductibles. * These services include, but are not limited to: Routine physicals; Pediatric wellness examination; Selected preventive, diagnostic, and cancer screenings; and Certain Pediatric Preventive Services, including but not limited to, oral health assessment, sensory screening, and developmental and behavioral assessment.

These preventive services are covered based on the guidelines and recommendations of the United States Preventive Services Task Force (USPSTF). For a complete listing of these guidelines and recommendations please visit: [https://www.healthcare.gov/what-are-my-preventive-care-benefits/](https://www.healthcare.gov/what-are-my-preventive-care-benefits/)

Preventive Services for Women without cost share

(The following list is not all-inclusive.)

- Well-woman visits: Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including prenatal visits billed outside of global obstetric care.
- Screening for gestational diabetes.
- Testing for human papillomavirus (HPV test) annually or as recommended by physician.
- Sterilization procedures and associated services rendered on the same day (Reversal procedures are not covered).
- Breastfeeding support and associated supplies and counseling. (Includes lactation support and counseling provided by a trained provider in conjunction with birth; also includes purchase, or rental cost up to purchase price, of breastfeeding equipment from a network provider if available. Purchase is limited to one per pregnancy and purchase from a retail store is not covered.)
- Screening and counseling for interpersonal and domestic violence
These preventive services for women are covered based on recommendations of the independent Institute of Medicine and supported by the Health Resources and Services Administration. Unless otherwise stated in this Summary Plan Description, these services are provided with no cost-sharing for adult women only. See Defined Terms.

The services shown under this section, “Routine Wellness / Preventive Services,” are covered based on the guidelines and recommendations of the United States Preventive Services Task Force (USPSTF). For a complete listing of these guidelines and recommendations, please visit: [https://www.healthcare.gov/what-are-my-preventive-care-benefits/](https://www.healthcare.gov/what-are-my-preventive-care-benefits/)

A plan may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for which a recommended preventive service will be available without cost-sharing to the extent not specified in a recommendation or guideline.

<table>
<thead>
<tr>
<th>Facility</th>
<th>Medicare Part B Deductible: $147</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Surgical Facility:</td>
<td></td>
</tr>
<tr>
<td>Emergency Room:</td>
<td>100% of Part B deductible and Medicare coinsurance up to Medicare Allowable expense</td>
</tr>
<tr>
<td>Other Outpatient Facility:</td>
<td></td>
</tr>
</tbody>
</table>

**Mental Health and Substance Use Disorders**

<table>
<thead>
<tr>
<th>Inpatient / Partial Facility:</th>
<th>100% of Allowable expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional:</td>
<td>Not covered by Medicare</td>
</tr>
<tr>
<td>Outpatient Facility:</td>
<td></td>
</tr>
<tr>
<td>Office Therapy:</td>
<td></td>
</tr>
</tbody>
</table>

**Preventive Services**

**Routine Adult**

| Office Visit:                  | 100%                         |
| Office Diagnostic:             | Offset by Medicare Payment; paid regardless of Medicare Allowable expense |
| Outpatient Diagnostic:         |                             |

<table>
<thead>
<tr>
<th>Colonoscopy / Colorectal Screening:</th>
<th>(Routine Or Diagnostic)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammmogram:</td>
<td>(Routine Or Diagnostic)</td>
</tr>
</tbody>
</table>

**Chiropractic**

| Chiropractic:                     | 100% up to maximum allowable of $25 per visit |
|                                   | 25 visits per Benefit Year |
|                                   | Not covered by Medicare   |

**All Other Covered Expenses**

<table>
<thead>
<tr>
<th>Services Not Covered By Medicare:</th>
<th>Plan will Reimburse</th>
</tr>
</thead>
<tbody>
<tr>
<td>First 3 pints of blood each Benefit Year</td>
<td>100% of the 3 pint deductible, if the blood is not replaced.</td>
</tr>
<tr>
<td>Private duty nursing:</td>
<td>The Part B Benefit Year deductible, 20% of allowable expenses, in excess of the Benefit Year deductible.</td>
</tr>
</tbody>
</table>

**Pharmacy** *(Contact information listed on Identification Card)*

| Retail 30 day supply:               | Prescription Drug copay = 40% of Prescription Cost |
| Mail Order 90 day supply:           | $25,000 Benefit Year Maximum |

**Miscellaneous Notes**

**Contraceptives:** Includes preventive services for women as required by Healthcare Reform without cost share for prescribed FDA approved contraceptives, whether generic or brand if generic is unavailable, including: oral contraceptives, transdermal and vaginal ring. *(Contraceptive devices, injectables and implants, while excluded under Prescription Drug Plan are included under the Medical Plan. See Contraceptive Management under Routine Wellness section.)*

**Smoking Cessation Products:** Included with prescription without cost share: Nicotine replacement therapy (i.e., gum, lozenge, transdermal patches, inhaler and nasal spray), Sustained release Bupropion, Varenicline.
**Preventive Medications:** Includes certain prescribed over-the-counter products without cost share as required by PPACA.

### Dental Covered Under Medical

Certain dental procedures will be Covered Charges under Medical Benefits:

- Removal of wisdom teeth.
- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Emergency repair due to injury to sound natural teeth.
- Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
- Excision of benign bony growths of the jaw and hard palate.
- External incision and drainage of cellulitis.
- Incision of sensory sinuses, salivary glands or ducts.
- Reduction of dislocations and excision of temporomandibular joints (TMJs).
- When Medically Necessary, replacement of teeth lost as a direct result of chemotherapy and/or radiation treatment.
- Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct, provided:
  - The deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
  - Orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease; or
  - Orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review Physician.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures. Oral surgeons will be paid at the Network level of benefits.

### Special Services Included

**Anesthetics and other certain items including administration**  
Certain items including anesthetics; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions are covered, including the administration thereof.

**Attention Deficit / Hyperactivity Disorder**  
Attention Deficit / Hyperactivity Disorder is covered as any other expense.

**Diabetes Care Management**  
The plan will provide coverage for Medically Necessary diabetes self-management training and educational services.

**Eyeglasses, Lenses, Frames**  
Medical Plan covers purchase of the first pair of eyeglasses, lenses, frames or contact lenses as prescribed following keratoconus or cataract surgery.

**Family Therapy / Counseling**  
Family Therapy / Counseling is considered an eligible expense when provided by a licensed mental health practitioner.

**Genetic Testing**  
Charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease.

Genetic testing is considered Medically Necessary (and therefore covered) based on the diagnosis, provided:

- A person has symptoms or signs of a genetically-linked inheritable disease or
- The testing is performed as part of oncology treatment.

Genetic testing requires documentation of Medical Necessity via medical records or a letter of Medical Necessity if:

- It has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome or
- The therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer reviewed, evidence-based, scientific literature to directly impact treatment options as outlined in the letter of medical Necessity noted above.

If genetic testing is determined to be Medically Necessary and meets the criteria outlined above, genetic counseling
may be covered. Genetic counseling is limited to 3 visits per Benefit Year.

**Hearing Aids**

For covered dependent children to age 19 only: hearing aids ordered by a physician or audiologist are covered for one hearing aid per ear every 36 months, including related services for initial hearing aids, replacement hearing aids, new hearing aids when alterations cannot adequately meet the needs of the individual, initial hearing aid evaluation, fitting, adjustments and supplies including ear molds.

**Obesity Treatment – Non-Surgical Medical Services**

Medically Necessary treatment of obesity and/or Morbid Obesity is covered. This does not include any form of food supplement, exercise program, exercise equipment, weight control program, injection of any fluid, use of medications or educational program, if not otherwise covered.

**Obesity Treatment – Surgical Services**

Medically Necessary charges for the surgical treatment of obesity will be covered, subject to these requirements and limitations:

- The Plan Participant must have a history of obesity and/or a Morbid Obesity Diagnosis for at least five years;
- During the past two years that a Plan Participant has been covered by this Plan, he/she must have a documented history of participating in a 12-month medically supervised weight loss program;
- The Plan Participant must have documented proof of adequate preoperative evaluations for surgery, which includes patient’s understanding of the procedure, the procedure’s risks and benefits, the length of stay in the Hospital, behavioral changes required prior to and after the surgery (including dietary and exercise requirements), follow-up requirements and anticipated psychological changes;
- Psychological assessment by a mental health professional of the patient’s ability to understand and adhere to the program. The assessment must include expected levels of depression, eating behaviors, stress management, cognitive abilities, social functioning, self-esteem, personality factors or other mental health diagnoses that may affect treatment, readiness and ability to adhere to required lifestyle modifications and follow-up/social support.
- The Plan Participant must be an acceptable age (at least 18 years old at the time of the surgery) and risk for surgery as determined by his/her primary care or family Physician and the attending surgeon;
- Precertification of the surgery is required.

**Sleep Disorders**

Treatment of sleep disorders is covered when determined to be Medically Necessary.

**Teladoc**

Teladoc is covered 100%; deductible waived.

**Telemedicine**

Telemedicine is covered as any other covered office service.

**Termination of Pregnancy**

Abortions are covered for all Employees and Spouses who are Plan Participants when the life of the mother would be endangered if the unborn child was carried to term or the pregnancy is the result of rape or incest. Complications of abortion are covered for all Employees and Spouses who are Plan Participants. Abortions and / or complications of abortion are not covered for Dependent Daughters.

**Special Services Excluded**

- Acupuncture; acupressure, hypnotherapy, biofeedback.
- Administrative costs for completing claim forms or reports; for providing medical records requested by the Plan; postage, shipping and handling charges; interest or financing charges; telephone calls, conferences; consultations. This exclusion does not apply to Telemedicine or Teladoc benefits.
- Purchase of breastfeeding equipment from a retail store.
- Chelation therapy except as Medically Necessary for the treatment of heavy metal poisoning.
- Educational or vocational testing. Services for educational or vocational testing or training. This Exclusion does not apply to diabetic self-management programs for training for the use of diabetic supplies.
- Foot care. Charges resulting from weak, unstable or flat feet; bunions (unless an open-cutting operation is performed); routine foot care including corn and callus treatment or removal; nail trimming (unless needed in treatment of a metabolic or peripheral-vascular disease).
- Orthopedic foot appliances, including custom molded foot orthotics, may be covered when used as an integral part of a brace, applied tightly thereto, or when used to treat a condition requiring more than a supportive device of the foot. Shoe inserts are not considered orthotic devices by this Plan and are not covered.
- Genetic testing and counseling, except as noted in the Schedule of Benefits section of this document. Genetic testing for the purposes of determining the paternity of a child or the sex of a child is not covered.
- Hair loss, including wigs, toupees, hair transplants, hair prostheses, hair weaving, or any drug that promises hair growth, whether or not prescribed by a Physician. This Exclusion does not apply to the wig(s) purchased following cancer treatment.
- Impotence. Care, treatment, services, supplies or medications in connection with impotence.
- Infertility. Coverage as any other illness will be provided for the treatment of an underlying medical condition up to...
the point an infertility condition is diagnosed. However, the Plan does not cover reversal of voluntary sterilization; artificial insemination; gamete intra-fallopian transfer (GIFT); zygote intra-fallopian transfer (ZIFT); in vitro fertilization (IVF), donation, preservation, preparation, analysis and storage of sperm, eggs or embryos; drug treatments for stimulating ovulation, any costs related to surrogate parenting, infertility services required because of a sex change by a Plan Participant or a Plan Participant’s partner, or any assisted reproductive technology or related treatment. The Plan will not cover any costs for Infertility diagnosis, treatment or artificial means of conception if the covered Employee or covered Spouse has had a prior sterilization procedure or if infertility is the result of a normal physiological change such as menopause.

**Learning and Developmental Disorders.** Services, treatment and diagnostic testing related to learning and/or developmental disorders/delays. However, **Attention Deficit or Hyperactivity Disorder** will be covered as any other expense.

**Psychological or psychiatric counseling** incurred as a result of or in connection with behavior, conduct and/or behavioral disorders, including but not limited to truancy, delinquency, and/or tantrums or stealing where there is no underlying mental or emotional disorder.

**Residential Treatment.** Residential treatment for Mental Health and Substance Use Disorders is not covered for the following:
- The use of foster homes or halfway houses.
- For wilderness center training.
- For therapeutic boarding schools.
- For custodial care, situation or environmental change.

**Sex Change / Sexual Dysfunctions.** Charges for services due to sexual dysfunctions, sex transformation, non-congenital transsexualism, gender dysphoria or sexual reassignment or sex change are excluded. This Exclusion includes, but is not limited to, medications, implants, hormone therapy, surgery, medical or psychiatric treatment, sex therapy programs or psychotherapy for problems related to sexual dysfunction or sex change.

Please refer to Summary Plan Description (SPD) for further details on benefit provisions, definitions and exclusions. In the event of discrepancy between this Schedule and the Summary Plan Description (booklet), the approved Summary Plan Description (booklet) will govern.