SUMMARY PLAN DESCRIPTION
FOR THE
RETIREE MEDICAL BENEFIT PLAN (THE "PLAN")
OF MASSACHUSETTS INSTITUTE OF TECHNOLOGY (THE "INSTITUTE")
(THE "PLAN SPONSOR" AND "PLAN ADMINISTRATOR") (Plan No. 507)

ABOUT THIS SUMMARY PLAN DESCRIPTION

This document, together with the Subscriber Certificate(s) and Rider(s), the Evidence of Coverage, Summary of Benefits and/or Benefit Descriptions for the medical benefit plan you have selected (identified in Appendix I), constitute the Summary Plan Description for your retiree medical and prescription drug benefits, and is intended to comply with the disclosure requirements set forth in regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act of 1974 (ERISA). You should use these materials to understand the retiree medical benefits the Institute provides to you.

The Institute reserves the right to amend, modify or terminate the Plan or any part thereof with or without notice, at any time at its sole discretion. If there is a discrepancy between this document and the official Plan document(s), the provisions of the Plan document(s) and/or any related insurance contracts are controlling and will govern.

Effective January 1, 2014

MIT
RETIREE MEDICAL BENEFIT PLAN
SUMMARY PLAN DESCRIPTION (SPD)

This document presents basic information about the retiree medical, dental and prescription drug benefits provided by the Plan, as of the effective date on the front cover, and your rights to retiree medical, dental and prescription drugs benefits as a Plan participant. This document, together with the Subscriber Certificate(s) and Rider(s), the Evidence of Coverage, Summary of Benefits and/or Benefit Descriptions for the medical and dental benefit plan you have selected (collectively referred to in this document as the "Booklet"), constitute the Summary Plan Description ("SPD") for your retiree medical benefits.

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.

1. **Plan Name and Type**

   This Plan is the MIT Retiree Medical Benefit Plan. Under ERISA, the Plan is an employee welfare benefit plan.

2. **Employer Identification Number ("EIN"), Name and Address of Plan Sponsor and Plan Number**

   EIN: 04-2103594

   Plan Number: 507

   Name: Massachusetts Institute of Technology (the "Institute")

   Address: 77 Massachusetts Avenue, E19-215
   Cambridge, MA 02139

   Telephone Number: 617-253-6151

3. **Plan Administrator**

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

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

Service of legal process may be made upon Plan Administrator.

5. **Plan Year**

The Plan Year is the 12 month period of July 1st to June 30th.

6. **Authority of Plan Administrator**

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

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

7. **Plan Eligibility and Benefits**

Retiree Eligibility

In order to be eligible for retiree medical, dental and prescription drug benefits from the Institute, the retiree must satisfy the requirements for eligibility detailed in the applicable Booklet and terminate employment with the Institute after satisfying the following requirements:

- The retiree must have attained age 55;
- The retiree must have, after attaining age 45, 10 or more years of "Active Health Plan Eligible Service." For this purpose, Active Health Plan Eligible Service means:
  - With respect to service as an employee prior to July 2, 2011, service during which the employee is eligible to participate and accrues pension benefits in the Massachusetts Institute of Technology Basic Retirement Plan.
  - With respect to service as an employee on or after July 2, 2011, service during which the Employee is eligible to participate in any of the health plan options made available to active Employees by the Institute and is an eligible Employee as defined by the Basic Retirement Plan.

- Alternatively, an employee, who (i) before July 1, 1995, had terminated employment from the Institute and was eligible for retiree health insurance benefits, or (ii) on July 1, 1995 was actively employed by the Institute and eligible to accrue service in the Massachusetts Institute of Technology Retirement Plan, and before July 1, 1995, had either attained age 65, or had attained age 55 with at least 10 years of service in the Massachusetts Institute of Technology Retirement Plan, is also eligible for retiree medical and prescription drug benefits.

To satisfy the above eligibility requirements, a retiree who has less than 10 years of Active Health Plan Eligible Service with the Institute may receive a credit of Active Health Plan Eligible Service, after age 45, for service that qualified the individual for health or retirement plan benefits with another non-profit organization that qualifies for tax exempt status under Code section 501(c)(3). Such service (i) was earned after age 45; (ii) was earned immediately prior to becoming an Active Health Plan Eligible employee with the Institute; (iii) is limited to the amount of Active Health Plan Eligibility Service earned with the Institute since the later of age 45 and most recent date of hire and immediately prior to termination from the Institute; (iv) for employees rehired after age 45, may be used in place of, not in addition to, their MIT Active Health Plan Eligibility Service earned after age 45 as of their prior termination date; and, (v) shall not count for purposes of increasing the Institute's share of the cost of coverage.

Retiree Medical Benefits

Medical benefit options under the Plan for eligible retirees who are not eligible for Medicare (e.g., retirees under age 65) consist of the following:

- *Blue Cross and Blue Shield of Massachusetts, Inc., MIT Traditional Health Plan*
- *Blue Cross and Blue Shield of Massachusetts, Inc., MIT Choice Plan*
- *Blue Cross and Blue Shield of Massachusetts, Inc., Blue Care Elect Preferred (PPO) Plan*

Medical benefit options under the Plan for eligible retirees who are eligible for Medicare consist of the following:

- *Blue Cross and Blue Shield of Massachusetts, Inc., Medex*
- *Blue Cross and Blue Shield of Massachusetts, Inc., Managed Blue for Seniors (frozen to new members as of 1/1/12)*
- *Tufts, Tufts Medicare Preferred Plan*
- *Tufts, Tufts Medicare Complement Plan (frozen to new members as of 1/1/12)*

Retiree Dental Benefits

Dental benefit options under the Plan for eligible retirees consist of the following:

- *Delta Dental, Delta Dental MIT Group Retiree Plan*

Spouse or Domestic Partner Eligibility and Benefits

If the retiree satisfies all of the above criteria at the time of his or her retirement from the Institute, the retiree's spouse or domestic partner may also be eligible for medical, dental and prescription drug benefit coverage to the extent provided under the benefit options available under the *MIT Traditional Health Plan, MIT Choice Plan, Blue Care Elect Preferred (PPO) Plan, Managed Blue for Seniors Plan, Medex, Tufts Medicare Preferred Plan and Tufts Medicare Complement Plan, and Delta Dental MIT Group Retiree Plan* (collectively, the "*Spousal Plan*").

However, effective for retirements from the Institute occurring after December 31, 2003:

- under no circumstances will any person who becomes a retiree's spouse or domestic partner on or after the retiree's retirement from the Institute be eligible under the *Spousal Plan*; and
- under no circumstances will any person who ceases to be a retiree's spouse or domestic partner on or before the retiree's retirement from the Institute be eligible under the *Spousal Plan*.

If the retiree dies after retirement from the Institute, his or her spouse or domestic partner may remain eligible under the Plan after the retiree's death, subject to the terms of the Plan and the applicable benefit options. Please contact the Institute for additional information.

Dependent Children Eligibility and Benefits

If the retiree satisfies all of the above criteria at the time of his or her retirement from the Institute, the retiree's children (and the children of his or her spouse or domestic partner) who are under age 26 may also be eligible for coverage to the extent provided under the benefit options available under *MIT Traditional Health Plan, MIT Choice Plan and Blue Care Elect Preferred (PPO) Plan, and Delta Dental MIT Group Retiree Plan (*"*Dependent Plans*"). The Plan covers children under age 26 and children of any age who are totally disabled on the date coverage would otherwise end.

If the retiree dies after retirement from the Institute, his or her children (and the children of his or her spouse or domestic partner, if applicable) may remain eligible under the Plan

after the retiree's death, subject to the terms of the Plan and the applicable benefit options. Please contact the Institute for additional information.

Prescription Drug Benefits

Participants under age 65 are automatically enrolled in a prescription drug plan managed by Express Scripts ("ESI") when they sign up for coverage under the *MIT Traditional Health Plan*, the *MIT Choice Plan* or the *Blue Care Elect Preferred (PPO) Plan*. The benefit provides a variety of cost savings for eligible prescription drug expenses when they are prescribed by a plan doctor. Participants can obtain their medications by mail or at an ESI network pharmacy.

The Institute offers a Medicare Part D Plan for retirees age 65 and over enrolled in the *Medex, Managed Blue for Seniors Plan, Tufts Medicare Preferred Plan* or *Tufts Medicare Complement Plan* medical options. This prescription drug coverage is administered by ESI, and goes hand-in-hand with the medical coverage available under the relevant options. Unless you opt out of this coverage, you will be automatically enrolled. If you opt out of this prescription drug coverage, you will no longer have medical coverage through the Institute and will therefore need to find new medical insurance.

The list of preferred and non-preferred brand name drugs available under this prescription drug benefit will reflect Medicare's specific guidelines. These guidelines are in place to ensure you have access to the broadest selection of preferred brand name drugs. A list of drugs (called a formulary) covered under the Plan can be obtained from ESI.

In 2015, the cost of prescription drugs for Participants age 65 or older is:

Retail Pharmacy Co-payments
(for up to 30-day supply)

- Generic $8
- Preferred brand name $35
- Non-preferred brand name $50

Mail Order Pharmacy Co-payments
(for up to 90-day supply)

- Generic $16
- Preferred brand name $50
- Non-preferred brand name $80

There is no deductible for retail pharmacy drugs under this prescription drug coverage. Additionally, the premium for your medical coverage also covers your prescription drug

coverage. You may need to pay an extra premium for this prescription drug coverage, however, if your income is greater than $85,000 for a single tax-filer or greater than $170,000 for a joint tax-filer. The Social Security Administration will notify you with the amount and payment options if you fall into this category.

For a complete description of your prescription drug benefits, please refer to the information provided by ESI. You can also access this information at www.express-scripts.com, or call them at 1-877-309-6408.

Circumstances That May Cause the Loss of Medical, Dental and Prescription Drug Benefits

The Plan contains some restrictions on the type and amount of medical, dental and prescription drug benefits payable as well as the circumstances under which benefits are paid. Circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of any benefits are described in the separate Booklet(s). You should review the applicable Booklet(s) in order to acquaint yourself with these provisions. Your coverage under the Plan will terminate upon the earliest of the following dates: 1) the date you fail to make any required contributions or monthly payments; 2) the date the Plan Sponsor discontinues or terminates the Plan; or 3) any other such date as contained in your applicable Booklet.

Your dependent's medical, dental and prescription drug coverage will terminate if: 1) he or she becomes covered as an Institute employee; 2) he or she is no longer an eligible dependent; 3) your coverage ends; or 4) the Plan no longer offers coverage for dependents.

Under some circumstances, you may continue your health care coverage through COBRA continuation coverage, which is described later in this Summary Plan Description.

Provider Directories/Listings

Provider directories/listings for the applicable medical provider networks utilized by the Plan will be available through the third party administrator or health plan provider via the internet. Paper copies will be made available upon request from the third party administrator, health plan provider or the Plan Sponsor free of charge.

8. Plan Funding and Contributions

Medical, dental and prescription drug benefits under the Plan are funded through a combination of the Plan insurance coverage and a trust established by the Plan Sponsor.

Fully Insured Benefits. The following medical benefits are provided through a fully insured group insurance contract entered into by the Plan and Tufts Health Plan ("Tufts"):

- *Tufts Medicare Preferred Plan*
- *Tufts Medicare Complement Plan*

The following medical benefits are provided through a fully insured group insurance contract entered into by the Plan and Blue Cross and Blue Shield of Massachusetts, Inc. ("BCBS").

- *Managed Blue for Seniors Plan*

The following dental benefits are provided through a fully insured group insurance contract entered into by the Plan and Delta Dental of Massachusetts ("Delta Dental").

- *Delta Dental MIT Group Retiree Plan*

Medical and dental coverage that is fully insured provides benefits under one or more insurance policies or contracts issued to the Plan Sponsor and it is funded through insurance premiums received by the insurance carrier. Insurance carriers issuing these policies are solely responsible for financing and providing the benefits under the insurance policies and contracts. While the insurance carriers and the Plan Sponsor share responsibility for administering the terms of the Plan, the insurance carriers are responsible for processing and paying benefit claims and for handling appeals of denied claims. The Plan Sponsor has no liability for any benefits due or alleged to be due under any such insurance policies or contracts. The address for the insurance carriers are provided in their respective Booklet.

Self-Funded Benefits. Medical and prescription drug benefits, as indicated below, are provided through a self-insured plan administered by a third party administrator, BCBS. BCBS is designated to provide administrative services, make medical claim determinations based on the Plan's medical policy, and process claims for:

- *MIT Traditional Health Plan (medical and prescription drug)*
- *MIT Choice Plan (medical only)*
- *Blue Care Elect Preferred (PPO)Plan (medical only)*
- *Medex Plan (medical only)*

The address for BCBS is provided in the Booklet.

In the following plans, prescription drug benefits are provided through a self-insured plan administered by ESI. ESI is designated to provide administrative services, make medical claim determinations based on the Plan's medical policy, and process claims for prescription drug benefits.

- *Tufts Medicare Preferred Plan*
- *Tufts Medicare Complement Plan*
- *Managed Blue for Seniors Plan*
- *Medex Plan*
- *MIT Choice Plan*
- *Blue Care Elect Preferred (PPO) Plan*

The address for ESI is provided in the applicable Booklet. Medical, prescription drug and dental 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 coverages.

Trust Fund. Amounts needed to pay some medical premiums/benefits under the Plan may, in the sole discretion of the Plan Sponsor, be contributed to a trust fund established by the Plan Sponsor for this purpose. The name of the trust fund is the Massachusetts Institute of Technology Retiree Medical Benefit Plan Trust (the "Trust Fund").

The trustees of the Trust Fund are:

John S. Reed
L. Rafael Reif
Israel Ruiz
Seth D. Alexander
Robert B. Millard
David L. Anderson
Armen A. Avanessians
Denis A. Bovin
John K. Castle
Gururaj (Desh) Deshpande
Cathy E. Minehan
F. Helmut Weymar
John A. Thain

Address: 77 Massachusetts Avenue; NE49-3142
Cambridge, MA 02139-4301.

Cost Sharing

In order to participate in a benefit option which requires contributions by a participant, participants must pay to the Institute, or if directed to the Trust Fund, such amounts as are required by the Plan or by the Institute. The amount of participant contributions required

for each benefit option is set forth in Schedule I. These amounts may be changed by the Institute from time to time, and such changes will be reflected in an updated version of Schedule I.

For Participants under Age 65

- If a participant elects an Institute -sponsored under-65 coverage option other than the MIT Traditional Health Plan, the Institute will contribute for that participant the same dollar amount the Institute would have contributed for the MIT Traditional Health Plan.

For Participants Age 65 and Over

- If a participant elects an Institute -sponsored post-65 coverage option other than Medex, the Institute will contribute for that participant the same dollar amount the Institute would have contributed for Medex if the participant had enrolled in Medex.

Grandfathered Retirees and their Dependents

You qualify for grandfathered eligibility if, on July 1, 1995, you: 1) retired from the Institute and were eligible for retiree health insurance benefits; or 2) were actively employed by the Institute and had attained at least age 65 prior to this date – or age 55 with at least 10 years of retirement-plan-eligible service. If you qualify for grandfathered eligibility and you (or your dependents) are over the age of 65, the Institute pays the full cost of Medex coverage and subsidizes the other post-65 coverage options up to the cost of Medex. If you or your dependent is under the age of 65 and you qualify for grandfathered eligibility, you or your dependent (as applicable) will pay the same amount for coverage as active employees of the Institute under age 65. This cost sharing method for grandfathered retirees reflects the method of cost sharing in effect since December 31, 2003. The actual monthly participant contributions for grandfathered retirees are reflected in Schedule I.

9. Claims Denials and Appeals

Claims for Fully Insured Benefits. All claims and appeals of denied claims involving medical benefits under the Tufts Medicare Preferred Plan and the Tufts Medicare Complement Plan shall be submitted to Tufts, all claims and appeals of denied claims involving medical benefits under the Managed Blue for Seniors Plan shall be submitted to

BCBS, and all claims and appeals of denied claims involving dental coverage under the Delta Dental MIT Group Retiree Plan shall be submitted to Delta Dental. The insurance carrier 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 by the insurance carrier on review shall in all cases be final, and the Plan Sponsor does not have any authority to overrule any determination by the insurance carrier of a fully insured benefit under the Plan.

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

All claims and appeals of denied claims involving a prescription drug benefit under the plans listed below shall be submitted to ESI, which is solely responsible for administering all such claims in accordance with ERISA (including the Department of Labor Regulations thereunder) and state law, as applicable. Note that the denial of a prescription drug claim at the pharmacy is not a denial of benefits under the MIT Choice Plan or the Blue Care Elect Preferred (PPO) Plan. You may contact ESI for more information about claims procedures relating to your benefit option under the Plan.

- Medex Plan
- Tufts Medicare Preferred Plan
- Tufts Medicare Complement Plan
- Management Blue for Seniors Plan
- MIT Choice Plan
- Blue Care Elect Preferred (PPO) 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 Requirements. 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, dental or prescription drug benefits within 12 months from the date of service. You or your dependent(s) must complete the claims and appeals process described in the Claims and Appeals Section of the Plan, or your applicable Booklet, before you may bring legal action or, where applicable, pursue external review. You may not file a lawsuit for benefits if the initial claim or appeal is not made within the time periods described in the Claims and Appeals section of your Plan or applicable Booklet.

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

10. 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 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, in consideration for the advancement of benefits, the Plan is subrogated to all of your rights against any party liable for your injury, sickness, or other condition, or is or may be 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, as well as your rights under the Plan to bring an action to clarify your rights under the Plan. 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.

<u>Reimbursement to Plan if You Recover Payment for an Injury or Illness</u>

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 any insurance carrier.

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

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

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

To secure the rights of the Plan under this section, and because of the Plan's advancement of benefits, you must acknowledge that the Plan shall have first priority against the proceeds of any such settlement, arbitration award, verdict, or any other amounts received by you and assign to the Plan any benefits you may have under any automobile policy or other coverage, to the extent of the Plan's claim for reimbursement. You shall sign and deliver, at the request of the Plan or its agents, any documents needed to protect such priority or reimbursement right, or to effect such assignment of benefits. By accepting any benefits advanced by the Plan under this section, you acknowledge that any proceeds of settlement or judgment, including your claim to such proceeds held by another person, held by you or by another, are being held for the benefit of the Plan under these provisions.

You shall cooperate with the Plan and its agents, and shall sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan's right of reimbursement,

provide any relevant information, and take such actions as the Plan or its agents reasonably request to assist the Plan making a full recovery of the reasonable value of the benefits provided.

You shall not take any action that prejudices the Plan's rights of reimbursement and consents to the right of the Plan, by and through its agent, to impress an equitable lien or constructive trust on the proceeds of any settlement to enforce the Plan's rights under this section, and/or to 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. Specifically, no court costs or attorney's fees may be deducted from the Plan's recovery without the express written consent of the Plan. Any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right.

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.

11. 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 retirees, 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.

12. Plan Documents

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

13. **Statement of ERISA Rights**

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or

ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a 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.

14. COBRA Rights for Covered Dependents

The Plan extends continuation coverage to all eligible dependents, including domestic partners and those with a legal relationship other than as a dependent child or spouse (although COBRA does not require continuation coverage for this group). References to COBRA in this section are to the Plan's continuation coverage and not necessarily legally required under COBRA.

Retiree medical coverage under this Plan is considered alternative medical coverage to any COBRA coverage you or your family members may have been entitled to elect under the Institute active health plan when you retired from the Institute.

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 when you would otherwise lose your group health coverage.

What is COBRA Continuation Coverage?

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."

When the qualifying event is your divorce, the termination of your domestic partnership, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

Retirees do not have COBRA rights under this Plan.

If you are the spouse or domestic partner of a retiree, you will become a qualified beneficiary if you lose your coverage under the Plan due to a divorce or the termination of your domestic partnership.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parents become divorced or their domestic partnership is terminated; 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.

You Must Give Notice of Some Qualifying Events

When the qualifying event is your divorce, a termination of your domestic partnership, or a dependent child's losing eligibility for coverage as a dependent child, you must notify the Plan Administrator within 60 days after the qualifying event occurs.

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. Parents may elect COBRA continuation coverage on behalf of their children.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

15. **Protecting Your Privacy**

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

16. **Qualified Medical Child Support Orders (QMCSOs)**

As required by ERISA, the Plan recognizes qualified medical child support orders (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 is enrolled as a dependent of the retiree. 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.

17. **Newborns' and Mothers' Health Protection Act of 1996**

In compliance with federal regulation, the Plan and the health insurance issuer generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal

delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan and the health insurance issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

18. **Reservation of Rights**

The Institute has the right to amend, modify or terminate the Plan and any benefits under it at any time. If such steps are taken, you will be notified. You will also be informed of the effect that any material change to the Plan will have on your right to benefits. Neither the Plan nor the benefits described in this Summary Plan Description can be orally amended. All oral statements and representation shall be without force or effect even if such statements and representation are made by the Plan Administrator, by any delegate of the Plan Administrator, or by the Institute management. Only written statements by the Plan Administrator or its delegate, issued in accordance with the delegation of authority, shall bind the Plan.

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

Domestic partners generally do not qualify as spouses or dependents for federal income tax purposes. Therefore, the value of Institute-provided medical coverage 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 the Institute, the Institute reserves the right to collect the employee FICA tax liability directly from you.

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

SCHEDULE I

As of January 1, 2015 the Benefit Options under the Plan consist of the following[*]:

Participants under age 65

1. MIT Traditional Health Plan
2. MIT Choice Plan
3. Blue Care Elect Preferred (PPO) Plan

Monthly Participant Contributions for each Benefit Option						
	MIT Traditional Health Plan		MIT Choice Plan		Blue Care Elect Preferred (PPO) Plan	
Years of Service	Individual	Family	Individual	Family	Individual	Family
10	$323.00	$839.80	$343.00	$891.80	$373.00	$969.80
11	$310.08	$806.21	$330.08	$858.21	$360.08	$936.21
12	$297.16	$772.62	$317.16	$824.62	$347.16	$902.62
13	$284.24	$739.03	$304.24	$791.03	$334.24	$869.03
14	$271.32	$705.44	$291.32	$757.44	$321.32	$835.44
15	$258.40	$671.84	$278.40	$734.84	$308.40	$801.84
16	$245.48	$638.25	$265.48	$690.25	$295.48	$768.25
17	$232.56	$604.66	$252.56	$656.66	$282.56	$734.66
18	$219.64	$571.07	$239.64	$623.07	$269.64	$701.07
19	$206.72	$537.48	$226.72	$589.48	$256.72	$667.48
20 or more	$193.80	$503.88	$213.80	$555.88	$243.80	$633.88
Grandfathered	$194.00	$553.00	$214.00	$605.00	$244.00	$683.00

[*] This table displays only full years of Active Health Plan Eligible Service. Your Active Health Plan Eligible Service will be expressed in full years and months if you left MIT prior to 2013 and in full 6-month increments if you left MIT in 2013 or later, and your cost will be calculated accordingly.

Participants age 65 and over

1. Medex
2. Tufts Medicare Preferred Plan
3. Tufts Medicare Complement Plan
4. Managed Blue for Seniors Plan

Monthly Participant Contributions for each Benefit Option				
Years of Service	Medex	Tufts Medicare Preferred Plan	Tufts Medicare Complement Plan	Managed Blue for Seniors Plan
10	$195.00	$155.00	$216.00	$195.00
11	$187.20	$147.20	$208.20	$187.20
12	$179.40	$139.40	$200.40	$179.40
13	$171.60	$131.60	$192.60	$171.60
14	$163.80	$123.80	$184.80	$163.80
15	$156.00	$116.00	$177.00	$156.00
16	$148.20	$108.20	$169.20	$148.20
17	$140.40	$100.40	$161.40	$140.40
18	$132.60	$92.60	$153.60	$132.60
19	$124.80	$84.80	$145.80	$124.80
20 or more	$117.00	$77.00	$138.00	$117.00
Grandfathered	$0.00	$0.00	$21.00	$0.00

* This table displays only full years of Active Health Plan Eligible Service. Your Active Health Plan Eligible Service will be will be expressed in full years and months if you left MIT prior to 2013 and in full 6-month increments if you left MIT in 2013 or later, and your cost will be calculated accordingly.

As of January 1, 2014 the Benefit Options under the Plan consist of the following[*]:

Participants under age 65

4. MIT Traditional Health Plan
5. MIT Choice Plan
6. Blue Care Elect Preferred (PPO) Plan

Monthly Participant Contributions for each Benefit Option						
	MIT Traditional Health Plan		MIT Choice Plan		Blue Care Elect Preferred (PPO) Plan	
Years of Service	Individual	Family	Individual	Family	Individual	Family
10	$301.00	$782.60	$321.00	$834.60	$351.00	$912.60
11	$288.96	$751.30	$308.96	$803.30	$338.96	$881.30
12	$276.92	$720.00	$296.92	$772.00	$326.92	$850.00
13	$264.88	$688.69	$284.88	$740.69	$314.88	$818.69
14	$252.84	$657.39	$272.84	$709.39	$302.84	$787.39
15	$240.80	$626.08	$260.80	$678.08	$290.80	$756.08
16	$228.76	$594.78	$248.76	$646.78	$278.76	$724.78
17	$216.72	$563.48	$236.72	$615.48	$266.72	$693.48
18	$204.68	$532.17	$224.68	$584.17	$254.68	$662.17
19	$192.64	$500.87	$212.64	$552.87	$242.64	$630.87
20 or more	$180.60	$469.56	$200.60	$521.56	$230.60	$599.56
Grandfathered	$181.00	$512.00	$201.00	$564.00	$231.00	$642.00

[*] This table displays only full years of Active Health Plan Eligible Service. Your Active Health Plan Eligible Service will be expressed in full years and months if you left MIT prior to 2013 and in full 6-month increments if you left MIT in 2013 or later, and your cost will be calculated accordingly.

Participants age 65 and over

5. Medex
6. Tufts Medicare Preferred Plan
7. Tufts Medicare Complement Plan
8. Managed Blue for Seniors Plan

Monthly Participant Contributions for each Benefit Option				
Years of Service	Medex	Tufts Medicare Preferred Plan	Tufts Medicare Complement Plan	Managed Blue for Seniors Plan
10	$186.50	$136.50	$201.50	$186.50
11	$179.04	$129.04	$194.04	$179.04
12	$171.58	$121.58	$186.58	$171.58
13	$164.12	$114.12	$179.12	$164.12
14	$156.66	$106.66	$171.66	$156.66
15	$149.20	$99.20	$164.20	$149.20
16	$141.74	$91.74	$156.74	$141.74
17	$134.28	$84.28	$149.28	$134.28
18	$126.82	$76.82	$141.82	$126.82
19	$119.36	$69.36	$134.36	$119.36
20 or more	$111.90	$61.90	$126.90	$111.90
Grandfathered	$0.00	$0.00	$15.00	$0.00

* This table displays only full years of Active Health Plan Eligible Service. Your Active Health Plan Eligible Service will be will be expressed in full years and months if you left MIT prior to 2013 and in full 6-month increments if you left MIT in 2013 or later, and your cost will be calculated accordingly.

APPENDIX I

Retiree Medical Plan of Massachusetts Institute of Technology
Health Plan Benefit Descriptions

- Schedule of Benefits, *Blue Care Elect Preferred (PPO) Plan*
- Schedule of Benefits, *MIT Traditional Health Plan*
- Subscriber Certificate and Rider(s), *Managed Blue for Seniors Plan*
- Schedule of Benefits, *MIT Choice Plan*
- Evidence of Coverage, *Tufts Medicare Preferred Plan*
- Evidence of Coverage, *Tufts Medicare Complement*
- Benefit Description and Rider(s), *Medex Plan*
- Express Scripts – Summary of Benefits and Coverage