The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, please contact MIT at 1-800-327-1021 or email at MITinfo@scmedical.org. For general definitions of common terms, such as allowed account, balance billing, coinsurance, copayment, deductible, provider or other underlined terms, see the Glossary at www.healthcare.gov/sbc-glossary or call 1-877-380-0193 to request a copy. .

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$1,750/person or $3,500/family 3+** Out-of-Network: **$3,500/person or $7,000/family 3+**	Generally, you must pay all the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, the overall family **deductible** must be met before the **plan** begins to pay.
Are there services covered before you meet your deductible?	Yes. Includes **preventive care**, **screening** and **immunization** at an **in-network provider.**	This **plan** covers some items and services even if you haven't met the **deductible** amount. But a **copayment** or **coinsurance** may apply. This **plan** covers some items and services even if you haven't met the deductible amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost-sharing** and before you meet your **deductible**. See a list of covered **preventive services** at **https:www.healthcare.gov/coverage/preventive-care-benefits/**.
Are there other deductibles for specific services?	No, there are no other **deductibles**.	You don't have to meet **deductibles** for specific service.
What is the out-of-pocket limit for this plan?	In-Network: **$5,000/person or $10,000/family 3+** (Individual max of $8,150 is embedded for members with dependent coverage) Out-of-Network: **Unlimited** Annual Maximum including Transplants: **Unlimited**	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limit** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	**Premiums**, **balance-billed** charges, penalties for failure to obtain **pre-authorization** for services and health care this plan doesn't cover. Please see below and your SPD for more information on non-essential health benefit (EHB) **specialty drugs** that fall outside the **out-of-pocket limits**.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Will you pay less if you use a network provider?	Yes. See https://www.paisc.com/members/scmamembersinsurancetrust.aspx or call 1-800-327-1021 for a list of **network providers**.	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the plan's network. You will pay the most if you use an **out-of-network provider** and you receive a bill from a **provider** for the difference between the **provider's** charge and what your **plan** pays (**balance billing**). Be aware your **network provider** might use an **out-of-network-provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a referral to see a specialist?	No	You can see the **specialist** you choose without a **referral**.

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All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 **copay**/visit	50% **coinsurance** after **deductible**	You may have to pay for services that aren't **preventive**. Ask your **provider** if services needed are preventive. Then check what your **plan** will pay for.
	Specialist visit	$60 **copay**/visit	50% **coinsurance** after **deductible**	Excludes any other procedures performed during the visit.
	Preventive care/**screening**/ **Immunization**	No Charge	Not Covered	Includes **preventive** health services specified in the health care reform law.
If you have a test	**Diagnostic test** (x-ray, blood work)	30% **coinsurance** after **deductible**	50% **coinsurance** after **deductible**	----------None----------
	Imaging (CT/PET scans, MRIs)	30% **coinsurance** after **deductible**	50% **coinsurance** after **deductible**	----------None----------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Prescription Card	$12/$40/$100	Not Covered	
	Specialty Drugs (except non-EHB non-**Specialty Drugs**)	$250 **copay**	Not Covered	Step Therapy required. Specialty prescriptions must be processed through our preferred specialty pharmacy after one retail fill.
	Non-EHB **Specialty Drugs**	Not Covered	Not Covered	When implemented, 100% coverage will be available at no cost to you through SaveOnSP Program Participation. Please see your SPD and contact your Plan Administrator for more information regarding SaveOnSp Program implementation.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% **coinsurance** after **deductible**	50% **coinsurance** after **deductible**	
	Physician/surgeon fees	30% **coinsurance** after **deductible**	50% **coinsurance** after **deductible**	There are **pre-authorization** requirements for all in-patient admissions and certain out-patient procedures.
If you need immediate medical attention	**Emergency room care**	$300 **copay** & 30% **coinsurance** after **deductible**	$300 **copay** & 50% **coinsurance** after **deductible**	**Copay** waived if admitted from **Emergency Room**. Must meet Emergency criteria.
	Emergency medical transportation	30% **coinsurance** after **deductible**	50% **coinsurance** after **deductible**	Must meet Emergency criteria.
	Urgent care	30% **coinsurance** after **deductible**	50% **coinsurance** after **deductible**	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	30% **coinsurance** after **deductible**	50% **coinsurance** after **deductible**	**Pre-authorization** is required for all in-patient admissions. If you don't get **preauthorization**, benefits could be reduced by $500 (waived for the first noncompliance event)
	Physician/surgeon fees	30% **coinsurance** after	50% **coinsurance** after	----------None----------

* For more information about limitations and exceptions, see the plan or policy document at www.scmamit.com.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% **coinsurance** after **deductible**	50% **coinsurance** after **deductible**	----------None----------
	Inpatient services	30% **coinsurance** after **deductible**	50% **coinsurance** after **deductible**	**Pre-authorization** is required for all in-patient admissions. If you don't get **pre-authorization**, benefits could be reduced by $500 (waived for the first noncompliance event)
If you are pregnant	Office visits	$30 **copay**/visit	50% **coinsurance** after **deductible**	----------None----------
	Childbirth/delivery professional services	30% **coinsurance** after **deductible**	50% **coinsurance** after **deductible**	**Pre-authorization** requirements apply. **Cost sharing** does not apply to certain **preventive services**. Depending on the type of services, a **coinsurance** may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	30% **coinsurance** after **deductible**	50% **coinsurance** after **deductible**	
If you need help recovering or have other special health needs	**Home health care**	30% **coinsurance** after **deductible**	50% **coinsurance** after **deductible**	60 days/calendar year
	Rehabilitation services (Combined max of 30 visits/yr.)	30% **coinsurance** after **deductible**	50% **coinsurance** after **deductible**	**Pre-authorization** requirements apply.
	Habilitation services	30% **coinsurance** after **deductible**	50% **coinsurance** after **deductible**	**Pre-authorization** requirements apply.
	Skilled nursing care	30% **coinsurance** after **deductible**	50% **coinsurance** after **deductible**	**Pre-authorization** requirements 60 days/calendar year
	Durable medical equipment	30% **coinsurance** after **deductible**	50% **coinsurance** after **deductible**	**Pre-authorization** required
	Hospice services	**Deductible**	**Deductible**	60 days/lifetime
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Certain **preventive services** are covered elsewhere in the SBC.
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

* For more information about limitations and exceptions, see the plan or policy document at www.scmamit.com.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

• Acupuncture • Bariatric Surgery • Charges for counseling or other mental/emotional/spiritual health services regardless of who renders the services except as noted under "Covered Services" in the SPD • Chiropractic Care • Cosmetic Surgery • Dental & Routine Eye Care (Adult) • Dependent Child Pregnancy • Experimental/Investigational Services • Genetic Testing • Infertility Treatments • Long-Term Care • Non-emergency care outside the U.S.• Over the Counter Vitamins/Supplements • Routine foot care • Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

• Hearing Aids • Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help you if you want to continue your coverage after it ends. The contact information is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help you if you have a complaint against your plan fora denial of a claim. This complaint is called a grievance or appeal. For your information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice or assistance, contact: MIT at 1-800-327-1021 or your employer's human resources department. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make payment when you filed your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

* For more information about limitations and exceptions, see the plan or policy document at www.scmamit.com.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,750
Specialist copayment	$60
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,732**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,750
Copayments	$30
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$2,000

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,750
Specialist copayment	$60
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,389**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,750
Copayments	$900
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$3,050

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,750
Specialist copayment	$60
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,925**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,300
Copayments	$90
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,690

*Amounts owed are based upon in-network providers/facilities.

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The plan would be responsible for the other costs of these EXAMPLE covered services.