



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](mailto:MITinfo@scmedical.org). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-800-380-0193 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	In-Network: <b>\$2,500/employee; \$5,000/family 3+</b> Out-of-Network: <b>\$5,000/employee; \$10,000/family 3+</b>	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. Includes <u>preventive care</u> , <u>screening</u> and <u>immunization</u> at an <u>in-network provider</u> .	You must pay all the costs up to the <u>deductible</u> amount before this plan pays for any services.
Are there other <u>deductibles</u> for specific services?	No, there are no other <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	In-Network: <b>\$2,500/employee; \$5,000/family 3+</b> Out-of-Network: <b>Unlimited</b> Annual Maximum including Transplants: <b>Unlimited</b>	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billed</u> charges, penalties for failure to obtain <u>pre-authorization</u> for services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.paisc.com/members/scmamembersinsurance/trust.aspx">http://www.paisc.com/members/scmamembersinsurance/trust.aspx</a> or call 1-800-327-1021 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without <u>referral</u> .

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For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. To request a copy please call 1-800-327-1021 or email [MITinfo@scmedical.org](mailto:MITinfo@scmedical.org).

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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	<u>Deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	-----None----- You may have to pay for services that aren't <b>preventive</b> . Ask your <b>provider</b> if the services needed are preventive. Then check what your <b>plan</b> will pay for
	<a href="#">Specialist</a> visit	<u>Deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	-----None-----
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not Covered	Includes <b>preventive</b> health services specified in the health care reform law.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	<u>Deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	-----None-----
	Imaging (CT/PET scans, MRIs)	<u>Deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	-----None-----
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Generic drugs	<u>Deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	
	Brand drugs	<u>Deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	
	Specialty drugs	<u>Deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Step Therapy required. Specialty prescriptions must be processed through our preferred specialty pharmacy after one retail fill.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	<u>Deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	There are <b>pre-authorization</b> requirements for all in-patient admissions and certain out-patient procedures.
	Physician/surgeon fees	<u>Deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	<u>Deductible</u>	<u>Deductible</u>	Must meet Emergency criteria.
	<a href="#">Emergency medical transportation</a>	<u>Deductible</u>	<u>Deductible</u>	Must meet Emergency criteria.
	<a href="#">Urgent care</a>	<u>Deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	<u>Deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	<b>Pre-authorization</b> is required for all in-patient admissions. If you don't get <b>pre-authorization</b> , benefits could be reduced by \$500 (waived for the first noncompliance event)
	Physician/surgeon fees	<u>Deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	-----None-----

[\* For more information about limitations and exceptions, see the plan or policy document at [www.scmamit.com](http://www.scmamit.com).]

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 need mental health, behavioral health, or substance abuse services	Outpatient services	<u>Deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	-----None-----
	Inpatient services	<u>Deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	<b>Pre-authorization</b> is required for all in-patient admissions. If you don't get <b>pre-authorization</b> , benefits could be reduced by \$500 (waived for the first noncompliance event)
If you are pregnant	Office visits	<u>Deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	-----None-----
	Childbirth/delivery professional services	<u>Deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	<b>Pre-authorization</b> requirements apply. <b>Cost sharing</b> does not apply to certain preventive services. Depending on the type of services, a <b>coinsurance</b> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery facility services	<u>Deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	<u>Deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	60 days/calendar year
	<a href="#">Rehabilitation services</a> (Combined max of 30 visits/yr.)	<u>Deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	<b>Pre-authorization</b> requirements apply.
	<a href="#">Habilitation services</a>	<u>Deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	
	<a href="#">Skilled nursing care</a>	<u>Deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	<b>Pre-authorization</b> requirements 60 days/calendar year
	<a href="#">Durable medical equipment</a>	<u>Deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	<b>Pre-authorization</b> required
	<a href="#">Hospice services</a>	<u>Deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	60 days/lifetime
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Certain <b>preventive services</b> are covered elsewhere in the SBC.
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

### 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 if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administrator at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more 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](http://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 a payment when you file 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.—————

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)

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

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

- The [plan's](#) overall [deductible](#) \$2,500
- [Specialist coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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**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*)

**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*)

**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		\$12,731	Total Example Cost		\$7,389	Total Example Cost		\$1,925
<b>In this example, Peg would pay: \$</b>			<b>In this example, Joe would pay:</b>			<b>In this example, Mia would pay:</b>		
<i>Cost Sharing</i>			<i>Cost Sharing</i>			<i>Cost Sharing</i>		
Deductibles	\$2,500		Deductibles	\$2,500		Deductibles	\$1,925	
Copayments	\$0		Copayments	\$0		Copayments	\$0	
Coinsurance	\$0		Coinsurance	\$0		Coinsurance	\$0	
<i>What isn't covered</i>			<i>What isn't covered</i>			<i>What isn't covered</i>		
Limits or exclusions	\$0		Limits or exclusions	\$0		Limits or exclusions	\$0	
<b>The total Peg would pay is</b>	<b>\$2,500</b>		<b>The total Joe would pay is</b>	<b>\$2,500</b>		<b>The total Mia would pay is</b>	<b>\$1,925</b>	

\*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.