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 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/ or call 1-877-380-0193 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network*: **$1,000/person or $3,000/family of 3+** Out-of-Network: **$2,000/person or $6,000/family of 3+**	Generally, you must pay all of 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. 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	No, there are no other deductibles.	You don't have to meet deductibles for specific service, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	In-Network*: **$3,000/person or $9,000/family of 3+** 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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for services, certain specialty drugs, 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 of 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 http://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 (with the exception of certain ambulance services, emergency services, and non-emergency services furnished at a network provider facility) and you might 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 referral.

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*Includes certain Out-of-Network providers of ambulance services, emergency services, and non-emergency services furnished at an In-Network provider facility.

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	20% coinsurance after deductible	50% coinsurance after deductible	----------None---------- You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	Specialist visit	20% coinsurance after deductible	50% coinsurance after deductible	----------None----------
	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)	20% coinsurance after deductible**	50% coinsurance after deductible	----------None----------
	Imaging (CT/PET scans, MRIs)	20% 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.optumrx.com	Prescription Drug Coverage (generic, preferred brand, non-preferred brand, specialty)	20% coinsurance after deductible (30 day), 50% coinsurance after deductible (90 day)	Not Applicable	Specialty limited to 30-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible**	50% coinsurance after deductible	There are pre-authorization requirements for all in-patient admissions and certain out-patient procedures.
	Physician/surgeon fees	20% coinsurance after deductible**	50% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	$100 fee & 20% coinsurance after deductible**	$100 fee & 50% coinsurance after deductible	Fee waived if admitted from Emergency Room. Must meet Emergency criteria.
	Emergency medical transportation	20% coinsurance after deductible**	50% coinsurance after deductible	Must meet Emergency criteria.
	Urgent care	20% coinsurance after deductible**	50% coinsurance after deductible	----------None----------

** "In-Network" also includes certain services performed by an Out-of-Network provider at an In-Network provider facility (unless the Out-of-Network provider has satisfied advance patient notice and consent requirements).

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	 Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	20% 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)
	Physician/surgeon fees	20% coinsurance after deductible***	50% coinsurance after deductible	----------None----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible***	50% coinsurance after deductible	----------None----------
	Inpatient services	20% 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	20% coinsurance after deductible	50% coinsurance after deductible	----------None----------
	Childbirth/delivery professional services	20% coinsurance after deductible	50% coinsurance after deductible	Pre-authorization requirements apply. Cost sharing does not apply for 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	20% coinsurance after deductible	50% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	50% coinsurance after deductible	60 days/calendar year
	Rehabilitation services (Combined max of 30 visits/yr.)	20% coinsurance after deductible	50% coinsurance after deductible	Pre-authorization requirements apply.
	Habilitation services	20% coinsurance after deductible	50% coinsurance after deductible	
	Skilled nursing care	20% coinsurance after deductible	50% coinsurance after deductible	Pre-authorization requirements 60 days/calendar year
	Durable medical equipment	20% coinsurance after deductible	50% coinsurance after deductible	Pre-authorization required
	Hospice services	Deductible	Deductible	180 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	

*** "In-Network" also includes certain services performed by an Out-of-Network provider at an In-Network provider facility (unless the Out-of-Network provider has satisfied advance patient notice and consent requirements).

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 • 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	• Alternative Treatment Plan ("ATP") if approved by the plan

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

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. 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 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 on how 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**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for a premium tax credit.

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.

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	$1,000
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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*)

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

■ The plan's overall deductible	$1,000
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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*)

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

■ The plan's overall deductible	$1,000
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$3,000

Total Example Cost	**$7,389**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$2,300

Total Example Cost	**$1,925**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,300

*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.