

 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 account, 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 1-877-380-0193 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	In-Network*: <b>\$3,250/person; \$6,500/family</b> Out-of-Network: <b>\$6,500/person; \$13,000/family</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.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. Includes <u>preventive care</u> , <u>screening</u> and <u>immunization</u> at an <u>in-network provider</u> .	This <u>plan</u> covers some items and services even if you haven't met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your deductible. See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No, there are no other <u>deductibles</u> .	You do not have to meet <u>deductibles</u> for specific service, but see the chart starting on page 2 for other costs for services this <u>plan</u> covers.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	In-Network*: <b>\$7,900/person; \$15,800/family</b> (Individual maximum of \$8,150 is embedded for covered individuals with dependent coverage) 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 <u>out-of-pocket limit</u> must be met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>balance-billed</u> charges, penalties for failure to obtain <u>pre-authorization</u> for services, certain <u>specialty drugs</u> , and health care this <u>plan</u> doesn't cover. Please see below and your SPD for more information on non-essential health benefit (EHB) <u>specialty drugs</u> that fall outside the <u>out-of-pocket limits</u> .	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.paisc.com/members/scmamembersinsurancetrust.aspx">http://www.paisc.com/members/scmamembersinsurancetrust.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> (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 <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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No	You can see the <u>specialist</u> you choose without a <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).

\*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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$30 <u>copay</u>	50% <u>coinsurance</u> after <u>deductible</u>	-----None----- You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
	<u>Specialist</u> visit	\$60 <u>copay</u>	50% <u>coinsurance</u> after <u>deductible</u>	-----None-----
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	Includes <u>preventive</u> health services specified in the health care reform law.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>coinsurance</u> after <u>deductible**</u>	50% <u>coinsurance</u> after <u>deductible</u>	-----None-----
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u> after <u>deductible**</u>	50% <u>coinsurance</u> after <u>deductible</u>	-----None-----
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.optumrx.com">www.optumrx.com</a>	Prescription Drug Coverage (generic/preferred brand/non-preferred brand)	\$12/\$40/\$100 (30 day), \$30/\$100/\$250 (90 day-mail), \$36/\$120/\$300 (90 day-retail)	Not Applicable	-----None-----
	Prescription Drug Coverage (specialty)	\$250 <u>copay</u>	Not Applicable	Specialty limited to 30-day supply
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u> after <u>deductible**</u>	50% <u>coinsurance</u> after <u>deductible</u>	There are <u>pre-authorization</u> requirements for all in-patient admissions and certain out-patient procedures.
	Physician/surgeon fees	30% <u>coinsurance</u> after <u>deductible**</u>	50% <u>coinsurance</u> after <u>deductible</u>	
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$300 <u>copay</u> & 30% <u>coinsurance</u> after <u>deductible**</u>	\$300 <u>copay</u> & 50% <u>coinsurance</u> after <u>deductible</u>	Copay waived if admitted from <u>Emergency Room</u> . Must meet Emergency criteria.
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u> after <u>deductible**</u>	50% <u>coinsurance</u> after <u>deductible</u>	Must meet Emergency criteria.
	<u>Urgent care</u>	30% <u>coinsurance</u> after <u>deductible**</u>	50% <u>coinsurance</u> after <u>deductible</u>	-----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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	30% <u>coinsurance</u> after <u>deductible</u> ***	50% <u>coinsurance</u> after <u>deductible</u>	<u>Pre-authorization</u> is required for all in-patient admissions. If you do not get <u>pre-authorization</u> , benefits could be reduced by \$500 (waived for the first non-compliance event)
	Physician/surgeon fees	30% <u>coinsurance</u> after <u>deductible</u> ***	50% <u>coinsurance</u> after <u>deductible</u>	-----None-----
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	30% <u>coinsurance</u> after <u>deductible</u> ***	50% <u>coinsurance</u> after <u>deductible</u>	<u>Pre-authorization</u> is required for all in-patient admissions. If you do not get <u>pre-authorization</u> , benefits could be reduced by \$500 (waived for the first non-compliance event)
	Inpatient services	30% <u>coinsurance</u> after <u>deductible</u> ***	50% <u>coinsurance</u> after <u>deductible</u>	
<b>If you are pregnant</b>	Office visits	\$30 <u>copay</u>	50% <u>coinsurance</u> after <u>deductible</u>	<u>Pre-authorization</u> requirements apply. <u>Cost-sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	
	Childbirth/delivery facility services	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	60 days/calendar year
	<u>Rehabilitation services</u> (Combined max of 30 visits/yr.)	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	<u>Pre-authorization</u> requirements apply
	<u>Habilitation services</u>	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	
	<u>Skilled nursing care</u>	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	<u>Pre-authorization</u> requirements 60 days/calendar year
	<u>Durable medical equipment</u>	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	<u>Pre-authorization</u> required
	<u>Hospice services</u>	<u>No coinsurance</u> after <u>deductible</u>	<u>No coinsurance</u> after <u>deductible</u>	180 days/lifetime
<b>If your child needs dental or eye care</b>	Children's eye exam	Not Covered	Not Covered	Certain <u>preventive services</u> 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.)		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric Surgery</li><li>• Chiropractic Care</li><li>• Cosmetic Surgery</li><li>• Dental &amp; Routine Eye Care (Adult)</li></ul>	<ul style="list-style-type: none"><li>• Dependent Child Pregnancy</li><li>• Experimental/Investigational Services</li><li>• Genetic Testing</li><li>• Infertility Treatments</li><li>• Long-Term Care</li></ul>	<ul style="list-style-type: none"><li>• Non-Emergency care outside the U.S.</li><li>• Over the Counter Vitamins/Supplements</li><li>• Routine Foot Care</li><li>• Weight Loss Programs</li></ul>
Other Covered Services (Limitations may apply to these services). This isn't a complete list. Please see your plan document).		
<ul style="list-style-type: none"><li>• Hearing Aids</li></ul>	<ul style="list-style-type: none"><li>• Alternative Treatment Plan ("ATP") if approved by the plan</li></ul>	

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

**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](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 you if you have a complaint against your [plan](#) for a 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 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](http://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](#).

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*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)

■ The plan's overall deductible	\$3,525
■ Specialist copay	\$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*)

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$3,250
■ Specialist copay	\$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*)

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$3,250
■ Specialist copay	\$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		\$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>		
<u>Deductibles</u>	\$3,300	<u>Deductibles</u>	\$3,300	<u>Deductibles</u>	\$1,300			
<u>Copayments</u>	\$60	<u>Copayments</u>	\$360	<u>Copayments</u>	\$300			
<u>Coinsurance</u>	\$3,700	<u>Coinsurance</u>	\$1,800	<u>Coinsurance</u>	\$325			
<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>\$7,060</b>	<b>The total Joe would pay is</b>	<b>\$5,460</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.