




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 1-800-327-1021 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|--|
| What is the overall deductible? | In-Network: \$3,000/employee; \$6,000/family Out-of-Network: \$6,000/employee; \$12,000/family | 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 preventative care 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 www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | In-Network: \$4,500/employee; \$9,000/family 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-billing charges (unless balance-billing is prohibited), penalties for failure to obtain pre-authorization for services, and health care this plan does not cover. | 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://printadirectory.rrd.com/?source=PAI 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 |

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| | | 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 . |

 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 | 10% Coinsurance | 50% Coinsurance | None |
| | Specialist visit | 10% Coinsurance | 50% Coinsurance | None |
| | Preventive care/screening/immunization | No Charge | Not Covered | 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. |
| If you have a test | Diagnostic test (x-ray, blood work) | 10% Coinsurance | 50% Coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 10% Coinsurance | 50% Coinsurance | None |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com | Generic drugs | 10% Coinsurance | Not Covered | Covers up to a 90 day supply as indicated |
| | Preferred brand drugs | | | |
| | Non-preferred brand drugs | | | |
| | Specialty drugs | | | Specialty limited to 30-day supply |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 10% Coinsurance | 50% Coinsurance | There are preauthorization requirements for all in-patient admissions and certain out-patient procedures. If you don't get preauthorization , benefits could be reduced by \$500 (waived for the first noncompliance event). Assistant surgeon allowable fee limited to 25% of primary |
| | Physician/surgeon fees | 10% Coinsurance | 50% Coinsurance | |

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|---|--|--|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | | | | surgeon's allowable fee. |
| If you need immediate medical attention | Emergency room care | 10% Coinsurance | 10% Coinsurance | Must meet Emergency criteria. |
| | Emergency medical transportation | 10% Coinsurance | 10% Coinsurance | Must meet Emergency criteria. |
| | Urgent care | 10% Coinsurance | 50% Coinsurance | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 10% Coinsurance | 50% Coinsurance | Preauthorization 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 | 10% Coinsurance | 50% Coinsurance | Assistant surgeon allowable fee limited to 25% of primary surgeon's allowable fee. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 10% Coinsurance | 50% Coinsurance | None |
| | Inpatient services | 10% Coinsurance | 50% Coinsurance | Preauthorization 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). |
| If you are pregnant | Office visits | 10% Coinsurance | 50% Coinsurance | None |
| | Childbirth/delivery professional services | 10% Coinsurance | 50% Coinsurance | Preauthorization requirements apply. If you don't get preauthorization , benefits could be reduced by \$500 (waived for the first noncompliance event). 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 | 10% Coinsurance | 50% Coinsurance | |
| If you need help recovering or have other special health needs | Home health care | 10% Coinsurance | 50% Coinsurance | 60 days/calendar year |
| | Rehabilitation services | 10% Coinsurance | 50% Coinsurance | Combined 30 visits/calendar year for physical/occupational therapy. Preauthorization requirements apply. If you don't get preauthorization , benefits could be reduced by \$500 (waived for the first noncompliance event). |
| | Habilitation services | 10% Coinsurance | 50% Coinsurance | |
| | Skilled nursing care | 10% Coinsurance | 50% Coinsurance | 60 days/calendar year. Preauthorization requirements apply. If you don't get |

| 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) | |
| | | | | preauthorization , benefits could be reduced by \$500 (waived for the first noncompliance event). |
| | Durable medical equipment | 10% Coinsurance | 50% Coinsurance | Preauthorization requirements apply. If you don't get preauthorization , benefits could be reduced by \$500 (waived for the first noncompliance event). |
| | Hospice services | 10% Coinsurance | 50% Coinsurance | 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 | |

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"> • Abortions (except when the life of the mother is endangered or medical condition of fetus makes it incompatible with life) • Acupuncture • Autism and Autism Spectrum Disorder • Bariatric Surgery • Blood or blood plasma (replaced by blood bank) • Breast implant removal (if initially cosmetic, non-reconstructive) or reduction if under age 16 • Chiropractic Care • Cosmetic Surgery • Custodial care • Dental care (Adult) • Dependent Child Pregnancy • Drug testing (court-ordered) | <ul style="list-style-type: none"> • Egg or sperm donor (if not covered by MIT) • Expenses covered by workers' compensation or occupational disease policy, resulting from war, hostilities or military service, or illegal occupation/conduct • Experimental/Investigational Services • Gender change, sexual function restoration and sterilization reversal • Genetic Testing • Long-Term Care • Non-Emergency Care when traveling outside the U.S. • Nutritional counseling • Over the Counter Vitamins/Supplements • Prescription drugs purchased outside the U.S. | <ul style="list-style-type: none"> • Private Duty Nursing • Reduction mammoplasty under age 16 • Educational, occupational, recreational, rehabilitative therapy • Relationship counseling • Routine Eye Care (Adult) • Routine Foot Care • Routine hearing exams or treatment • Services provided by a related person • Surrogate parenting • Treatment/tests as inpatient or in outpatient facility that could have been performed in less expensive setting • Weight Loss Programs • Weight reduction or obesity |
|---|---|---|

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"> • Hearing Aids | <ul style="list-style-type: none"> • Infertility Treatments up to \$25,000/lifetime |
|--|--|

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 resource 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 the [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](#).

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](#) \$3,000
- [Specialist coinsurance](#) 10%
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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 | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$3,000 |
| Copayments | \$0 |
| Coinsurance | \$970 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Peg would pay is | \$3,970 |

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$3,000
- [Specialist coinsurance](#) 10%
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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 | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$3,000 |
| Copayments | \$0 |
| Coinsurance | \$260 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$3,260 |

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$3,000
- [Specialist coinsurance](#) 10%
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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 | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$2,800 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,800 |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.