




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

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	In-Network: <b>\$5,000/employee;</b> <b>\$10,000/family</b> Out-of-Network: <b>\$10,000/employee;</b> <b>\$30,000/family</b>	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. Includes <a href="#">preventative care</a> at an in- <a href="#">network provider</a> .	This <a href="#">plan</a> covers some items and services even if you haven't met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	In-Network: <b>\$7,500/employee;</b> <b>\$15,000/family</b> (Embedded individual OOP Max for members with dependent coverage: \$9,100) Out-of-Network: <b>Unlimited</b> Annual Maximum including Transplants: <b>Unlimited</b>	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges (unless <a href="#">balance-billing</a> is prohibited), penalties for failure to obtain <a href="#">pre-authorization</a> for services, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you</b>	Yes. See	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's

Important Questions	Answers	Why This Matters:
use a <a href="#">network provider</a> ?	<a href="http://printadirectory.rrd.com/?source=PAI">http://printadirectory.rrd.com/?source=PAI</a> Or call 1-800-327-1021 for a list of <a href="#">network providers</a> .	network. You will pay the most if you use an <a href="#">out-of-network provider</a> (with the exception of certain ambulance services, emergency services, and non-emergency services furnished at a <a href="#">network provider</a> facility) and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance-billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without <a href="#">referral</a> .

 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	10% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	None
	<a href="#">Specialist</a> visit	10% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	10% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	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.optumrx.com">www.optumrx.com</a>	Generic drugs	10% <a href="#">Coinsurance</a>	Not Covered	Covers up to a 90 day supply as indicated
	Preferred brand drugs			
	Non-preferred brand drugs			
	<a href="#">Specialty drugs</a>			Specialty limited to 30-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	There are <a href="#">preauthorization</a> requirements for all in-patient admissions and certain out-patient procedures. If you don't get <a href="#">preauthorization</a> ,
	Physician/surgeon fees	10% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	

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)	
				benefits could be reduced by \$500 (waived for the first noncompliance event). Assistant surgeon allowable fee limited to 25% of primary surgeon's allowable fee.
If you need immediate medical attention	<a href="#">Emergency room care</a>	10% <a href="#">Coinsurance</a>	10% <a href="#">Coinsurance</a>	Must meet Emergency criteria.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">Coinsurance</a>	10% <a href="#">Coinsurance</a>	Must meet Emergency criteria.
	<a href="#">Urgent care</a>	10% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	<a href="#">Preauthorization</a> is required for all in-patient admissions. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by \$500 (waived for the first noncompliance event).
	Physician/surgeon fees	10% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	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% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	None
	Inpatient services	10% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	<a href="#">Preauthorization</a> is required for all in-patient admissions. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by \$500 (waived for the first noncompliance event).
If you are pregnant	Office visits	10% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	None
	Childbirth/delivery professional services	10% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	<a href="#">Preauthorization</a> requirements apply. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by \$500 (waived for the first noncompliance event). <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . 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% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	60 days/calendar year
	<a href="#">Rehabilitation services</a>	10% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	Combined 30 visits/calendar year for physical/occupational therapy. <a href="#">Preauthorization</a> requirements apply. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by
	<a href="#">Habilitation services</a>	10% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	

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)	
				\$500 (waived for the first noncompliance event).
	<a href="#">Skilled nursing care</a>	10% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	0 days/calendar year. <a href="#">Preauthorization</a> requirements apply. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by \$500 (waived for the first noncompliance event).
	<a href="#">Durable medical equipment</a>	10% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	<a href="#">Preauthorization</a> requirements apply. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by \$500 (waived for the first noncompliance event).
	<a href="#">Hospice services</a>	10% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	180 days/lifetime
<b>If your child needs dental or eye care</b>	Children's eye exam	Not Covered	Not Covered	Certain <a href="#">preventive services</a> 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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Abortions (except when the life of the mother is endangered or medical condition of fetus makes it incompatible with life)</li> <li>• Acupuncture</li> <li>• Autism and Autism Spectrum Disorder</li> <li>• Bariatric Surgery</li> <li>• Blood or blood plasma (replaced by blood bank)</li> <li>• Breast implant removal (if initially cosmetic, non-reconstructive) or reduction if under age 16</li> <li>• Chiropractic Care</li> <li>• Cosmetic Surgery</li> <li>• Custodial care</li> <li>• Dental care (Adult)</li> <li>• Dependent Child Pregnancy</li> <li>• Drug testing (court-ordered)</li> </ul>	<ul style="list-style-type: none"> <li>• Egg or sperm donor (if not covered by MIT)</li> <li>• Expenses covered by workers' compensation or occupational disease policy, resulting from war, hostilities or military service, or illegal occupation/conduct</li> <li>• Experimental/Investigational Services</li> <li>• Gender change, sexual function restoration and sterilization reversal</li> <li>• Genetic Testing</li> <li>• Long-Term Care</li> <li>• Non-Emergency Care when traveling outside the U.S.</li> <li>• Nutritional counseling</li> <li>• Over the Counter Vitamins/Supplements</li> <li>• Prescription drugs purchased outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private Duty Nursing</li> <li>• Reduction mammoplasty under age 16</li> <li>• Educational, occupational, recreational, rehabilitative therapy</li> <li>• Relationship counseling</li> <li>• Routine Eye Care (Adult)</li> <li>• Routine Foot Care</li> <li>• Routine hearing exams or treatment</li> <li>• Services provided by a related person</li> <li>• Surrogate parenting</li> <li>• Treatment/tests as inpatient or in outpatient facility that could have been performed in less expensive setting</li> <li>• Weight Loss Programs</li> <li>• Weight reduction or obesity</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)	
<ul style="list-style-type: none"> <li>• Hearing Aids</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility Treatments up to \$25,000/lifetime</li> </ul>

**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 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](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 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](#) \$5,000
- [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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$5,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$770
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$5,770</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$5,000
- [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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$5,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$60
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$5,060</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$5,000
- [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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$2,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

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