




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>\$4,000/employee;</b> <b>\$8,000/family</b> Out-of-Network: <b>\$7,500/employee;</b> <b>\$20,000/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>\$7,250/employee;</b> <b>\$14,000/family</b> (Embedded individual OOP Max for members with dependent coverage: \$9,200) 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

For more information about limitations and exceptions, see the [plan](#) or policy document at <https://scmamit.com/forms-resources/>

Important Questions	Answers	Why This Matters:
use a <a href="#">network provider</a> ?	<a href="https://shoppingforcare.sapphirethreesixtyfive.com">https://shoppingforcare.sapphirethreesixtyfive.com</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	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	None
	<a href="#">Specialist</a> visit	20% <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)	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	20% <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.express-scripts.com">www.express-scripts.com</a>	Generic drugs	20% <a href="#">Coinsurance</a> (30 day), 40% <a href="#">Coinsurance</a> (90 day mail) 40% <a href="#">Coinsurance</a> (90 day retail)	Not Covered	Covers up to a 90-day supply as indicated
	Preferred brand drugs			
	Non-preferred brand drugs	20% <a href="#">Coinsurance</a>	Not Covered	Specialty limited to 30-day supply
	<a href="#">Specialty drugs</a> (except Non-EHB non- <a href="#">Specialty drugs</a> )			
Non-EHB <a href="#">Specialty drugs</a>	Not Covered	Not Covered	100% coverage is available at no cost to you through SaveOnSP Program Participation. Please see your	

For more information about limitations and exceptions, see the [plan](#) or policy document at <https://scmamit.com/forms-resources/>

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)	
				SPD and contact your Plan Administrator for more information regarding SaveOnSP Program.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <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> , 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.
	Physician/surgeon fees	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">Coinsurance</a>	20% <a href="#">Coinsurance</a>	Must meet Emergency criteria.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">Coinsurance</a>	20% <a href="#">Coinsurance</a>	Must meet Emergency criteria.
	<a href="#">Urgent care</a>	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <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	20% <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	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	None
	Inpatient services	20% <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	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	None
	Childbirth/delivery professional services	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	

For more information about limitations and exceptions, see the [plan](#) or policy document at <https://scmamit.com/forms-resources/>

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 need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	60 days/calendar year
	<a href="#">Rehabilitation services</a>	20% <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 \$500 (waived for the first noncompliance event).
	<a href="#">Habilitation services</a>	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	
	<a href="#">Skilled nursing care</a>	20% <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>	20% <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>	20% <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> </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> </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</li> </ul>

For more information about limitations and exceptions, see the [plan](#) or policy document at <https://scmamit.com/forms-resources/>

**Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)**

- Dental care (Adult)
- Dependent Child Pregnancy
- Drug testing (court-ordered)
- Nutritional counseling
- Over the Counter Vitamins/Supplements
- Prescription drugs purchased outside the U.S.
- 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.)**

- Hearing Aids
- 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](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](#) \$4,000
- [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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$4,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,740
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$5,740</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$4,000
- [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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$4,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$320
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$4,320</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$4,000
- [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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
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.

For more information about limitations and exceptions, see the [plan](#) or policy document at <https://scmamit.com/forms-resources/>