**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: **$6,000/employee; $12,000/family**<br>Out-of-Network: **$10,000/employee; $30,000/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: **$7,500/employee; $15,000/family**<br>(Embedded individual out-of-pocket limit for members with dependent coverage: $9,200)<br>Out-of-Network: **Unlimited**<br>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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been 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** | Yes. See | This plan uses a provider network. You will pay less if you use a provider in the plan's |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **use a network provider?** | https://shoppingforcare.sapphirethreesixtyfive.com Or call 1-800-327-1021 for a list of network providers. | 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. |

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.express-scripts.com | Generic drugs | 10% Coinsurance (30 day), 25% (90 day mail), 25% (90 day retail) | Not Covered | Covers up to a 90 day supply as indicated |
| | Preferred brand drugs | | | |
| | Non-preferred brand drugs | | | |
| | Specialty drugs (except Non-EHB non-Specialty drugs) | 10% Coinsurance | | Specialty limited to 30-day supply |
| | Non-EHB Specialty drugs | Not Covered | Not Covered | 100% coverage is available at no cost to you through SaveOnSP Program Participation. Please see your |

| 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) | 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 surgeon's allowable fee. |
| | Physician/surgeon fees | 10% Coinsurance | 50% Coinsurance | |
| **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 | |

| 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 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 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.)**

- 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
- 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.
- 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

| 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) | • Nutritional counseling | expensive setting |
| • Dependent Child Pregnancy | • Over the Counter Vitamins/Supplements | • Weight Loss Programs |
| • Drug testing (court-ordered) | • Prescription drugs purchased outside the U.S. | • 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. 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** | **$6,000** |
| **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 | $6,000 |
| Copayments | $0 |
| Coinsurance | $670 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$6,670** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$6,000** |
| **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 | $5,600 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$5,600** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$6,000** |
| **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.

For more information about limitations and exceptions, see the plan or policy document at https://scmamit.com/forms-resources/