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 803-798-6207 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 https://www.healthcare.gov/sbc-glossary or call 803-798-6207 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. Specialty non-EHB drugs costs do not count against the deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care at an in-network provider is covered before you meet your deductible.	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: **$7,900/employee; $15,800/family** (Embedded individual out-of-pocket limit for members with dependent coverage: $9,200) Out-of-Network: **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 limit 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, penalties for failure to obtain pre-authorization for services, transplants, Specialty non-EHB drugs, 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 www.myhealthtoolkitbsa.com Or call 803-798-6207 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 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.

Important Questions	Answers	Why This Matters:
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	$30 Copay/visit Deductible does not apply	65% Coinsurance	None
	Specialist visit	$60 Copay/visit Deductible does not apply	65% 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)	30% Coinsurance	65% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% Coinsurance	65% 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 (Tier 1)	$12 Copay (30-day) $30 Copay (90-day mail) $36 Copay (90-day retail)	Not Covered	Covers 1-90 day supply (retail) and 90 day supply (mail order). Deductible does not apply. Step therapy is required.
	Preferred brand (Tier 2)	$80 Copay (30-day) $200 Copay (90-day mail) $240 Copay (90-day retail)		
	Non-preferred brand (Tier 3)	$200 Copay (30-day) $500 Copay (90-day mail) $600 Copay (90-day retail)		
	Specialty EHB drugs	$300 Copay		Limited to 30-day supply. Must be processed through Express Scripts Specialty Pharmacy after one retail fill. Deductible does not apply. Step therapy is required.

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)	
	Specialty non-EHB drugs	Not Covered	Not Covered	100% coverage is available at no cost to you through SaveOnSP Program Participation.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance	65% Coinsurance	There are preauthorization requirements for all in-patient admissions and certain out-patient procedures. If you don't get preauthorization, benefits are 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	30% Coinsurance	65% Coinsurance	
If you need immediate medical attention	Emergency room care	$300 Copay & 30% Coinsurance	$300 Copay & 30% Coinsurance	Copay waived if admitted to hospital from Emergency Room Care or if treated for an accidental injury or if referred to Emergency Room Care by Physician. Must meet Emergency criteria.
	Emergency medical transportation	30% Coinsurance	30% Coinsurance	Must qualify as Emergency Services or Air Ambulance services required to be covered by federal law.
	Urgent care	$60 Copay/visit	65% Coinsurance	Copay applies where in-network visit is coded as office visit. Otherwise 30% coinsurance applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance	65% Coinsurance	Preauthorization is required for all in-patient admissions. If you don't get preauthorization, benefits are reduced by $500 (waived for the first noncompliance event).
	Physician/surgeon fees	30% Coinsurance	65% Coinsurance	None
If you need mental health, behavioral health, or	Outpatient services	Office visit: $30 Copay; Deductible does not apply	65% Coinsurance	None

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)	
substance abuse services		Other outpatient services: 30% Coinsurance		
	Inpatient services	30% Coinsurance	65% 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	$30 Copay/visit	65% Coinsurance	None
	Childbirth/delivery professional services	30% Coinsurance	65% Coinsurance	Preauthorization requirements apply. If you don't get preauthorization, benefits are reduced by $500 (waived for the first noncompliance event). Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery facility services	30% Coinsurance	65% Coinsurance	
If you need help recovering or have other special health needs	Home health care	30% Coinsurance	65% Coinsurance	60 days/calendar year
	Rehabilitation services	30% Coinsurance	65% Coinsurance	Combined 30 visits/calendar year for physical/occupational therapy. Preauthorization requirements apply. If you don't get preauthorization, benefits are reduced by $500 (waived for the first noncompliance event).
	Habilitation services	30% Coinsurance	65% Coinsurance	
	Skilled nursing care	30% Coinsurance	65% Coinsurance	60 days/calendar year. Preauthorization requirements apply. If you don't get preauthorization, benefits are reduced by $500 (waived for the first noncompliance event).
	Durable medical equipment	30% Coinsurance	65% Coinsurance	Preauthorization requirements apply. If you don't get preauthorization, benefits are reduced by $500 (waived for the first noncompliance event).
	Hospice services	30% Coinsurance	65% Coinsurance	180 days/lifetime

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 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
- Assisted reproductive technology (ART) and other assisted reproductive services
- 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
- Complications of a non-covered illness, injury or treatment
- Cosmetic or reconstructive procedures and any related services or supplies
- Cosmetic Surgery
- Custodial care
- Dental care (Adult)
- Dental treatment charges by hospital or professional in connection with fittings/wearings of dentures/dental implants, orthodontic/ prosthodontic care or malocclusion, and operations other than tumor removal, accidental injury, and excision/extraction of impacted teeth
- Dependent child pregnancy
- Drug testing (court-ordered)
- Educational, occupational, recreational, or rehabilitative therapy
- Egg or sperm donor
- Excessive sweating
- Expenses covered by workers' compensation or occupational disease policy, or resulting from war, hostilities invasion, civil war or military service, committing or attempting to commit assault, felony or other illegal act, or illegal occupation
- Expenses incurred outside the U.S. or Canada except while traveling on short-term basis on business or for pleasure
- Experimental/Investigational Services
- Gender change, sexual function improvement or restoration and sterilization reversal
- Genetic Testing
- Home health care non-treatment services
- Home medical/first aid supplies
- Long-Term Care
- Non-EHB Specialty drugs
- Non-Emergency Care when traveling outside the U.S.
- Non-labeled or off-labeled use of drugs
- Nutritional counseling, over the Counter Vitamins/Supplements, and dietary supplies
- Obesity, weight reduction or weight control
- Prescription drugs purchased outside the U.S.
- Private Duty Nursing
- Relationship counseling
- Routine Eye Care (Adult)
- Routine eye or hearing exams or treatment
- Routine Foot Care
- Services provided by a related person
- Services/supplies not specifically listed as Covered Services
- Surrogate parenting
- TMJ and other orthognathic services
- Treatment/tests as inpatient or in outpatient facility that could have been performed in less expensive setting
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Hearing Aids	• Infertility (other than ART and other assisted reproductive services)

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 803-798-6207 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 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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,000
Copayments	$60
Coinsurance	$2,910
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$5,970**

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 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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$3,000
Copayments	$30
Coinsurance	$780
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,810**

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

The plan's overall deductible	$3,000
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	**$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/