




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, contact Group Administrators, Ltd. at [www.groupadministrators.com](http://www.groupadministrators.com) or call 1-800-323-1683. 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.groupadministrators.com](http://www.groupadministrators.com) or call 1-800-323-1683 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<p><a href="#">Network providers</a>: \$1,500/Individual or \$3,000/family</p> <p><a href="#">Non-network providers</a>: \$3,000/individual or \$6,000 family</p> <p><a href="#">Coinsurance</a> and <a href="#">copayments</a> do not apply towards the <a href="#">deductible</a>.</p>	Generally, you must pay all of the costs from providers 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> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> , primary care services, specialist care services, and urgent care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet 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="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<p><a href="#">Network providers</a>: \$3,000/individual or \$6,000/family</p> <p><a href="#">Non-network providers</a>: \$6,000/individual or \$12,000/family</p> <p>(includes deductible, medical copayments &amp; medical and Rx coinsurance)</p>	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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Cost containment penalties, charges above reasonable and customary, expenses not covered under the plan, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.multiplan.com">www.multiplan.com</a> or call 1-888-650-7427 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's 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 <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	\$40 <a href="#">copay</a> /visit only; <a href="#">Deductible</a> does not apply	30% <a href="#">coinsurance</a>	The copay applies to office visit only; all other services are subject to deductible and coinsurance.
	<a href="#">Specialist</a> visit	\$70 <a href="#">copay</a> /visit only; <a href="#">Deductible</a> does not apply	30% <a href="#">coinsurance</a>	The copay applies to office visit only; all other services are subject to deductible and coinsurance.
	<a href="#">Preventive care/screening/immunization</a>	No charge	30% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	'No charge' if done through <i>Labcard</i> ; otherwise 20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Medical Concierge must be contacted for Imaging services otherwise \$200 penalty will apply.
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a> if done through <i>One Call</i> ; otherwise 20% coinsurance	30% <a href="#">coinsurance</a>	The Plan utilizes <i>Labcard</i> for lab services and <i>One Call</i> for imaging services. Please see your ID card for applicable phone numbers.
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.caremark.com">www.caremark.com</a>	Generic drugs (Tier 1)	20% of discounted drug cost Network <a href="#">deductible</a> and <a href="#">out-of-pocket</a> apply		No charge for generic FDA approved forms of contraceptive for women.
	Preferred brand drugs (Tier 2)	20% of discounted drug cost Network <a href="#">deductible</a> and <a href="#">out-of-pocket</a> apply		
	Non-preferred brand drugs (Tier 3)	20% of discounted drug cost Network <a href="#">deductible</a> and <a href="#">out-of-pocket</a> apply		
	<a href="#">Specialty drugs</a> (Tier 4)	20% of discounted drug cost Network <a href="#">deductible</a> and <a href="#">out-of-pocket</a> apply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Medical Concierge must be contacted otherwise \$200 penalty will apply.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$250 copay plus 20% <a href="#">coinsurance</a> , <a href="#">deductible</a>	\$250 copay plus 20% <a href="#">coinsurance</a> , <a href="#">network</a>	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)	
		<a href="#">applies</a>	<a href="#">deductible</a> applies	
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> , <a href="#">network deductible</a> applies	None
	<a href="#">Urgent care</a>	\$60 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	The copay applies to Urgent Care visit only; all other services are subject to deductible and coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Precertification</a> is required, if not obtained \$500 penalty will apply. Medical Concierge must also be contacted.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	50% <a href="#">coinsurance</a> , includes physician visits	50% <a href="#">coinsurance</a>	Maximum payable per visit - \$20
	Inpatient services	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Precertification</a> is required, if not obtained \$500 penalty will apply.
If you are pregnant	Office visits	\$40 copay/visit	30% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. <a href="#">Precertification</a> may be required depending on length of stay.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Medical Concierge must be contacted otherwise \$200 penalty will apply.
	<a href="#">Rehabilitation services</a>	Physical therapy - 0% <a href="#">coinsurance</a> ; Speech & occupational therapy - 20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Developmental delays and learning disorders are not covered. Medical Concierge must be contacted for all therapies otherwise \$200 penalty will apply.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Excludes vehicle modifications, home modifications and exercise equipment.
	<a href="#">Hospice services</a>	Hospice - 20% <a href="#">coinsurance</a> ; Bereavement - 50% coinsurance	Hospice - 30% <a href="#">coinsurance</a> ; Bereavement - 50% coinsurance	Bereavement counseling 15/visits lifetime maximum. Services must be furnished within six months of patient's death.
If your child needs	Children's eye exam	No charge if part of	Not covered	Covered benefit under PPACA preventive care

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)	
dental or eye care		preventive care visit		services.
	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"> <li>• Cosmetic Surgery</li> <li>• Dental Care</li> <li>• Gastric Bypass</li> <li>• Hearing Aids</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility Treatment</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>• Routine eye care (Adult)</li> <li>• Routine Foot Care</li> <li>• Weight Loss Programs</li> </ul> |
|---|---|---|

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"> <li>• Acupuncture</li> <li>• Bariatric Surgery (except Gastric Bypass) - based on medical necessity for treatment of Morbid Obesity only. Prior authorization required.</li> </ul> | <ul style="list-style-type: none"> <li>• Chiropractic Care</li> </ul> | <ul style="list-style-type: none"> <li>• Private Duty Nursing</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: state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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 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: Middlebury Community Schools at 1-574-825-9425.

**Does this plan provide Minimum Essential Coverage?** Yes.

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet 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](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-574-825-9425.

----- *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](#) \$1,500
- [Specialist copayment](#) \$70
- 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>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$30
Coinsurance	\$1,470
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,060</b>

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copayment](#) \$70
- 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>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles*	\$1,500
Copayments	\$90
Coinsurance	\$925
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$2,575</b>

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copayment](#) \$70
- 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>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles*	\$1,450
Copayments	\$370
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,820</b>