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 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 or call 1-800-323-1683 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers: $1,500/Individual or $3,000/family Non-network providers: $3,000/individual or $6,000 family Coinsurance and copayments do not apply towards the deductible.	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, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, primary care services, specialist care services, and urgent care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet 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 https://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?	Network providers: $3,000/individual or $6,000/family Non-network providers: $6,000/individual or $12,000/family (includes deductible, medical copayments & medical and Rx coinsurance)	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?	Cost containment penalties, charges above reasonable and customary, expenses not covered under the plan, premiums, balance-billing charges, and health care this plan doesn't 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.multiplan.com or call 1-888-650-7427 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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a 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	$40 copay/visit only; Deductible does not apply	30% coinsurance	The copay applies to office visit only; all other services are subject to deductible and coinsurance.
	Specialist visit	$70 copay/visit only; Deductible does not apply	30% coinsurance	The copay applies to office visit only; all other services are subject to deductible and coinsurance.
	Preventive care/screening/ immunization	No charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive.
If you have a test	Diagnostic test (x-ray, blood work)	'No charge' if done through *Labcard*; otherwise 20% coinsurance	30% coinsurance	Medical Concierge must be contacted for Imaging services otherwise $200 penalty will apply. The Plan utilizes *Labcard* for lab services and *One Call* for imaging services. Please see your ID card for applicable phone numbers.
	Imaging (CT/PET scans, MRIs)	10% coinsurance if done through *One Call*; otherwise 20% coinsurance	30% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com	Generic drugs (Tier 1)	20% of discounted drug cost Network deductible and out-of-pocket apply		No charge for generic FDA approved forms of contraceptive for women.
	Preferred brand drugs (Tier 2)	20% of discounted drug cost Network deductible and out-of-pocket apply		
	Non-preferred brand drugs (Tier 3)	20% of discounted drug cost Network deductible and out-of-pocket apply		
	Specialty drugs (Tier 4)	20% of discounted drug cost Network deductible and out-of-pocket apply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	Medical Concierge must be contacted otherwise $200 penalty will apply.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	$250 copay plus 20% coinsurance, deductible	$250 copay plus 20% coinsurance, *network*	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)	
		applies	deductible applies	
	Emergency medical transportation	20% coinsurance	20% coinsurance, *network* deductible applies	None
	Urgent care	$60 copay/visit; deductible does not apply	30% coinsurance	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% coinsurance	30% coinsurance	Precertification is required, if not obtained $500 penalty will apply. Medical Concierge must also be contacted.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	50% coinsurance, includes physician visits	50% coinsurance	Maximum payable per visit - $20
	Inpatient services	20% coinsurance	20% coinsurance	Precertification is required, if not obtained $500 penalty will apply.
If you are pregnant	Office visits	$40 copay/visit	30% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Precertification may be required depending on length of stay.
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	Medical Concierge must be contacted otherwise $200 penalty will apply.
	Rehabilitation services	Physical therapy - 0% coinsurance; Speech & occupational therapy - 20% coinsurance	30% coinsurance	Developmental delays and learning disorders are not covered. Medical Concierge must be contacted for all therapies otherwise $200 penalty will apply.
	Habilitation services	20% coinsurance	30% coinsurance	
	Skilled nursing care	20% coinsurance	30% coinsurance	None
	Durable medical equipment	20% coinsurance	30% coinsurance	Excludes vehicle modifications, home modifications and exercise equipment.
	Hospice services	Hospice - 20% coinsurance; Bereavement - 50% coinsurance	Hospice - 30% coinsurance; 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.)

- Cosmetic Surgery
- Dental Care
- Gastric Bypass
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric Surgery (except Gastric Bypass) - based on medical necessity for treatment of Morbid Obesity only. Prior authorization required.
- Chiropractic Care
- Private Duty Nursing

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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 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)*

Total Example Cost	$12,800

In this example, Peg would pay:

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

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)*

Total Example Cost	$7,400

In this example, Joe would pay:

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

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)*

Total Example Cost	$1,900

In this example, Mia would pay:

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

The plan would be responsible for the other costs of these EXAMPLE covered services.