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: $750 per Individual / No family maximum Non-network providers: $1,500 Individual / No family maximum (each individual must meet the applicable deductible.) Copayments do not apply to 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. Network: preventive care, primary 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?	Yes. Prescription drugs have a $200 deductible per person. This does not include specialty drugs.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network providers: $4,000 individual / $8,000 family Non-network providers: $5,500 individual / $11,000 family For Rx network and non-network $1,700 individual / $3,400 family There is an overall out of pocket maximum of $6,350 individual / $12,700 family for in-network and $7,900 individual / $15,800 family for non-network (Includes deductible, coinsurance, copayments and prescriptions.)	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?	Outpatient mental health/substance abuse treatment charges, inpatient mental health/substance abuse charges if not pre-certified through the EAP, cost containment penalties, charges above reasonable & customary, 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 PHCS PPO at 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)	Non-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	$35 copay/visit; deductible does not apply	40% coinsurance	Network copay includes lab/x-ray performed on the same bill as the office visit.
	Specialist visit	$60 copay/visit; deductible does not apply	40% 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 you need are preventive.
If you have a test	Diagnostic test (x-ray, blood work)	$35 copay if performed during office visit; otherwise 20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge if One Call is utilized; otherwise 20% coinsurance	40% coinsurance	Member is required to call the Medical Concierge prior to scheduling imaging services, otherwise $250 penalty applies.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.serve-you-rx.com	Generic drugs (Tier 1)	20% copay/prescription (retail & mail order)	20% copay/prescription (retail & mail order)	Separate deductible & out-of-pocket applies to all prescriptions except Specialty drugs, they will be paid through the medical plan benefit limits (not the prescription out-of-pocket limits). Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	20% copay/prescription (retail & mail order)	20% copay/prescription (retail & mail order)	
	Non-preferred brand drugs (Tier 3)	20% copay/prescription (retail & mail order)	20% copay/prescription (retail & mail order)	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Specialty drugs (Tier 4)	20% copay/prescription (retail & mail order) Medical deductible and out-of-pocket apply	20% copay/prescription (retail & mail order) Medical deductible and out-of-pocket apply	Note: Non-participating pharmacy – discounts cannot be guaranteed and the cost to the member will likely be higher. All maintenance drugs must be obtained through mail order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Member is required to call the Medical Concierge prior to surgery, otherwise $250 penalty applies.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$250 copay/visit plus 20% coinsurance	$250 copay/visit plus 20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$75 copay/visit; deductible does not apply	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Precertification is required; or a penalty of 10% up to $250 applies. Member is also required to call the Medical Concierge otherwise a $250 penalty applies.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Outpatient 30 visits/year; Inpatient 15 days/year Services must be EAP approved to be covered at network level. Precertification is required for Inpatient stays otherwise a penalty of 10% up to $250 applies.
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	$35 copay/visit	40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Precertification may be required; if not obtained a penalty of 10% up to $250 may apply.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	100 visits/year. Member is required to call the Medical Concierge or a penalty of $250 applies.
	Rehabilitation services	20% coinsurance	40% coinsurance	Developmental delays and learning disorders are not covered.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	60 days/year
	Durable medical equipment	20% coinsurance	40% coinsurance	If over $5,000 member is required to call the

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				Medical Concierge or a $250 penalty applies.
	Hospice services	20% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge if done as part of routine care	Not covered	Covered benefit under PPACA for preventive care 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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care
- Developmental delays & learning disorders
- Glasses
- 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.)

- Bariatric Surgery if through BariNet only
- Chiropractic Care
- Private Duty Nursing

Medical Concierge Service: Concord Community Schools offers a Medical Concierge Service through Akeso Care Management (ACM), which all plan participants are enrolled in. This service is designed to assist you, the member, in locating the highest quality provider (based upon national statistics) for services rendered. The Concierge will negotiate with the selected provider for the best reimbursement rate for both the member and the plan. This will help control health care and plan costs which in turn will help control premium costs. Before assessing inpatient or outpatient services you will need to call the Concierge at 877-654-6229 or a $250 penalty will be incurred. This number can also be found on your ID card.

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: your 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: Concord Community Schools at 1-574-875-5161.

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 1-574-875-5161.

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	$750
Specialist copayment	$60
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	$750
Copayments	$0
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,210

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

The plan's overall deductible	$750
Specialist copayment	$60
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*	$750
Copayments	$225
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$2,135

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

The plan's overall deductible	$750
Specialist copayment	$60
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*	$750
Copayments	$60
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,010

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

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: $1,250 Individual / No family maximum Non-network providers: $2,500 Individual / No family maximum (each individual must meet the applicable deductible.) Copayments do not apply to 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. Network: preventive care, primary 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?	Yes. Prescription drugs have a $200 deductible per person. This does not include specialty drugs.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network providers: $5,500 individual / $11,000 family Non-network providers: $8,000 individual / $16,000 family For Rx network and non-network $1,700 individual/$3,400 family There is an overall out of pocket maximum of $7,700 individual / $15,400 family for in-network and $10,200 individual / $20,400 family for non-network. (Includes deductible, coinsurance, copayments and prescriptions)	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?	Outpatient mental health/substance abuse treatment charges, inpatient mental health/substance abuse charges if not pre-certified through the EAP, cost containment penalties, charges above reasonable & customary, 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 PHCS PPO at 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)	Non-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; deductible does not apply	50% coinsurance	Network copay includes lab/x-ray performed on the same bill as the office visit
	Specialist visit	$70 copay/visit; deductible does not apply	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 you need are preventive.
If you have a test	Diagnostic test (x-ray, blood work)	$40 copay if performed during office visit; otherwise 30% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge if One Call is utilized; otherwise 30% coinsurance	50% coinsurance	Member is required to call the Medical Concierge prior to scheduling imaging services, otherwise $250 penalty applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.serve-you-rx.com	Generic drugs (Tier 1)	20% copay/prescription (retail & mail order)	20% copay/prescription (retail & mail order)	Separate deductible and out-of-pocket applies to all prescriptions except Specialty drugs, they will be paid through the medical plan benefit limits (not the prescription out-of-pocket limits). Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription). Note: Non-participating pharmacy – discounts cannot be guaranteed and the cost to the member will likely be higher. All maintenance drugs must be obtained through mail order
	Preferred brand drugs (Tier 2)	20% copay/prescription (retail & mail order)	20% copay/prescription (retail & mail order)	
	Non-preferred brand drugs (Tier 3)	20% copay/prescription (retail & mail order)	20% copay/prescription (retail & mail order)	
	Specialty drugs (Tier 4)	20% copay/prescription (retail & mail order) Medical deductible and out-of-pocket apply	20% copay/prescription (retail & mail order) Medical deductible and out-of-pocket apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Member is required to call the Medical Concierge prior to surgery, otherwise $250 penalty applies.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	$250 copay/visit plus 30% coinsurance	$250 copay/visit plus 30% coinsurance	None
	Emergency medical transportation	30% coinsurance	30% coinsurance	
	Urgent care	$85 copay/visit; deductible does not apply	50% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Precertification is required; or a penalty of 10% up to $250 applies. Member is also required to call the Medical Concierge or a penalty of $250 applies.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	50% coinsurance	Outpatient 30 visits/year ;Inpatient 15 days/year Services must be EAP approved to be covered at network level. Precertification is required for Inpatient stays otherwise a penalty of 10% up to $250 applies.
	Inpatient services	30% coinsurance	50% coinsurance	
If you are pregnant	Office visits	$40 copay/visit	50% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Precertification may be
	Childbirth/delivery professional services	30% 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)	Non-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	required; if not obtained a penalty of 10% up to $250 may apply.
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	100 visits/year. Member is required to call the Medical Concierge or a penalty of $250 applies.
	Rehabilitation services	30% coinsurance	50% coinsurance	Developmental delays and learning disorders are not covered.
	Habilitation services	30% coinsurance	50% coinsurance	
	Skilled nursing care	30% coinsurance	50% coinsurance	60 days/year
	Durable medical equipment	30% coinsurance	50% coinsurance	If over $5,000 member is required to call the Medical Concierge or a $250 penalty applies.
	Hospice services	30% coinsurance	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge if done as part of routine care	Not covered	Covered benefit under PPACA for preventive care 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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care
- Developmental delays & learning disorders
- Glasses
- 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.)

- Bariatric Surgery if through BariNet only
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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.

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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 1-574-875-5161.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

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Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,250
Specialist copayment	$70
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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,250
Copayments	$0
Coinsurance	$3,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$4,810

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

The plan's overall deductible	$1,250
Specialist copayment	$70
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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$1,250
Copayments	$260
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$2,570

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

The plan's overall deductible	$1,250
Specialist copayment	$70
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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,250
Copayments	$70
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,420

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