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, call 1-800-348-7468 x3364 or go to http://mennoniteusa.org/executive-board/the-corinthian-plan. 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 1-800-348-7468 x3364 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,400 for network providers $2,800 for out-of-network providers	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive 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. 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?	$1,400 for network providers $2,800 for out-of-network providers	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	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.highmarkbcbs.com or call 1-800-810-BLUE (2583) 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 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	No charge	No charge	None
	Specialist visit	No charge	No charge	None
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Network benefit applies for immunizations required for foreign travel provided by out-of-network providers.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	None
	Imaging (CT/PET scans, MRIs)	No charge	No charge	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling 1-800-348-7468 x2460	Retail drugs (generic and brand)	No charge	Not covered	Covers specialty drugs up to a 30-day supply. Covers all other drugs up to a 30-day supply for retail purchase at a participating pharmacy; 90-day supply for mail order purchase and retail purchase at mail order pricing at a CVS retail pharmacy. Preauthorization required for compound drugs costing $300 or more, any drug costing $5,000 or more and all specialty drugs. No benefits without preauthorization or if specialty drugs are not purchased as directed by CVS Caremark from a Caremark specialty pharmacy. No benefits if drug card is not used.
	Mail order drugs (generic and brand)	No charge	Not covered	
	Specialty drugs	No charge	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	None
	Physician/surgeon fees	No charge	No charge	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)	
If you need immediate medical attention	Emergency room care	No charge	No charge	Network deductible applies for emergency room care and emergency medical transportation provided by out-of-network providers.
	Emergency medical transportation	No charge	No charge	
	Urgent care	No charge	No charge	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	Preauthorization is required 7-10 days prior to a planned admission; within 48 hours following emergency admission.
	Physician/surgeon fees	No charge	No charge	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	No charge	None
	Inpatient services	No charge	No charge	Preauthorization is required 7-10 days prior to a planned admission; within 48 hours following emergency admission.
If you are pregnant	Office visits	No charge	No charge	Cost sharing does not apply to preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	No charge	
	Childbirth/delivery facility services	No charge	No charge	Preauthorization is required in advance of extension of inpatient stay beyond 48 hours for vaginal delivery or 96 hours for cesarean delivery.
If you need help recovering or have other special health needs	Home health care	No charge	No charge	None
	Rehabilitation services	No charge	No charge	Physical medicine limited to 20 visits/year; speech therapy limited to 20 visits/year; occupational therapy limited to 20 visits/year.
	Habilitation services	No charge	No charge	
	Skilled nursing care	No charge	No charge	Limited to 100 days/year. Preauthorization is required 7-10 days prior to a planned inpatient admission; within 48 hours following emergency inpatient admission.
	Durable medical equipment	No charge	No charge	Excludes vehicle modifications, home modifications, and exercise equipment.
	Hospice services	No charge	No charge	Preauthorization is required 7-10 days prior to a planned inpatient admission; within 48 hours following emergency inpatient admission.

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	Excluded service
	Children's glasses	Not covered	Not covered	Excluded service
	Children's dental check-up	Not covered	Not covered	Excluded service

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 (except to correct a congenital defect, a condition resulting from an accident, or a functional impairment resulting from a covered disease or injury)
- Dental care (Adult)
- Dental check-up (Child)
- Eye exam and glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care (except when related to treatment of diabetes)
- 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
- Chiropractic care, up to 20 visits/year
- Infertility treatment, limited to diagnosis and treatment of underlying medical condition
- Private-duty nursing

Your Rights to Continue Coverage: For more information on your rights to continue coverage, contact the plan at 1-800-348-7468 x3364. Other coverage options may be available to you, 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: Assistance is available 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: Highmark Blue Cross Blue Shield at 1-800-226-2239 or Duncan Smith, Director of The Corinthian Plan at 1-866-866-2872 x34255.

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 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** **$1,400**
- **Specialist** **overall deductible applies**
- **Hospital (facility)** **overall deductible applies**
- **Other** **overall deductible applies**

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	$1,400
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,460**

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

- **The plan's overall deductible** **$1,400**
- **Specialist** **overall deductible applies**
- **Hospital (facility)** **overall deductible applies**
- **Other** **overall deductible applies**

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	$1,400
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,420**

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

- **The plan's overall deductible** **$1,400**
- **Specialist** **overall deductible applies**
- **Hospital (facility)** **overall deductible applies**
- **Other** **overall deductible applies**

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	$1,400
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

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