



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 <a href="#">deductible</a> ?	\$3,000 for <a href="#">network providers</a> \$6,000 for <a href="#">out-of-network providers</a>	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> 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. 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> ?	\$3,000 for <a href="#">network providers</a> \$6,000 for <a href="#">out-of-network providers</a>	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<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.highmarkbcbs.com">www.highmarkbcbs.com</a> or call 1-800-810-BLUE (2583) 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 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	No charge	No charge	None
	<a href="#">Specialist</a> visit	No charge	No charge	None
	<a href="#">Preventive care/screening/immunization</a>	No charge. <a href="#">Deductible</a> does not apply.	Not covered	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 <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for. Network benefit applies for immunizations required for foreign travel provided by <a href="#">out-of-network providers</a> .
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	No charge	None
	Imaging (CT/PET scans, MRIs)	No charge	No charge	None
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available by calling 1-800-348-7468 x2460	Retail drugs (generic and brand)	No charge	Not covered	Covers <a href="#">specialty drugs</a> 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. <a href="#">Preauthorization</a> required for compound drugs costing \$300 or more, any drug costing \$5,000 or more and all <a href="#">specialty drugs</a> . No benefits without <a href="#">preauthorization</a> or if <a href="#">specialty drugs</a> 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	
	<a href="#">Specialty drugs</a>	No charge	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	None
	Physician/surgeon fees	No charge	No charge	

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	<a href="#">Emergency room care</a>	No charge	No charge	Network <a href="#">deductible</a> applies for <a href="#">emergency room care</a> and <a href="#">emergency medical transportation</a> provided by <a href="#">out-of-network providers</a> .
	<a href="#">Emergency medical transportation</a>	No charge	No charge	
	<a href="#">Urgent care</a>	No charge	No charge	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	<a href="#">Preauthorization</a> 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	<a href="#">Preauthorization</a> 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	<a href="#">Cost sharing</a> does not apply to <a href="#">preventive services</a> . 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	<a href="#">Preauthorization</a> 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	<a href="#">Home health care</a>	No charge	No charge	None
	<a href="#">Rehabilitation services</a>	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.
	<a href="#">Habilitation services</a>	No charge	No charge	
	<a href="#">Skilled nursing care</a>	No charge	No charge	Limited to 100 days/year. <a href="#">Preauthorization</a> is required 7-10 days prior to a planned inpatient admission; within 48 hours following emergency inpatient admission.
	<a href="#">Durable medical equipment</a>	No charge	No charge	Excludes vehicle modifications, home modifications, and exercise equipment.
	<a href="#">Hospice services</a>	No charge	No charge	<a href="#">Preauthorization</a> 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](http://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](#) \$3,000
- [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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$0
<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](#) \$3,000
- [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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,020</b>

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

- The [plan's](#) overall [deductible](#) \$3,000
- [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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,900
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>