

**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services  
**Congregational Employee Plan: Mennonite Church USA**

**Coverage Period:** 01/01/23 – 12/31/23  
**Coverage for:** Family | **Plan Type:** HDHP PPO



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 x3264 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 x3264 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$4,000/family for <a href="#">network providers</a> \$8,000/family 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. If you have other family members on the <a href="#">plan</a> , the overall family <a href="#">deductible</a> must be met before the <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> ?	\$4,000/family for <a href="#">network providers</a> \$8,000/family 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. If you have other family members on this <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limit</a> must be met.
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	Well360 virtual Health visits available only through the Amwell physician network.
	<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 Express Scripts at 1-800-818-9787	Retail drugs (generic & 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 Walgreens retail pharmacy. <a href="#">Preauthorization</a> required for all <a href="#">specialty drugs</a> . No benefits without <a href="#">preauthorization</a> . No benefits if drug card is not used.
	Mail order drugs (generic & 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	
<b>If you need immediate medical attention</b>	<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
<b>If you have a hospital stay</b>	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	

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 need mental health, behavioral health, or substance abuse services</b>	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.
<b>If you are pregnant</b>	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.
<b>If you need help recovering or have other special health needs</b>	<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. (Numerical limits do not apply for mental health diagnosis including autism).
	<a href="#">Habilitation services</a>	No charge	No charge	
	<a href="#">Skilled nursing care</a>	No charge	No charge	
	<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.
<b>If your child needs dental or eye care</b>	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
- 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
- Non-emergency care when traveling outside the U.S. (Blue Cross Blue Shield Global Core Program)
- 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 x3264. 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**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

### 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 family coverage with an aggregate [deductible](#).

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

- The [plan's](#) overall [deductible](#) \$4,000
- [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>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$4,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,060</b>

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

- The [plan's](#) overall [deductible](#) \$4,000
- [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>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$4,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$4,020</b>

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

- The [plan's](#) overall [deductible](#) \$4,000
- [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>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$2,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>