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

**Coverage Period: 01/01/24 – 12/31/24**
**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 deductible?** | $6,000/family for network providers<br>$12,000/family 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. If you have other family members on the plan, the overall family deductible must be met before the 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?** | $6,000/family for network providers<br>$12,000/family for out-of-network providers | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on this plan, the overall family out-of-pocket limit must be met. |
| **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 | Well360 virtual Health visits available only through the Amwell physician network. |
| | 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 Express Scripts at 1-800-818-9787 | Retail drugs (generic & 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 Walgreens retail pharmacy. Preauthorization required for all specialty drugs. No benefits without preauthorization. No benefits if drug card is not used. |
| | Mail order drugs (generic & 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 | |
| **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 | |

| 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 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. (Numerical limits do not apply for mental health diagnosis including autism). |
| | 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. Items purchased from non-contracted suppliers (including online suppliers). |
| | 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. |
| **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
- 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 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 $6,000**
- **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)*

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $6,000 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$6,060** |

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

- **The plan's overall deductible $6,000**
- **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)*

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $5,400 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$5,420** |

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

- **The plan's overall deductible $6,000**
- **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)*

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,800 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,800** |

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