
 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 x3368. 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 x3368 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$1,500/individual or \$3,000/family for network providers \$3,000/individual or \$6,000/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 , 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. Preventive care services, prescription drugs, and office visits 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 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	For network providers \$8,150 individual / \$16,300 family; for out-of-network providers \$5,500 individual / \$11,000 family. For prescription drug copayments \$3,000 individual.	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 ?	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 [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)	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	\$25 copay /office visit (deductible does not apply). 30% coinsurance for other outpatient services. \$15 copay /Amwell virtual physician visit (deductible does not apply).	50% coinsurance	Amwell virtual physician visits available only through the Amwell network of physicians.
	Specialist visit	\$25 copay /office visit (deductible does not apply). 30% coinsurance for other outpatient services	50% coinsurance	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.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	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	Tier 1 Generic drugs	Deductible does not apply. 10% copay / prescription (retail & mail order).	Not covered	Mandatory generic step therapy applies. Covers specialty drugs up to a 30-day supply. Covers all other drugs up to a 60-day supply for retail purchase at participating pharmacy; 90-day supply for retail purchase at mail order pricing at CVS retail pharmacy; 90-day supply for mail order purchase. 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 prescription drug card is not used.
	Tier 2 Preferred brand drugs	Deductible does not apply. 30% copay / prescription (retail & mail order)	Not covered	
	Tier 3 Non-preferred brand drugs	Deductible does not apply. 50% copay / prescription (retail & mail order)	Not covered	
	Tier 4 Specialty drugs	Deductible does not apply. 30% copay / prescription	Not covered	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	None
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	Network deductible applies for emergency room care and emergency medical transportation provided by out-of-network providers .
	Emergency medical transportation	30% coinsurance	30% coinsurance	
	Urgent care	\$25 copay /office visit (deductible does not apply). 30% coinsurance for other outpatient services	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Preauthorization is required 7-10 days prior to a planned admission; within 48 hours following emergency admission.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 copay /office visit (deductible does not apply). 30% coinsurance for other outpatient services	50% coinsurance	None
	Inpatient services	30% coinsurance	50% coinsurance	Preauthorization is required 7-10 days prior to a planned admission; within 48 hours following emergency admission.
If you are pregnant	Office visits	30% coinsurance	50% coinsurance	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	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	Preauthorization is required prior to extension of inpatient stay beyond 48 hours for vaginal delivery or 96 hours for cesarean delivery.

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 help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	None
	Rehabilitation services	30% coinsurance	50% coinsurance	Physical medicine limited to 25 visits/year; speech therapy limited to 25 visits/year; occupational therapy limited to 25 visits/year.
	Habilitation services	30% coinsurance	50% coinsurance	
	Skilled nursing care	30% coinsurance	50% coinsurance	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	30% coinsurance	50% coinsurance	Excludes vehicle modifications, home modifications, and exercise equipment.
	Hospice services	30% coinsurance	50% coinsurance	Preauthorization 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](#).)

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| <ul style="list-style-type: none"> • 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) | <ul style="list-style-type: none"> • Dental care (Adult) • Dental check-up (Child) • Eye exam and glasses (Child) • Hearing aids • Long-term care | <ul style="list-style-type: none"> • Routine eye care (Adult) • Routine foot care (except when related to treatment of diabetes) • Weight loss programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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| <ul style="list-style-type: none"> • Bariatric surgery • Chiropractic care, up to 25 visits/year | <ul style="list-style-type: none"> • Infertility treatment (diagnosis and treatment of underlying medical condition) • Infertility services (assisted fertilization) up to \$5,000 per lifetime | <ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. (Blue Cross Blue Shield Global Core Program) • Private-duty nursing |
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Your Rights to Continue Coverage: For more information on your rights to continue coverage, contact the plan at 1-574-535-7000. 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: 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 your plan representative at 1-574-535-7000.

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](#) \$1,500
- [Specialist copayment](#) \$25
- 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$300
The total Peg would pay is	\$3,300

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copayment](#) \$25
- 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$1,300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,820

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copayment](#) \$25
- 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$50
Coinsurance	\$70
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,620

Non-Discrimination Notice

Discrimination is Against the Law

Goshen College complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Goshen College does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Goshen College:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Deanna A. Risser, VP for Finance, at 1-574-535-7557.

If you believe that Goshen College has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Deanna A. Risser, VP for Finance
Goshen College, 1700 S. Main Street, Goshen, IN 46526
Telephone: 1-574-535-7557
Fax: 1-574-535-7060
Email: deannaar@goshen.edu

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Deanna A. Risser, VP for Finance, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATTENTION: If you speak any of the languages below, language assistance services, free of charge, are available to you. Call 1-574-535-7557.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-574-535-7557.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-574-535-7557。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-574-535-7557.

Wann du Deitsch (Pennsylvania German / Dutch) schwetzsch, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-574-535-7557.

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 1-574-535-7557.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-574-535-7557.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-574-535-7557. 번으로 전화해 주십시오.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-574-535-7557.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-574-535-7557.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-574-535-7557 まで、お電話にてご連絡ください。

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-574-535-7557.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-574-535-7557.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-574-535-7557.

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-574-535-7557 'ਤੇ ਕਾਲ ਕਰੋ।

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-574-535-7557. पर कॉल करें।