
 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, go to www.GuideStone.org/Summaries. 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 1-844-467-4843 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall deductible ? | \$0. This plan pays 100% of your Medicare Part A deductible per benefit period and 100% of your annual Medicare Part B deductible. | See the Common Medical Event chart below for your costs for services this plan covers. |
| Are there services covered before you meet your deductible ? | No. | Medicare covers certain preventive services without cost sharing . 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 ? | \$8,150. | 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 , Part A and Part B medical costs, prescription drugs, health care this plan doesn't cover, and out-of-network balance-billing charges. | 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 ? | Not applicable. | This plan does not use a provider network . You can receive covered services from any provider . |
| 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 | No charge | No charge | Must be a Medicare-approved expense. |
| | Specialist visit | No charge | No charge | |
| | Preventive care/screening/immunization | No charge | No charge | Abortive services and certain contraceptives are not covered. |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge | No charge | Must be a Medicare-approved expense. |
| | Imaging (CT/PET scans, MRIs) | No charge | No charge | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.GuideStone.org | Generic drugs | Not covered | Not covered | None. |
| | Preferred brand drugs | | | |
| | Non-preferred brand drugs | | | |
| | Specialty drugs | | | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | No charge | Must be a Medicare-approved expense. |
| | Physician/surgeon fees | | | |
| If you need immediate medical attention | Emergency room care | No charge | No charge | Must be a Medicare-approved expense. Foreign travel emergency covered at 80% coinsurance after \$250 deductible with a \$50,000 lifetime max. |
| | Emergency medical transportation | | | |
| | Urgent care | | | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | No charge | Must be a Medicare-approved expense. |
| | Physician/surgeon fees | No charge | No charge | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | No charge | No charge | Must be a Medicare-approved expense. |
| | Inpatient services | 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 are pregnant | Office visits | No charge | No charge | Must be a Medicare-approved expense. |
| | Childbirth/delivery professional services | No charge | No charge | |
| | Childbirth/delivery facility services | No charge | No charge | |
| If you need help recovering or have other special health needs | Home health care | No charge | No charge | Medically necessary skilled care services and medical supplies. Must be a Medicare-approved expense. |
| | Rehabilitation services | No charge | No charge | Must be a Medicare-approved expense. |
| | Habilitation services | No charge | No charge | |
| | Skilled nursing care | 100% after 100 days | 100% after 100 days | Skilled nursing care in a facility. |
| | Durable medical equipment | No charge | No charge | Must be a Medicare-approved expense. |
| Hospice services | No charge | No charge | Must meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services. | |
| If your child needs dental or eye care | Children's eye exam | Not covered | Not covered | This is an individual plan. Dependents will have separate coverage. |
| | Children's glasses | | | |
| | Children's dental check-up | | | |

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](#).)

- Abortion
- Acupuncture
- Certain contraceptives
- Cosmetic surgery
- Dental care (Adult)
- Experimental or investigational treatment
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Prescription drugs
- Private-duty nursing
- Private hospital room
- Routine eye care (Adult)
- Routine foot care
- Weight loss program

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Bariatric surgery
- Chiropractic care — limited to 20 visits per coverage period

Your Rights to Continue Coverage:

Church plans are not covered by the federal COBRA continuation coverage rules. Other options to continue coverage are 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: There are agencies that can help 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: Express Scripts at 1-866-544-2976 or visit www.express-scripts.com and Highmark Blue Cross Blue Shield at 1-866-472-0924 or visit www.highmarkbcbs.com.

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.

For seminary students: This plan is Minimum Essential Coverage only if you are (1) an ordained, commissioned or licensed minister or (2) a paid employee of a Southern Baptist employer, or approved evangelical ministry, working 20 or more hours/week.

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](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-844-INS-GUIDE (1-844-467-4843).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-INS-GUIDE (1-844-467-4843).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-INS-GUIDE (1-844-467-4843).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-INS-GUIDE (1-844-467-4843).

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 | \$0 |
| ■ Office visit copayment | \$0 |
| ■ Hospital (facility) copayment | \$0 |
| ■ Hospital (facility) coinsurance | 0% |

This EXAMPLE event includes services like:

Office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,730 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$100 |
| The total Peg would pay is | \$100 |

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|---|-----|
| ■ The plan's overall deductible | \$0 |
| ■ Office visit copayment | \$0 |
| ■ Hospital (facility) copayment | \$0 |
| ■ Hospital (facility) coinsurance | 0% |

This EXAMPLE event includes services like:

Office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$7,390 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$4,260 |
| The total Joe would pay is | \$4,260 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|---|-----|
| ■ The plan's overall deductible | \$0 |
| ■ Office visit copayment | \$0 |
| ■ Hospital (facility) copayment | \$0 |
| ■ Hospital (facility) coinsurance | 0% |

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 | \$1,930 |
|---------------------------|----------------|

In this example, Mia would pay:

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