



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](http://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 <a href="#">deductible</a> ?	In-network: \$2,000 person / \$4,000 family. Out-of-network: \$4,000 person / \$8,000 family.	Generally, you must pay all of the costs from providers 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> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care 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. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. 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> ?	For <a href="#">network providers</a> \$5,750 individual / \$11,500 family; for <a href="#">out-of-network providers</a> \$24,000 individual / \$28,000 family.	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 in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copayments</a> for certain services, specialty drug <a href="#">copayments</a> paid by the manufacturer, <a href="#">premiums</a> , health care this <a href="#">plan</a> doesn't cover, and out-of-network <a href="#">balance-billing</a> charges.	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 1-800-810-2583 for a list of participating providers.	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 [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)	
<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	\$25 <a href="#">copay</a> /office visit; <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	-----None-----
	<a href="#">Specialist</a> visit	\$45 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	-----None-----
	<a href="#">Preventive care/screening/immunization</a>	No charge for covered services	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (X-ray, blood work)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	If performed in a primary care or specialist office, primary care or specialist <a href="#">copay</a> applies.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----None-----
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.GuideStone.org">www.GuideStone.org</a>	Generic drugs	\$15 <a href="#">copay</a> /prescription retail \$30 <a href="#">copay</a> /prescription mail	100% of drug cost. Upon manual claim form submission, you will be reimbursed based on plan benefits and allowable charges for covered drugs.	Covers up to 30-day supply retail and 90-day supply mail order. The difference in cost of brand drugs over available generic drugs is a non-covered penalty. A \$10 penalty will apply after the second 30-day retail fill of maintenance drugs. See plan booklet for more details. The above penalties do not accumulate toward the <a href="#">deductible</a> or <a href="#">out-of-pocket limits</a> . Certain contraceptives are not covered.
	Preferred brand drugs	\$50 <a href="#">copay</a> /prescription retail \$100 <a href="#">copay</a> /prescription mail		
	Non-preferred brand drugs	\$75 <a href="#">copay</a> /prescription retail \$150 <a href="#">copay</a> /prescription mail		
	Diabetic supplies (generic, preferred, non-preferred)	\$20 <a href="#">copay</a> /prescription mail		
	Preferred insulin	\$75 <a href="#">copay</a> /prescription mail		
	<a href="#">Specialty drugs</a>	Generic: \$50 <a href="#">copay</a> /prescription Preferred: \$75 <a href="#">copay</a> /prescription Non-preferred: \$100 <a href="#">copay</a> /prescription		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----None-----
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----None-----

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>	20% <a href="#">coinsurance</a> after \$250 <a href="#">copay</a>	20% <a href="#">coinsurance</a> after \$250 <a href="#">copay</a>	50% <a href="#">coinsurance</a> after a \$250 <a href="#">copay</a> out-of-network for non-emergency services.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	If an emergency, pays at the in-network level and waives <a href="#">deductible</a> .
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> after \$500 <a href="#">copay</a>	-----None-----
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	-----None-----
	Inpatient services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> after \$500 <a href="#">copay</a>	Precertification may be required.
If you are pregnant	Office visits	\$25 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	-----None-----
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----None-----
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> after \$500 <a href="#">copay</a>	-----None-----
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Maximum 120 visits per year.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	See plan booklet. Limits may apply.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	See plan booklet. Limits may apply.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Maximum 120 days per year.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Rental or purchase option determined by the claims administrator. Rental costs cannot exceed the total cost of purchase.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----None-----
If your child needs dental or eye care	Children's eye exam	\$25 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	See <i>Preventive Care Schedule</i> for age limits on child vision screening.
	Children's glasses	Not covered	Not covered	-----None-----
	Children's dental check-up	Not covered	Not covered	See <i>Preventive Care Schedule</i> for exceptions.

## Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"><li>• Abortion</li><li>• Acupuncture</li><li>• Certain contraceptives</li><li>• Cosmetic surgery</li></ul>	<ul style="list-style-type: none"><li>• Dental care (Adult)</li><li>• Experimental or investigational treatment</li><li>• Infertility treatment</li><li>• Long-term care</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing</li><li>• Private hospital room</li><li>• Routine foot care</li><li>• Weight loss program</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"><li>• Bariatric surgery</li><li>• Routine eye care (Adult)</li><li>• Hearing aids</li></ul>	<ul style="list-style-type: none"><li>• Chiropractic care — limited to 12 visits per coverage period</li></ul>	<ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li></ul>

## 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](http://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](http://www.Express-Scripts.com) and Highmark Blue Cross Blue Shield at 1-866-472-0924 or visit [www.HighmarkBCBS.com](http://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](#) \$2,000
- [Office visit](#) copayment \$25
- [Hospital \(facility\)](#) copayment \$0
- [Hospital \(facility\)](#) coinsurance 20%

**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*)

<b>Total Example Cost</b>	<b>\$12,730</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$150
Coinsurance	\$2,080
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$4,230</b>

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

- The [plan's](#) overall [deductible](#) \$2,000
- [Office visit](#) copayment \$25
- [Hospital \(facility\)](#) copayment \$0
- [Hospital \(facility\)](#) coinsurance 20%

**This EXAMPLE event includes services like:**

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

<b>Total Example Cost</b>	<b>\$7,390</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$130
Copayments	\$1,320
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Joe would pay is</b>	<b>\$1,460</b>

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

- The [plan's](#) overall [deductible](#) \$2,000
- [Office visit](#) copayment \$25
- [Hospital \(facility\)](#) copayment \$0
- [Hospital \(facility\)](#) coinsurance 20%

**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>\$1,930</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,630
Copayments	\$140
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,770</b>