



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/PlanBooklets](http://www.GuideStone.org/PlanBooklets). 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: \$1,000 person / \$2,000 family. Out-of-network: \$2,000 person / \$4,000 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> , primary care services, office visits and <a href="#">prescription drugs</a> 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> \$5,000 individual / \$8,250 family; for <a href="#">out-of-network providers</a> \$22,000 individual / \$24,000 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.guidestonehealth.org">www.guidestonehealth.org</a> or call 1-855-497-1230 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<br>(You will pay the least)  | Out-of-Network Provider<br>(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 <a href="#">copay</a> /office visit  | 50% <a href="#">coinsurance</a>  | -----None-----  |
|  | <a href="#">Specialist</a> visit                       | \$45 <a href="#">copay</a> /office 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 <a href="#">plan</a> will pay for.   |
| If you have a test   | <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>  | Prior authorization (PA) required for non-emergency advanced imaging procedures (e.g., MRI, CT, PET) performed in an outpatient setting.  |
| If you need drugs to treat your illness or condition<br>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<br>\$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<br>\$100 <a href="#">copay</a> /prescription mail   |  |   |
|  | Non-preferred brand drugs                              | \$75 <a href="#">copay</a> /prescription retail<br>\$150 <a href="#">copay</a> /prescription mail   |  |   |
|  | Diabetic Supplies (Generic, Preferred, Non-preferred)  | \$20 <a href="#">copay</a> /prescription mail   |  | Covers up to a 90-day supply.   |
|  | Participating Insulin                                  | \$75 <a href="#">copay</a> /prescription mail   |  | Covers up to a 90-day supply. Insulin copay applies to select insulin products whose manufacturers have chosen to participate in the Patient Assurance Program.   |
|  | <a href="#">Specialty drugs</a>                        | Generic:<br>\$50 <a href="#">copay</a> /prescription<br>Preferred:<br>\$75 <a href="#">copay</a> /prescription<br>Non-preferred:<br>\$100 <a href="#">copay</a> /prescription |  | Covers up to a 30-day supply. <a href="#">Copayments</a> for certain <a href="#">specialty medications</a> will be set to the maximum available manufacturer <a href="#">copay</a> assistance and be paid by the manufacturer.  |

[\* For more information about limitations and exceptions, see the plan or policy document at [www.GuideStone.org/PlanBooklets](http://www.GuideStone.org/PlanBooklets).]

| Common Medical Event  | Services You May Need                            | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information   |
|---|--|---|---|--|
|   |  | Network Provider<br>(You will pay the least)                      | Out-of-Network Provider<br>(You will pay the most)                |  |
| If you have outpatient surgery  | 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-----   |
| 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> | -----None-----   |
|   | <a href="#">Emergency medical transportation</a> | 20% <a href="#">coinsurance</a>                                   | 50% <a href="#">coinsurance</a>                                   | Air ambulance always pays at the in network level. If an emergency, other transportation types pay 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 30 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-----   |

[\* For more Information about limitations and exceptions, see the plan or policy document at [www.GuideStone.org/PlanBooklets](http://www.GuideStone.org/PlanBooklets).]

| Common Medical Event                          | Services You May Need      | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Information                        |
|---|----------------------------|--|--|---|
|   |                            | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |   |
| <b>If your child needs dental or eye care</b> | 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.                           |

[\* For more Information about limitations and exceptions, see the plan or policy document at [www.GuideStone.org/PlanBooklets](http://www.GuideStone.org/PlanBooklets).]

## 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
- Infertility treatment
- Long-term care
- Private-duty nursing
- Private hospital room
- 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
- Routine eye care (Adult)
- Chiropractic care — limited to 12 visits per year
- Non-emergency care when traveling outside the U.S.
- Hearing Aids

**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: MyQHealth Care Coordinators at 1-855-497-1230 or visit [www.guidestonehealth.org](http://www.guidestonehealth.org).

### 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](#).

**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.* —————

[\* For more Information about limitations and exceptions, see the plan or policy document at [www.Guidestone.org/PlanBooklets](http://www.Guidestone.org/PlanBooklets).]

## 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$45    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 20%     |

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> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,000        |
| Copayments                        | \$70           |
| Coinsurance                       | \$2,300        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Peg would pay is</b> | <b>\$3,370</b> |

### Managing Joe's type 2 Diabetes

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

|   |         |
|---|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$45    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 20%     |

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> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$100          |
| Copayments                        | \$1,000        |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Joe would pay is</b> | <b>\$1,100</b> |

### Mia's Simple Fracture

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

|   |         |
|---|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$45    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 20%     |

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic tests](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,000        |
| Copayments                        | \$400          |
| Coinsurance                       | \$300          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,700</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.