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. 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?	In-network: $5,000 person / $10,000 family. Out-of-network: Not Covered	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, primary care services, office vists and prescription drugs 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 or coinsurance 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 $9,100 individual / $18,200 family; for out-of-network providers Not Covered	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?	Copayments for certain services, specialty drug copayments paid by the manufacturer, premiums, 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?	Yes. See www.guidestonehealth.org or call 1-855-497-1230 for a list of participating 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	$20 copay/office visit	Not Covered	---------None---------
	Specialist visit	$50 copay/office visit	Not Covered	---------None---------
	Preventive care/screening/ immunization	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.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not Covered	If performed in a primary care or specialist office, primary care or specialist copay applies.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not Covered	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 More information about prescription drug coverage is available at www.GuideStone.org	Generic drugs	$10 copay/prescription retail $20 copay/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 deductible or out-of-pocket limits. Certain contraceptives are not covered.
	Preferred brand drugs	$50 copay/prescription retail $100 copay/prescription mail		
	Non-preferred brand drugs	$150 copay/prescription retail $300 copay/prescription mail		
	Diabetic Supplies (Generic, Preferred, Non-preferred)	$20 copay/prescription mail		Covers up to a 90-day supply.
	Participating Insulin	$75 copay/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.
	Specialty drugs	Generic: $100 copay/prescription Preferred: $150 copay/prescription Non-preferred: $300 copay/prescription		Covers up to a 30-day supply. Copayments for certain specialty medications will be set to the maximum available manufacturer copay 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.]

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not Covered	---------None---------
	Physician/surgeon fees	30% coinsurance	Not Covered	---------None---------
If you need immediate medical attention	Emergency room care	30% coinsurance after $500 copay	30% coinsurance after $500 copay	---------None---------
	Emergency medical transportation	30% coinsurance	Not Covered	Air ambulance always pays at the in network level. If an emergency, other transportation types pay at the in-network level and waives deductible.
	Urgent care	$75 copay/visit	Not Covered	---------None---------
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not Covered	---------None---------
	Physician/surgeon fees	30% coinsurance	Not Covered	---------None---------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit	Not Covered	---------None---------
	Inpatient services	30% coinsurance	Not Covered	Precertification may be required.
If you are pregnant	Office visits	$20 copay/visit	Not Covered	---------None---------
	Childbirth/delivery professional services	30% coinsurance	Not Covered	---------None---------
	Childbirth/delivery facility services	30% coinsurance	Not Covered	---------None---------
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not Covered	Maximum 120 visits per year.
	Rehabilitation services	30% coinsurance	Not Covered	See plan booklet. Limits may apply.
	Habilitation services	30% coinsurance	Not Covered	See plan booklet. Limits may apply.
	Skilled nursing care	30% coinsurance	Not Covered	Maximum 30 days per year.
	Durable medical equipment	30% coinsurance	Not Covered	Rental or purchase option determined by the claims administrator. Rental costs cannot exceed the total cost of purchase.
	Hospice services	30% coinsurance	Not Covered	---------None---------

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

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 your child needs dental or eye care	Children's eye exam	$20 copay/visit	Not Covered	See *Preventive Care Schedule* 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 *Preventive Care Schedule* for exceptions.

[* For more Information about limitations and exceptions, see the plan or policy document at 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	• Dental care (Adult)	• Private-duty nursing
• Acupuncture	• Experimental or investigational treatment	• Private hospital room
• Certain contraceptives	• Infertility treatment	• Routine foot care
• Cosmetic surgery	• Long-term 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 12 visits per coverage period	• Non-emergency care when traveling outside the U.S.
• Routine eye care (Adult)		• 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 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.

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, kwiijigo 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.]

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	**$5,000**
Specialist copayment	**$50**
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$60
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$7,360**

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

The plan's overall deductible	**$5,000**
Specialist copayment	**$50**
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,100**

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

The plan's overall deductible	**$5,000**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic tests (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,700**

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