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. Medicare has a Part A deductible per benefit period. You pay 50% of the Part A 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	Not covered	Not covered	Medicare Part B expenses not covered.
	Specialist visit			
	Preventive care/screening/ immunization			
If you have a test	Diagnostic test (x-ray, blood work)	Not covered	Not covered	Medicare Part B expenses not covered.
	Imaging (CT/PET scans, MRIs)			
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)	Not covered	Not covered	Medicare Part B expenses not covered.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	Not covered	Not covered	Medicare Part B expenses not covered.
	Emergency medical transportation			
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)	You pay 50% of the Medicare Part A deductible.	You pay 50% of the Medicare Part A deductible.	Deductible applies for every benefit period, which begins when you are admitted and ends when you have not received hospital or skilled nursing facility treatment for 60 days in a row. Medicare Part B expenses not covered.
	Physician/surgeon fees	Not covered	Not covered	Medicare Part B expenses 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 need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	Medicare Part B expenses not covered.
	Inpatient services	You pay 50% of the Medicare Part A deductible.	You pay 50% of the Medicare Part A deductible.	Deductible applies for every benefit period, which begins when you are admitted and ends when you have not received hospital or skilled nursing facility treatment for 60 days in a row. Medicare Part B expenses not covered.
If you are pregnant	Office visits	Not covered	Not covered	Medicare Part B expenses not covered.
	Childbirth/delivery professional services	Not covered	Not covered	Medicare Part B expenses not covered.
	Childbirth/delivery facility services	You pay 50% of the Medicare Part A deductible.	You pay 50% of the Medicare Part A deductible.	Deductible applies for every benefit period, which begins when you are admitted and ends when you have not received hospital or skilled nursing facility treatment for 60 days in a row. Medicare Part B expenses not covered.
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	Medicare Part B expenses not covered.
	Rehabilitation services			
	Habilitation services			
	Skilled nursing care			
	Durable medical equipment			
	Hospice 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
- Chiropractic care
- 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

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, 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.

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:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$3,770
The total Peg would pay is	**$3,770**

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:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$7,390
The total Joe would pay is	**$7,390**

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:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,930
The total Mia would pay is	**$1,930**

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