



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:
<a href="#">What is the overall deductible?</a>	\$0. Medicare has a Part A deductible per benefit period. You pay 50% of the Part A deductible. You pay 100% of the Medicare Part B deductible.	See the Common Medical Event chart below for your costs for services this <a href="#">plan</a> covers.
<a href="#">Are there services covered before you meet your deductible?</a>	No.	Medicare covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</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> .
<a href="#">Are there other deductibles for specific services?</a>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<a href="#">What is the out-of-pocket limit for this plan?</a>	\$9,100	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.
<a href="#">What is not included in the out-of-pocket limit?</a>	<a href="#">Premiums</a> , Part A and Part B medical costs, prescription drugs, 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> .
<a href="#">Will you pay less if you use a network provider?</a>	Not applicable.	This <a href="#">plan</a> does not use a <a href="#">provider network</a> . You can receive covered services from any <a href="#">provider</a> .
<a href="#">Do you need a referral to see a 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 provider's office or clinic</b>	Primary care visit to treat an injury or illness	No charge	No charge	Medicare Part B deductible applies.
	<u>Specialist</u> visit			
	<u>Preventive care/screening/immunization</u>			Abortive services and certain contraceptives are not covered.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No charge	No charge	Medicare Part B deductible applies.
	Imaging (CT/PET scans, MRIs)			
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.GuideStone.org">www.GuideStone.org</a>	Generic drugs	Not covered	Not covered	None.
	Preferred brand drugs			
	Non-preferred brand drugs			
	<u>Specialty drugs</u>			
	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	Medicare Part B deductible applies.
<b>If you have outpatient surgery</b>	Physician/surgeon fees	No charge	No charge	Medicare Part B deductible applies.
	<u>Emergency room care</u>			
	<u>Emergency medical transportation</u>			
	<u>Urgent care</u>			

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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 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	No charge	No charge	Medicare Part B deductible applies.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	No charge	Medicare Part B deductible applies.
	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	No charge	No charge	Medicare Part B deductible applies.
	Childbirth/delivery professional services	No charge	No charge	Medicare Part B deductible applies.
	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	<a href="#">Home health care</a>	Not covered	Not covered	None.
	<a href="#">Rehabilitation services</a>	No charge	No charge	Medicare Part B deductible applies. Visit limits apply. See plan booklet for details.
	<a href="#">Habilitation services</a>	No charge	No charge	Medicare Part B deductible applies. Visit limits apply. See plan booklet for details.
	<a href="#">Skilled nursing care</a>	Not covered	Not covered	None.
	<a href="#">Durable medical equipment</a>	No charge	No charge	Medicare Part B deductible applies.
	<a href="#">Hospice services</a>	Not covered	Not covered	None.
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			

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## 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.)

<ul style="list-style-type: none"><li>• Abortion</li><li>• Acupuncture</li><li>• Certain contraceptives</li><li>• Cosmetic surgery</li><li>• Dental care (Adult)</li><li>• Experimental or investigational treatment</li></ul>	<ul style="list-style-type: none"><li>• Hearing aids</li><li>• Infertility treatment</li><li>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S.</li><li>• Prescription drugs</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing</li><li>• Private hospital room</li><li>• Routine eye care (Adult)</li><li>• Routine foot care</li><li>• Weight loss program</li></ul>
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### 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](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](#) and Highmark Blue Cross Blue Shield at 1-866-472-0924 or visit [www.HighmarkBCBS.com](#).

### 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).

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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## 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](#)
- [Specialist copayment](#)
- Hospital (facility) [coinsurance](#)
- Other [coinsurance](#)

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** **\$12,690**

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinurance	\$0

#### What isn't covered

Limits or exclusions **\$270**

**The total Peg would pay is** **\$270**

### Managing Joe's type 2 Diabetes

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

- The [plan's overall deductible](#)
- [Specialist copayment](#)
- Hospital (facility) [coinsurance](#)
- Other [coinsurance](#)

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	\$200
Copayments	\$0
Coinurance	\$0

#### What isn't covered

Limits or exclusions **\$3,490**

**The total Joe would pay is** **\$3,690**

### Mia's Simple Fracture

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

- The [plan's overall deductible](#)
- [Specialist copayment](#)
- Hospital (facility) [coinsurance](#)
- Other [coinsurance](#)

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** **\$2,810**

In this example, Mia would pay:

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