**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 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: $1,000 Individual / $2,000 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, prescription benefits, certain office visits (please see the appropriate plan booklet for details), and insulin 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. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductible for specific services. |
| **What is the out-of-pocket limit for this plan?** | For network providers: $5,000 Individual / $8,250 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. Premiums, balance-billing charges, health care this plan doesn't cover, and penalties do not count toward the out-of-pocket limit. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance billed charges, costs of health care drugs this plan doesn't cover, and out-of-network copayments. | 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.myhighmark.com or call 1-866-472-0924 between 8AM-8PM EST 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). |
| **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 | $25 copay | Not covered | ----------None---------- |
| | Specialist visit | $45 copay | 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. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | Not covered | ----------None---------- |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | Not covered | OneImaging is the designated provider for non-urgent MRI and CT scan services. To receive covered services under your health plan, non-urgent MRI and CT scans must be scheduled through OneImaging. Some exceptions apply. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at **www.GuideStone.org** | Generic drugs (Retail/Mail Order) | $15 copay / $30 copay | 100% of drug cost. Upon manual claim form submission, you will be reimbursed based on plan benefits and allowable charges for covered drugs. | Brand over generic costs will be a noncovered penalty. Maintenance drugs require 90 day fills (mail order or approved retail) to be covered. Penalties do not apply to annual accumulators. Certain contraceptives are not covered. Please see plan booklet for additional details on your prescription benefits. |
| | Preferred brand drugs (Retail/Mail Order) | $50 copay / $100 copay | | |
| | Non-preferred brand drugs (Retail/Mail Order) | $75 copay / $150 copay | | |
| | Diabetic Supplies (Generic, Preferred, Non-preferred) | $20 copay | | Covers up to a 90-day supply. Deductible does not apply. |
| | Participating Insulin | $75 copay / prescription mail | | Covers up to a 90-day supply. Deductible does not apply. |
| | Specialty drugs (Generic/Preferred) | $50 copay / $75 copay / $100 copay | | Covers up to a 30-day supply. Please see plan booklet for additional details on your prescription benefits. |

[* 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 you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | Not covered | Important note: Carrum Health is the designated benefits coordinator for bariatric procedures, certain spinal procedures, and knee and hip replacements for GuideStone health plan members (age 18+). To ensure you receive high-quality care that is covered by your health plan, GuideStone requires that these services be scheduled through Carrum Health. Some exceptions apply. |
| | Physician/surgeon fees | 20% coinsurance | Not covered | See Carrum Health requirements above. |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance after $250 copay | 20% coinsurance after $250 copay | ----------None---------- |
| | Emergency medical transportation | 20% coinsurance | Not covered | If an emergency, pays at the in-network level. |
| | Urgent care | $50 copay | Not covered | Waive copay for MHSA diagnosis if copay would otherwise apply. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | Not covered | Precertification may be required. |
| | Physician/surgeon fees | 20% coinsurance | Not covered | ----------None---------- |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office Visit:$25 copay<br>Other:20% coinsurance | Not covered | ----------None---------- |
| | Inpatient services | 20% coinsurance | Not covered | Precertification may be required. |
| **If you are pregnant** | Office visits | Maternity: 20% coinsurance<br>Other: $25 copay | Not covered | See plan booklet. |
| | Childbirth/delivery professional services | 20% coinsurance | Not covered | ----------None---------- |
| | Childbirth/delivery facility services | 20% coinsurance | Not covered | ----------None---------- |
| | Home health care | 20% coinsurance | Not covered | Maximum 120 visits per year. |
| | Rehabilitation services | 20% coinsurance | Not covered | See plan booklet. Limits may apply. PT/OT/ST take specialist copay if applicable. |
| | Habilitation services | 20% coinsurance | Not covered | |

[* 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 you need help recovering or have other special health needs** | Skilled nursing care | 20% coinsurance | Not covered | Maximum 30 days per year. |
| | Durable medical equipment | 20% coinsurance | Not covered | Rental or purchase option determined by the claims administrator. Rental costs cannot exceed the total cost of purchase. |
| | Hospice services | 20% coinsurance | Not covered | ----------None---------- |
| **If your child needs dental or eye care** | Children's eye exam | $25 copay | 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 |

## 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
- Hearing Aids
- Routine Eye Care (Adult)
- Non-emergency care when traveling outside the U.S.
- Chiropractic Care - Limited to 12 visits per coverage period.

**Your Rights to Continue Coverage:** Church plans are not covered by the federal COBRA continuation coverage rules. Other coverage options may be available to you, too, 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 on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, call your Well360 Team at 1-866-472-0924 or visit www.myhighmark.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.

**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** | **$1,000** |
| **Specialist copay** | **$45** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **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)*

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

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

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

| | |
|---|---|
| **The plan's overall deductible** | **$1,000** |
| **Specialist copay** | **$45** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **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)*

| **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** | **$1,000** |
| **Specialist copay** | **$45** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other 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)*

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,000 |
| Copayments | $600 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | $1,800 |

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