




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> ?	\$0. This plan pays 100% of your Medicare Part A deductible per benefit period and 100% of your annual Medicare Part B deductible.	See the Common Medical Event chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">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> .
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> ?	\$8,150	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.
What is not included in the <a href="#">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> .
Will you pay less if you use a <a href="#">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> .
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 (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	No charge	No charge	Must be a Medicare-approved expense.
	<a href="#">Specialist</a> visit			
	<a href="#">Preventive care/screening/immunization</a>			Abortive services and certain contraceptives are not covered.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	No charge	Must be a Medicare-approved expense.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition <b>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.GuideStone.org">www.GuideStone.org</a></b>	Generic drugs	Not covered	Not covered	None.
	Preferred brand drugs			
	Non-preferred brand drugs			
	<a href="#">Specialty drugs</a>			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	Must be a Medicare-approved expense.
	Physician/surgeon fees			
If you need immediate medical attention	<a href="#">Emergency room care</a>	No charge	No charge	Must be a Medicare-approved expense. Foreign travel emergency covered at 80% coinsurance after \$250 deductible with a \$50,000 lifetime max.
	<a href="#">Emergency medical transportation</a>			
	<a href="#">Urgent care</a>			

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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)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No charge	No charge	Must be a Medicare-approved expense.
	Physician/surgeon fees	No charge	No charge	Must be a Medicare-approved expense.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	No charge	No charge	Must be a Medicare-approved expense.
	Inpatient services	No charge	No charge	Must be a Medicare-approved expense.
<b>If you are pregnant</b>	Office visits	No charge	No charge	Must be a Medicare-approved expense.
	Childbirth/delivery professional services	No charge	No charge	Must be a Medicare-approved expense.
	Childbirth/delivery facility services	No charge	No charge	Must be a Medicare-approved expense.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge	No charge	Medically necessary skilled care services and medical supplies. Must be a Medicare-approved expense.
	<a href="#">Rehabilitation services</a>	No charge	No charge	Must be a Medicare-approved expense.
	<a href="#">Habilitation services</a>	No charge	No charge	Must be a Medicare-approved expense.
	<a href="#">Skilled nursing care</a>	100% after 100 days	100% after 100 days	Skilled nursing care in a facility.
	<a href="#">Durable medical equipment</a>	No charge	No charge	Must be a Medicare-approved expense.
	<a href="#">Hospice services</a>	No charge	No charge	Must meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.
<b>If your child needs dental or eye care</b>	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](#).)

- Abortion
- Acupuncture
- Certain contraceptives
- 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
- 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](http://www.Express-Scripts.com) and Highmark Blue Cross Blue Shield at 1-866-472-0924 or visit [www.HighmarkBCBS.com](http://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, kwijigo 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$0
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	0%

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>\$12,690</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$70</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>	\$0
■ <a href="#">Specialist copayment</a>	\$0
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	0%

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>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$3,490
<b>The total Joe would pay is</b>	<b>\$3,490</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>	\$0
■ <a href="#">Specialist copayment</a>	\$0
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	0%

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>\$2,810</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$10</b>

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