



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: \$2,000 Individual / \$4,000 Family. Out-of-network: \$4,000 Individual / \$8,000 Family. | 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 : \$5,750 Individual / \$11,500 Family; for out-of-network providers : \$24,000 Individual / \$28,000 Family. | 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 | 50% coinsurance | -----None----- |
| | Specialist visit | \$45 copay | 50% coinsurance | -----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 | 50% coinsurance | -----None----- |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 50% coinsurance | Prior authorization 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 (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. Covers up to a 90-day supply. Deductible does not apply. Covers up to a 90-day supply. Deductible does not apply. Covers up to a 30-day supply. 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 | | |
| | Participating Insulin | \$75 copay / prescription mail | | |
| | Specialty drugs (Generic/Preferred) | \$50 copay / \$75 copay / \$100 copay | | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 50% coinsurance | -----None----- |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | -----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 you need immediate medical attention | Emergency room care | 20% coinsurance after \$250 copay | 20% coinsurance after \$250 copay | -----None----- |
| | Emergency medical transportation | 20% coinsurance | 50% coinsurance | If an emergency, pays at the in-network level. |
| | Urgent care | \$50 copay | 50% coinsurance | Waive copay for MHSA diagnosis if copay would otherwise apply. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | 50% coinsurance after \$500 copay | Precertification may be required. |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | -----None----- |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office Visit:\$25 copay Other:20% coinsurance | 50% coinsurance | -----None----- |
| | Inpatient services | 20% coinsurance | 50% coinsurance after \$500 copay | Precertification may be required. |
| If you are pregnant | Office visits | \$25 copay | 50% coinsurance | -----None----- |
| | Childbirth/delivery professional services | 20% coinsurance | 50% coinsurance | -----None----- |
| | Childbirth/delivery facility services | 20% coinsurance | 50% coinsurance after \$500 copay | -----None----- |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | 50% coinsurance | Maximum 120 visits per year. |
| | Rehabilitation services | 20% coinsurance | 50% coinsurance | See plan booklet. Limits may apply. |
| | Habilitation services | 20% coinsurance | 50% coinsurance | PT/OT/ST take specialist copay if applicable. |
| | Skilled nursing care | 20% coinsurance | 50% coinsurance | Maximum 30 days per year. |
| | Durable medical equipment | 20% coinsurance | 50% coinsurance | Rental or purchase option determined by the claims administrator. Rental costs cannot exceed the total cost of purchase. |
| | Hospice services | 20% coinsurance | 50% coinsurance | -----None----- |
| If your child needs dental or eye care | Children's eye exam | \$25 copay | Not covered | See <i>Preventive Care Schedule</i> 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 <i>Preventive Care Schedule</i> 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, contact: Clarity's Patient Advocacy Team at 1-866-472-0924 or visit www.myhighmark.com.

Does this plan provide Minimum Essential Coverage? True

[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? True

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).]

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](#) \$2,000
- [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 | \$2,000 |
| Copayments | \$70 |
| Coinsurance | \$2,100 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Peg would pay is | \$4,170 |

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$2,000
- [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](#) \$2,000
- [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 | \$1,700 |
| Copayments | \$600 |
| Coinsurance | \$70 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,370 |

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