GuideStone®

GLOBAL METHODIST CHURCH

MEMBER ENROLLMENT BOOKLET

REVIEW YOUR PLAN BENEFITS

2024/2025 GM Church Member Enrollment Booklet

GuideStone®

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WELCOME TO YOUR GUIDESTONE MEDICAL PLAN

Welcome to the GuideStone® family. We look forward to serving you!

With GuideStone, you're receiving quality, cost-effective, true medical coverage created by Christians specifically for those who serve in ministry.

Let's get started!

TRANSITIONING INTO YOUR NEW PLAN

You are busy with your ministry, so we've done our best to provide you with the tools you need to make a seamless transition to your new medical plan. All the forms and facts you need to enroll in, access and update your coverage are included here.

UTILIZING YOUR BENEFITS

You'll also find valuable resources to guide you in utilizing your benefits. The medical plan road map in this booklet provides an at-a-glance view of your plan's benefits. Plus, you'll find insight on how to make the most of your options, along with information about some bonus benefits that might surprise you.

FINDING ANSWERS

At GuideStone, your satisfaction is our top priority. Answers to your benefit questions are just a tap, click or call away. Quantum Health is your one resource to contact whenever you need help with your medical, wellness or pharmacy benefits.

Quantum Health: **1-855-497-1230**, *GuideStoneHealth.org* or the Quantum Health app.

GuideStone Customer Solutions: **1-844-INS-GUIDE** (1-844-467-4843)

GM Church GuideStone Landing Page: *GuideStone.org/GMChurch*

Email: *GMChurch@GuideStone.org*

MEDICAL PLANS

Global Methodist Church® Clergy

GuideStone Health Plans

GuideStone® believes when the Body of Christ is healthy, it's free to transform the world — and we want to help guide and equip your ministry and its people to do just that.

That's why GuideStone and Global Methodist Church have teamed up to offer best-in-class Christian health plans. We understand the health care landscape can be complicated, and we want to help make it easier! Our priority is delivering quality medical coverage designed for churches of all shapes and sizes so you can focus on fulfilling your calling.

Effective July 1, 2024

Monthly Rates	Health Choice 1000	Health Choice 5000[1]	Health Choice 2000[2]	Health Choice 4000[1,2]
Annual deductibles: individual/family	$1,000/$2,000	$5,000/$10,000	$2,000/$4,000 (aggregate)	$4,000/$8,000 (embedded)
Plan pays/individual pays (co-insurance)/(after deductible)	80%/20%	70%/30%	90%/10%	80%/20%
Maximum out-of-pocket (medical and prescription): individual/family (in-network services only, including deductible, co-pays and co-insurance)	$5,000 Individual/$8,250 Family	$6,500 Individual/$12,700 Family	$4,000 Individual/ $7,500 Family	$6,000 Individual/ $12,000 Family
Wellness and preventive care visit (in-network, per *Preventive Schedule*)	0% no co-pay	0% no co-pay	0% (no deductible)	0% (no deductible)
Primary care or retail clinic visit/specialist visit	$25/$45 co-pay	$25/$45 co-pay	10% after deductible	20% after deductible
Outpatient rehabilitation and habilitation services (Physical Therapy (PT)/Occupational Therapy (OT)/Speech Therapy (ST))	$45 co-pay	$45 co-pay	10% after deductible	20% after deductible
Teladoc®	$0 co-pay	$0 co-pay	0% after deductible[3]	0% after deductible[3]
Urgent care	$50 co-pay	$50 co-pay	10% after deductible	20% after deductible
Outpatient services (CT scan, MRI, diagnostic) and outpatient surgery facility	20% after deductible	30% after deductible	10% after deductible	20% after deductible
Hospital inpatient (including maternity)	20% after deductible	30% after deductible	10% after deductible	20% after deductible
Emergency room services (per visit)	$250 co-pay, then 20%	$250 co-pay, then 30%	$250 co-pay, then 10% after deductible	$250 co-pay, then 20% after deductible
Mental health/substance abuse — inpatient	20% after deductible	30% after deductible	10% after deductible	20% after deductible
Mental health/substance abuse — office and professional services	$25 co-pay	$25 co-pay	10% after deductible	20% after deductible
Chiropractic services	$45 co-pay	$45 co-pay	10% after deductible	20% after deductible
Prescription drugs program[4,5,6,7,8,9]	$15 co-pay generic retail $30 co-pay generic mail order Preferred, non-preferred and specialty drugs subject to co-pays	$15 co-pay generic retail $30 co-pay generic mail order Preferred, non-preferred and specialty drugs subject to co-pays	10% after deductible	20% after deductible
Diabetic supplies	$20 co-pay	$20 co-pay	10% (no deductible)	20% (no deductible)
Participating insulin[10]	$75 co-pay	$75 co-pay	$75 co-pay (no deductible)	$75 co-pay (no deductible)

[1]This plan does not constitute "creditable coverage" for Massachusetts residents.
[2]Plan deductible must be met before co-insurance applies. The maximum out-of-pocket limit includes the deductible and co-insurance for eligible, in-network services
[3]Members are required to pay the full consultation fee until they have met their deductible/co-insurance requirements
[4]If the cost of the prescription is less than the co-pay, the member pays the full cost of the prescription.
[5]Retail available as 30-day supply, mail order/preferred retail pharmacy (Walgreens® or CVS) as 90-day supply and specialty as 30-day supply through mail order.
[6]Thirty-day supply of maintenance medications filled at retail will incur a $10 penalty after the second retail fill. The $10 penalty does not accumulate toward the deductible or the maximum out-of-pocket limit. This penalty does not apply to Affordable Care Act (ACA) preventive medications.
[7]If a non-generic drug is purchased when a generic is available, the member must pay a penalty of the difference in drug cost of the non-generic drug over its generic equivalent. This penalty does not accumulate toward the deductible or the maximum out-of-pocket limit.
[8]A 90-day supply of maintenance drugs can be filled either by preferred retail pharmacy (Walgreens or CVS) or by mail order.
[9]Co-pays for certain specialty medications will be set to the maximum available manufacturer co-pay assistance. These co-pays will be paid by the manufacturer after the participant applies for co-pay assistance and will not apply toward maximum out-of-pocket (MOOP). Choosing not to enroll in co-pay assistance will result in a 30% co-insurance on applicable specialty medications.
[10]Select products used to treat diabetes, including participating insulin, may be available for a $75 co-pay for a 90-day supply.

Plan	Coverage Tier	Church	Pastor
Health Choice 1000	Employee	$875	$123.77
Health Choice 1000	Employee + Spouse or Employee + Child(ren)	$1,650	$247.66
Health Choice 1000	Employee + Family	$2,250	$346.80
Health Choice 5000	Employee	$875	$10.51
Health Choice 5000	Employee + Spouse or Employee + Child(ren)	$1,650	$32.47
Health Choice 5000	Employee + Family	$2,250	$52.33
Health Saver 2000	Employee	$875	$107.23
Health Saver 2000	Employee + Spouse or Employee + Child(ren)	$1,650	$224.58
Health Saver 2000	Employee + Family	$2,250	$253.81
Health Saver 4000	Employee	$875	-$16.33
Health Saver 4000	Employee + Spouse or Employee + Child(ren)	$1,650	-$10.18
Health Saver 4000	Employee + Family	$2,250	-$67.45

For negative amounts, the pastor's share is zero and the amount listed is first credited towards any dental or vision premiums if the pastor elects these. Any remaining amounts will otherwise be deposited into the pastor's HSA.

GuideStone's Health Saver plans are HSA-qualified High Deductible Health Plans (HDHPs). Global Methodist Local Church will contribute $1,000 for employee or $2,000 for employee plus spouse, employee plus child(ren) or family coverage to an HSA on an annual basis.

The rates set forth above have been determined by Global Methodist Church. They have not been determined nor reviewed by GuideStone and are being provided solely at the request of Global Methodist Church for ease of reference. If any conflicts should occur between the information in this rate chart and the actual rate deducted, or should you have any questions or concerns about the rates provided, please contact Global Methodist Church.

Wellness Tools and Programs

Staying healthy is easier than ever — you just need the right tools! Learn what's available in your GuideStone health plan.

- Teladoc (telemedicine provider) means that you have access to U.S. board-certified doctors all day, every day — even on holidays. Your Teladoc services include General Medical, Dermatology and Mental Health.
- SmartShopper® allows you to earn cash rewards of up to $1,000 and reduce your out-of-pocket health care costs by shopping for health care procedures with SmartShopper.
- And much more!
- Visit *GuideStone.org/WellnessTools* to learn more.

Additional Benefits

Your GuideStone health plan protects more than your health. It also provides for your entire well-being with these additional benefits.

- BCBS Global® Core — Members traveling outside the United States have access to doctors and hospitals in more than 200 countries and territories around the world.
- Blue365® — This member discount program can help you save on products and services that are not part of your health coverage.
- Experian IdentityWorks℠ — Highmark® BCBS® provides Experian IdentityWorks to help members who are victims of identity theft.

Visit *GuideStone.org/AdditionalBenefits* to learn more.

Review the *Summary of Benefits and Coverages* or the *Benefit Overviews* for additional information.

This guide provides an overview of the Global Methodist Church Benefits Program and should not be considered complete. If any conflicts exist between the information in this guide and the actual contracts for benefits or benefit programs/policies, the benefit contract/policies will rule. Please note that Global Methodist Church reserves the right to change or terminate any benefits at any time with or without notice.

GuideStone®

MEDICAL PLAN BENEFIT OVERVIEWS

Health Choice 1000

Effective 01/01/2024

IN-NETWORK	Deductible for individual coverage	$1,000
	Deductible for family coverage (Embedded deductible)	$2,000
	Plan pays/individual pays (co-insurance) after deductible	80%/20%
	Maximum out-of-pocket (medical and prescription)	$5,000 individual /$8,250 family
	Primary care or retail clinic visit	$25
	Specialist office visit (includes virtual visits)	$45
	Teladoc®	$0
	Wellness and preventative care (primary care/ specialist)	0% no deductible
	Hospital inpatient (including maternity)	20% after deductible
	Outpatient surgery	20% after deductible
	Emergency room services	$250 copay, then 20%
	Urgent care	$50
	Outpatient services (CT scans, MRI, diagnostic)	20% after deductible
	Chiropractic services (12 visits anually)	$45
	Mental health/substance abuse: inpatient services	20% after deductible
	Mental health/substance abuse: office visit	$25
	Vision exam (one exam every 12 months)	$25
OUT-OF-NETWORK	Deductible for an individual	$2,000
	Deductible for a family	$4,000
	Plan pays/individual pays (co-insurance) after deductible	50%/50%
	Co-insurance and deductible out of pocket limit for an individual	$22,000
	Co-insurance and deductible out of pocket limit for a family	$24,000
	Wellness and preventive care	Not Covered
	Hospital inpatient (including maternity)	$500 copay, then 50% after deductible
	Outpatient surgery	50% after deductible
	Emergency Room Services	$250 copay, then 20%
	Mental health/substance abuse: inpatient services	$500 copay, then 50% after deductible
	Mental health/substance abuse: office visit	50% after deductible

PRESCRIPTION DRUG PROGRAM[1]

RETAIL	30-Day Supply	Generic	$15
		Preferred	$50
		Non-Preferred	$75
MAIL ORDER/ WALGREENS	90-Day Supply	Generic	$30
		Preferred	$100
		Non-Preferred	$150
		Diabetic Supplies	$20
		Participating Insulin	$75
SPECIALTY	30-Day Supply	Generic	$50
		Preferred	$75
		Non-Preferred	$100

Additional Plan Information

The participant pays the Co-payment or drug cost, whichever is less.
Maintenance drugs filled at retail, other than the member selected retail pharmacy(CVS or Walgreens), will incur a $10 penalty after the second retail fill. The $10 penalty does not accumulate toward the deductible or the maximum out-of-pocket limit. This penalty does not apply to ACA preventive medications.
If a non-generic drug is purchased when a generic drug is available, the participant must pay a penalty of the difference in drug cost of the non-generic drug over its generic equivalent. This penalty does not accumulate toward the deductible or the maximum out-of-pocket limit.
A 90-day supply of maintenance drugs can be filled either by member selected retail pharmacy (Walgreens or CVS) or by mail order. Prices may vary.
Medical claims incurred outside the United States where no network exists will be considered In-Network.
The deductible is met by both medical and prescription expenses.
Copays for certain specialty medications will be set to the maximum available manufacturer Copay assistance. This copay adjustment will only apply after deductible satisfaction if this is a qualified high deductible plan. These Co-pays will be paid by the manufacturer after the participant applies for Co-pay assistance and will not apply toward MOOP.
Insulin copay applies to select insulin products whose manufacturers have chosen to participate in the Patient Assurance Program.

Glossary of Terms

Co-insurance — The percentage of eligible claims you pay after you meet your deductible.

Co-insurance and deductible out of pocket limit (out-of-network) — The most you will have to pay in a year in out-of-network deductibles and co-insurance for covered benefits.

Co-pay — The fixed, up-front dollar amount you pay for certain covered expenses. Co-pay amounts apply after your in-network or out-of-network deductible and do not apply to your out-of-network coinsurance maximum.

Deductible (family) — This is the amount a family is required to pay before benefits begin for services not covered by co-pays. Once this amount is met, the plan will consider all family members to have met their deductibles. One individual cannot contribute more than the individual deductible amount. This is an embedded deductible.

Deductible (individual) — This is the amount an individual is required to pay before benefits begin for services not covered by co-pays. Once this amount is met, the plan will begin paying claims for that individual at the co-insurance level.

Emergency care — Medical services from the Emergency department of a hospital to evaluate a medical condition that, in the absence of immediate medical attention, would place the health of the individual in serious jeopardy, cause serious impairment to bodily functions or cause serious and permanent dysfunction to any bodily organ or part.

Generic — A bioequivalent to the brand-name drug made available to the public after the patent has expired on the brand-name drug. The generic version usually results in a less expensive drug. In-network — Health care services received from a provider in a network.

Mail order — Mail order is a service that allows you to refill recurring prescriptions (90-day supply) through an online pharmacy. You receive your prescriptions by mail.

Maximum out-of-pocket (medical and prescription) — The maximum out-of-pocket limit includes the deductible and co-insurance for eligible, in-network services. After the individual or family amount has been satisfied, the health plan covers all eligible, in-network health care expenses for the rest of the plan year. For family coverage, one individual cannot be responsible for more than the current IRS limit.

Network provider — A doctor, hospital or other health care facility that has entered into a contract to provide medical services or supplies at agreed-upon rates to you or your covered dependents under the plan.

Non-preferred drugs — A list of prescribed medications that are not on the plan's formulary.

Preferred drugs — Also known as formulary drugs, this is a list of commonly prescribed, brand-name medications that are selected based on their clinical effectiveness and opportunities to help control plan costs.

Retail pharmacy benefits — This refers to filling your prescriptions at a participating network pharmacy. This approach is best for short-term prescriptions (up to 30-day). You could save money by filling recurring prescriptions via mail order (see above).

Specialist — Any physician not considered a primary care physician.

Specialty drug — Specific prescriptions used to treat complex, chronic or special health conditions.

Telemedicine — The use of telephone and/or live video technology in order to provide medical care.

Urgent care — Treatment at an urgent care facility for the onset of symptoms that require prompt medical attention.

Vision exam — Covers one annual eye exam per covered family member, which may include an eye health examination, dilation and/or refraction. Coverage does not include glasses or contact lenses (unless there has been a cataract extraction), eye surgery or retinal telescreening. See the Preventive Care Schedule for additional vision screening coverage for children when performed by a pediatrician or primary care physician as part of an annual well-child visit.

Wellness and preventive care — Refers to the services listed on the Preventive Care Schedule, which are covered at 100%, not subject to the deductible. The Preventive Care Schedule is based on services required under the Affordable Care Act of 2010 (ACA), as amended.

This information only highlights the depth of coverage and benefits you can receive when you protect yourself with GuideStone. There are limitations and exclusions that apply. This is a general overview of plans that are offered. The official plan documents and insurance contracts set forth the eligibility rules, limitations, exclusions and benefits. These alone govern and control the actual operation of the plan.

Note: A corresponding Summary of Benefits and Coverage was created to help consumers more easily understand their insurance benefits and compare plans. To view and download the Summary of Benefits and Coverage documents for all GuideStone medical plans available to you, visit ***GuideStone.org/Summaries***.

You may also request printed copies by calling **1-844-INS-GUIDE (1-844-467-4843)** Monday through Friday, between 7 a.m. and 6 p.m. CST.

Health Choice 5000

Effective 01/01/2024

IN-NETWORK	Deductible for individual coverage	$5,000
	Deductible for family coverage (Embedded deductible)	$10,000
	Plan pays/individual pays (co-insurance) after deductible	70%/30%
	Maximum out-of-pocket (medical and prescription)	$6,500 individual /$12,700 family
	Primary care or retail clinic visit	$25
	Specialist office visit (includes virtual visits)	$45
	Teladoc®	$0
	Wellness and preventative care (primary care/ specialist)	0% no deductible
	Hospital inpatient (including maternity)	30% after deductible
	Outpatient surgery	30% after deductible
	Emergency room services	$250 copay, then 30%
	Urgent care	$50
	Outpatient services (CT scans, MRI, diagnostic)	30% after deductible
	Chiropractic services (12 visits anually)	$45
	Mental health/substance abuse: inpatient services	30% after deductible
	Mental health/substance abuse: office visit	$25
	Vision exam (one exam every 12 months)	$25
OUT-OF-NETWORK	Deductible for an individual	$10,000
	Deductible for a family	$20,000
	Plan pays/individual pays (co-insurance) after deductible	50%/50%
	Co-insurance and deductible out of pocket limit for an individual	$40,000
	Co-insurance and deductible out of pocket limit for a family	$50,000
	Wellness and preventive care	Not Covered
	Hospital inpatient (including maternity)	$500 copay, then 50% after deductible
	Outpatient surgery	50% after deductible
	Emergency Room Services	$250 copay, then 30%
	Mental health/substance abuse: inpatient services	$500 copay, then 50% after deductible
	Mental health/substance abuse: office visit	50% after deductible

PRESCRIPTION DRUG PROGRAM[1]

RETAIL	30-Day Supply	Generic	$15
		Preferred	$50
		Non-Preferred	$75
MAIL ORDER/ WALGREENS	90-Day Supply	Generic	$30
		Preferred	$100
		Non-Preferred	$150
		Diabetic Supplies	$20
		Participating Insulin	$75
SPECIALTY	30-Day Supply	Generic	$50
		Preferred	$75
		Non-Preferred	$100

Additional Plan Information

This plan does not constitute “creditable coverage” for Massachusetts residents.
The participant pays the Co-payment or drug cost, whichever is less.
Maintenance drugs filled at retail, other than the member selected retail pharmacy(CVS or Walgreens), will incur a $10 penalty after the second retail fill. The $10 penalty does not accumulate toward the deductible or the maximum out-of-pocket limit. This penalty does not apply to ACA preventive medications.
If a non-generic drug is purchased when a generic drug is available, the participant must pay a penalty of the difference in drug cost of the non-generic drug over its generic equivalent. This penalty does not accumulate toward the deductible or the maximum out-of-pocket limit.
A 90-day supply of maintenance drugs can be filled either by member selected retail pharmacy (Walgreens or CVS) or by mail order. Prices may vary.
Medical claims incurred outside the United States where no network exists will be considered In-Network.
The deductible is met by both medical and prescription expenses.
Copays for certain specialty medications will be set to the maximum available manufacturer Copay assistance. This copay adjustment will only apply after deductible satisfaction if this is a qualified high deductible plan. These Co-pays will be paid by the manufacturer after the participant applies for Co-pay assistance and will not apply toward MOOP.
Insulin copay applies to select insulin products whose manufacturers have chosen to participate in the Patient Assurance Program.

Glossary of Terms

Co-insurance — The percentage of eligible claims you pay after you meet your deductible.

Co-insurance and deductible out of pocket limit (out-of-network) — The most you will have to pay in a year in out-of-network deductibles and co-insurance for covered benefits.

Co-pay — The fixed, up-front dollar amount you pay for certain covered expenses. Co-pay amounts apply after your in-network or out-of-network deductible and do not apply to your out-of-network coinsurance maximum.

Deductible (family) — This is the amount a family is required to pay before benefits begin for services not covered by co-pays. Once this amount is met, the plan will consider all family members to have met their deductibles. One individual cannot contribute more than the individual deductible amount. This is an embedded deductible.

Deductible (individual) — This is the amount an individual is required to pay before benefits begin for services not covered by co-pays. Once this amount is met, the plan will begin paying claims for that individual at the co-insurance level.

Emergency care — Medical services from the Emergency department of a hospital to evaluate a medical condition that, in the absence of immediate medical attention, would place the health of the individual in serious jeopardy, cause serious impairment to bodily functions or cause serious and permanent dysfunction to any bodily organ or part.

Generic — A bioequivalent to the brand-name drug made available to the public after the patent has expired on the brand-name drug. The generic version usually results in a less expensive drug. In-network — Health care services received from a provider in a network.

Mail order — Mail order is a service that allows you to refill recurring prescriptions (90-day supply) through an online pharmacy. You receive your prescriptions by mail.

Maximum out-of-pocket (medical and prescription) — The maximum out-of-pocket limit includes the deductible and co-insurance for eligible, in-network services. After the individual or family amount has been satisfied, the health plan covers all eligible, in-network health care expenses for the rest of the plan year. For family coverage, one individual cannot be responsible for more than the current IRS limit.

Network provider — A doctor, hospital or other health care facility that has entered into a contract to provide medical services or supplies at agreed-upon rates to you or your covered dependents under the plan.

Non-preferred drugs — A list of prescribed medications that are not on the plan's formulary.

Preferred drugs — Also known as formulary drugs, this is a list of commonly prescribed, brand-name medications that are selected based on their clinical effectiveness and opportunities to help control plan costs.

Retail pharmacy benefits — This refers to filling your prescriptions at a participating network pharmacy. This approach is best for short-term prescriptions (up to 30-day). You could save money by filling recurring prescriptions via mail order (see above).

Specialist — Any physician not considered a primary care physician.

Specialty drug — Specific prescriptions used to treat complex, chronic or special health conditions.

Telemedicine — The use of telephone and/or live video technology in order to provide medical care.

Urgent care — Treatment at an urgent care facility for the onset of symptoms that require prompt medical attention.

Vision exam — Covers one annual eye exam per covered family member, which may include an eye health examination, dilation and/or refraction. Coverage does not include glasses or contact lenses (unless there has been a cataract extraction), eye surgery or retinal telescreening. See the Preventive Care Schedule for additional vision screening coverage for children when performed by a pediatrician or primary care physician as part of an annual well-child visit.

Wellness and preventive care — Refers to the services listed on the Preventive Care Schedule, which are covered at 100%, not subject to the deductible. The Preventive Care Schedule is based on services required under the Affordable Care Act of 2010 (ACA), as amended.

This information only highlights the depth of coverage and benefits you can receive when you protect yourself with GuideStone. There are limitations and exclusions that apply. This is a general overview of plans that are offered. The official plan documents and insurance contracts set forth the eligibility rules, limitations, exclusions and benefits. These alone govern and control the actual operation of the plan.

Note: A corresponding Summary of Benefits and Coverage was created to help consumers more easily understand their insurance benefits and compare plans. To view and download the Summary of Benefits and Coverage documents for all GuideStone medical plans available to you, visit ***GuideStone.org/Summaries***.

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Health Saver 2000

This is an HSA-qualified High Deductible Helath Plan, eligible for use with a Health Savings Account(HSA).

Effective 01/01/2024

IN-NETWORK	Deductible for individual coverage	$2,000
	Deductible for family coverage (Non-Embedded deductible)	$4,000
	Plan pays/individual pays (co-insurance) after deductible	90%/10%
	Maximum out-of-pocket (medical and prescription)	$4,000 individual /$7,500 family
	Primary care or retail clinic visit	10%after deductible
	Specialist office visit (includes virtual visits)	10% after deductible
	Teladoc®	0% after deductible
	Wellness and preventative care (primary care/ specialist)	0% no deductible
	Hospital inpatient (including maternity)	10% after deductible
	Outpatient surgery	10% after deductible
	Emergency room services	$250 copay, then 10% after deductible
	Urgent care	10% after deductible
	Outpatient services (CT scans, MRI, diagnostic)	10% after deductible
	Chiropractic services (12 visits anually)	10% after deductible
	Mental health/substance abuse: inpatient services	10% after deductible
	Mental health/substance abuse: office visit	10% after deductible
	Vision exam (one exam every 12 months)	10% after deductible
OUT-OF-NETWORK	Deductible for an individual	$8,000
	Deductible for a family	$16,000
	Plan pays/individual pays (co-insurance) after deductible	50%/50%
	Co-insurance and deductible out of pocket limit for an individual	$28,000
	Co-insurance and deductible out of pocket limit for a family	$46,000
	Wellness and preventive care	Not Covered
	Hospital inpatient (including maternity)	$500 copay, then 50% after deductible
	Outpatient surgery	50% after deductible
	Emergency Room Services	$250 copay, then 10% after deductible
	Mental health/substance abuse: inpatient services	$500 copay, then 50% after deductible
	Mental health/substance abuse: office visit	50% after deductible

PRESCRIPTION DRUG PROGRAM[1]

RETAIL	30-Day Supply	Generic	10% after deductible
		Preferred	10% after deductible
		Non-Preferred	10% after deductible
MAIL ORDER/ WALGREENS	90-Day Supply	Generic	10% after deductible
		Preferred	10% after deductible
		Non-Preferred	10% after deductible
		Diabetic Supplies	10%
		Participating Insulin	$75
SPECIALTY	30-Day Supply	Generic	10% after deductible
		Preferred	10% after deductible
		Non-Preferred	10% after deductible

Additional Plan Information

If a non-generic drug is purchased when a generic drug is available, the participant must pay a penalty of the difference in drug cost of the non-generic drug over its generic equivalent. This penalty does not accumulate toward the deductible or the maximum out-of-pocket limit.

A 90-day supply of maintenance drugs can be filled either by member selected retail pharmacy (Walgreens or CVS) or by mail order. Prices may vary.

Medical claims incurred outside the United States where no network exists will be considered In-Network.

The deductible is met by both medical and prescription expenses.

Copays for certain specialty medications will be set to the maximum available manufacturer Copay assistance. This copay adjustment will only apply after deductible satisfaction if this is a qualified high deductible plan. These Co-pays will be paid by the manufacturer after the participant applies for Co-pay assistance and will not apply toward MOOP.

Insulin copay applies to select insulin products whose manufacturers have chosen to participate in the Patient Assurance Program.

Glossary of Terms

Co-insurance — The percentage of eligible claims you pay after you meet your deductible.

Co-insurance and deductible out of pocket limit (out-of-network) — The most you will have to pay in a year in out-of-network deductibles and co-insurance for covered benefits.

Co-pay — The fixed, up-front dollar amount you pay for certain covered expenses. Co-pay amounts apply after your in-network or out-of-network deductible and do not apply to your out-of-network coinsurance maximum.

Deductible for individual coverage — This applies only to an employee who has no dependents included on their coverage. The individual is responsible for paying for medical and prescription drug claim costs up to the plan's individual deductible amount before GuideStone® begins paying claims.

Deductible for family coverage — This applies to an employee who has dependents included on their coverage. The employee and dependents are responsible for paying for medical and prescription drug claim costs up to the plan's family deductible amount before GuideStone begins paying claims for anyone in the family. The family deductible may be met by one individual or by multiple family members' combined claims. This is known as an non-embedded deductible.

Emergency care — Medical services from the Emergency department of a hospital to evaluate a medical condition that, in the absence of immediate medical attention, would place the health of the individual in serious jeopardy, cause serious impairment to bodily functions or cause serious and permanent dysfunction to any bodily organ or part.

Generic — A bioequivalent to the brand-name drug made available to the public after the patent has expired on the brand-name drug. The generic version usually results in a less expensive drug. In-network — Health care services received from a provider in a network.

Mail order — Mail order is a service that allows you to refill recurring prescriptions (90-day supply) through an online pharmacy. You receive your prescriptions by mail.

Maximum out-of-pocket (medical and prescription) — The maximum out-of-pocket limit includes the deductible and co-insurance for eligible, in-network services. After the individual or family amount has been satisfied, the health plan covers all eligible, in-network health care expenses for the rest of the plan year. For family coverage, one individual cannot be responsible for more than the current IRS limit.

Network provider — A doctor, hospital or other health care facility that has entered into a contract to provide medical services or supplies at agreed-upon rates to you or your covered dependents under the plan.

Non-preferred drugs — A list of prescribed medications that are not on the plan's formulary.

Preferred drugs — Also known as formulary drugs, this is a list of commonly prescribed, brand-name medications that are selected based on their clinical effectiveness and opportunities to help control plan costs.
Embedded V. Aggregate Deductibles:

Retail pharmacy benefits — This refers to filling your prescriptions at a participating network pharmacy. This approach is best for short-term prescriptions (up to 30-day). You could save money by filling recurring prescriptions via mail order (see above).

Specialist — Any physician not considered a primary care physician.

Specialty drug — Specific prescriptions used to treat complex, chronic or special health conditions.

Telemedicine — The use of telephone and/or live video technology in order to provide medical care.

Urgent care — Treatment at an urgent care facility for the onset of symptoms that require prompt medical attention.

Vision exam — Covers one annual eye exam per covered family member, which may include an eye health examination, dilation and/or refraction. Coverage does not include glasses or contact lenses (unless there has been a cataract extraction), eye surgery or retinal telescreening. See the Preventive Care Schedule for additional vision screening coverage for children when performed by a pediatrician or primary care physician as part of an annual well-child visit.

Wellness and preventive care — Refers to the services listed on the Preventive Care Schedule, which are covered at 100%, not subject to the deductible. The Preventive Care Schedule is based on services required under the Affordable Care Act of 2010 (ACA), as amended.

This information only highlights the depth of coverage and benefits you can receive when you protect yourself with GuideStone. There are limitations and exclusions that apply. This is a general overview of plans that are offered. The official plan documents and insurance contracts set forth the eligibility rules, limitations, exclusions and benefits. These alone govern and control the actual operation of the plan.

Note: A corresponding Summary of Benefits and Coverage was created to help consumers more easily understand their insurance benefits and compare plans. To view and download the Summary of Benefits and Coverage documents for all GuideStone medical plans available to you, visit ***GuideStone.org/Summaries***.

You may also request printed copies by calling **1-844-INS-GUIDE (1-844-467-4843)** Monday through Friday, between 7 a.m. and 6 p.m. CST.

Health Saver 4000

This is an HSA-qualified High Deductible Helath Plan, eligible for use with a Health Savings Account(HSA).

Effective 01/01/2024

IN-NETWORK	Deductible for individual coverage	$4,000
	Deductible for family coverage (Embedded deductible)	$8,000
	Plan pays/individual pays (co-insurance) after deductible	80%/20%
	Maximum out-of-pocket (medical and prescription)	$6,000 individual /$12,000 family
	Primary care or retail clinic visit	20%after deductible
	Specialist office visit (includes virtual visits)	20% after deductible
	Teladoc®	0% after deductible
	Wellness and preventative care (primary care/ specialist)	0% no deductible
	Hospital inpatient (including maternity)	20% after deductible
	Outpatient surgery	20% after deductible
	Emergency room services	$250 copay, then 20% after deductible
	Urgent care	20% after deductible
	Outpatient services (CT scans, MRI, diagnostic)	20% after deductible
	Chiropractic services (12 visits anually)	20% after deductible
	Mental health/substance abuse: inpatient services	20% after deductible
	Mental health/substance abuse: office visit	20% after deductible
	Vision exam (one exam every 12 months)	20% after deductible
OUT-OF-NETWORK	Deductible for an individual	$8,000
	Deductible for a family	$16,000
	Plan pays/individual pays (co-insurance) after deductible	50%/50%
	Co-insurance and deductible out of pocket limit for an individual	$28,000
	Co-insurance and deductible out of pocket limit for a family	$46,000
	Wellness and preventive care	Not Covered
	Hospital inpatient (including maternity)	$500 copay, then 50% after deductible
	Outpatient surgery	50% after deductible
	Emergency Room Services	$250 copay, then 20% after deductible
	Mental health/substance abuse: inpatient services	$500 copay, then 50% after deductible
	Mental health/substance abuse: office visit	50% after deductible

PRESCRIPTION DRUG PROGRAM[1]

RETAIL	30-Day Supply	Generic	20% after deductible
		Preferred	20% after deductible
		Non-Preferred	20% after deductible
MAIL ORDER/ WALGREENS	90-Day Supply	Generic	20% after deductible
		Preferred	20% after deductible
		Non-Preferred	20% after deductible
		Diabetic Supplies	20%
		Participating Insulin	$75
SPECIALTY	30-Day Supply	Generic	20% after deductible
		Preferred	20% after deductible
		Non-Preferred	20% after deductible

Additional Plan Information

This plan does not constitute “creditable coverage” for Massachusetts residents.

If a non-generic drug is purchased when a generic drug is available, the participant must pay a penalty of the difference in drug cost of the non-generic drug over its generic equivalent. This penalty does not accumulate toward the deductible or the maximum out-of-pocket limit.

A 90-day supply of maintenance drugs can be filled either by member selected retail pharmacy (Walgreens or CVS) or by mail order. Prices may vary.

Medical claims incurred outside the United States where no network exists will be considered In-Network.

The deductible is met by both medical and prescription expenses.

Copays for certain specialty medications will be set to the maximum available manufacturer Copay assistance. This copay adjustment will only apply after deductible satisfaction if this is a qualified high deductible plan. These Co-pays will be paid by the manufacturer after the participant applies for Co-pay assistance and will not apply toward MOOP.

Insulin copay applies to select insulin products whose manufacturers have chosen to participate in the Patient Assurance Program.

Glossary of Terms

Co-insurance — The percentage of eligible claims you pay after you meet your deductible.

Co-insurance and deductible out of pocket limit (out-of-network) — The most you will have to pay in a year in out-of-network deductibles and co-insurance for covered benefits.

Co-pay — The fixed, up-front dollar amount you pay for certain covered expenses. Co-pay amounts apply after your in-network or out-of-network deductible and do not apply to your out-of-network coinsurance maximum.

Deductible (family) — This is the amount a family is required to pay before benefits begin for services not covered by co-pays. Once this amount is met, the plan will consider all family members to have met their deductibles. One individual cannot contribute more than the individual deductible amount. This is an embedded deductible.

Deductible (individual) — This is the amount an individual is required to pay before benefits begin for services not covered by co-pays. Once this amount is met, the plan will begin paying claims for that individual at the co-insurance level.

Emergency care — Medical services from the Emergency department of a hospital to evaluate a medical condition that, in the absence of immediate medical attention, would place the health of the individual in serious jeopardy, cause serious impairment to bodily functions or cause serious and permanent dysfunction to any bodily organ or part.

Generic — A bioequivalent to the brand-name drug made available to the public after the patent has expired on the brand-name drug. The generic version usually results in a less expensive drug. In-network — Health care services received from a provider in a network.

Mail order — Mail order is a service that allows you to refill recurring prescriptions (90-day supply) through an online pharmacy. You receive your prescriptions by mail.

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MEDICAL PLAN BENEFITS

LEARNING YOUR HEALTH PLAN'S VOCABULARY CAN SAVE YOU MONEY

Here are explanations (and proper spellings) for some of the most commonly misunderstood health coverage terms, where they fit into your overall coverage and how understanding them can enhance your experience with your plan.

These terms are commonly used when discussing health plan types:

Preferred Provider Organization (PPO) Plan

A type of health plan that contracts with medical providers — such as hospitals and doctors — to create a network of participating providers. You have less out-of-pocket costs if you use providers that belong to the plan's network; however, you can use doctors, hospitals, and providers outside of the network but higher out-of-network costs will be applicable.

Exclusive Provider Organization (EPO) Plan

A managed care plan where services are covered only if you go to doctors, specialists or hospitals in the plan's network (except in an emergency).

High Deductible Health Plan (HDHP)

A plan with a higher deductible than a traditional insurance plan because it is designed to be used with a health savings account (HSA) allowing you to pay for certain medical expenses with money free from federal taxes. While the monthly premium is usually lower for an HDHP, you will pay more health care costs yourself (your deductible) before the insurance company starts to pay its share. All of GuideStone's HDHPs are considered HSA-Qualified High Deductible Health Plans by the IRS and are designed to be combined with an HSA.

MEDICAL PLAN VOCABULARY

These are the terms you're most likely to see in relation to discussions about what is and isn't covered by your health plan.

- **BENEFIT:** This describes the portion of your claims costs that are covered by your health plan. Understanding your benefits can help you predict the portion of a claim your plan will pay.

- **CLAIMS:** These are your health care expenses that are filed with your insurer to request payment. In most cases, the claims are filed by your medical provider. Create an account on your health provider's website to monitor your claims as they move through the payment process and review the Explanation of Benefits (EOBs) provided by your plan.

- **CO-INSURANCE:** This term refers to the percentage of costs of a covered health care service for which you are responsible. For example, if your co-insurance is 20% and your providers submit a claim for $10,000, your portion will be $2,000 and your health plan will pay $8,000. Co-insurance, deductibles and co-pays make up the total costs you pay toward a claim.

- **CO-PAY:** This fixed, out-of-pocket payment is made by the plan participant at the time a medical service is rendered. For example, there will be a co-pay for a doctor's office visit or a prescription refill. Co-pays, deductibles and co-insurance make up the total costs you pay toward a claim.

- **DEDUCTIBLE:** Generally speaking, a deductible is the predetermined amount of money a participant pays on claims before the plan starts to pay. There are two general categories of deductibles:

  - **EMBEDDED DEDUCTIBLE:** Each individual on your health plan has his or her own deductible. These embedded (individual) deductibles also accumulate toward an aggregate (family) deductible. For example, if your plan provides coverage for two adults and two children with embedded deductibles of $2,000, each person will have his or her own individual $2,000 deductible or reach the aggregate (family) deductible before benefits are paid at the co-insurance level.

  - **AGGREGATE DEDUCTIBLE:** An aggregate deductible is a set amount that either one individual or all family members can contribute toward. For example, if the aggregate deductible is $2,000 per individual or $6,000 per family, you will have to meet the $2,000 deductible for individual-only coverage (no dependents on the plan). If you have dependents on the plan, the individual deductible goes away completely and you are responsible for contributing toward a family deductible.

PRESCRIPTION PLAN VOCABULARY

These terms help describe the prescription benefits included in your medical plan.

- **FORMULARY:** Also known as a preferred formulary, this is a list of prescription drugs covered by your health plan. Most formularies include generic prescription and brand-name drugs. Physicians use the formulary to determine which drugs are most effective at the best possible price. The formulary is a living document and will change as new drugs enter the market. You can find the formulary on your prescription provider's website. Working with your physician to choose prescriptions that are part of the formulary will lower your out-of-pocket costs.

- **TIERED PRICING:** Co-pays for prescription drug prices are differentiated by the levels, or tiers. Tier 1 is generally the lowest co-pay and is for generic drugs. Tier 2 is generally reserved for preferred brand-name drugs. Tier 3 is usually non-preferred or specialty drugs for which members will pay the largest co-pay. Request Tier 1 drugs from your physician to keep your costs low through the payment process.

PROVIDER VOCABULARY

There are a variety of medical providers from which you can receive care.

- **NETWORK:** Health care providers who agree to work with a health plan to provide services to those in the plan at discounted rates are considered to be a part of a network. Keep your costs low by choosing a provider within your health plan's network where you will receive the deepest discounts.

- **PRIMARY CARE PROVIDERS:** This type of doctor or medical practitioner provides preventive and routine care. These can be pediatricians, family practice physicians, obstetricians/gynecologists and internal medicine doctors. Developing a relationship with a primary care provider can help you stay healthy.

- **SPECIALIST:** A doctor or medical practitioner with advanced training in a specific subset of care is considered to be a specialist. You will usually see these physicians only for a short term. Work with your primary care provider to find a specialist who understands your condition and is in your health plan.

Learning your health plan's vocabulary can help you navigate your benefits and find the lowest-cost, best-quality care.

www.GuideStone.org

GuideStone®

A ROAD MAP TO YOUR GUIDESTONE MEDICAL COVERAGE

Your GuideStone medical plan is more robust and better than ever. Here's a road map to guide you in maximizing your benefits journey.

STOP 1: QUANTUM HEALTH

Think of Quantum Health as your personal team of nurses, benefit experts and claims specialist who will do whatever it takes to support your unique health care needs. Quantum Health is your one resource to contact whenever you need help with your medical, wellness or pharmacy benefits.

You have one mobile app, one website and one phone number.

Get to know *Quantum Health*.

- **Download the Quantum Health app**
- **Visit *GuideStoneHealth.org***
- **Call 1-855-497-1230**

STOP 2: HELP CENTER

Have a question?

Visit *Help.GuideStone.org* to find answers regarding:

- **Prescriptions**
- **Benefits**
- **Claims**

STOP 3: PREVENTIVE CARE

An ounce of prevention saves you cash and keeps you healthy.

Visit *GuideStone.org/PreventiveCare* to download preventive care information and download your Preventive Schedule at *GuideStone.org/PreventiveSchedule*. Here are some of your covered benefits:

- **Your annual checkup**
- **Preventive mammograms and well-woman screenings**
- **Some cancer, diabetes and blood pressure screenings**

STOP 4: WELLNESS TOOLS AND PROGRAMS

GuideStone's Wellness Tools and Programs page is the place to learn more about your benefits.

Visit *GuideStone.org/WellnessTools* to:

- **Access Teladoc® (telemedicine provider)**
- **Earn cash with SmartShopper®**
- **Take Advantage of Health Coaching**

STOP 5: ADDITIONAL BENEFITS

Your GuideStone medical plan is rich with extras you don't want to miss.

Visit *GuideStone.org/AdditionalBenefits* to discover how to:

- **Access overseas coverage using BCBS Global® Core**
- **Get discounts for products and services using Blue365®**
- **Minimize damage from identity theft with Experian IdentityWorks℠**

GuideStone®

WHERE TO GO FOR CARE

HOW TO MAKE THE SMART CHOICE WHEN CHOOSING MEDICAL CARE

You need medical care, but where should you go? Your GuideStone® medical coverage provides five basic options. See which one is right for you.

	Telemedicine (Teladoc®)	Primary Care Physician	Urgent Care	Hospital-based ER	Freestanding ER*
Some Common Conditions	Cold and flu	Regular health screenings	Sprains and strains	Persistent chest pain	Sudden, severe headache
	Bronchitis	Regular health checkups	Sports injuries	Difficulty speaking, altered mental status	Fever in a newborn baby
	Allergies	Fever without a rash	Cuts that require stitches	Sudden or unexplained loss of consciousness	Severe pain
Why Visit	The convenient choice	The in-office choice	The urgent and after-hours choice	The emergency choice	The emergency choice
Cost	$	$$	$$$	$$$$$	$$$$$
Hours	24/7/365	Weekdays only (typically)	8 a.m.– 9 p.m. every day (typically)	24/7/365	24/7/365
Wait Time	15-minute call-back time	By appointment only	Varies depending on demand. Online check-in may be an option.	Could wait hours before seeing a doctor	Generally shorter wait times than a hospital-based emergency room

*Freestanding emergency rooms generally do not accept patients delivered via ambulance. Remember, if you are facing a life-threatening situation, always go to the hospital-based emergency room first. Freestanding emergency room treatment can cost thousands more than the same treatment at an urgent care clinic.

URGENT CARE OR FREESTANDING EMERGENCY ROOM? HOW TO KNOW THE DIFFERENCE

Distinguishing between an urgent care facility and a freestanding emergency room can be tricky. It's important to know where you are being treated, because freestanding emergency room treatment can cost thousands more than the same treatment at an urgent care clinic.

Look for the following clues to distinguish the difference. Freestanding emergency rooms:

- **Include the word "emergency" in the facility name**
- **Are never attached to a hospital**
- **Are usually located in more affluent neighborhoods**
- **Offer more complex treatment options than urgent care**
- **Do not accept Medicare and Medicaid patients**
- **Charge much higher prices than urgent care facilities**

BE PREPARED TO ACCESS THE RIGHT CARE

While we all hope never to need emergency, urgent or after-hours care, it is wise to be prepared by:

Registering with *Teladoc.com/GuideStone* now so you can easily access care when you are ill. Our Teladoc services include General Medical, Dermatology and Mental Health.

Familiarizing yourself with the location of your nearest urgent care clinics.

Learning which hospital emergency rooms are part of your network by visiting *GuideStoneHealth.org*, using Quantum Health app or calling **1-855-497-1230**.

It is also important to be familiar with your insurance provider's options for treatment. GuideStone members can review the options for seeking treatment and benefit levels in your plan booklet available at *My.GuideStone.org*.

GuideStone®

WELLNESS TOOLS AND ADDITIONAL BENEFITS

Available in Your GuideStone® Medical Plan

GuideStone's health plans include a rich array of tools to help members maximize your coverage dollars and additional benefits designed to enrich your life.

WELLNESS TOOLS AND PROGRAMS

Staying healthy is easier than ever — **you just need the right tools!** Learn what's available in your GuideStone medical plan.

Visit *GuideStone.org/WellnessTools*.

Quantum Health

Think of Quantum Health as your personal team of nurses, benefit experts and claims specialists who will do whatever it takes to support your unique health care needs. Quantum Health is your one resource to contact whenever you need help with your medical, wellness or pharmacy benefits.

Quantum Health is just a tap, click or call away. You have one mobile app, one website and one phone number.

Quantum Health app | *GuideStoneHealth.org* | **1-855-497-1230**

Get to know Quantum Health

See what they are saying about Quantum Health:

"My care coordinator was amazing!! She made me feel heard and took the situation out of my hands and handled it! I don't owe my doctors anymore!"

"Carolyn did such an excellent job. I felt like she listened to me, she heard my concerns, she was solutions-oriented, she researched everything thoroughly, and most of all, she connected with me as an individual. It was an excellent experience, which does which doesn't happen often, and I got off the call feeling so happy with my experience! She made me feel seen and heard, and I cannot tell you how much that meant to me and made my day!"

Save on Health Care

- SmartShopper® allows you to earn cash rewards of up to $1,000 and reduce your out-of-pocket health care costs by shopping for health care procedures with SmartShopper. Access SmartShopper by simply calling **1-866-285-7475** to speak to a personal assistant.
- Teladoc® (telemedicine provider) means that you have access to U.S. board-certified doctors, including pediatricians, all day, every day — even holidays for general medical care. Register today at *Teladoc.com/GuideStone*. Your Teladoc services include *General Medical*, *Dermatology* and *Mental Health*.

Take Charge of Your Health

- **Quantum Health** gives you a comprehensive set of tools, resources, care management, wellness and member solutions to lead your healthiest possible life. Take advantage of programs like health coaching and the Early Steps Maternity program.
- **Blue Distinction Centers** are high-quality hospitals that can lower your chance for complications and shorten your stay. Blue Distinction is a designation awarded by the Blue Cross Blue Shield Association to hospitals proven to deliver superior results for complicated, costly procedures.
- **Sword Virtual Physical Care Program** pairs you virtually with a sword-licensed physical therapist, who assesses your pain and tailors a program to your unique needs. Sword offers a digital solution for those experiencing pain in the back, neck, shoulder, elbow, wrist, hip, knee, or ankle. Utilizing wearable FDA-listed motion sensors and the sword tablet to guide movement, the physical therapists evaluate real time biofeedback as you go through the exercise sessions. The physical therapist provides ongoing virtual support and guidance throughout the program and is available for questions along your journey. You have access to this benefit at no cost and with no visit limitations. Please review the Sword Virtual Physical Care Tutorial and Frequently Asked Questions for additional information. Book your free consultation today at *Join.SwordHealth.com/BCBS.*
- **Twin Health** delivers individualized guidance to help members with Type 2 diabetes. It is a dynamic, digital representation of a person's unique metabolism, built from thousands of data points gathered daily from non-invasive wearable sensors and self-reported preferences. For additional information, please view the Twin Health – Just for You video and review the Frequently Asked Questions. Start reversing your Type 2 diabetes by signing up for Twin Health at *Partner.TwinHealth.com/GuideStone*.

  Watch the video at *GuideStone.org/TwinHealth* to see how Twin Health has helped GuideStone members reverse Type 2 diabetes.

ADDITIONAL BENEFITS

Your GuideStone medical plan protects **more than your health.** It also provides for your entire well-being with these additional benefits.

Visit *GuideStone.org/AdditionalBenefits*.

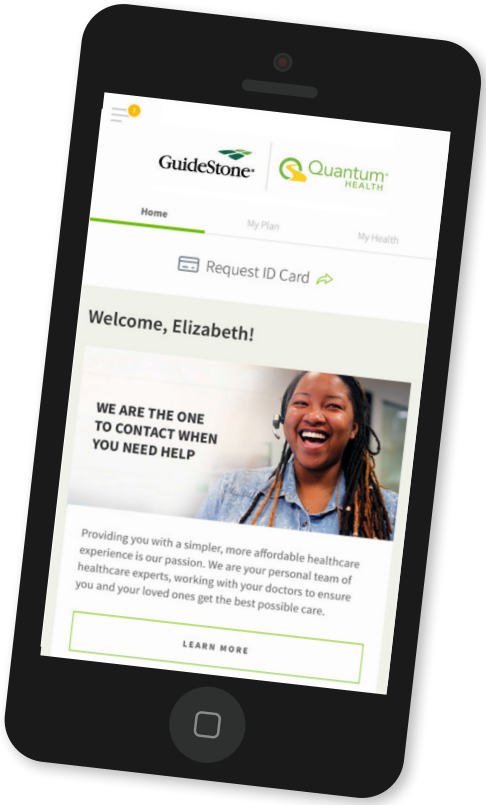
- **BCBS Global Core** — Members traveling outside the United States have access to doctors and hospitals in more than 200 countries and territories around the world. Download the BCBS Global Core app or go to *BCBSGlobalCore.com* to help you find doctors, translate medical terms and access emergency care information when you're outside the United States.
- **Blue365®** — This member discount program can help you save on products and services that are not part of your medical coverage. To browse all the deals, go to *Blue365Deals.com*.
- **Experian IdentityWorks℠** — Highmark BCBS provides Experian IdentityWorks to help members who are victims of identity theft. Enrollment is required at *ExperianIDWorks.com/Highmark*. Members must provide their personal information to enroll online or via phone. **Please note:** You will receive an email in December to confirm your coverage for the next year.
- **Vision Benefit** — For individuals in the majority of GuideStone's plans, your vision benefit covers one annual eye exam per covered family member. The coverage does not include the cost of glasses or contact lenses. You must use an in-network provider to receive this benefit. The vision benefit is not available in all plans. Please review your plan booklet for details.

GuideStone®

MEDICAL PLAN ADDITIONAL DETAILS

MEDICAL AND PRESCRIPTION COVERAGE

You have one card for both your medical and prescription benefits.



HIGHMARK

PLAN INFORMATION

GS Group Number for GuideStone National Network Health Plans* — **CQM363**
Member Number — Your Social Security Number
Benefit Questions — **1-855-497-1230**

EXPRESS SCRIPTS®

PLAN INFORMATION

GS Group Number for GuideStone National Network Health Plans**— **ABSBC01**
Benefit Questions — **1-855-497-1230**
RX Bin for GuideStone Health Plans (No PCN number required) — **610014**

WHAT IF I HAVEN'T RECEIVED MY ID CARD?

If you need to visit the doctor or pharmacy before receiving your ID card, reference the plan information below.

ORDERING A NEW ID CARD

Employees are encouraged to call Quantum Health directly at **1-855-497-1230** to request replacement ID cards. You can also print them online at *GuideStoneHealth.org* or access the virtual member ID card in the Quantum Health app.

If you have questions about accessing your benefits before you receive your card, contact our customer solutions specialists by email at *Insurance@GuideStone.org* or by phone at **1-844-INS-GUIDE** (1-844-467-4843) between 7 a.m. and 6 p.m. CT Monday through Friday.

GuideStone®

GET STARTED WITH QUANTUM HEALTH

HOW TO REGISTER

The Quantum Health app and website make managing your healthcare and benefits easier than ever.

1. **Download** the Quantum Health app or go to *GuideStoneHealth.org*.
   Note: If you have had Quantum Health with a previous health plan, you will need to re-register with your GuideStone® ID information
2. Click on **Register**.
3. **Provide the information** requested. Anything with an asterisk (*) is required. You'll need to provide your first and last name, date of birth and last four digits of the plan holder's Social Security number.
4. Click **Next**.
5. **Set up** two-factor authentication using your email or mobile phone number.
6. **Check** for a verification code that will be sent to your email or phone.
7. **Enter** the verification code to complete your registration.

Your Quantum Health Care Coordinators are here to help

If you can't find what you need or have any questions, contact us. We're just a tap, click or call away!

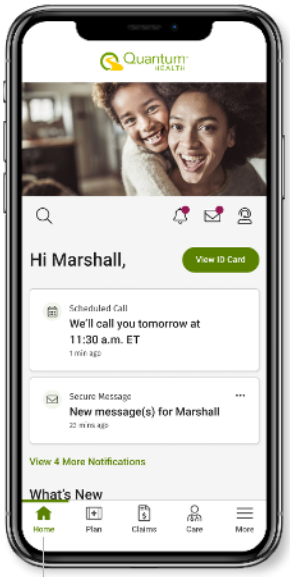
Download on the App Store
GET IT ON Google Play

GuideStoneHealth.org

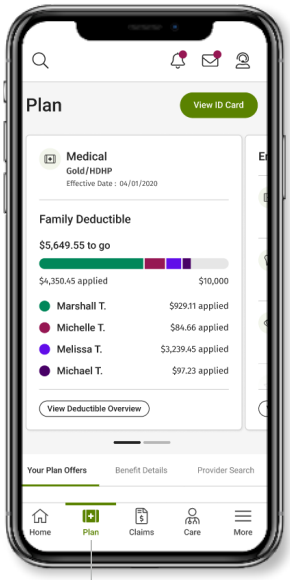
(855) 497-1230
(Monday-Friday, 8:30 a.m.-10 p.m. ET)

GuideStone® Quantum® HEALTH

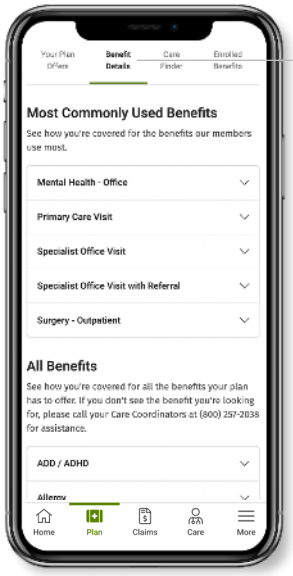
NAVIGATING THE QUANTUM HEALTH APP AND WEBSITE



1 Home page: See your new notifications, secure messages, upcoming appointments and download your ID card.

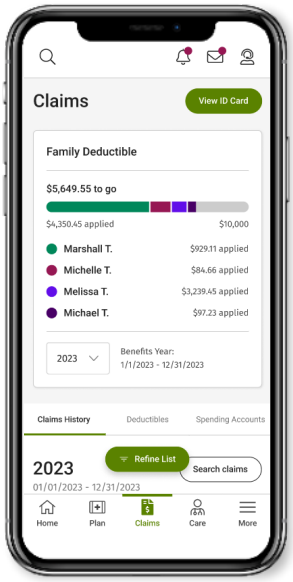


2 Plan tab: View your plan and benefits details.



3 See your medical benefits:

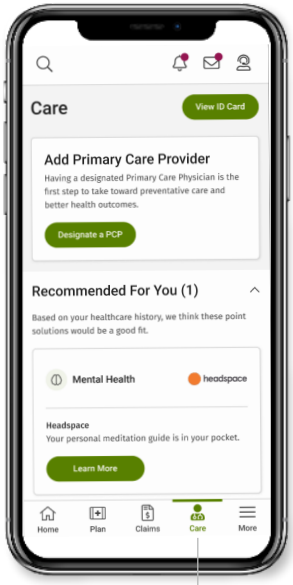
1. Go to **Plan** and click on **Benefit Details.**
2. Tap or click on the dropdown menu to see the benefit you want to learn more about.



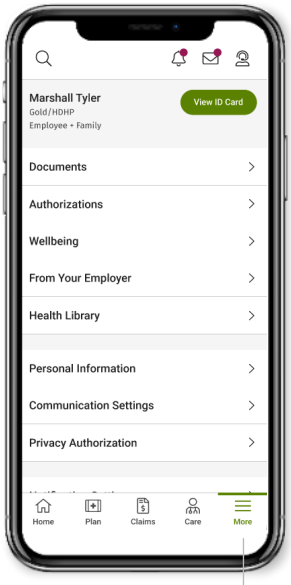
4 Claims tab: Manage your claims, review your deductibles and manage your accounts.

Go to **Claims** and click on **Claims History** to view all claims for you and your dependents.

NOTE: If your dependent is age 18 or over, they'll need to create their own account to give you access to their claims. In their Profile and Settings, under Privacy Authorization, your dependent will need to check the box for you to have access.



5 Care tab: Search for in-network providers, enter a primary care provider and review recommended care.



6 More menu: Update your profile, see plan documents and more.

Download on the App Store
GET IT ON Google Play

GuideStoneHealth.org

(855) 497-1230
(Monday-Friday, 8:30 a.m.-10 p.m. ET)

GuideStone® Quantum® HEALTH

8768 1288895 02/2024

Teladoc HEALTH | GuideStone®

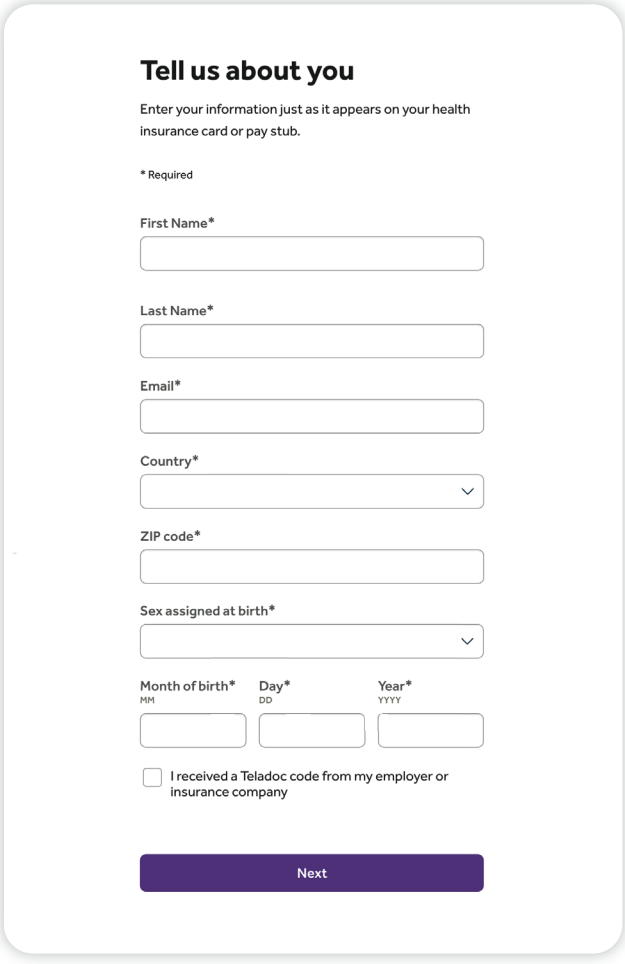
Get started with Teladoc Health

Simply visit *Teladoc.com/GuideStone*, click "Sign in" and then "Create a new account". Then simply follow the instructions below.

Note: If you have accessed Teladoc through a previous health plan, you must re-register with your GuideStone® ID card.

1 Confirm benefits

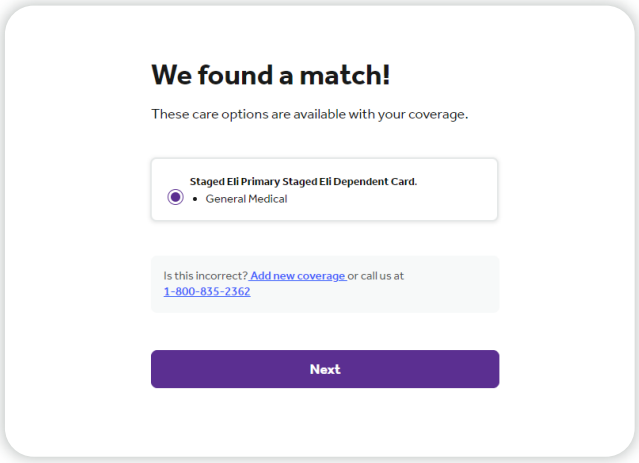
Provide some information about yourself to confirm your eligibility.



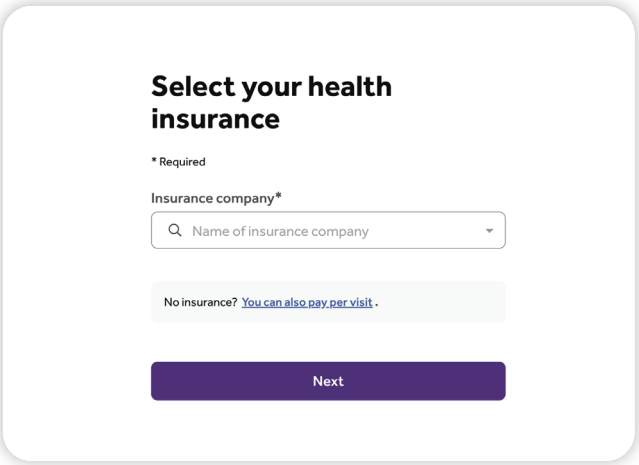
Note: You will need to use the exact name that is listed on your ID card.

2 Find your coverage

You may see one of these two screens, but both will effectively get you started.



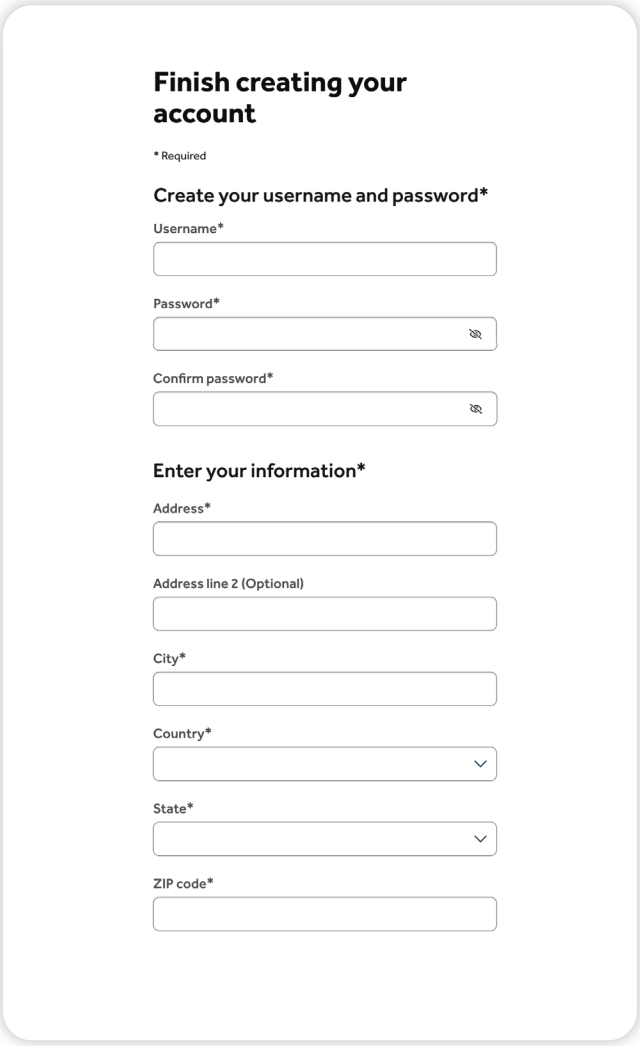
Confirm the coverage that has been matched to you. You will then be asked for your member ID located on your ID card.

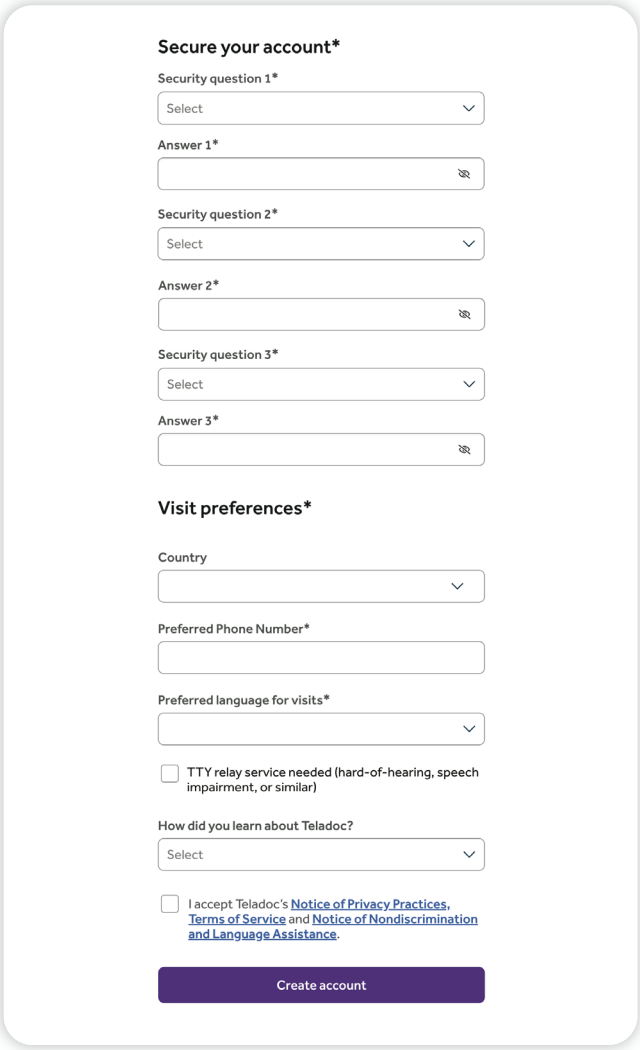


Pick your health plan from the drop-down menu and enter **Highmark Blue Cross Blue Shield.**

3 Create account

Enter your contact information, username, password and security questions.





Once your account is created, eligible dependents under 18 years of age can be added in your account settings under the primary member. Dependents older than 18 should follow the steps above to create their own account.

Set up your Teladoc Health account today

Visit *Teladoc.com/GuideStone* | Call 1-800-TELADOC (800-835-2362) | Download the app

*Teladoc Health is not available internationally.

Hello SmartShopper

Offered by Highmark Blue Cross Blue Shield, SmartShopper saves money and helps you earn rewards when you have routine medical procedures and tests.

How it works

1. SHOP
by phone or online

2. GO
to a cost-effective, in-network location you choose

3. EARN
$25 or more in rewards

Why SmartShopper?

- Prices for the same in-network, high-quality procedure can vary dramatically between locations
- SmartShopper lets you compare convenient, in-network locations and choose the best option
- You save money out-of-pocket and earn a share of the overall savings as a reward
- It's easy to shop online or with a Personal Assistant, who can also schedule your procedure

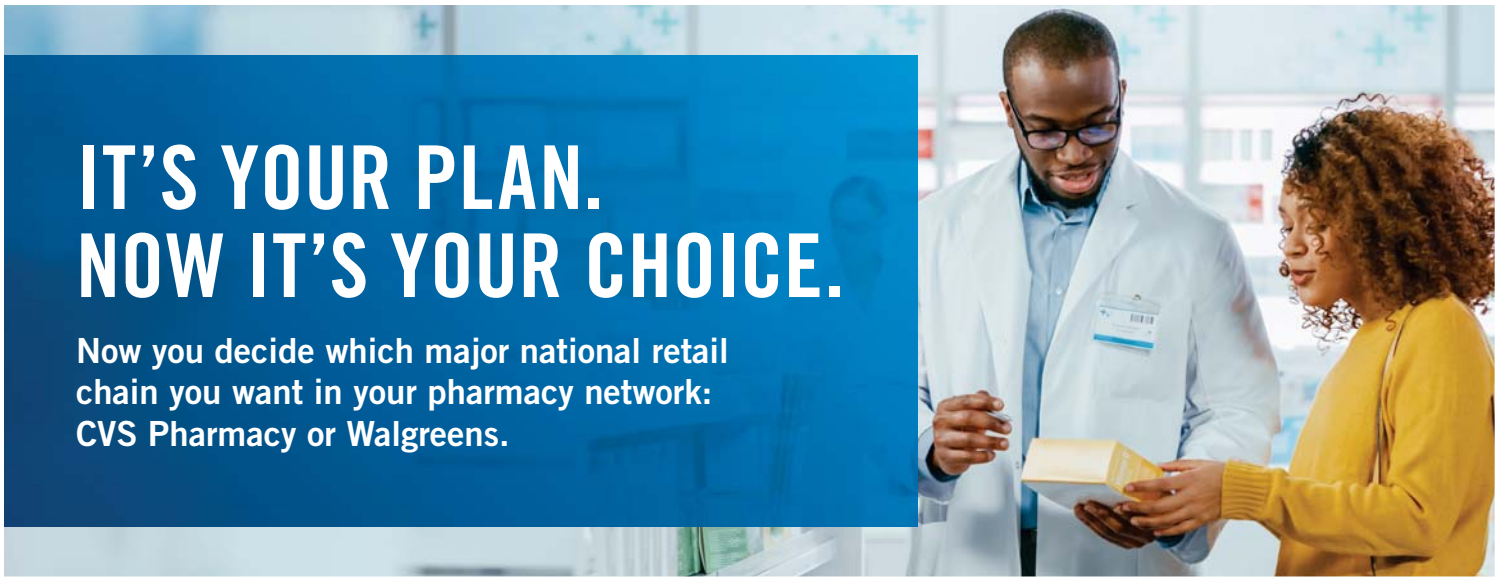
98% of SmartShoppers would recommend this program to a friend or co-worker.
2019 Survey of SmartShopper Users

Call the SmartShopper Personal Assistant Team at 1-866-285-7475.
Call the SmartShopper Personal Assistant Team Monday through Thursday from 8 a.m. to 8 p.m. and Friday from 8 a.m. to 6 p.m. ET.

HIGHMARK

GuideStone®
Do well. Do right.®

SmartShopper®



IT'S YOUR PLAN. NOW IT'S YOUR CHOICE.

Now you decide which major national retail chain you want in your pharmacy network: CVS Pharmacy or Walgreens.

Welcome to your new Express Scripts® prescription plan that gives you the flexibility and control to create the pharmacy network that's right for you.

Now you and each of your covered family members can choose which major national retail pharmacy chain you want in your network: **CVS Pharmacy or Walgreens.** The major chain you choose will remain your choice for the year, and the other chain will be considered out of network.

Regardless of which major chain you select, you can still:

- Choose to fill prescriptions at any of the over 55,000 other in-network pharmacies
- Choose to fill a three-month supply of long-term medications instead of three one-month supplies and save money
- Choose home delivery from Express Scripts® Pharmacy and save time

How to select the major national pharmacy you want in your network:

1. To get you started, we've assigned you and your covered family members to either CVS Pharmacy or Walgreens, based on which you've used most often in the past. But the ultimate choice is up to you.
2. To see – or switch – your selection, log on to express-scripts.com, go to "Account" and then "Pharmacy Preferences." Any changes you make will be updated in approximately 24 hours.
3. During the year, if you move or have another life event and need to change your selection, please call us at 1-800-555-3432.

Express Scripts is available to help if you have any questions or need assistance making your selection. Call 1-800-555-3432, 7 days a week 24 hours a day. TTY users, call 800.716.3231.

EXPRESS SCRIPTS®

FREQUENTLY ASKED QUESTIONS

What's changing?

For the first time, everyone in the plan will get to choose which national pharmacy chain they want in their pharmacy network: either CVS Pharmacy or Walgreens. Everyone will continue to have access to over 55,000 other retail pharmacies, including other major chains as well as independent and regional pharmacies.

Who is impacted?

You and each of your covered family members on your prescription plan will get to choose which national retail chain they want in their pharmacy network, either CVS Pharmacy or Walgreens.

Why does everyone in my family have to choose between either CVS Pharmacy or Walgreens?

You may find that you all want to choose the same pharmacy, and that's certainly OK. But we recognize that you each may have different needs. For example, a college student living away may not have one of the chains close by, so giving you this flexibility to customize by family member makes it easy for everyone.

When do I need to make my choice?

On day one of your plan, we've assigned you and each of your covered family members to either CVS Pharmacy or Walgreens, based on which you've used most often in the past. If you are good with the selection, you don't need to do anything. If you want to switch, you should do it now.

Why the change?

Research shows that most people use only a handful of different pharmacies to fill their prescriptions. Having unlimited choice of national pharmacy chains when you only use a few can drive up the cost of your plan. It's like paying for unlimited channels on your television plan when you only watch a handful of them. By giving you a choice of either CVS Pharmacy or Walgreens, we're helping to bring down health care costs – while still giving you the control to choose the "go-to" pharmacies you want and trust and that work best for you and your family.

Does this mean I always have to use either CVS Pharmacy or Walgreens to fill my medications?

Absolutely not. You can choose to fill your prescriptions at any of over 55,000 in-network retail pharmacies across the nation. Now you just choose to include either CVS Pharmacy or Walgreens as one of your options. To see a full list of network pharmacies and locations available to you, go to express-scripts.com.

What if I don't plan on using CVS Pharmacy or Walgreens during the year?

Even if you don't think you'll use CVS Pharmacy or Walgreens, we encourage you to choose one anyway. Having one of these large, major national chains available to you as an in-network option could be important to you if you find yourself in need of medications while traveling and away from your usual pharmacy.

I already use Walgreens as my go-to pharmacy for all my medications. Do I still have to choose?

No, you don't need to take any action. We've automatically set your choice as Walgreens to stay in-network, and CVS Pharmacy will be out of network. Conversely, for people who already use CVS Pharmacy as their go-to pharmacy, CVS Pharmacy stays in-network and Walgreens will be out of network.

What happens if I pick CVS Pharmacy, but my family moves and there is no CVS location near me?

If you move or have another life-changing event and you would prefer to switch from CVS Pharmacy to Walgreens (or vice versa), you can make that change online at express-scripts.com (or by phone) and the change will go into effect in about 24 hours.

Can I still get a three-month supply of my long-term medications?

Yes! It's a great way to save time and money. You can get a three-month supply of medications at the national chain you choose or choose from multiple other pharmacies in your network, including Express Scripts® Pharmacy. To see all your options, go to express-scripts.com.

EXPRESS SCRIPTS®

PREVENTIVE CARE

AN OUNCE OF PREVENTION

SAVES YOU CASH AND KEEPS YOU HEALTHY

Preventive care helps you stay healthy by checking for health problems early when they are easier to manage. Your GuideStone® medical coverage offers a wide array of preventive care services with no out-of-pocket costs to you!

All you have to do is follow your plan's Preventive Care Schedule to receive services such as:

- Annual checkups for adults
- Cancer, diabetes and blood pressure screenings
- Mammograms and well-woman screenings
- Immunizations for children and adults
- Prenatal and fetal screenings
- Routine checkups for infants, children and teens
- Developmental screenings for toddlers
- Special preventive services for at-risk individuals

Find out what's covered in your plan's Preventive Care Schedule by visiting *GuideStone.org/PreventiveSchedule*.

For answers to frequently asked questions about preventive care, go to *Help.GuideStone.org/PreventiveCare*.

GuideStone®

PLAN YOUR CARE AND SAVE YOUR CASH

Your GuideStone health plan includes a robust schedule of preventive care services.

Here's a simple five-step plan for accessing them.

1. FOCUS ON THE *PREVENTIVE CARE SCHEDULE*

- Download your Preventive Care Schedule by visiting *GuideStone.org/PreventiveSchedule*.
- Review the services available to you based on your age and gender.
- Get paid to shop for your preventive care mammograms and colonoscopies. Learn About SmartShopper®.

2. STAY IN YOUR NETWORK

- Access provider information at *GuideStoneHealth.org*.
- Follow the "Find Care" tab to find in-network health care providers in your neighborhood.

3. SCHEDULE AN APPOINTMENT

- Tell the provider you are coming in for preventive services.
- Bring a copy of your *Preventive Care Schedule* with you.

4. PLAN FOR FOLLOW-UP

- Schedule follow-up appointments if necessary.
- Understand that any treatment administered in subsequent appointments will be subject to your standard coverage rules, not the *Preventive Care Schedule*.

5. MONITOR YOUR *EXPLANATION OF BENEFITS* (EOB) STATEMENTS

- Review your statements when they arrive.
- If there are any issues, work with your provider or contact Quantum Health to assure the procedures were submitted with the accurate information.

What's the difference between preventive care and diagnostic visits?

A Highmark BCBS customer advocate explains how the codes on your claims determine how your benefits are paid at *GuideStone.org/PreventiveClaims*.

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DENTAL PLAN BENEFITS

Global Methodist Church

DENTAL PLANS

Effective July 1, 2024

Monthly Rates	Premier Dental Care Plan[1]	Choice Dental Care Plan[1]	Cigna Dental Care DHMO Plan
Employee	$39.93	$29.51	$22.80
Employee + Spouse	$79.86	$59.02	$38.53
Employee + Child(ren)	$99.83	$73.78	$53.81
Employee + Family	$139.76	$103.29	$63.38

Dental Plan Comparison Chart	Premier Dental Care Plan[1]	Choice Dental Care Plan[1]	Cigna Dental Care DHMO Plan
Providers	May use any provider or save with network providers	May use any provider or save with network providers	May use only providers in the network
Deductible (per person per year)[2]	$50	$50	No deductible
Annual maximum benefit (per person)	$1,500	$1,200	No annual maximum
Preventive services	0%	10%	$5 office visit co-pay + applicable fee (if any)[3]
Basic restorative care	20%	30%	$5 office visit co-pay + applicable fee (if any)[3]
Major restorative care	50%	50%	$5 office visit co-pay + applicable fee (if any)[3]
Orthodontia	50% with a lifetime maximum benefit of $1,000	50% with a lifetime maximum benefit of $1,000	$5 office visit co-pay + applicable fee (if any)[3]

[1]Coverage percentages based on reasonable and customary charges.
[2]Deductibles apply to basic and major services for the Premier Dental Care and Choice Dental Care plans.
[3]The Cigna DHMO is not available in the following states: AK, ME, MT, NH, NM, ND, SD, VT and WY.

HELPFUL PLAN TIPS:

Premier and Choice Dental Care Plans

- The Premier Dental Care Plan and the Choice Dental Care Plan both allow you to use any provider and receive benefits. However, the plans also allow you to take advantage of cost savings through Cigna's Dental PPO network.
- An annual maximum in-network benefit is either $1,500 (Premier) or $1,200 (Choice). The out-of-network annual maximum benefit is either $1,200 (Premier) or $1,000 (Choice). Once the plan has paid the annual maximum for the year, you will be responsible for 100 percent of the costs for your dental care for the rest of that year. This maximum benefit is for each family member covered by the plan.

Cigna Dental Care DHMO Plan

- With the Cigna Dental Care DHMO Plan (not available in all areas), you must select a primary care provider or dental office in the Cigna Dental Care Access Plus network to receive benefits.
- One of every five dentists is in both the Cigna DPPO and Cigna Dental Care Plus networks. There are more than 31,000 dentists in 40+ states and growing. It has a lower monthly premium with predictable costs based on the Patient Charge Schedule.

To find a PPO or HMO dental network provider in your area, visit *Cigna.com* or call **1-800-CIGNA24.**

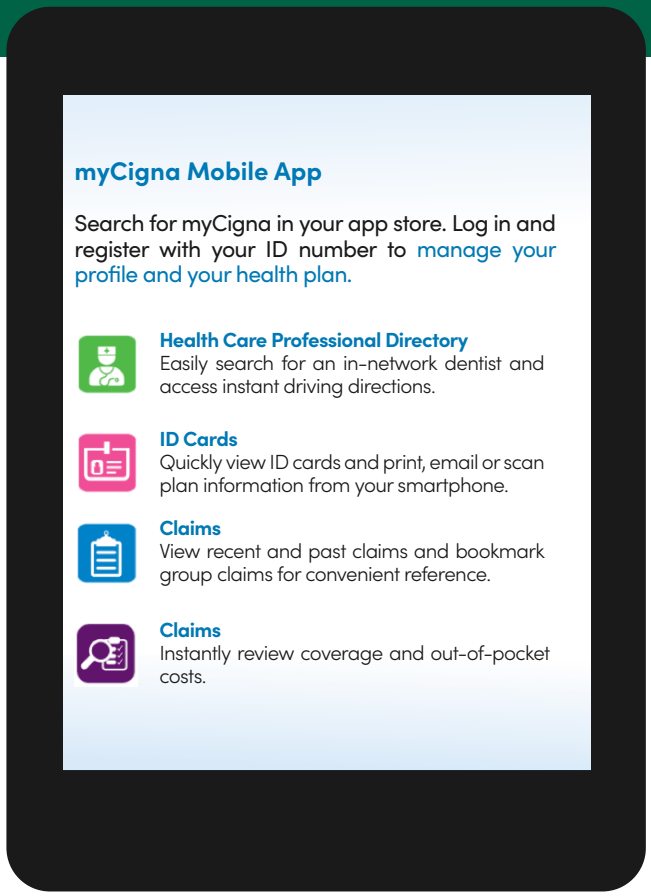
These dental products are administered by Cigna Health and Life Insurance Company through GuideStone Financial Resources' benefits program.

DENTAL COVERAGE

Cigna®

To find a dentist near you, view your dental plan or print an ID card, visit *my.Cigna.com* or download the myCigna app.

If you have benefit questions call **1-800-244-6224**.



YOUR DENTAL ID CARD IS AVAILABLE VIRTUALLY

Cigna dental plan information for your reference.

PLAN INFORMATION

GuideStone Group Number — **3172000**
GuideStone HMO Group Number — **10112922**
Subscriber ID — Your Social Security number
Benefit questions — **1-800-CIGNA24** (1-800-244-6224)

GuideStone®

GUIDESTONE GIVES YOU DENTAL PLANS TO SMILE ABOUT!

My.Cigna.com

Everything you need to know about accessing and managing your dental benefits is just a click away.

my.Cigna.com

Find A Dentist

Use providers in the Cigna Dental PPO network (Premier Dental Care and Choice Dental Care) to receive services at a discounted rate.

my.Cigna.com

Cigna Healthy Rewards®

Access discounts on health and wellness products and programs.

my.Cigna.com | **1-800-Cigna24**

Oral Health Integration Program®

These enhanced benefits are available to pregnant women and those diagnosed with certain health conditions.

GuideStone.org/AdditionalBenefits

1-800-Cigna24

Dental Plan Schedules

See what's included in your dental plan benefits.

GuideStone.org/MemberResources

Dental FAQs

Here's where you can find answers to all your dental plan questions.

GuideStone.org/DentalFAQs

Explore all your additional dental benefits at:
GuideStone.org/AdditionalBenefits.

VISION PLAN BENEFITS

Global Methodist Church

VISION PLANS

Everyone needs vision care. Enroll in a GuideStone® vision plan to get personalized vision care for you and your family. You will have access to the VSP Choice Network which includes independent doctors and retail chains such as Visionworks®, Pearle Vision®, Walmart®, Costco® and more.

Effective July 1, 2024

Monthly Rates	Advanced Vision Plan	Standard Plus Vision Plan	Standard Vision Plan
Employee	$12.22	$11.11	$9.62
Employee + Spouse	$21.50	$19.46	$16.44
Employee + Child(ren)	$22.81	$20.61	$17.42
Employee + Family	$34.69	$31.29	$26.14

Benefits	Advanced Vision Plan	Standard Plus Vision Plan	Standard Vision Plan
Exams			
WellVision® exam co-pay	$10	$10	$10
Contact lens exam (fitting and evaluation)	Up to $60	Up to $60	Up to $60
Frames			
Prescription glasses co-pay	$20	$25	$25
VSP Network Doctors and VisionWorks®	$175 allowance; plus 20% off any amount above the allowance	$150 allowance; plus 20% off any amount above the allowance	$150 allowance; plus 20% off any amount above the allowance
Contacts			
Elective contact lenses (prescription contact lenses, in lieu of glasses)	$175 allowance	$150 allowance	$150 allowance
Necessary contact lenses (medically necessary prescription contact lenses, in lieu of glasses)	Covered in full after co-pay	Covered in full after co-pay	Covered in full after co-pay
Frequency			
Exam	Every twelve months	Every twelve months	Every twelve months
Lenses	Every twelve months	Every twelve months	Every twelve months
Frames	Every twelve months	Every twelve months	Every twenty-four months

Lens Enhancements	Single Vision	Multifocal
Anti-glare coating (standard)	$41	$41
Scratch-resistant coating	$17	$17
Impact-resistant lenses for children	Covered in full	Covered in full
Impact-resistant lenses for adults	$35	$35
Standard progressives	N/A	Covered in full
Premium and custom progressives	N/A	$95 - $175
Solid tints/dyes	$15	$15
Photochromic lenses	$75	$75
UV protection	$10	$10

For additional plan details, view the *Advanced Vision Plan Benefit Summary*, *Standard Plus Vision Plan Benefit Summary* and the *Standard Vision Plan Benefit Summary* at *GuideStone.org/PlanDocuments*.

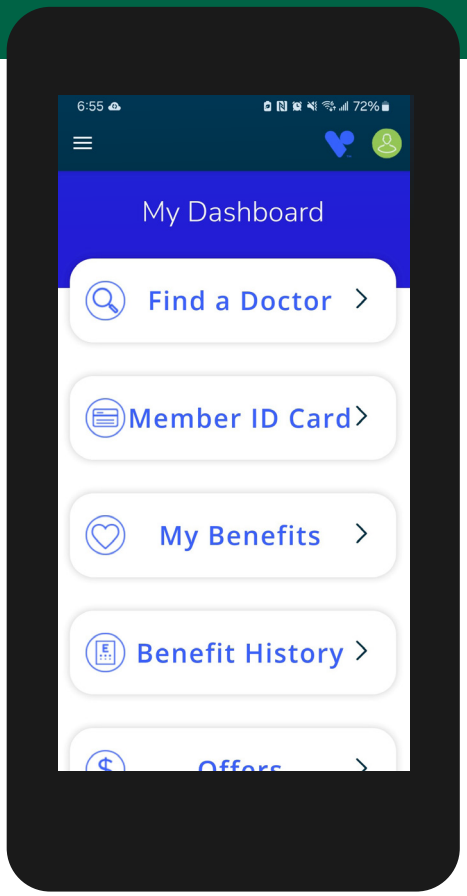
These vision products are administered by Vision Service Plan Insurance Company through GuideStone Financial Resources' benefits program.

VISION COVERAGE

vsp vision care

To find a local VSP network doctor, or view your vision plan, visit *VSP.com* or download the VSP Vision Care app.

For benefit questions call **1-800-877-7195**.



YOUR VISION ID CARD IS AVAILABLE VIRTUALLY

You can print a member vision card if you would like one, but no ID card is necessary. Just tell your vision provider you have VSP.

GuideStone®

VISION PLANS WITH ACCESS TO EXCLUSIVE MEMBER BENEFITS

VSP.com

Create an account, find your local VSP network doctor, and see your benefit at vsp.com today!

VSP.com

Eye Exam

Whether it's a routine check-up or your very first time, a WellVision Exam® from your VSP® network doctor is a great step to taking care of your eyes and your overall health. Learn what you can expect when you go to see your eye doctor at your WellVision Exam.

GuideStone.org/WellVision

Eyeconic

Eyeconic® seamlessly connects your eyewear, your insurance coverage, and the VSP® doctor network. Plus, you get the convenience of online shopping along with the personal touch from a VSP doctor.

Eyeconic.com

Essential Medical Eye Care

GuideStone provides eye care that supports your overall health and wellness. With your vision benefits, you have access to supplemental coverage for urgent and medical eye care.

GuideStone.org/EssentialEyeCare

Member Extras

Get access to more than $3,000 in savings from VSP and other popular brands for your eye care and overall wellness needs.

VSP.com/Offers

TruHearing

Like vision loss, hearing loss can have a huge impact on your quality of life. TruHearing makes hearing aids affordable by providing exclusive savings to all VSP® Vision Care members.

TruHearing.com/VSP

Explore all your additional term life benefits at:
GuideStone.org/AdditionalBenefits.

TERM LIFE AND ACCIDENT PLAN BENEFITS

Global Methodist Church

Term Life and Accident Plans

Effective July 1, 2024

Employee Term Life and Accidental Death & Dismemberment (AD&D)	
Employer Paid	
Term Life Coverage Amount	$50,000*
AD&D Coverage Amount	$50,000*

Employee Optional Term Life	
Employee Paid	
Coverage Amount	Guaranteed issue is available in flat amounts from $10,000 to $50,000 during initial 31-day eligibility period. A flat amount of $100,000 or one to eight times annual salary are also available with *Evidence of Good Health Application*.
Coverage Maximum	Lesser of eight times salary or $750,000*
See Monthly Optional Term Life rates below.	

Spouse Term Life	
Employer Paid - No Evidence of Good Health is required.	
Coverage Amount	$15,000

Spouse Optional Term Life	
Employee Paid	
Coverage Amount	May select up to 50% of the employee's total life coverage. Must be in a $5,000 increment.
See Monthly Optional Term Life rates below.	
Evidence of Good Health Application is required.	

Monthly Optional Term Life Rates	
Age	**Rate per $1,000**
24 & Under	$0.04
25 - 29	$0.05
30-34	$0.06
35-39	$0.10
40-44	$0.15
45-49	$0.25
50-54	$0.43
55-59	$0.65
60-64	$1.03
65+	$2.25

*Employee Term Life, Employee Optional Term Life, Employee AD&D, and Employee Supplemental AD&D benefit amounts reduce at age 65 for active employees to 65% of current amount but will not reduce below $20,000 of coverage.

Child Life	
Employer Paid	
Coverage Amount	$10,000 per child
Guaranteed issue is available at initial eligibility; coverage continues to age 26. Application after initial eligibility requires *Evidence of Good Health Application*.	

Employee Supplemental AD&D	
Employee Paid	
Pays you or your beneficiary if you die or suffer a specified loss (eyesight, speech, hearing, hand or foot) in an accident	
Available Coverage Amounts	$25,000 increments up to a maximum of $500,000*
Rate: $0.025 per $1,000 per month	
Participation in the Employee Term Life Plan is not required. Evidence of Good Health is not required for accident plans.	

Spouse Supplemental AD&D
Employee Paid
Pays you or your beneficiary if you die or suffer a specified loss (eyesight, speech, hearing, hand or foot) in an accident
Spouse can be covered at 50% of the employee's supplemental AD&D coverage.
Rate: $0.025 per $1,000 per month
Participation in the Employee Term Life Plan is not required. Evidence of Good Health is not required for accident plans.

The above amounts of coverage are not available for Term life and accident coverage to participants working in the following countries: Afghanistan, Algeria, Central African Republic, Chad, Congo, East Timor, Eritrea, Iran, Iraq, Kenya, Lebanon, Pakistan, Somalia, South Sudan, Sudan, Syria, Tanzania, Uganda, Uzbekistan or Yemen.

*Employee Term Life, Employee Optional Term Life, Employee AD&D, and Employee Supplemental AD&D benefit amounts reduce at age 65 for active employees to 65% of current amount but will not reduce below $20,000 of coverage.

ADDITIONAL BENEFITS

Life Planning Financial & Legal Resources
Financial, legal and grief support in the event of a death or diagnosis of a terminal illness.

Assist America®
24-hour network of emergency medical and legal resources offering worldwide emergency assistance to active employees and their families who are traveling.

Accelerated Benefits
Allows terminally ill participants with a life expectancy of 12 months or less to receive up to 50 percent of the death benefit ($250,000 maximum) prior to death.

Portability or Conversion of Coverage
Employees and their dependents can continue coverage if employment is terminated, or they otherwise lose eligibility.

Add Children Without Underwriting
No underwriting is required to add a dependent child within 60 days of the child's birth, adoption, or placement for adoption.

Additional AD&D Benefits
AD&D plan pays additional death benefits if you die traveling more than 100 miles from home while properly wearing a seatbelt or when protected by an airbag. The plan also pays an additional education benefit to each of your qualified, college-age dependents if you die.

GUIDESTONE GIVES YOU THE HELP TO DEAL WITH THE CHALLENGES AND TRIUMPHS OF TOMORROW.

Designate a Beneficiary

Choosing a primary and secondary beneficiary assures that your benefits are inherited according to your wishes. Be sure to update your beneficiary designations in your *My*GuideStone account.

My.GuideStone.org

Life Planning

When a loved one is terminally ill, or passes away, you may need help with the personal, financial and legal decisions that need to be made.

GuideStone.org/LifePlanning

Portability and Conversion

You and your dependents can continue coverage by converting to a policy directly through Unum if you leave your employer or otherwise lose eligibility.

GuideStone.org/TermLifeFAQs

Accelerated Death Benefit

Allows terminally ill participants with a life expectancy of 12 months or less to receive up to 50% of the death benefit prior to death.

GuideStone.org/TermLifeFAQs

Education Benefit

For qualified dependents, your GuideStone AD&D coverage includes an additional education benefit of 6% of the full amount of the AD&D benefit, up to $6,000 a year for up to four years.

GuideStone.org/TermLifeFAQs

Explore all your additional term life benefits at:
GuideStone.org/AdditionalBenefits.

DISABILITY PLAN BENEFITS

Global Methodist Church

DISABILITY PLAN

Effective July 1, 2024

IN-NETWORK	Long-Term Disability Plan[1]	Premier
	Elimination period	90 days
	Benefit percentage	Up to 60% of monthly earnings
	Maximum monthly benefit	$15,000 per month
	Definition of disability	3 years own occupation
	Social Security integration	Self
	Self-reported mental/nervous limitation	24 months
	Rehabilitation & Return to Work Program	Included
	Maximum benefit period	ADEA II

For more information regarding the Age Discrimination Employment Act (ADEA), please visit our *Disability FAQs*.

[1]Long-term disability plans are not available to participants working in the following countries: Afghanistan, Algeria, Central African Republic, Chad, Congo, East Timor, Eritrea, Iran, Iraq, Kenya, Lebanon, Pakistan, Somalia, South Sudan, Sudan, Syria, Tanzania, Uganda, Uzbekistan or Yemen.

Maximum Benefit Period

This is the length of time benefits are paid while the employee is disabled and depends on employee's age at the time disability begins.

ADEA II	Age At Disability	Maximum Period of Payment
	Less than 60	Greater of age 65 or 5 years
	60 to 64	5 years
	65 to 69	Greater of age 70 or 1 year
	70 and over	1 year

Additional Benefits

These valuable programs are included at no additional cost with your disability plan.

Survivor Benefits

If you die after receiving benefits for 180 or more consecutive days, your survivor receives a lump sum payment of three times your last month's gross disability benefit.

Rehabilitation and Return to Work Program

To encourage individuals to return to work as soon as they become physically able, individuals receive an additional benefit for participation in a rehabilitation program.

Unum Work/Life Balance

Through Unum's work/life balance services, employees will have access to live, one-on-one support, along with resources to help with family, health, life, money, work and legal issues. (Benefit available only for long-term disability.)

GUIDESTONE GIVES YOU VALUABLE PROGRAMS AT NO ADDITIONAL COST WITH YOUR DISABILITY PLANS.

Survivor Benefits

If you die after receiving disability benefits for 180 or more consecutive days, your survivor will receive a lump sum payment of three times your last month's gross disability benefit.

Rehabilitation and Return to Work Program

Individuals receive an additional benefit for participating in a rehabilitation program.

Assist America

A 24-hour network of emergency medical and legal resources offering worldwide emergency assistance to active employees and their families who are traveling.

GuideStone.org/AssistAmerica

Unum Employee Assistance Program

Life's stresses aren't a game. That's why GuideStone has teamed up with our long-term disability benefits provider, Unum, to offer a free employee assistance program.

GuideStone.org/WorkLifeBalance

Explore all your additional disability benefits at:
GuideStone.org/AdditionalBenefits.

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