



Oklahoma Baptist University

2025 Benefits Guide



GuideStone®

WELCOME

OBU ENROLLMENT GUIDE

BENEFITS OFFERED

January 1, 2025 – December 31, 2025

Welcome to your Oklahoma Baptist University (OBU) Benefits Guide. This Benefits Guide provides a broad overview of the benefits available to you and your family. The Guide includes benefit highlights for each plan and a quick reference page with provider and resource contact information. It is important that you understand your OBU benefits.

OBU is excited to announce that we will be utilizing GuideStone® for our health plan. GuideStone's health plans are created by Christians specifically for those who serve in ministry. GuideStone believes when the body of Christ is healthy, it's free to transform the world – and they are ready to help guide and equip OBU to do just that.

HEALTH

Medical | **GuideStone®/Highmark Blue Cross Blue Shield (BCBS)**

Prescription | **GuideStone/Express Scripts**

Health Plan Navigation | **Highmark Clarity**

Virtual Visits | **Teladoc®**

Dental | **Principal**

Vision | **Principal**

Health Savings Accounts | **Employee Benefit Corporation (EBC)**

Flexible Spending Accounts | **Employee Benefit Corporation (EBC)**

LIFE

Life & AD&D | **Dearborn Group**

Long-Term Disability | **New York Life**

Accident | **Principal**

Critical Illness | **Principal**

Hospital Indemnity | **Principal**

EXTRAS

Life Assistance Program | **New York Life**

ENROLLMENT

All team members have access to our online benefits enrollment platform 24/7, where you have the ability to enroll, select or change your benefits online during the annual open enrollment period, new hire orientation, and qualifying events.

- ✓ Accessible 24/7
- ✓ View all benefit plan options and your elections
- ✓ View important carrier forms and links
- ✓ Report a qualifying event
- ✓ Make changes to beneficiary designations and more.

Ready to Enroll?

Go to [https://
workforcenow.adp.com/](https://workforcenow.adp.com/)



Helpful Tips To Consider Before You Enroll

1. Do you plan to enroll an eligible dependent(s)?
If so, make sure to have their Social Security numbers and birthdates available. You cannot enroll your dependent(s) without this information.
2. Have you recently been married/divorced or had a baby?
If so, remember to add or remove any dependent(s) and/or update your beneficiary designation.
3. Did any of your covered children reach their 26th birthday this year?
If so, they may no longer be eligible for benefits unless they meet specific criteria.

ELIGIBILITY

RULES | REQUIREMENTS

EMPLOYEE ELIGIBILITY

You are eligible to participate if you are full-time and work a minimum of 30 hours per week. Your coverage will be effective on the date you are hired.

DEPENDENT ELIGIBILITY

The legal Spouse of an employee

- The definition of “legal spouse” is A person of the opposite biological sex to whom you are married at the relevant time by a religious or civil ceremony effective under the laws of the state in which the marriage was contracted.

Children up to age 26

The definition of “your child” includes:

- Your and/or your Spouse’s biological child
- Your and/or your Spouse’s legally adopted child or a child placed in your home for adoption
- Your and/or your Spouse’s stepchild or foster child
- Your and/or your Spouse’s grandchild who is dependent on you for support and maintenance. (This definition must be met in order for any claims to be covered under the plan even during the first 31 days after the birth of the grandchild to your covered dependent.)
- A child for whom you or your Spouse must provide health care by court order or order of a state agency authorized to issue National Medical Support Notices under federal law

Incapacitated children of any age who meet the following requirements:

- You and/or your Spouse must be the legal guardian or managing conservator for the incapacitated child.
- The child must be developmentally disabled or physically handicapped and incapable of earning a living.
- The child must be incapacitated when his or her plan coverage would have ended because they turn 26.
- You must provide GuideStone with proof of the child’s disability or physical handicap at least 31 days before your child’s regular coverage is scheduled to end. This is normally during the month before their 26th birthday.
- You must provide additional proof whenever asked to show that your child is still incapacitated.

- Coverage will remain in place through the approval process.
- A new employee may apply for coverage for an incapacitated child over age 26 during the initial eligibility as long as their prior coverage had approved the child as incapacitated.
- An existing employee may not add an incapacitated child to the coverage if they were not previously covered before reaching age 26.

SPECIAL ENROLLMENT EVENTS

The Health Insurance Portability and Accountability Act (HIPAA) requires that active employees in a group health plan be given the opportunity to enroll themselves and/or eligible dependents in health care coverage outside of the annual enrollment period after experiencing certain life events.

There are three categories of special enrollment events:

- Dependent additions
- Loss of other coverage
- Employee or dependent becomes eligible for premium assistance under Medicaid or CHIP

A full list of qualifying events can be found in the [Group Plans HIPAA Notice of Special Enrollment Rights](#).

IMPORTANT

You cannot make changes to these elections during the year unless you experience a qualified family status change, which must be reported to Human Resources within 60 days of the event.

If you separate from employment, continuation of coverage may be available.



MEDICAL COVERAGE



WELCOME TO YOUR GUIDESTONE HEALTH 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 health 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 health plan road map in this booklet provides an at-a-glance view of your plan's benefits. Plus, you'll find insights 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. Clarity is your one resource to contact whenever you need help with your health, wellness or pharmacy benefits.

- **Clarity:** 1-866-472-0924 or the My Highmark app
- **GuideStone Customer Solutions:** 1-844-INS-GUIDE (1-844-467-4843)

"GuideStone cares about the individuals. It's not just about the bottom line or about their own product, but it really is about helping churches and the pastors and staff of those local churches from a perspective of real love and care."

— Terry Hurt, Executive/Worship Pastor
Great Hills Baptist Church, Austin, Texas

NATIONWIDE NETWORKS





MEDICAL PLAN OVERVIEWS



Effective 01/01/2025

IN-NETWORK	Deductible for individual coverage	\$3,000
	Deductible for family coverage (Embedded deductible)	\$5,000
	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	\$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
	Outpatient PT/OT/ST (30 visit limit per therapy type; visit limit waived with mental health services diagnosis)	\$45
	Chiropractic services (12 visits annually)	\$45
	OUT-OF-NETWORK	Mental health/substance abuse: inpatient services
Mental health/substance abuse: office visit		\$25
Vision exam (one exam every 12 months)		\$25
Deductible for an individual		Not covered
Deductible for a family		Not covered
Plan pays/individual pays (co-insurance)		Not covered
Co-insurance and deductible out of pocket limit for an individual		Not covered
Co-insurance and deductible out of pocket limit for a family		Not covered
Wellness and preventive care		Not covered
Hospital inpatient (including maternity)		Not covered
Outpatient surgery		Not covered
Emergency Room Services		See In-Network Emergency Room Services
Mental health/substance abuse: inpatient services		Not covered
Mental health/substance abuse: office visit	Not covered	

PRESCRIPTION DRUG PROGRAM¹

RETAIL	30-Day Supply	Generic	\$15
		Preferred	\$50
		Non-Preferred	\$75
MAIL ORDER/ RETAIL	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 Copayment 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.

Accumulators are met by both medical and prescription expenses. Copays do not accumulate towards your deductible.

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 Copays will be paid by the manufacturer after the participant applies for Copay 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.

Effective 01/01/2025

IN-NETWORK	Deductible for individual coverage	\$5,000
	Deductible for family coverage (Embedded deductible)	\$10,000
	Plan pays/individual pays (co-insurance) after deductible	80%/20%
	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)	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
	Outpatient PT/OT/ST (30 visit limit per therapy type; visit limit waived with mental health services diagnosis)	\$45
	Chiropractic services (12 visits annually)	\$45
	OUT-OF-NETWORK	Mental health/substance abuse: inpatient services
Mental health/substance abuse: office visit		\$25
Vision exam (one exam every 12 months)		\$25
Deductible for an individual		Not covered
Deductible for a family		Not covered
Plan pays/individual pays (co-insurance)		Not covered
Co-insurance and deductible out of pocket limit for an individual		Not covered
Co-insurance and deductible out of pocket limit for a family		Not covered
Wellness and preventive care		Not covered
Hospital inpatient (including maternity)		Not covered
Outpatient surgery		Not covered
Emergency Room Services		See In-Network Emergency Room Services
Mental health/substance abuse: inpatient services		Not covered
Mental health/substance abuse: office visit	Not covered	

PRESCRIPTION DRUG PROGRAM¹

RETAIL	30-Day Supply	Generic	\$15
		Preferred	\$50
		Non-Preferred	\$75
MAIL ORDER/ RETAIL	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

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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.

Accumulators are met by both medical and prescription expenses. Copays do not accumulate towards your deductible.

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 Copays will be paid by the manufacturer after the participant applies for Copay 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.



BlueHPN Saver 6000

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

Effective 01/01/2025

IN-NETWORK	Deductible for individual coverage	\$6,000
	Deductible for family coverage (Embedded deductible)	\$12,000
	Plan pays/individual pays (co-insurance) after deductible	100%/0%
	Maximum out-of-pocket (medical and prescription)	\$6,000 individual /\$12,000 family
	Primary care or retail clinic visit	0% after deductible
	Specialist office visit (includes virtual visits)	0% after deductible
	Teladoc®	0% after deductible
	Wellness and preventative care (primary care/specialist)	0% no deductible
	Hospital inpatient (including maternity)	0% after deductible
	Outpatient surgery	0% after deductible
	Emergency room services	\$0 copay, then 0% after deductible
	Urgent care	0% after deductible
	Outpatient services (CT scans, MRI, diagnostic)	0% after deductible
	Outpatient PT/OT/ST (30 visit limit per therapy type; visit limit waived with mental health services diagnosis)	0% after deductible
	Chiropractic services (12 visits annually)	0% after deductible
OUT-OF-NETWORK	Mental health/substance abuse: inpatient services	0% after deductible
	Mental health/substance abuse: office visit	0% after deductible
	Vision exam (one exam every 12 months)	0% after deductible
	Deductible for an individual	Not covered
	Deductible for a family	Not covered
	Plan pays/individual pays (co-insurance)	Not covered
	Co-insurance and deductible out of pocket limit for an individual	Not covered
	Co-insurance and deductible out of pocket limit for a family	Not covered
	Wellness and preventive care	Not covered
	Hospital inpatient (including maternity)	Not covered
	Outpatient surgery	Not covered
	Emergency Room Services	See In-Network Emergency Room Services
	Mental health/substance abuse: inpatient services	Not covered
Mental health/substance abuse: office visit	Not covered	

PRESCRIPTION DRUG PROGRAM¹

RETAIL	30-Day Supply	Generic	0% after deductible
		Preferred	0% after deductible
		Non-Preferred	0% after deductible
MAIL ORDER/ RETAIL	90-Day Supply	Generic	0% after deductible
		Preferred	0% after deductible
		Non-Preferred	0% after deductible
		Diabetic Supplies	0%
		Participating Insulin	\$75
SPECIALTY	30-Day Supply	Generic	0% after deductible
		Preferred	0% after deductible
		Non-Preferred	0% 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.

Accumulators are met by both medical and prescription expenses. Copays do not accumulate towards your deductible.

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 Copays will be paid by the manufacturer after the participant applies for Copay 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.

Health Choice 3000 (80-20)



Effective 01/01/2025

IN-NETWORK	Deductible for individual coverage	\$3,000
	Deductible for family coverage (Embedded deductible)	\$5,000
	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	\$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
	Outpatient PT/OT/ST (30 visit limit per therapy type; visit limit waived with mental health services diagnosis)	\$45
	Chiropractic services (12 visits annually)	\$45
	OUT-OF-NETWORK	Mental health/substance abuse: inpatient services
Mental health/substance abuse: office visit		\$25
Vision exam (one exam every 12 months)		\$25
Deductible for an individual		\$5,000
Deductible for a family		\$10,000
Plan pays/individual pays (co-insurance) after deductible		50%/50%
Co-insurance and deductible out of pocket limit for an individual		\$25,000
Co-insurance and deductible out of pocket limit for a family		\$30,000
Wellness and preventive care		Not covered
Hospital inpatient (including maternity)		\$500 copay, then 50% after deductible
Outpatient surgery		50% after deductible
Emergency Room Services		See In-Network Emergency Room Services
Mental health/substance abuse: inpatient services		\$500 copay, then 50% after deductible
Mental health/substance abuse: office visit		50% after deductible

PRESCRIPTION DRUG PROGRAM¹

RETAIL	30-Day Supply	Generic	\$15
		Preferred	\$50
		Non-Preferred	\$75
MAIL ORDER/ RETAIL	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 Copayment 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.

Accumulators are met by both medical and prescription expenses. Copays do not accumulate towards your deductible.

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 Copays will be paid by the manufacturer after the participant applies for Copay 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.

Health Choice 5000 (80-20)



Effective 01/01/2025

IN-NETWORK	Deductible for individual coverage	\$5,000
	Deductible for family coverage (Embedded deductible)	\$10,000
	Plan pays/individual pays (co-insurance) after deductible	80%/20%
	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)	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
	Outpatient PT/OT/ST (30 visit limit per therapy type; visit limit waived with mental health services diagnosis)	\$45
	Chiropractic services (12 visits annually)	\$45
OUT-OF-NETWORK	Mental health/substance abuse: inpatient services	20% after deductible
	Mental health/substance abuse: office visit	\$25
	Vision exam (one exam every 12 months)	\$25
	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	See In-Network Emergency Room Services
	Mental health/substance abuse: inpatient services	\$500 copay, then 50% after deductible
	Mental health/substance abuse: office visit	50% after deductible

PRESCRIPTION DRUG PROGRAM¹

RETAIL	30-Day Supply	Generic	\$15
		Preferred	\$50
		Non-Preferred	\$75
MAIL ORDER/ RETAIL	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

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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.

Accumulators are met by both medical and prescription expenses. Copays do not accumulate towards your deductible.

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 Copays will be paid by the manufacturer after the participant applies for Copay 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.



Health Saver 6000

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

Effective 01/01/2025

IN-NETWORK	Deductible for individual coverage	\$6,000
	Deductible for family coverage (Embedded deductible)	\$12,000
	Plan pays/individual pays (co-insurance) after deductible	100%/0%
	Maximum out-of-pocket (medical and prescription)	\$6,000 individual /\$12,000 family
	Primary care or retail clinic visit	0% after deductible
	Specialist office visit (includes virtual visits)	0% after deductible
	Teladoc®	0% after deductible
	Wellness and preventative care (primary care/specialist)	0% no deductible
	Hospital inpatient (including maternity)	0% after deductible
	Outpatient surgery	0% after deductible
	Emergency room services	\$0 copay, then 0% after deductible
	Urgent care	0% after deductible
	Outpatient services (CT scans, MRI, diagnostic)	0% after deductible
	Outpatient PT/OT/ST (30 visit limit per therapy type; visit limit waived with mental health services diagnosis)	0% after deductible
	Chiropractic services (12 visits annually)	0% after deductible
OUT-OF-NETWORK	Mental health/substance abuse: inpatient services	0% after deductible
	Mental health/substance abuse: office visit	0% after deductible
	Vision exam (one exam every 12 months)	0% after deductible
	Deductible for an individual	\$18,000
	Deductible for a family	\$36,000
	Plan pays/individual pays (co-insurance) after deductible	70%/30%
	Co-insurance and deductible out of pocket limit for an individual	\$30,000
	Co-insurance and deductible out of pocket limit for a family	\$60,000
	Wellness and preventive care	Not covered
	Hospital inpatient (including maternity)	\$500 copay, then 30% after deductible
	Outpatient surgery	30% after deductible
	Emergency Room Services	See In-Network Emergency Room Services
	Mental health/substance abuse: inpatient services	\$500 copay, then 30% after deductible
	Mental health/substance abuse: office visit	30% after deductible

PRESCRIPTION DRUG PROGRAM¹

RETAIL	30-Day Supply	Generic	0% after deductible
		Preferred	0% after deductible
		Non-Preferred	0% after deductible
MAIL ORDER/ RETAIL	90-Day Supply	Generic	0% after deductible
		Preferred	0% after deductible
		Non-Preferred	0% after deductible
		Diabetic Supplies	0%
		Participating Insulin	\$75
SPECIALTY	30-Day Supply	Generic	0% after deductible
		Preferred	0% after deductible
		Non-Preferred	0% 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.

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Accumulators are met by both medical and prescription expenses. Copays do not accumulate towards your deductible.

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 Copays will be paid by the manufacturer after the participant applies for Copay 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

Coinsurance – The percentage of eligible claims you pay after you meet your deductible.

Coinsurance 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 coinsurance for covered benefits.

Copay – The fixed, up-front dollar amount you pay for certain covered expenses. Copay 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 copays. 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 copays. Once this amount is met, the plan will begin paying claims for that individual at the coinsurance 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 coinsurance 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](https://www.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.



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

A ROAD MAP TO YOUR GUIDESTONE HEALTH COVERAGE

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

STOP 1: HIGHMARK® CLARITY

Your personal Clarity team of advocates is made up of health, benefits and service experts who can help you understand your benefits and find high-quality care.

Get to know Highmark Clarity:

- Visit [MyHighmark.com](https://www.MyHighmark.com)
- Call 1-866-472-0924

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

- 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](https://www.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](https://www.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 IdentityWorksSM

HEALTH AND PRESCRIPTION COVERAGE

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



PLAN INFORMATION

GS Group Number for GuideStone National Network Health Plans* – **CQM363**

Blue High Performance Network Plans – **N2Q363**

GS Group Number for Medicare-coordinating Plans – **OBF363**

Member Number – Your Social Security Number

Benefit Questions – **1-866-472-0924**



PLAN INFORMATION

GS Group Number for GuideStone National Network Health Plans** – **ABSBC01**

GS Group Number for Blue High Performance Network Plans – **ABSBC01**

GS Group Number for Medicare-coordinating Plans – **ABSBC02**

Benefit Questions – **1-866-472-0924**

Rx Bin for GuideStone Health Plans Except Secure Health™
(No PCN number required) – **610014**

Rx Bin for Secure Health Plans – **003858**

PCN Number for Secure Health Plans – **A4**



WHAT IF I HAVEN'T RECEIVED MY ID CARD?

If you need to visit a health care provider or pharmacy before receiving your ID card, reference the plan information below.

ORDERING A NEW ID CARD

Members are encouraged to call Highmark Clarity directly at **1-866-472-0924** to request replacement ID cards. You can also print them online at [MyHighmark.com](https://myhighmark.com) or access the virtual member ID card in the My Highmark app.

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

*All plans except Blue High Performance Network and Medicare-coordinating.

**All plans except Blue High Performance Network, Secure Health and Medicare-coordinating.



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](https://www.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 [MyHighmark.com](https://www.myhighmark.com) or calling 1-866-472-0924.

It is also important to be familiar with your health plan 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](https://www.myguidestone.org).



WELLNESS TOOLS AND ADDITIONAL BENEFITS

Available in Your GuideStone® Health Plan

GuideStone's health plans include a rich array of tools to help you maximize 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 health plan*.

Visit [GuideStone.org/WellnessTools](https://www.guidestone.org/WellnessTools).

Clarity

The Clarity Team offers a personalized approach to navigating your care. Not only do they listen and understand your health care needs, but they also use their expertise to help you better manage your condition and care.

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

[MyHighmark app](#) | 1-866-472-0924

Get to know [Clarity](#).

See what they are saying about Clarity:



"Diane was fabulous. I used to have coverage under my husband and had to switch to COBRA. The deductible was supposed to be merged, and it didn't happen. I was lucky enough to get Diane, and she did the research to make sure that everything was getting merged. Diane called me today to let me know it was all taken care of. Diane was great and took the extra step and effort to make sure everything was handled and taken care of. She is a gem that we have."

"I just spoke with Brenda, and she wanted to let us know that Erik did a fantastic job. He took the time to give me information, and I had a lot of questions. He deserves an A+ and high ratings on everything he did today."

Save on Health Care

- [Highmark's Provider Search Tool](#) enables you to stay in-network and estimate your cost.
- [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 calling **1-866-285-7475** to speak to a personal assistant.
- [Teladoc](#)® (telemedicine provider) means that you have access to certified providers, all day, every day — even holidays for general medical care. Register today at [Teladoc.com/GuideStone](https://www.teladoc.com/GuideStone). Your Teladoc services include [General Medical](#), [Dermatology](#) and [Mental Health](#).

*Cigna International and Medicare-coordinating plans are excluded from wellness tools and additional benefits. Global Core plans do not have access to Clarity. SmartShopper is not available to Blue HPN plans. Teladoc mental health benefits are not available on Secure Health™ plans.

Take Charge of Your Health

- **Highmark** 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 [Baby BluePrints 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.
- **Thrive by Sword** pairs you virtually with a sword-licensed physical therapist, who assesses your pain and tailors a program to your unique needs. Thrive by 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 prediabetes and 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 prediabetes and 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 prediabetes and 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 find health care providers, 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 health 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.





Get started with Teladoc Health

It's quick and easy to set up your account online. Simply visit Teladoc.com/GuideStone, click "Sign in" and then "Create a new account". Then simply follow the instructions below.

1 Confirm benefits

Provide some information about yourself to confirm your eligibility.

Tell us about you

Enter your information just as it appears on your health insurance card or pay stub.

* Required

First Name*

Last Name*

Email*

Country*

ZIP code*

Sex assigned at birth*

Month of birth* Day* Year*

I received a Teladoc code from my employer or insurance company

Next

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.

We found a match!

These care options are available with your coverage.

Staged Eil Primary Staged Eil Dependent Card.

- General Medical

Is this incorrect? [Add new coverage](#) or call us at [1-800-835-2352](tel:1-800-835-2352)

Next

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

Select your health insurance

* Required

Insurance company*

No insurance? [You can also pay per visit.](#)

Next

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.

Finish creating your account

* Required

Create your username and password*

Username*

Password*

Confirm password*

Enter your information*

Address*

Address line 2 (Optional)

City*

Country*

State*

ZIP code*

Secure your account*

Security question 1*

Answer 1*

Security question 2*

Answer 2*

Security question 3*

Answer 3*

Visit preferences*

Country

Preferred Phone Number*

Preferred language for visits*

TTY relay service needed (hard-of-hearing, speech impairment, or similar)

How did you learn about Teladoc?

I accept Teladoc's [Notice of Privacy Practices](#), [Terms of Service](#) and [Notice of Nondiscrimination and Language Assistance](#).

Create account

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.

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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](https://www.guidestone.org/preventiveschedule).

For answers to frequently asked questions about preventive care, go to [Help.GuideStone.org/PreventiveCare](https://www.guidestone.org/preventivecare).

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 SCHEDULE

- Download your *Preventive Schedule* by visiting [GuideStone.org/PreventiveSchedule](https://www.GuideStone.org/PreventiveSchedule).
- Review the services available to you based on your age and gender.

2. STAY IN YOUR NETWORK

- Access provider information at [MyHighmark.com](https://www.MyHighmark.com).
- Under "For Members" follow the "Find Care" tab to find in-network health care providers in your area.

3. SCHEDULE AN APPOINTMENT

- Tell the provider you are coming in for preventive services.
- Bring a copy of your *Preventive 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 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 Highmark® Clarity to assure the procedures were submitted with the accurate information.

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

A Highmark BSBC® customer advocate explains how the codes on your claims determine how your benefits are paid at [GuideStone.org/PreventiveClaims](https://www.GuideStone.org/PreventiveClaims).

FLEXIBLE SPENDING ACCOUNT

FSA | Tax Saving Vehicle

Flexible Spending Accounts (FSA) allow you to reduce your taxable income by setting aside pre-tax dollars from each paycheck to pay for eligible out-of-pocket health care and dependent care expenses* for yourself, your spouse and your dependent children.

In order to participate in the FSA, you must enroll each year. Your annual contribution stays in effect during the entire year (**January 1st through December 31st**). The only time you can change your election is during the enrollment period or if you experience a change-in-status event. Also, you must elect this benefit within **30 days** of your hire date or first date of benefits eligibility.

ELIGIBLE EXPENSES

- A full list of qualified FSA expenses can be found in IRS Publication 502 at [irs.gov](https://www.irs.gov).
- You can learn more about FSA qualified expenses and also make purchases by visiting the FSA Store at fsastore.com.

HEALTH CARE & LIMITED PURPOSE FSA

MAXIMUM ANNUAL CONTRIBUTION | \$3,300

All eligible health care expenses – such as deductibles, medical and prescription copays, dental expenses, and vision expenses – can be reimbursed from your general purpose FSA account.

With the Health Care FSA or Limited Purpose FSA, you can spend up to the full amount of your annual election as soon as your account has been set up.

LIMITED PURPOSE FSA | ADDITIONAL REQUIREMENTS

- If you open or contribute to a Health Saving Account (HSA), you may only enroll in a Limited Purpose FSA.
- If you enroll in a HDHP (High Deductible Health Plan) and elect a Health FSA, you will automatically be enrolled in the Limited Purpose FSA.
- A limited purpose FSA will reimburse you for dental and vision expenses, but you cannot claim the same expense on both the FSA and HSA Accounts.

DEPENDENT CARE FSA

The Dependent Care FSA allows you to pay for eligible dependent care expenses with tax-free dollars so that you and your spouse can work or attend school FT.

Unlike the Health Care FSA, funds in a Dependent Care FSA are only available once they have been deposited into your account and you cannot use the funds ahead of time.

- You may set aside up to **\$5,000** annually in pre-tax dollars, or **\$2,500** if you are married and file taxes separately from your spouse.
- If you participate in a Dependent Care FSA, you cannot apply the same expenses for a dependent care tax credit when you file your income taxes.

IMPORTANT FSA RULES

“USE IT” OR “LOSE IT”

“Unused” FSA funds do not roll over from year to year.

Both the Health Care and Dependent Care FSA have a “grace period”. This means that you have until March 31, 2026 to submit your claims.

*ELIGIBLE DEPENDENT CARE EXPENSES INCLUDE:

1. ‘Care’ for your dependent child who is under the age of 13 that you can claim as a dependent on your federal tax return;
2. ‘Care’ for your dependent child who resides with you and who is physically or mentally incapable of caring for themselves; or
3. ‘Care’ for your spouse, parent or grandparent who is physically or mentally incapable of caring for themselves and spends at least eight hours a day in your home.

‘Care’ is defined as: In-home baby-sitting services (not by an individual you claim as a dependent); care of a preschool child by a licensed nursery or day care provider; before and after-school care; summer day camp (provided it is not overnight); and in-home dependent day care.

HEALTH SAVINGS ACCOUNT

HSA | Tax Advantage Vehicle

ENROLLED IN AN HSA ELIGIBLE HEALTH PLAN?

Take charge of your health care spending with a Health Savings Account (HSA).

Contributions to an HSA are tax-free, and no matter what, the money in the account is yours!

A Health Savings Account (HSA) is a tax-free savings account that is owned by you, is 100% vested from day one, and lets you build up savings for future needs. The funds may be used to pay for qualifying healthcare expenses not covered by insurance or any other plan for yourself, your spouse, or tax dependents. You decide how much you would like to contribute, when and how to spend the money on eligible expenses, and how to invest the balance.

UNDERSTANDING YOUR HSA

- Pre-tax contributions are deducted through payroll and deposited into your HSA account
- You can use your HSA available funds to pay for qualified medical expenses tax-free
- HSA funds can be used for non-eligible expenses, but will be subject to regular income taxes and a 20% excise tax penalty
- Unused funds remain in your account for future use and roll over each calendar year
- HSAs remain with you even if you change health plans or companies. If you open an HSA and later become ineligible to make contributions, you can still use your remaining funds
- You can change your HSA contribution at any time during the plan year for any reason

2025 HSA FUNDING LIMITS

Each year, the IRS places a limit on the maximum amount that can be contributed to HSA accounts.

HSA Contribution Limits

Employee	\$4,300
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Two Person/Family	\$8,550
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HSA "Catch-Up" Contributions

Age 55 or older	\$1,000 a year
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DENTAL, VISION, LIFE AND DISABILITY BENEFITS



DENTAL

Coverage Overview



PLAN FEATURES

Network Details	High Plan	Low Plan
Benefit Period	Calendar Year	

DEDUCTIBLE

Single	\$100	\$100
Family	\$300	\$300

When does it apply? Deductibles apply for basic and major in-network and non-network services. (Does not apply for preventive services)

COVERED SERVICES

Class I: Preventive Services	Covered at 100%	Covered at 100%
Class II: Basic Services	Covered at 80%	Covered at 80%
Class III: Major Services	Covered at 50%	Covered at 50%
Class IV: Orthodontic Services (Child Only)	Covered at 50%	N/A

ANNUAL MAXIMUM

Annual Maximum Benefit <i>Allowed per Benefit Period</i>	\$1,000 per person	\$1,000 per person
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MAXIMUM ORTHODONTIA – CHILD ONLY

Lifetime Maximum	\$1,500	N/A
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Monthly Cost By Tier	High Plan		Low Plan	
	Employer Cost Per Month	Employee Cost Per Month	Employer Cost Per Month	Employee Cost Per Month
Employee Only	\$21.68	\$14.58	\$21.68	\$5.42
Employee + Spouse	\$37.22	\$32.90	\$37.22	\$17.52
Employee + Child(ren)	\$42.17	\$53.95	\$42.17	\$19.85
Family	\$63.81	\$73.33	\$63.81	\$30.03

Need to locate an in-network provider?

Visit [Principal.com/Find-Dentist](https://www.principal.com/Find-Dentist) and search by zip code.

VISION

Coverage Overview



PLAN FEATURES – VSP CHOICE NETWORK

Covered Charges	Benefit	Frequency
Vision Exam	\$10 co-pay	1 per 12 months

COVERED SERVICES – LENSES/FRAMES

Prescription Glasses	\$25 co-pay	
Lenses	Single vision, lined bifocal, lined trifocal, and lenticular lenses; polycarbonate lenses for dependent children under age 18	1 pair per 12 month
Frames*	\$200 allowance for a wide selection of frames; 20% off amount over allowance ¹	1 pair per 12 month
Lens Enhancements ¹	\$0 co-pay standard progressive lenses Most other popular options are covered after a co-pay, saving members an average of 30%. Members should see their doctor for special pricing on additional lens enhancements.	1 per 12 months

COVERED SERVICES – CONTACTS

Necessary contacts ²	\$25 co-pay	1 per 12 months
	Covered in full for members who have specific conditions. Contact lenses can be chosen instead of glasses.	Instead of lens and frames benefit
Elective contacts	Up to \$60 co-pay for standard and premium elective contact lens exams (fitting and evaluation)	1 per 12 months
	\$200 allowance for elective contacts	Instead of lens and frames benefit

ADDITIONAL SAVINGS

Savings on laser vision correction and additional pairs of prescription glasses and non-prescription sunglasses.

¹Based on applicable laws; benefit may vary by doctor location. Savings may not apply at participating retail chains.

²Prescribed to correct extreme visual problems that cannot be corrected with regular lenses.

³The benefit amount is the lesser of the maximum payment limit or billed amount minus the applicable co-pay.

*VSP has agreements established with some participating retail chain providers that may also provide benefits for this covered service. Up to a \$100 allowance is given for a wide selection of frames from Costco or Walmart/Sam's Club. Not all providers at participating retail chains are in-network for exam services. Please talk to your provider or contact VSP customer care for further details.

NON-NETWORK PROVIDERS

Covered Charges	Benefit ³	Frequency
Exams	Up to \$45	1 per 12 months
Single vision lenses	Up to \$30	1 pair per 12 months
Lined bifocal lenses	Up to \$50	1 pair per 12 months
Lined trifocal lenses	Up to \$65	1 pair per 12 months
Lenticular lenses	Up to \$100	1 pair per 12 months
Frames	Up to \$70	1 set per 12 months
Necessary Contacts ²	Up to \$210	1 per 12 months Instead of lens and frame benefits
Elective Contacts	Up to \$105	1 per 12 months Instead of lens and frames benefits

¹Based on applicable laws; benefit may vary by doctor location. Savings may not apply at participating retail chains.

²Prescribed to correct extreme visual problems that cannot be corrected with regular lenses.

³The benefit amount is the lesser of the maximum payment limit or billed amount minus the applicable co-pay.

*VSP has agreements established with some participating retail chain providers that may also provide benefits for this covered service. Up to a \$110 allowance is given for a wide selection of frames from Costco or Walmart/Sam's Club. Not all providers at participating retail chains are in-network for exam services. Please talk to your provider or contact VSP customer care for further details.

Monthly Cost By Tier	Employee Cost
Employee Only	\$10.70
Employee + Spouse	\$17.14
Employee + Child(ren)	\$17.48
Family	\$28.20

Need to locate an in-network provider?

Visit [VSP.com/Eye-Doctor](https://www.vsp.com/Eye-Doctor) and search by location, doctor name or office name.

BASIC LIFE

Coverage Overview



BASIC LIFE INSURANCE

BENEFICIARY(IES)

It's very important to designate beneficiaries. Taking a few minutes to designate your beneficiaries now will help ensure that your assets will be distributed according to your direction.

A **Beneficiary** is the person you designate to receive your life insurance benefits in the event of your death. It is important that your beneficiary designation is clear so there is no question as to your intentions.

It is also important that you name a **Primary** and **Contingent Beneficiary**. A contingent beneficiary will receive the benefits of your life insurance if the primary beneficiary cannot. You can change beneficiaries at any time.

You should review your beneficiary elections on a regular basis to ensure they are updated as life changes. Even if you are single, your beneficiary can use your life insurance to pay off your debts, such as: credit cards, mortgages, and other expenses.

**You designate your beneficiary(ies) when enrolling for your benefits.*

Life insurance is an important part of your financial security. Life insurance helps protect your family from financial risk and sudden loss of income in the event of your death. AD&D insurance is equal to your life benefit in the event of your death being a result of an accident, and may also pay benefits for certain injuries sustained.

Company Paid Benefit - Provided to you at no cost

Coverage Amount 1x Annual Salary up to \$200,000

Accidental Death and Dismemberment (AD&D) Amount equal to your Life benefit

Benefit Reduction Schedule Your insurance will reduce to:
– 65% at age 65
– 50% at age 70

ADDITIONAL PLAN PROVISIONS

Conversion When coverage ends under the plan, you can convert to an individual permanent life policy without evidence of insurability.



WHAT WILL MY BENEFICIARY RECEIVE?

In The Event That Death Occurs:

- Your Basic Life insurance is paid to your beneficiary.
- **If death occurs from an accident:** 100% of the AD&D benefit would be payable to your beneficiary(ies) in addition to your Basic Life insurance.

SUPPLEMENTAL LIFE

Coverage Options for You & the Family

SUPPLEMENTAL LIFE INSURANCE



Employees have the opportunity to enroll in supplemental life insurance. If you choose to enroll in employee coverage, this will be in addition to your employer provided basic life coverage. Coverage is also available for your spouse and/or child dependents. It is typically required that you elect coverage for yourself in order to be eligible for coverage on your dependents.

PLAN OPTIONS

Cost of Coverage Premiums are based on age-rated tables and paid by the employee every pay period through a payroll deduction. These premiums are post-tax and benefits payable are tax-free.

Coverage Options

Employee Coverage

Choose in \$10,000 increments up to \$500,000

Spouse Coverage

Choose in \$5,000 increments up to \$100,000, not to exceed 50% of Employee's benefit

Dependent Coverage

Choose in \$1,000 increments up to \$10,000

Do I have to take a health exam to get coverage?

If you and your dependents enroll in coverage at your initial eligibility date, you may apply for up to the Guaranteed Issue amounts without medical questions.

Guaranteed Issue

Employee
\$100,000

Spouse
\$25,000

Dependent
\$10,000

PLAN PROVISIONS

Cost Calculation

Age Rated Benefit (Spouse Life based on employee's age)

Portability

If your employment ends or you retire, you may be eligible to continue your term insurance at group rates.

Conversion

When coverage ends under the plan, you can convert to an individual permanent life policy without evidence of insurability.



***Guaranteed Issue (GI) and Evidence of Insurability (EOI)**

When you are first eligible (at hire) for Voluntary Life and AD&D, you may purchase up to the Guaranteed Issue (GI) for yourself and your spouse without providing proof of good health (EOI).

Any amount elected over the GI will require EOI. If you elect optional life coverage, and are required to complete an EOI, it is your responsibility to complete the EOI and send to the provider (address will be listed on your form). In addition, your spouse will need to provide EOI to be eligible for coverage amounts over GI, or if coverage is requested at a later date.

Voluntary Life and AD&D
PREMIUM RATE GRID

Oklahoma Baptist University - #F019973

Eligibility

You are eligible to enroll if you work the minimum number of hours per week by your employer, and you have satisfied any waiting period.

Voluntary Life and AD&D

Employee Benefit: **\$10,000 to \$500,000 in \$10,000 increments.**

Spouse Benefit: **\$5,000 to \$100,000 in \$5,000 increments.**
(not to exceed 50% of the employee benefit)

Note: Spouse may not have coverage unless the employee has coverage.

Guarantee Issue*

Employee	\$100,000
Spouse	\$25,000

*NEW HIRES ONLY

Child Coverage

Birth to 14 days:	\$1,000
15 days to 6 months:	\$1,000
6 months to age 19:	\$1,000 to \$10,000 in increments of \$1,000

(Student Maximum Age: 23)

Employee Voluntary Life	
Monthly rates per \$1,000	
Age	Rates
Under 20	\$0.029
20-24	\$0.029
25-29	\$0.029
30-34	\$0.044
35-39	\$0.059
40-44	\$0.083
45-49	\$0.133
50-54	\$0.213
55-59	\$0.404
60-64	\$0.618
65-69	\$1.003
70+	\$1.911
Voluntary AD&D	
Monthly rates per \$1,000	
Employee	\$ 0.017
Dependent Life (Children)	
Monthly Premium per Family	
	Life AD&D
\$1,000	\$0.22 \$0.02
\$10,000	\$2.23 \$0.17

Voluntary Life and AD&D

Premium Cost (Based on 12 payroll deductions per year)

Benefit Amount	EE AD&D	ATTAINED AGE											
		<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
\$10,000	\$0.17	\$0.29	\$0.29	\$0.29	\$0.44	\$0.59	\$0.83	\$1.33	\$2.13	\$4.04	\$6.18	\$10.03	\$19.11
\$20,000	\$0.34	\$0.58	\$0.58	\$0.58	\$0.88	\$1.18	\$1.66	\$2.66	\$4.26	\$8.08	\$12.36	\$20.06	\$38.22
\$30,000	\$0.51	\$0.87	\$0.87	\$0.87	\$1.32	\$1.77	\$2.49	\$3.99	\$6.39	\$12.12	\$18.54	\$30.09	\$57.33
\$40,000	\$0.68	\$1.16	\$1.16	\$1.16	\$1.76	\$2.36	\$3.32	\$5.32	\$8.52	\$16.16	\$24.72	\$40.12	\$76.44
\$50,000	\$0.85	\$1.45	\$1.45	\$1.45	\$2.20	\$2.95	\$4.15	\$6.65	\$10.65	\$20.20	\$30.90	\$50.15	\$95.55
\$60,000	\$1.02	\$1.74	\$1.74	\$1.74	\$2.64	\$3.54	\$4.98	\$7.98	\$12.78	\$24.24	\$37.08	\$60.18	\$114.66
\$70,000	\$1.19	\$2.03	\$2.03	\$2.03	\$3.08	\$4.13	\$5.81	\$9.31	\$14.91	\$28.28	\$43.26	\$70.21	\$133.77
\$80,000	\$1.36	\$2.32	\$2.32	\$2.32	\$3.52	\$4.72	\$6.64	\$10.64	\$17.04	\$32.32	\$49.44	\$80.24	\$152.88
\$90,000	\$1.53	\$2.61	\$2.61	\$2.61	\$3.96	\$5.31	\$7.47	\$11.97	\$19.17	\$36.36	\$55.62	\$90.27	\$171.99
\$100,000	\$1.70	\$2.90	\$2.90	\$2.90	\$4.40	\$5.90	\$8.30	\$13.30	\$21.30	\$40.40	\$61.80	\$100.30	\$191.10
\$150,000	\$2.55	\$4.35	\$4.35	\$4.35	\$6.60	\$8.85	\$12.45	\$19.95	\$31.95	\$60.60	\$92.70	\$150.45	\$286.65
\$200,000	\$3.40	\$5.80	\$5.80	\$5.80	\$8.80	\$11.80	\$16.60	\$26.60	\$42.60	\$80.80	\$123.60	\$200.60	\$382.20
\$250,000	\$4.25	\$7.25	\$7.25	\$7.25	\$11.00	\$14.75	\$20.75	\$33.25	\$53.25	\$101.00	\$154.50	\$250.75	\$477.75
\$300,000	\$5.10	\$8.70	\$8.70	\$8.70	\$13.20	\$17.70	\$24.90	\$39.90	\$63.90	\$121.20	\$185.40	\$300.90	\$573.30
\$350,000	\$5.95	\$10.15	\$10.15	\$10.15	\$15.40	\$20.65	\$29.05	\$46.55	\$74.55	\$141.40	\$216.30	\$351.05	\$668.85
\$400,000	\$6.80	\$11.60	\$11.60	\$11.60	\$17.60	\$23.60	\$33.20	\$53.20	\$85.20	\$161.60	\$247.20	\$401.20	\$764.40
\$450,000	\$7.65	\$13.05	\$13.05	\$13.05	\$19.80	\$26.55	\$37.35	\$59.85	\$95.85	\$181.80	\$278.10	\$451.35	\$859.95
\$500,000	\$8.50	\$14.50	\$14.50	\$14.50	\$22.00	\$29.50	\$41.50	\$66.50	\$106.50	\$202.00	\$309.00	\$501.50	\$955.50

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Voluntary Life and AD&D
PREMIUM RATE GRID

Oklahoma Baptist University - #F019973

Eligibility

You are eligible to enroll if you work the minimum number of hours per week by your employer, and you have satisfied any waiting period.

Voluntary Life and AD&D

Employee Benefit: **\$10,000 to \$500,000 in \$10,000 increments.**

Spouse Benefit: **\$5,000 to \$100,000 in \$5,000 increments.**
(not to exceed 50% of the employee benefit)

Note: Spouse may not have coverage unless the employee has coverage.

Guarantee Issue*

Employee	\$100,000
Spouse	\$25,000

*NEW HIRES ONLY

Child Coverage

Birth to 14 days:	\$1,000
15 days to 6 months:	\$1,000
6 months to age 19:	\$1,000 to \$10,000 in increments of \$1,000

(Student Maximum Age: 23)

Spouse	
Voluntary Life	
Monthly rates per \$1,000	
<u>Age</u>	<u>Rates</u>
Under 20	\$0.029
20-24	\$0.029
25-29	\$0.029
30-34	\$0.044
35-39	\$0.059
40-44	\$0.083
45-49	\$0.133
50-54	\$0.213
55-59	\$0.404
60-64	\$0.618
65-69	\$1.003
70+	\$1.911
Voluntary AD&D	
Monthly rates per \$1,000	
Spouse	\$ 0.017
Dependent Life (Children)	
Monthly Premium per Family	
	Life AD&D
\$1,000	\$0.22 \$0.02
\$10,000	\$2.23 \$0.17

Voluntary Life and AD&D

Premium Cost (Based on 12 payroll deductions per year)

Benefit Amount	Spouse AD&D	ATTAINED AGE											
		<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
\$5,000	\$0.09	\$0.15	\$0.15	\$0.15	\$0.22	\$0.30	\$0.42	\$0.67	\$1.07	\$2.02	\$3.09	\$5.02	\$9.56
\$10,000	\$0.17	\$0.29	\$0.29	\$0.29	\$0.44	\$0.59	\$0.83	\$1.33	\$2.13	\$4.04	\$6.18	\$10.03	\$19.11
\$15,000	\$0.26	\$0.44	\$0.44	\$0.44	\$0.66	\$0.89	\$1.25	\$2.00	\$3.20	\$6.06	\$9.27	\$15.05	\$28.67
\$20,000	\$0.34	\$0.58	\$0.58	\$0.58	\$0.88	\$1.18	\$1.66	\$2.66	\$4.26	\$8.08	\$12.36	\$20.06	\$38.22
\$25,000	\$0.43	\$0.73	\$0.73	\$0.73	\$1.10	\$1.48	\$2.08	\$3.33	\$5.33	\$10.10	\$15.45	\$25.08	\$47.78
\$50,000	\$0.85	\$1.45	\$1.45	\$1.45	\$2.20	\$2.95	\$4.15	\$6.65	\$10.65	\$20.20	\$30.90	\$50.15	\$95.55
\$75,000	\$1.28	\$2.18	\$2.18	\$2.18	\$3.30	\$4.43	\$6.23	\$9.98	\$15.98	\$30.30	\$46.35	\$75.23	\$143.33
\$100,000	\$1.70	\$2.90	\$2.90	\$2.90	\$4.40	\$5.90	\$8.30	\$13.30	\$21.30	\$40.40	\$61.80	\$100.30	\$191.10

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DISABILITY

LONG-TERM DISABILITY

LONG-TERM DISABILITY (LTD)



Serious illnesses or accidents can come out of nowhere. They can interrupt your life and your ability to work for months – even years.

Long-term disability provides financial protection for you by paying a portion of your income, so you have financial support to manage your disability and your household.

PLAN FEATURES	LONG-TERM DISABILITY (LTD)
Cost of Coverage	100% Employer Paid
Elimination Period <i>This is the number of days that must pass between your first day of a covered disability & the day you can begin to receive your disability benefits.</i>	Your elimination period is 90 days
Benefit Duration <i>The maximum number of weeks you can receive benefits while you are sick or disabled.</i>	Payments will last for as long as you are disabled, or until you reach Social Security Normal Retirement Age You must be sick or disabled for the duration of the elimination period before you can receive a benefit payment.
Coverage Amount	Covers 60% of your monthly income , up to a maximum benefit of \$8,000 per month .
What's covered?	A variety of conditions and injuries. Typical claims would include: cancer, back disorders, injuries and poison, cardiovascular, joint disorders.
Definition of Earnings	Base Salary
ADDITIONAL PLAN PROVISIONS	
Benefit Payment Frequency	Monthly benefit may be reduced or offset by other sources of income.
Cost Calculation	Age Rated Benefit – Cost depends on your age on the effective date
Pre-Existing Condition Limitation	You have a pre-existing condition if you have received: medical treatment, consultation, care or services including diagnostic measures for the condition, or took prescribed drugs or medicines for it in the 12 months just prior to your effective date of coverage; and the disability begins in the first 12 months after your effective date of coverage.

Certain exclusions and any pre-existing condition limitations may apply. Please refer to the Provider's detailed benefit summary for details.

ACCIDENT, CRITICAL ILLNESS, & HOSPITAL INDEMNITY

VOLUNTARY BENEFITS



Accident Insurance

No one plans to have an accident. But it can happen at any moment throughout the day, whether at home or at play. Most major medical insurance plans only pay a portion of the bills. This coverage can help pick up where other insurance leaves off and provide cash to help cover the expenses.

FILING STATUS	Monthly Rate
Employee Only	\$7.86
Employee + Spouse	\$11.60
Employee + Child(ren)	\$13.86
Family	\$20.92

Critical Illness Insurance

Critical illness coverage can help offer peace of mind when a critical illness diagnosis occurs. The signs pointing to a critical illness are not always clear and may not be preventable, but this coverage can help offer financial protection in the event you are diagnosed.

Rates per \$1,000^{1,2}

Age	Employee	Spouse
<25	\$0.141	\$0.141
25-29	\$0.207	\$0.207
30-34	\$0.325	\$0.325
35-39	\$0.387	\$0.387
40-44	\$0.541	\$0.541
45-49	\$0.777	\$0.777
50-54	\$1.157	\$1.157
55-59	\$1.616	\$1.616
60-64	\$2.342	\$2.342
65-69	\$3.323	\$3.323
70+	\$4.828	\$4.828

¹ Children are automatically covered for no additional cost.

² Employee and spouse are charged separately, based on individual ages.

Hospital Indemnity Insurance

A hospital stay can be expensive. Be ready for costs not covered by your medical plan with hospital indemnity insurance. Principle Hospital Indemnity Insurance payments can be used to help cover these unexpected costs or to cover other expenses. A standard hospital insurance plan may include coverage for hospital admission, accident-related inpatient rehabilitation and hospital stays. For complete details on what this plan offers, please see the benefit summary.

FILING STATUS	Monthly Rate
Employee Only	\$14.92
Employee + Spouse	\$34.82
Employee + Child(ren)	\$24.26
Family	\$45.92



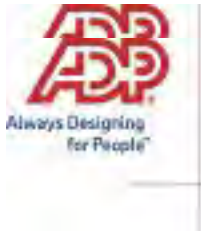
Always Designing
for People™

Employee Self-Service Guide

Employee Open Enrollment Communication and Instruction

ADP Benefits & Talent Solutions





Sample Communication

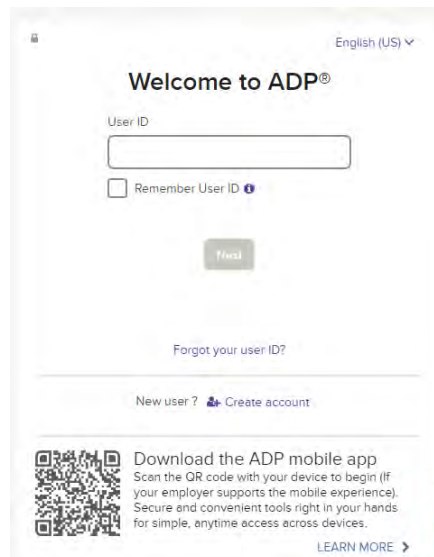
Dear Employee,

We are excited to announce the start of Open Enrollment on the *Employee Self Service** website.

This letter explains what you need to do to complete your enrollments. The Open Enrollment period will last **14 days**, starting **November 4th at 12:01 a.m.** and ending **November 17th at 11:59 p.m.** All changes to your benefits must be completed by **November 17th at 11:59 p.m.** The changes that you make to your benefits will take effect on **January 1st, 2025.**

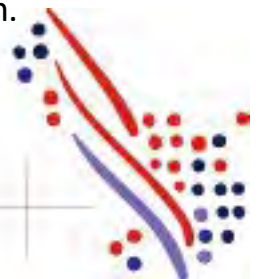
Log in to Workforce Now to access the Employee Self-Service* website.

<https://workforcenow.adp.com>



Enter your User ID and password, and then click **Sign In**.

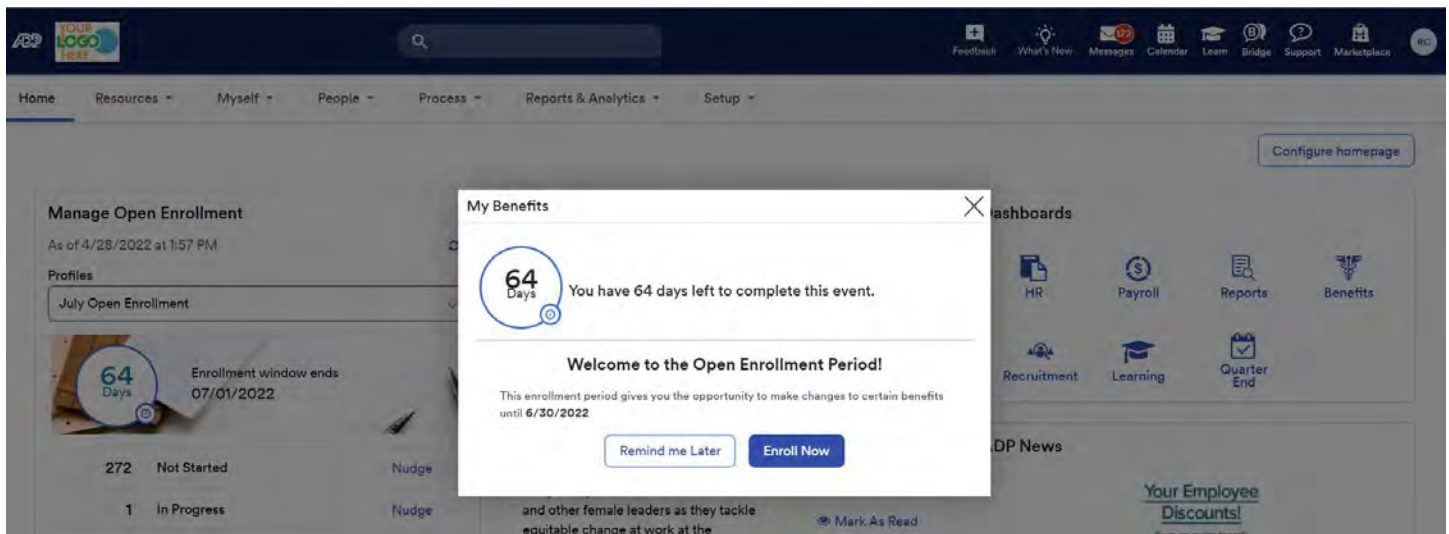
Note: If this is your first time logging in, click **Create account**. If you are unsure of the registration code, please try using your cell phone or email, or contact your HR team.



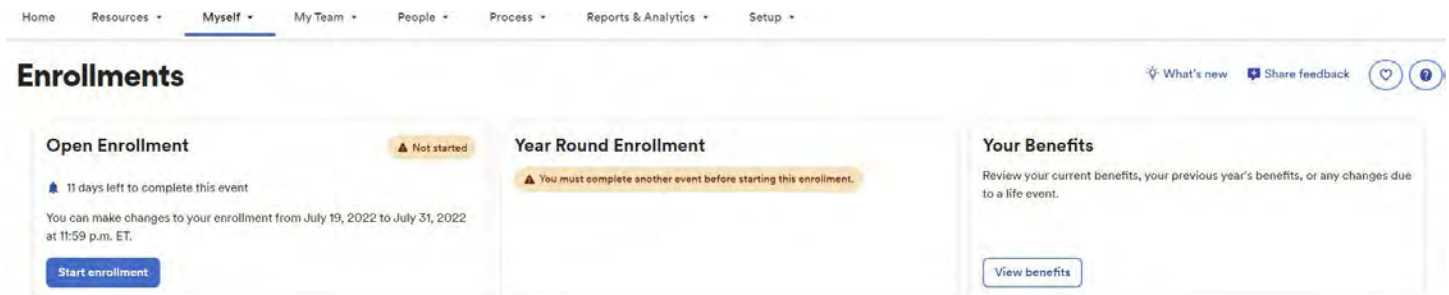


Upon logging in, you will be presented with a pop-up showing important information about this Open Enrollment period. You can click **Enroll Now** or **Remind Me Later**.

Note: This pop-up is displayed each time you log in during the Open Enrollment period. 24-hours after submitting your selections the pop-up will no longer display.



Select **Enroll Now** will bring you to the Myself – Benefits – Enrollments screen where you can click **Start Enrollment**.





You will be taken to the **Welcome Note**. Please review all information on this page, as there are often important details regarding your Open Enrollment options. Click **Next** after reviewing the Welcome Note to move to **Manage Dependents**.

Open Enrollment

Welcome

Welcome

Welcome to the Open Enrollment period. This enrollment period gives you the opportunity to make election changes for certain benefits. During this enrollment period you can:

- Make changes to plan contributions, such as health savings account (HSA) or retirement plans
- Add or change the level of your insurance coverage
- Add or update Beneficiary assignment
- Complete Beneficiary assignment

Please review your options and costs carefully. Once the enrollment period has ended your choices will be final until the next enrollment period or until you have a qualifying life event. Contact your Human Resources department if you have questions.

Back Next

The **Manage Dependents** page is where you can add/view/edit your dependent and beneficiaries. Select “**Add dependent or beneficiary**” to add a new dependent/beneficiary. You would use the *3-dot* action icon to view/edit an existing dependent/beneficiary.

Open Enrollment

Welcome

Manage Dependents

Review your dependents before you enroll.

Add dependent or beneficiary

Sally Snow

Type
Dependent

Relationship
Spouse

Finish later Back Next





Click **Next** to proceed to **Surveys**.

The **Survey** screen will prompt **only** if applicable based on the settings within the enrollment profile itself. If any tobacco attestation is required you must acknowledge the attestation (“I agree that all the information provided about my dependents and my tobacco usage is true and correct”) in order for **Next** to be available and allow you to continue to the **Select Benefits** page.





Employee Self Service is split up into three sections: Action Required, Selected Plans and Eligible Benefits.

- **Action Required** –*These are items that need to be reviewed to move forward. These plans could require a beneficiary to be designated or a waive reason to be provided.*

- **Selected Plans** –*These are benefit plans that you are already enrolled in and can make changes to. This section also displays any enrollments that are pending additional approval.*





- **Eligible Benefits** –*These are other benefit plans that are available for you to enroll in. If you select a benefit plan in the eligible benefits section, the enrollment will be moved to the Enrolled Benefits section.*

Open Enrollment

Eligible Plans
You're eligible to enroll in the following plans.

- Vision** [View all plans](#)
Vision, All Employee
You have 1 benefit options available to choose from. See what is right for you!
- Health Savings Account** [View all plans](#)
RC HSA
You have 1 benefit options available to choose from. See what is right for you!
- FSA Health Care** [View all plans](#)
Multiple available options

[Finish later](#) [Back](#) [Next](#)

Waive benefit should only display for benefit plan types that require a waive reason. Employees should only select **Waive benefit** if you do not want to continue enrollment in a benefit or are not enrolled currently and a waive reason is required.

If you chose to **waive** a benefit, you will be required to select a **Waive Reason**.

Waive Benefit

Are you sure you want to waive Dental benefit?

Warning: Waiving this benefit means you do not require coverage. You can still enroll in the plan while the enrollment period is open.

Waive Reason

Select a reason

- Coverage does not meet my needs
- Do not want to be insured
- Participating in Domestic Partner's Plan
- Participating in Parent's Plan
- Plan to participate in State Exchange Plan
- Participating in Spouse's Plan
- Participating in State Exchange Plan
- Too Expensive

[No, cancel](#) [Yes, waive benefit](#)





View all plans will allow the employee to view the plans that are available in that plan grouping.

Eligible Plans

You're eligible to enroll in the following plans.

Medical Waive benefit [View all plans](#)

Multiple available options
You have 3 benefit options available to choose from. See what is right for you!

While enrolling in a plan, please be sure to indicate which dependents should be covered in the **Covered Individuals** section, if applicable. Then proceed with your enrollment.

Available Plans

Medical

Select the plan that meets your needs and add the dependents you want to cover.

Your company requires you to enter a reason to waive this coverage.

Covered Individuals

John Snow (You) Sally Snow (Spouse)

4 Plans Available [Plan comparison](#)

Plan Name	Employer cost per paycheck	Your cost per paycheck
Aetna Choice PPO (1 individual selected) Provider: Aetna Inc. Select plan	\$245.90	\$112.52
RC HDHP (1 individual selected) Additional details		

[Waive benefit](#) [Back](#)

Note: The coverage level for your enrollment (Employee Only, Employee + Spouse, Employee + Child(ren), Employee + Family) is driven by which dependents you enroll.





When you choose to enroll in a plan, it will display the **Per Paycheck** cost for the employee and employer.

RC PPO, Medical PPO (1 individual selected)		
Provider Aetna Inc.	Employer cost per paycheck \$60.00	Your cost per paycheck \$57.00
⚠️ Confirm the details for this plan selection or waive this benefit.		Confirm details

Confirm details may include some additional information needed (i.e. PCP-ID).

Confirm Details

Aetna Inc.: RC PPO
Medical PPO

Covered Individual
You

Primary Care Physician Details

John Snow
Enter Primary Care Physician Details

First Name	Last Name	ID Number
<input type="text"/>	<input type="text"/>	<input type="text"/>

Per Paycheck Costs
Total Cost Per Paycheck
\$57.00

[Back](#) [Confirm](#)

Review your enrollment, costs, and covered individuals carefully before clicking on **Confirm**. Once confirmed, you will receive a confirmation message that you are now enrolled and the enrollment will be displayed under **Selected Plans**.

Select Benefits

You enrolled in RC PPO, Medical PPO.

47 days left to enroll Effective: October 1, 2022	Employer cost per paycheck \$60.00	Your cost per paycheck \$57.00	Go to section
---	--	--	-------------------------------

Selected Plans

You are enrolled in the following plans. You can make changes until the enrollment period closes.

Medical Waive benefit [View all plans](#)

RC PPO Effective: October 1, 2022	Selected
Who is covered? You	Per Paycheck \$57.00





Voluntary Life Elections and Beneficiaries:

When you elect Voluntary Life, you will also need to designate your beneficiaries. Start by clicking **View all plans**, and then choose the amount of coverage you want to elect from the drop down.

Available Plans ✕

Covered Individual

John Snow (You)

1 Plan Available

BT - Voluntary Life
(1 individual selected)

Provider
Guardian Life

Select Coverage Amount

Additional Coverage Total Actual Coverage Amount **\$240,000.00**

Evidence of Insurability will be required for this enrollment.

Over The Limit - Approval Required
The Total Actual Coverage Amount is over the guarantee issue amount of \$150,000.00. That amount requires Evidence of Insurability (EOI) and approval from the insurance carrier.

Per Paycheck Costs

Employer cost per paycheck	\$0.00	Your cost per paycheck	\$17.50
----------------------------	--------	------------------------	---------

[Back](#)

If the amount selected is over the Guarantee Issue amount, additional approval will be required, and you will be asked to complete **Evidence of Insurability (EOI)** and submit it to your employer. Your full election amount will not be approved until this process is completed. Next you will want to enter your beneficiary designation. Including **Primary** and **Secondary**, if applicable. All beneficiary delegation percentages combined must equal 100% for each category (Primary or Secondary).

Beneficiaries [Add beneficiary](#)

Allocate the percentages of your benefits payout. You can divide the percent paid to as many beneficiaries as you want, but the total must equal 100%.

Beneficiary	Primary	Secondary
Sally Snow Spouse	<input type="text" value="100"/> %	<input type="text" value="0"/> %
Total	100.00%	0.00%

Evidence of Insurability will be required for this plan selection. [Confirm details](#)

Click **Confirm details** and review your selection and beneficiary delegations.





Then click **Confirm** to continue with your enrollment elections.

Confirm Details

Guardian Life: BT - Voluntary Life

Covered Individual	
You	
Coverage	
Total Actual Coverage Amount	
\$240,000.00	
Beneficiaries	
Sally Snow (Spouse)	Primary (100.00%)
Per Paycheck Costs	
Employer Cost	Your Cost
\$0.00	\$17.50

[Back](#) [Confirm](#)

Continue through each step until all elections are complete and all tasks under the **Action Required** section are addressed. When ready to proceed to the Summary page, click **Next** to proceed to **Review and Submit** step.

Open Enrollment

- Welcome
- Manage Dependents
- Surveys
- Select Benefits**
- Review and Submit

Select Benefits

46 days left to enroll
Effective: October 1, 2022

Employer cost per paycheck: **\$553.26** Your cost per paycheck: **\$293.17** [Go to section](#)

Selected Plans

You are enrolled in the following plans. You can make changes until the enrollment period closes.

Medical [Waive benefit](#) [View all plans](#)

Aetna Choice PPO
Effective: October 1, 2022

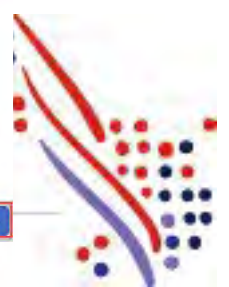
Who is covered?
You and Sally Snow

Selected

Per Paycheck
\$253.17

Dental [View all plans](#)

[Finish later](#) [Back](#) [Next](#)





Review all of your selections/changes. When you have confirmed them, click **Submit Enrollment**. Note that your benefit elections will not be processed until you click **Submit Enrollment**. If you click **Save for later** instead, these enrollments will not be submitted to your HR team until you fully submit the enrollment changes.

Open Enrollment

Navigation menu: Welcome, Manage Dependents, Surveys, Select Benefits, **Review and Submit**

Review and Submit

46 days left to enroll
Effective: October 1, 2022

Employer cost per paycheck: **\$553.26** Your cost per paycheck: **\$293.17**

Your benefit elections will not be effective until you click Submit enrollment.

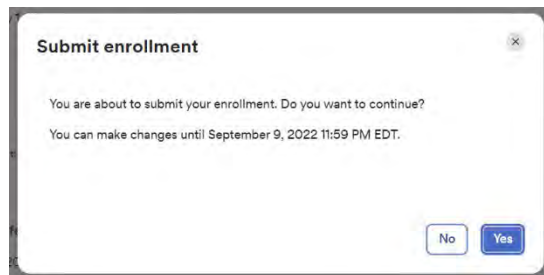
Enrolled plans

You are enrolled in the following plans. You can make changes until the enrollment period closes.

Medical Effective: October 1, 2022 Aetna Choice PPO Who is covered? You and Sally Snow	Enrolled \$253.17 Per Paycheck
---	--

Buttons: Finish later, Back, **Submit enrollment**

There will be a pop-up confirming your submission notating the date and time of submission. Please ensure you receive the confirmation note indicating your elections have been submitted.



Enrollments

You have completed your enrollment.
You have successfully completed your Open Enrollment October 2022 enrollment.

Open Enrollment

Submitted

46 days left to make changes

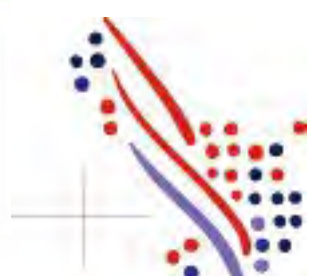
You can make changes to your enrollment from July 5, 2022 to September 9, 2022 at 11:59 p.m. ET.

[Manage enrollment](#)

Your Benefits

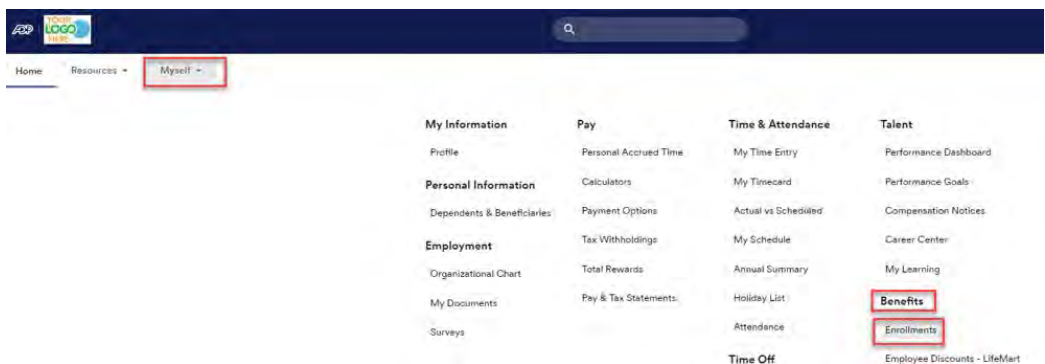
Review your current benefits, your previous year's benefits, or any changes due to a life event.

[View benefits](#)





If you would like to make additional changes or modifications during the Open Enrollment Period, you may log in and navigate to **Myself > Benefits > Enrollments** and click the **Manage Enrollment** option in the Open Enrollment box. This will bring you back to the beginning of the profile to make any desired election changes.



Enrollments

Open Enrollment ✔ Submitted

🔔 47 days left to make changes

The enrollment period is still open. You can make changes until September 9, 2022 at 11:59 p.m. ET.

[Manage enrollment](#) [Reset event](#)

You may also navigate by finding the **My Benefits** tile on the homepage and select **Manage**. The tile will also reflect the “Submitted” status with the date and time of submission.

My Benefits

Open Enrollment

Submitted

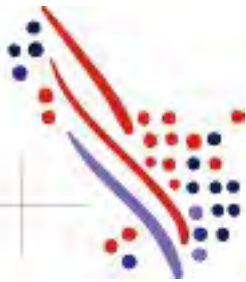
7/25/2022 6:41 AM

[Manage](#)

As of 7/25/2022 at 6:41 AM

Medical You

Aetna Inc.



Disclaimer: This Guide provides an overview of OBU's benefit programs and should not be considered complete. If any conflicts between the information in this guide and the actual insurance contracts or benefit programs/policies exist, the insurance contracts/policies will rule. Please note that OBU reserves the right to change or terminate any benefits at any time with or without notice .



GuideStone.org | 1-844-INS-GUIDE