

Health Saver 2600

Effective January 1, 2010

This chart provides a summary of the benefits and prescription drug program for Health Saver 2600, a qualified high deductible health plan, eligible for use with a Health Savings Account (HSA).

See the reverse side for a glossary of terms used.

PLAN FEATURES		
In-network	Deductible for an individual	\$2,600 ¹
	Deductible for a family	\$5,200 ¹
	Plan pays (after deductible)	100% ²
	Annual coinsurance maximum for an individual	N/A
	Annual coinsurance maximum for a family	N/A
	Primary care physician office visit / Specialist office visit	100% ²
	Wellness and preventive care (primary care / specialist)	100% (no deductible)
	Hospital inpatient including maternity (per admission)	100% ²
	Outpatient surgery (per occurrence)	100% ²
	Emergency room (per visit)	100% ²
	Outpatient services (CT scans; MRI; diagnostic)	100% ²
	Chiropractic services (20 visits annually)	100% ²
Mental health and substance abuse: all services	100% ²	
Out-of-network	Deductible for an individual	\$5,200 ¹
	Deductible for a family	\$10,400 ¹
	Plan pays / individual pays (coinsurance)	60% / 40%
	Annual coinsurance maximum for an individual	\$6,000
	Annual coinsurance maximum for a family	\$12,000
	Wellness and preventive care	Not covered
	Hospital inpatient including maternity (per admission)	60% ²
	Outpatient surgery (per occurrence)	60% ²
	Emergency room: for emergencies only, as determined by Highmark	100% ²
	Non-emergency use of emergency room	60% ²
Mental health and substance abuse: all services	60% ²	

PRESCRIPTION DRUG PROGRAM		
	Individual / family ¹	\$2,600 / \$5,200
Retail (30-day supply)	Generic	100% after deductible
	Preferred	100% after deductible ³
	Non-preferred	100% after deductible ³
Mail Order (90-day supply)	Generic	100% after deductible
	Preferred	100% after deductible ³
	Non-preferred	100% after deductible ³
	Specialty drug	100% after deductible

¹Your deductible is met by both medical and prescription drug expenses.

²Plan deductible must be met before benefits are paid.

³If a preferred or non-preferred drug is purchased when a generic is available, the cost difference between the preferred/non-preferred drug and its generic equivalent will not apply to the participant's deductible or out-of-pocket expenses. After the deductible is met, the participant must pay the cost difference between the preferred/non-preferred drug and its generic equivalent if available.



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Glossary of terms

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

Coinsurance maximum — The most you will have to pay in a year in coinsurance for covered benefits after you meet your deductible.

Deductible — The up-front, out-of-pocket expense. Participants must meet their deductible with eligible charges before claims will be paid.

Family deductible — When family members meet the plan amount determined to be the family deductible, the plan will consider all family members to have met their deductibles. One individual cannot contribute to the family deductible more than the amount determined to be the individual deductible (this is an embedded deductible).

Generic — A term used for prescription drugs identified by their chemical name. 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.

Individual deductible — When an individual meets the plan amount determined to be the individual deductible, the plan will begin paying claims for that individual at the coinsurance level.

In-network — Health care services received from a provider in a network.

Mail order — When you need a prescription drug on an ongoing basis, you can mail your prescription to the Medco by Mail™ service to receive prescriptions for up to a 90-day supply of medication.

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 your plan's costs.

Retail pharmacy benefits — When you need a prescription on a short-term basis, you can fill your prescription at a local participating network pharmacy to receive prescriptions for up to a 30-day supply.

Specialist — Any physician not considered a primary care physician.

Wellness and preventive care — Covered services are based on a preventive health schedule which includes preventive services for children and adults based on recommendations from the U.S. Preventive Service Task Force, the Centers for Disease Control and Prevention, the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics.

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 summary 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.