

Health Choice 3000

Schedule of Benefits



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Produced by GuideStone Financial Resources of the Southern Baptist Convention

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Intended For GuideStone Participant Use Only

Schedule of Benefits

This is your Schedule of Benefits for the Health Choice 3000 Plan (Plan). The Plan is offered by GuideStone Financial Resources of the Southern Baptist Convention. The Schedule of Benefits highlights the benefits available under the Plan and how your Copayments and Coinsurance works for You and your Dependent(s). It does not tell You all the details about your PPO Plan. Those details are in your Plan booklet, which tells you:

- How to enroll in the Plan
- When Plan coverage begins and ends
- What services and supplies the Plan covers
- Limitations on any Covered Services and Supplies
- What services and supplies are excluded from Plan coverage
- How to file a claim for benefits under the Plan
- Special meanings of some of the words used in the Schedule of Benefits

The effective date of the Plan is January 1, 2011, however your effective date is determined by the date You enter the Plan. If you received medical services or supplies before your effective date for this Plan, claims for those services or supplies will be paid under the terms of the applicable plan in effect when the claims were incurred. Usually, a claim is incurred when a Covered Service or Supply is received by a Covered Person.

Important phone numbers

GuideStone Customer Relations: **1-888-98GUIDE (984-8433)**

Highmark Blue Cross Blue Shield (Highmark): **1-866-472-0924**

Blue Cross Blue Shield Provider Network: **1-800-810-BLUE (2583)**

BlueCard Worldwide® (International Claims): **1-800-810-2583 with AT&T access code or collect 804-673-1177**

Highmark Maternity Education and Support Program (**Baby BluePrints**®): **1-866-918-5267**

Medco Health Solutions, Inc. (Medco Health): **1-800-555-3432**

Medco Health Solutions, Inc. (International Claims): **1-800-497-4641 with AT&T access code or collect 614-421-8292**

Important Web sites

www.GuideStone.org

www.bcbs.com

www.highmarkbcbs.com

www.medco.com

Benefit summary

Benefits	In-Network Care	Out-of-Network Care
Deductible Individual Family	\$3,000 \$5,000	\$5,000 \$10,000
Payment level/Coinsurance Excludes Copayments	70% after Deductible until Annual Coinsurance Maximum is met; then 100%	50% after Deductible until Annual Coinsurance Maximum is met; then 100% (based on Provider's Allowable Charge)
Annual Coinsurance Maximums (after deductible)	\$5,000 Individual \$5,000 Family	\$10,000 Individual \$10,000 Family
Lifetime Maximum	Unlimited	Unlimited
Physician office Visit (Primary Care) ¹ Includes lab and x-ray Services	100% after \$25 Copayment	50% after deductible
Specialist office Visit ¹ Includes lab and x-ray Services	100% after \$45 Copayment	50% after deductible
Wellness Benefit ²	100%	Not covered
Emergency Care ³	70% after \$100 Copayment	70% ³ after deductible
Emergency Room Services (other than for Emergency Care)	70% after deductible	50% after deductible
Ambulance	70% after deductible	50% after deductible
Hospital expenses Inpatient ⁴ Outpatient	70% after deductible 70% after deductible	50% after deductible 50% after deductible
Maternity	70% after deductible	50% after deductible
Infertility counseling and testing	70% after deductible	50% after deductible
Medical/Surgical expenses	70% after deductible	50% after deductible
Chiropractic treatment Maximum 20 Visits per Benefit Period	100% after \$45 Copayment	50% after deductible
Organ transplants	Blue Distinction Centers 100% after deductible Non Blue Distinction Centers 70% after deductible	50% after deductible
Diagnostic Services (Lab, x-ray and other tests)	70% after deductible	50% after deductible
Physical Therapy (Professional)	70% after deductible	50% after deductible
Speech & Occupational Therapy (Professional)	70% after deductible	50% after deductible
Durable Medical Equipment	70% after deductible	50% after deductible
Skilled Nursing Facility care Maximum 120 days	70% after deductible	50% after deductible

Benefits	In-Network Care	Out-of-Network Care
Home Health Care Maximum 120 Visits/Benefit Period	70% after deductible	50% after deductible
Hospice Maximum \$10,000 per episode	70% after deductible	50% after deductible
Autism Disorders for dependent children Applied Behavior Analysis ⁵ Speech Therapy ⁶ Occupational Therapy ⁷ Physical Therapy ⁸	70% after deductible	50% after deductible
Mental health and Alcohol or Drug Abuse Inpatient ⁴ Outpatient	70% 100% after \$25 Copayment	50% after deductible 50% after deductible
Pre-authorization requirements ⁴	Performed by member Failure to Pre-authorize an Inpatient admission will result in a 20% benefit reduction	

1. See Physician office Visit Copayments for limitations.
2. See **Covered Services and Supplies** for information about Wellness Benefit as defined by the preventive health schedule.
3. For services provided by an Out-of-Network emergency facility for Emergency Care (as determined by the Claims Administrator), the plan will pay 70% of whichever of the following amounts is greatest:
 - The median of the amounts negotiated with each Network Provider (excluding any applicable copayment or coinsurance);
 - The Allowable Charge (excluding any applicable copayment or coinsurance); or
 - The amount that would be paid under Medicare Parts A or B (excluding any applicable copayment or coinsurance).
4. Member is required to contact Blue Cross Blue Shield Healthcare Management Services prior to a planned Inpatient admission or within 48 hours of an admission to a Hospital as an Inpatient for Emergency Care. If this does not occur and it is later determined that all or part of the Inpatient stay was not Medically Necessary and Appropriate, the patient will be responsible for payment of any costs not covered.
5. Applied behavior analysis limited to \$35,000 per Benefit Period and \$150,000 per lifetime only available to dependent children through age 16.
6. Speech Therapy is limited to 50 visits per Benefit Period and only available to dependent children to age 6.
7. Occupational Therapy is limited to 50 visits per Benefit Period and only available to dependent children through age 16.
8. Physical Therapy is limited to 50 visits per Benefit Period and only available to dependent children through age 16.

Outpatient Prescription Drug	Plan pays	You pay ⁹	Individual ¹⁰ Deductible	Family ¹⁰ Deductible		
Retail (up to 30-day supply)						
Generic	Cost over Copayment	\$15	\$100	\$200		
Brand name preferred ¹¹	Cost over Copayment	\$35				
Brand name non-preferred ¹¹	Cost over Copayment	\$50				
Mail order (up to 90-day supply)						
Generic	Cost over Copayment	\$35				
Brand name preferred ¹¹	Cost over Copayment	\$90				
Brand name non-preferred ¹¹	Cost over Copayment	\$125				
Specialty drug	Cost over Copayment	\$50 for a 30 day supply				

⁹ Copayment or drug cost, whichever is less.

¹⁰ The Individual deductible and Family deductible for Retail and Mail order are combined.

¹¹ If a brand name drug is purchased when a generic is available, You must pay the generic Copayment **plus** the difference in cost between the brand name drug and its generic equivalent.

Medical benefits

Eligible Expenses

This Plan helps pay many of your medical expenses. However, it does not cover all medical expenses and it limits how much it pays for some expenses. Expenses that the Plan may cover are called Eligible Expenses.

To be an Eligible Expense, an expense must meet all of these rules:

- It must be a charge You have to pay for a Covered Service and Supply.
- It must not be more than the Allowable Charge for that Covered Service and Supply.
- It must not be excluded.
- It must not be more than any Plan limit on that Covered Service and Supply.

Benefit limits

The Plan limits what it covers for some medical Services and supplies. For example, the Plan limits the dollar amounts it pays for some Covered Services and Supplies. It also limits the number of days or Visits it pays for some covered Services.

Read the description of Services and supplies with Plan limits in **Covered Services and Supplies** in the PPO Plan Booklet and the **Benefit summary** for more information on the specific benefit limits.

Greater benefits when You use Network Providers

GuideStone has arranged for You to have access to the Blue Cross Blue Shield PPOs . A PPO is a Preferred Provider Organization made up of Physicians, Hospitals and other health care Providers (not including pharmacies). PPOs and other provider organizations are called “Networks.” They have agreed to accept a negotiated rate for their Services. The Plan calls the Providers in these negotiated arrangements “Network Providers.” All other Providers are called “Out-of-Network Providers.”

You will have access to the names of Network Providers in your area. Health care Providers participate in Networks by choice and they can choose to stop participating in a Network at any time. Network Service is care You receive from Providers in the PPO program’s Network. This Network includes Primary Care Physicians and a range of Specialist Physicians, as well as Hospitals and a variety of other treatment facilities. Remember to call **1-800-810-BLUE (2583)** or go to www.highmarkbcbs.com to locate the Provider nearest You or to check that your current Provider is in the Network. When You receive Covered Services and Supplies from Network Providers, You usually spend less Out-of-Pocket due to Network discounts and Coinsurance provisions. You present your Medical Identification Card (Medical ID card) to the Provider who submits your Claim to the local Blue Cross Blue Shield plan.

Deductibles and Copayments

A Deductible is the amount that You must pay out of your pocket for Eligible Expenses before the Plan pays any benefits. After You pay the Deductible, the Plan pays a percentage of the rest of your Eligible Expenses. As a general rule, the Plan counts the amounts You pay for Eligible Expenses from Network or Out-of-Network Providers toward your Deductibles.

A Copayment is the amount that You must pay out of your pocket for Eligible Expenses before the Plan pays any benefits. After You pay the Copayment, the Plan pays a percentage of the rest of your Eligible Expenses. Services subject to the Network Copayments are not subject to the individual or Family Deductible.

Four separate Deductibles and Copayments might apply:

- Individual Deductible.
- Family Deductible.
- Office Visit Copayment (per Visit).
- Emergency Care Copayment (per Visit)

Individual Deductible: An individual Deductible is the amount a Covered Person must pay for Eligible Expenses each Benefit Period before the Plan pays any benefits for the Covered Person for the rest of the Benefit Period. After You pay the individual Deductible, the Plan pays a percentage of the rest of your Eligible Expenses. Only payments for Eligible Expenses count toward the individual Deductible.

Your individual Deductible is:

- **\$3,000** if You go to a Network Provider.
- **\$5,000** if You go to an Out-of-Network Provider.

Family Deductible: A Family Deductible is the amount You and each Covered Person in your family must pay for Eligible Expenses each Benefit Period before the Plan pays any benefits for each Covered Person in your family for the rest of the Benefit Period. After You pay the Family Deductible, the Plan pays a percentage of the rest of the Eligible Expenses for each Covered Person in the family. Only payments for Eligible Expenses count toward the Family Deductible. No more than a specific amount for each Covered Person in your family will count toward the Family Deductible.

Your Family Deductible is:

- **\$5,000** if You or your Covered Dependents go to a Network Provider. No more than \$3,000 for each Covered Person in your family will count toward the Family Deductible.
- **\$10,000** if You or your Covered Dependents go to an Out-of-Network Provider. No more than \$5,000 for each Covered Person in your family will count toward the Family Deductible.

Office Visit Copayment: There is a special Copayment called the office Visit Copayment. **The office Visit Copayment is \$25 for Network Primary Care Physicians and \$45 for Network Specialist Physicians.** You may have to pay this when You visit a Network Physician. With respect to the office Visit Copayment, patient x-ray and laboratory charges will follow these rules:

- If You or an Eligible Dependent goes to a Network freestanding x-ray or laboratory facility, the office Visit Copayment will not apply and the normal Network level of benefits will apply. If the x-ray or laboratory facility is not a Network Provider, the level of benefits for Out-of-Network Providers will apply.
- If You or an Eligible Dependent goes to a Network Primary Care Physician and the Physician sends the x-ray or laboratory work to a Network facility for processing, the office Visit Copayment will apply.
- If You or an Eligible Dependent goes to a Network Primary Care Physician and the Physician sends the x-ray or laboratory work to an Out-of-Network facility for processing, the office Visit Copayment will apply.
- Under Wellness Benefit, if You or an Eligible Dependent goes to a Network Out-Patient Hospital or a Network freestanding facility for routine lab or x-ray charges, these routine Services will be considered at 100% subject to the preventive health schedule. See **Covered Services and Supplies.**

These special rules apply to the office Visit Copayment: Some Eligible Expenses for Covered Services and Supplies are not covered under the office Visit Copayment even if they are both provided and billed by the Network Physician. These include Services such as:

- Office Surgery (excludes venipuncture).
- MRIs, CT Scans, and PET Scans even if administered in a Physician's office.
- Applied Behavior Analysis.
- Occupational Therapy, Physical Therapy or Speech Therapy.

Eligible Expenses that are not included in Copayments are subject to the Deductibles.

- The office Visit Copayment does not count toward any Plan Deductible.
- The office Visit Copayment does not count toward any Annual Coinsurance Maximums and continues to apply once the Annual Coinsurance Maximum is met.

Emergency Care Copayment. This Copayment applies to each Emergency Care Visit regardless of whether You have met the individual or Family Deductible.

Your Emergency Care Copayment is:

- **\$100** if You go to a Network Provider.
- Emergency Care Copayment does not apply if You go to an Out-of-Network Provider; however, charges are subject to the Benefit Period Deductible.

Emergency Care Copayment exceptions:

- This Copayment does not apply if You are admitted as an Inpatient through the emergency room.
- This Copayment does not apply to the Annual Coinsurance Maximum and continues to apply once the Annual Coinsurance Maximum is met.

Coinsurance

In most cases, this Plan does not pay for all of your Eligible Expenses. It usually pays only a percentage of Eligible Expenses after You pay your Deductibles. This percentage is the Coinsurance. **There is one exception to this rule: If You go to a Network Primary Care Physician, your office Visit may be subject to the office Visit Copayment.** See **Deductibles and Copayments** for details.

The Plan's Coinsurance usually is:

- 70% of the negotiated rate for Eligible Expenses when You go to Network Providers. This does not apply to those Eligible Expenses that are covered by the office Visit Copayment.
- 50% of Eligible Expenses when You go to Out-of-Network Providers.
- 100% of the negotiated rate for Eligible Expenses when You go to a Network Primary Care Physician and You pay the office Visit Copayment. This applies only for those Eligible Expenses that are covered by the office Visit Copayment. See **Deductibles and Copayments** for details.

Your Coinsurance usually is:

- 30% of Eligible Expenses when You go to Network Providers. This does not apply to those Eligible Expenses that are covered by the office Visit Copayments.
- 50% of Eligible Expenses when You go to Out-of-Network Providers.

Exceptions to normal payment rules: The benefit rules described above do not apply when:

- A treatment or Service is performed by an Out-of-Network Provider at a Network Facility and the Out-of-Network Provider was not requested. Benefits for such treatment will be paid at the Network level.
- A treatment or Service is performed by a Specialist Physician for a listed Eligible Expense and a Network Provider is not available in the Network area. Benefits for such treatment will be paid at the Network level if approved by the claims Administrator prior to obtaining such treatment or Service.
- Emergency Care is performed due to an Emergency Medical Condition (see **Emergency Medical Conditions** in the Definitions section of the booklet). Benefits for such treatment will be paid at the Network level (see the Benefit summary for additional information). Then Emergency Care copayment does not apply if you go to an Out-of-Network Provider; however, charges are subject to the Benefit Period deductible.

Your Outpatient Prescription Drug coverage has different Copayments. See the **Benefit summary** for Prescription Drug Coverage.

Annual Coinsurance Maximum

Once You pay all applicable Deductibles, the Plan limits your Coinsurance for each Benefit Period. This means that after You have paid a certain amount in Coinsurance, the Plan covers 100% of your remaining Eligible Expenses for the rest of that Benefit Period. The Plan counts the amounts You pay for Eligible Expenses from either Network Providers or Out-of-Network Providers toward your Annual Coinsurance Maximum that applies to either type of Provider.

Office Visit Copayments, Emergency Care Copayments and penalties for not obtaining Pre-authorization review do not count toward the Annual Coinsurance Maximum.

There is an Annual Coinsurance Maximum for each Covered Person and an Annual Coinsurance Maximum for You together with all of your Covered Dependents.

Individual Annual Coinsurance Maximum: This is the amount that a Covered Person must pay in a Benefit Period (after Deductibles), before the Plan pays 100% of the Covered Person's Eligible Expenses for the rest of the Benefit Period.

Your individual Annual Coinsurance Maximum is:

- **\$5,000** if You go to a Network Provider.
- **\$10,000** if You go to an Out-of-Network Provider.

Family Annual Coinsurance Maximum: This is the amount that You and the Covered Dependents in your family must pay in a Benefit Period (after Deductibles) before the Plan pays 100% of a Covered Person's Eligible Expenses for the rest of the Benefit Period.

Your family Annual Coinsurance Maximum is:

- **\$5,000** if You go to a Network Provider.
- **\$10,000** if You go to an Out-of-Network Provider.

Out-of-Pocket reminders: These Services and supplies do not count toward the Annual Coinsurance Maximum:

- Office Visit Copayments.
- Emergency Care Copayments
- Outpatient Prescription Drugs.
- Deductibles.

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