

Health Select 200

Schedule of Benefits



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Produced by GuideStone Financial Resources of the Southern Baptist Convention

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Schedule of Benefits

This is your Schedule of Benefits for the Health Select 200 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	COVERAGE
Deductible Individual Family	\$200 \$400
Payment level/Coinsurance Excludes Copayments	80% after Deductible until Annual Coinsurance Maximum is met; then 100% (based on Provider's Allowable Charge)
Annual Coinsurance Maximums (after deductible)	\$2,000 Individual \$4,000 Family
Lifetime Maximum	Unlimited
Physician office Visits	80% after deductible
Wellness Benefit¹	100%
Emergency Care	80% after \$100 Copayment
Emergency Room Services (other than for Emergency Care)	80% after deductible
Ambulance	80% after deductible
Hospital Expenses Inpatient ² Outpatient	80% after deductible 80% after deductible
Maternity	80% after deductible
Infertility counseling and testing	80% after deductible
Medical/Surgical expenses	80% after deductible
Chiropractic treatment Maximum 20 Visits per Benefit Period	80% after deductible
Organ transplants	100% Blue Distinction Centers 80% Non Blue Distinction Centers
Diagnostic Services (Lab, x-ray, other tests)	80% after deductible
Physical Therapy (Professional)	80% after deductible
Outpatient Speech and Occupational Therapy (Professional)	80% after deductible
Durable Medical Equipment	80% after deductible
Skilled Nursing Facility Care Maximum 120 days	80% after deductible
Home Health Care Maximum 120 Visits/Benefit Period	80% after deductible
Hospice Maximum \$10,000 per episode	80% after deductible
Autism Disorders for dependent children Applied Behavior Analysis ³ Speech Therapy ⁴ Occupational Therapy ⁵ Physical Therapy ⁶	80% after deductible

BENEFITS	COVERAGE
Mental Health and Alcohol or Drug Abuse Inpatient ² Outpatient	80% after deductible 80% after deductible
Pre-authorization requirements²	Performed by member. Failure to Pre-authorize an Inpatient admission will result in a 20% benefit reduction

¹ See **Covered Services and Supplies** for information about the Wellness Benefit as defined in the preventive health schedule.

² Member is required to contact Blue Cross Blue Shield Healthcare Management Services prior to a planned Inpatient admission or within 48 hours of an emergency admission. 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.

³ Applied behavior analysis limited to \$35,000 per Benefit Period and \$150,000 per lifetime only available to dependent children through age 16.

⁴ Speech Therapy is limited to 50 visits per Benefit Period and only available to dependent children to age 6.

⁵ Occupational Therapy is limited to 50 visits per Benefit Period and only available to dependent children through age 16.

⁶ 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 ⁷
Retail (up to 30-day supply)		
Generic	Cost over Copayment	\$15
Brand name preferred ⁸	Cost over Copayment	\$35
Brand name non-preferred ⁸	Cost over Copayment	\$50
Mail order (up to 90-day supply)		
Generic	Cost over Copayment	\$35
Brand name preferred ⁸	Cost over Copayment	\$90
Brand name non-preferred ⁸	Cost over Copayment	\$125
Specialty drug	Cost over Copayment	\$50 for a 30 day supply

⁷ Copayment or drug cost, whichever is less.

⁸ 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 Plan Booklet and the **Benefit summary** for more information on the specific benefit limits.

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 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. Services subject to Copayments are not subject to the individual or Family Deductible

Three separate Deductibles or Copayments may apply:

- Individual Deductible.
- Family Deductible.
- 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: **\$200**.

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: **\$400**. No more than \$200 for each Covered Person in your family will count toward the Family Deductible.

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

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 individual or Family Deductible.
- The 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 and Copayments. This percentage is the Coinsurance.

The Plan's Coinsurance usually is:

- 80% of Eligible Expenses.

Your Coinsurance usually is:

- 20% of Eligible Expenses.

Annual Coinsurance Maximum

Once You pay all applicable Deductibles and Copayments, 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 toward your Annual Coinsurance Maximum.

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 and Copayments), 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: \$2,000.

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 and Copayments) 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: \$4,000. No more than \$2,000 for each Covered Person will count toward this Annual Coinsurance Maximum.

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

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

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