

Health Choice 3000 (80/20) for Group Plans

Effective January 1, 2012

This chart provides a summary of the benefits and prescription drug program for Health Choice 3000 (80/20).

See the reverse side for a glossary of terms used.

PLAN FEATURES		
In-network	Deductible for an individual	\$3,000
	Deductible for a family	\$5,000
	Plan pays / individual pays (coinsurance)	80% / 20%
	Annual coinsurance maximum for an individual / family	\$5,000 after deductible
	Primary care physician copay / Specialist copay	\$25 / \$45
	Wellness and preventive care copay (primary care/specialist)	100% no copay
	Hospital inpatient including maternity (per admission)	80% after deductible
	Outpatient surgery (per occurrence)	80% after deductible
	Emergency room (per visit)	80% after \$100 copay
	Outpatient services (CT scans; MRI; diagnostic)	80% after deductible
	Chiropractic services copay (20 visits annually)	\$45
	Mental health and substance abuse: inpatient / intensive outpatient services	80% after deductible
	Mental health and substance abuse: office and professional services copay	\$25
Vision (one exam every 12 months)	\$25	
Out-of-network	Deductible for an individual	\$5,000
	Deductible for a family	\$10,000
	Plan pays / individual pays (coinsurance)	50% / 50%
	Annual coinsurance maximum for an individual / family	\$10,000 after deductible
	Wellness and preventive care	Not covered
	Hospital inpatient including maternity (per admission)	50% after deductible
	Outpatient surgery (per occurrence)	50% after deductible
	Emergency room services: for emergency care only, as determined by Highmark	80% after \$100 copay
	Emergency room services: other than for emergency care	50% after deductible
	Mental health and substance abuse: all services	50% after deductible
Vision (one exam every 12 months)	50% after deductible	

PRESCRIPTION DRUG PROGRAM		
Retail (30-day supply)	Generic	\$15 copay
	Preferred	\$35 copay ¹
	Non-preferred	\$50 copay ¹
Mail Order (90-day supply)	Generic	\$35 copay
	Preferred	\$90 copay ¹
	Non-preferred	\$125 copay ¹
	Specialty drug	\$50 copay ²

¹If a preferred or non-preferred drug is purchased when a generic is available, the member must pay the generic copayment and the difference in the cost between the preferred/non-preferred drug and its generic equivalent. If the cost of the prescription is less than the copay, the participant will pay the full cost of the prescription.

²Eligible through specialty drug mail order program. \$50 copay up to 30-day supply.


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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. Once you reach your coinsurance maximum, you will still pay office visit and prescription copays.

Copay — The fixed, up-front dollar amount you pay for certain covered expenses. Office visit copay amounts do not apply toward your deductible or coinsurance maximum.

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

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.

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.

Primary care physician copay — The amount you pay for an office visit to a network primary care physician such as a pediatrician, general practitioner, family practitioner, internist or gynecologist.

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 recommendations from the Centers for Disease Control and Prevention, the American College of Obstetricians and Gynecologist, the American Cancer Society January 2008 Colorectal Cancer Screening guidelines and items/services required under the Patient Protection and Affordable Care Act of 2010 (PPACA).

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.