

Basic Health 5000 for Personal Plans

Effective January 1, 2012

This chart provides a summary of the benefits and prescription drug program for the Basic Health 5000 Plan. See the reverse side for a glossary of terms used.

PLAN FEATURES		
In-network	Annual deductible for an individual / family	\$5,000 per person
	Plan pays / individual pays (coinsurance)	50% / 50% ¹
	Annual coinsurance maximum (after deductible)	\$7,000 per person
	Primary care office visit copay (per person, not subject to deductible)	Visits 1–3: \$25 copay Visits 4+: 50% after \$45 copay
	Specialist office visit	50% after deductible
	Wellness visit (per Preventive Care Schedule)	100% no copay, not subject to deductible
	Hospital inpatient including maternity (per admission, after deductible)	50%
	Outpatient surgery (per occurrence, after deductible)	50%
	Emergency room services: for emergency care only, as determined by Highmark (deductible does not apply)	50% after \$150 copay
	Outpatient services (CT scan; MRI; Diagnostic) (after deductible)	50%
	Chiropractic services	Not covered
	Mental health and substance abuse: all services	Not covered
	Lifetime maximum benefit	Unlimited
Out-of-network	Annual deductible for an individual / family	\$10,000 per person
	Coinsurance maximum (after deductible)	No maximum
	Plan pays / individual pays (coinsurance)	50% / 50% ¹
	Wellness and preventive care	Not covered
	Hospital inpatient including maternity (per admission)	50% ¹
	Outpatient surgery (per occurrence)	50% ¹
	Emergency room services: for emergency care only, as determined by Highmark	50% after \$150 copay
	Emergency room services: other than emergency care	50% ¹
Mental health and substance abuse: all services	Not covered	

PRESCRIPTION DRUG PROGRAM	
Individual deductible ²	\$100 per person
Retail (30-day supply)	
Generic copay	\$15
Brand-name drug copay ³ (preferred & non-preferred)	You pay 33% of drug cost, to a maximum of \$300 per prescription
Mail Order (90-day supply)	
Generic copay	\$35
Brand-name drug copay ³ (preferred & non-preferred)	You pay 33% of drug cost, to a maximum of \$900 per prescription

¹Plan deductible must be met before benefits are paid.

²The individual/family prescription drug deductible is combined for retail and mail order.

³If a preferred or non-preferred drug is purchased when a generic is available, you must pay the generic copayment plus the difference between the cost of the preferred/non-preferred drug and the cost of its generic equivalent.

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 of any bodily organ or part.

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.

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

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.

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 Highmark's preventive health schedule for GuideStone.

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.