

Health Saver 3000 for Group Plans

Effective January 1, 2012

This chart provides a summary of the benefits and prescription drug program for Health Saver 3000, 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 employee-only coverage	\$3,000 ¹
	Deductible for employee + dependent(s) coverage (aggregate)	\$6,000 ¹
	Plan pays (coinsurance)	100% ²
	Annual coinsurance maximum	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
	Urgent care	100% ²
	Outpatient services (CT scans; MRI; diagnostic)	100% ²
	Chiropractic services (20 visits annually)	100% ²
	Mental health and substance abuse: inpatient / intensive outpatient services	100% ²
	Mental health and substance abuse: office and professional services	100% ²
Out-of-network	Deductible for employee-only coverage	\$6,000 ¹
	Deductible for employee + dependent(s) coverage (aggregate)	\$12,000 ¹
	Plan pays / individual pays (coinsurance)	60% / 40% ²
	Annual coinsurance maximum for employee-only coverage	\$8,000
	Annual coinsurance maximum for employee + dependent(s) coverage	\$15,000
	Wellness and preventive care	Not covered
	Hospital inpatient including maternity (per admission)	60% ²
	Outpatient surgery (per occurrence)	60% ²
	Emergency room services	100% ²
	Urgent care	100% ²
Mental health and substance abuse: all services	60% ²	

PRESCRIPTION DRUG PROGRAM		
	Individual / family ¹	\$3,000 / \$6,000
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.

Deductible for employee + dependent(s) coverage — This applies to an employee who has dependents included on their coverage. You and your dependents are responsible to pay for medical and prescription drug claim costs up to the plan's family deductible amount before GuideStone begins paying claims for anyone in the family. The family deductible may be met by one individual or by multiple family members' combined claims. This is known as an "aggregate" or combined deductible.

Deductible for employee-only coverage — This applies only to an employee who has no dependents included on their coverage. You are responsible to pay for medical and prescription drug claim costs up to the plan's individual deductible amount before GuideStone begins paying claims.

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.

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.

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.

Urgent care — Treatment at an urgent care facility for the on-set of symptoms that require prompt medical attention.

Wellness and preventive care — Covered services are based on CIGNA'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.