Comprehensive Plan Options for Personal Plans

Effective January 1, 2021

	MEDICAL BENEFITS	Health Choice 500	Health Choice 1000	Health Choice 2000	Health Choice 3000[1]	Health Choice 5000[1]	Health Choice 6000[1]
IN-NETWORK	Annual deductibles: individual/family	$500/$1,000	$1,000/$2,000	$2,000/$4,000	$3,000/$5,000	$5,000/$10,000	$6,000/$12,000
	Plan pays/individual pays (co-insurance) (after deductible)	80%/20%	80%/20%	80%/20%	70%/30%	70%/30%	70%/30%
	Maximum out-of-pocket (medical and prescription): individual/family (in-network services only, including deductible, co-pays and co-insurance)	$4,750/$7,500	$5,000/$8,250	$5,750/$11,500	$6,000/$12,000	$6,500/$12,700	$7,000/$14,000
	Wellness and preventive care visit (in-network, per *Preventive Schedule*) (no co-pay)	100%	100%	100%	100%	100%	100%
	Primary care or retail clinic visit/specialist visit co-pay	$25/$45	$25/$45	$25/$45	$25/$45	$25/$45	$25/$45
	Teladoc co-pay[2]	$0	$0	$0	$0	$0	$0
	Urgent care co-pay	$50	$50	$50	$50	$50	$50
	Outpatient surgery/outpatient services (CT scan, MRI, diagnostic)	80% after deductible	80% after deductible	80% after deductible	70% after deductible	70% after deductible	70% after deductible
	Hospital inpatient (including maternity)	80% after deductible	80% after deductible	80% after deductible	70% after deductible	70% after deductible	70% after deductible
	Emergency room services (per visit) (deductible does not apply)	$250 co-pay, then 80% (no deductible)	$250 co-pay, then 80% (no deductible)	$250 co-pay, then 80% (no deductible)	$250 co-pay, then 70% (no deductible)	$250 co-pay, then 70% (no deductible)	$250 co-pay, then 70% (no deductible)
	Emergency room services — care for non-emergencies	$250 co-pay, then 80% after deductible	$250 co-pay, then 80% after deductible	$250 co-pay, then 80% after deductible	$250 co-pay, then 70% after deductible	$250 co-pay, then 70% after deductible	$250 co-pay, then 70% after deductible
	Mental health/substance abuse: • Inpatient/intensive outpatient services (after deductible) • Office and professional services co-pay	80% after deductible $25	80% after deductible $25	80% after deductible $25	70% after deductible $25	70% after deductible $25	70% after deductible $25
	Chiropractic services co-pay (12 visits annually)	$45	$45	$45	$45	$45	$45
	Comprehensive routine eye exam co-pay (one exam every 12 months)	$25	$25	$25	$25	$25	$25
	PRESCRIPTION DRUG BENEFITS[3,4,7]						
RETAIL	Generic drug co-pay[5]	$15	$15	$15	$15	$15	$15
	Preferred drug co-pay[5,6]	$50	$50	$50	$50	$50	$50
	Non-preferred drug co-pay[5,6]	$75	$75	$75	$75	$75	$75
MAIL ORDER/ WALGREENS	Generic drug co-pay	$30	$30	$30	$30	$30	$30
	Preferred drug co-pay[6]	$100	$100	$100	$100	$100	$100
	Non-preferred drug co-pay[6]	$150	$150	$150	$150	$150	$150
	Diabetic supplies	$20 co-pay	$20 co-pay	$20 co-pay	$20 co-pay	$20 co-pay	$20 co-pay
	Select insulin[8]	$75 co-pay	$75 co-pay	$75 co-pay	$75 co-pay	$75 co-pay	$75 co-pay
SPECIALTY	Specialty generic drug co-pay	$50	$50	$50	$50	$50	$50
	Specialty preferred drug co-pay[6]	$75	$75	$75	$75	$75	$75
	Specialty non-preferred drug co-pay[6]	$100	$100	$100	$100	$100	$100

	MEDICAL BENEFITS	Health Choice 500	Health Choice 1000	Health Choice 2000	Health Choice 3000[1]	Health Choice 5000[1]	Health Choice 6000[1]
OUT-OF-NETWORK	Annual deductibles: individual/family	$1,000/$2,000	$2,000/$4,000	$4,000/$8,000	$5,000/$10,000	$10,000/$20,000	$12,000/$24,000
	Plan pays/individual pays (co-insurance) (after deductible)	60%/40%	50%/50%	50%/50%	50%/50%	50%/50%	50%/50%
	Co-insurance and deductible out-of-pocket limit: individual/family	$21,000/$22,000	$22,000/$24,000	$24,000/$28,000	$25,000/$30,000	$40,000/$50,000	$42,000/$54,000
	Wellness and preventive care visit (you pay 100%)	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
	Primary care or retail clinic visit/specialist visit (after deductible)	60%	50%	50%	50%	50%	50%
	Urgent care (after deductible)	60%	50%	50%	50%	50%	50%
	Outpatient surgery/outpatient services (CT scan, MRI, diagnostic)	60%	50%	50%	50%	50%	50%
	Hospital inpatient (including maternity)	$500 co-pay, then 60% after deductible	$500 co-pay, then 50% after deductible	$500 co-pay, then 50% after deductible	$500 co-pay, then 50% after deductible	$500 co-pay, then 50% after deductible	$500 co-pay, then 50% after deductible
	Emergency room services (per visit)	$250 co-pay, then 80% (no deductible)	$250 co-pay, then 80% (no deductible)	$250 co-pay, then 80% (no deductible)	$250 co-pay, then 70% (no deductible)	$250 co-pay, then 70% (no deductible)	$250 co-pay, then 70% (no deductible)
	Emergency room services — care for non-emergencies	$250 co-pay, then 60% after deductible	$250 co-pay, then 50% after deductible	$250 co-pay, then 50% after deductible	$250 co-pay, then 50% after deductible	$250 co-pay, then 50% after deductible	$250 co-pay, then 50% after deductible
	Mental health/substance abuse (after deductible): • Inpatient/intensive outpatient services • Office and professional services	$500 co-pay, then 60% after deductible 60%	$500 co-pay, then 50% after deductible 50%	$500 co-pay, then 50% after deductible 50%	$500 co-pay, then 50% after deductible 50%	$500 co-pay, then 50% after deductible 50%	$500 co-pay, then 50% after deductible 50%
	Chiropractic services (12 visits annually) (after deductible)	60%	50%	50%	50%	50%	50%
	Comprehensive routine eye exam (one exam every 12 months) (after deductible)	60%	50%	50%	50%	50%	50%

[1] This plan does not constitute "creditable coverage" for Massachusetts residents.
[2] Teladoc operates subject to state regulation.
[3] If the cost of the prescription is less than the co-pay, the participant pays the full cost of the prescription.
[4] Retail available as 30-day supply, mail order/Walgreens as 90-day supply and specialty as 30-day supply through mail order.
[5] Maintenance drugs filled at retail, other than Walgreens, will incur a $10 penalty after the second fill. The $10 penalty does not accumulate toward the deductible or the maximum out-of-pocket limit. This penalty does not apply to ACA preventive medications.
[6] If a non-generic drug is purchased when a generic is available, the participant must pay a penalty of the difference in drug cost of the non-generic drug over its generic equivalent. This penalty does not accumulate toward the deductible or the maximum out-of-pocket limit.
[7] Co-pays for certain specialty medications may be set to the maximum of any available manufacturer co-pay assistance. These co-pays will be paid by the manufacturer after the member applies for co-pay assistance and will not apply toward the maximum out-of-pocket.
[8] Select products used to treat diabetes, including select insulin, may be available for a $75 co-pay for a 90-day supply.

Note: A corresponding *Summary of Benefits and Coverage* was created to help consumers more easily understand their medical benefits and compare plans. To view and download the *Summary of Benefits and Coverage* documents for all GuideStone® medical plans available to you, visit *GuideStone.org/Summaries*. You may also request printed copies by calling **1-844-INS-GUIDE** (1-844-467-4843) Monday through Friday, between 7 a.m. and 6 p.m. CT.

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