Health Saver 2600

Effective January 1, 2017

The Health Saver 2600 is a federally-qualified High Deductible Health Plan, eligible for use with a Health Savings Account (HSA).

	PLAN FEATURES	
In-Network	Deductible for an individual	$2,600[1]
	Deductible for a family	$5,200[1]
	Plan pays/individual pays (co-insurance)	100% after deductible
	Maximum out-of-pocket (medical and prescription): individual/family (in-network services only, including deductible and co-insurance)	$2,600/$5,200
	Primary care physician or retail clinic visit/specialist office visit	100% after deductible
	Telemedicine (availability subject to state regulations)	100% after deductible
	Wellness and preventive care (primary care/specialist)	100% no deductible
	Hospital inpatient (including maternity)	100% after deductible
	Outpatient surgery	100% after deductible
	Emergency room services: for emergency care only	100% after deductible
	Emergency room services: care for non-emergencies	100% after deductible
	Urgent care	100% after deductible
	Outpatient services (CT scans, MRI, diagnostic)	100% after deductible
	Chiropractic services (20 visits annually)	100% after deductible
	Mental health and substance abuse: inpatient services	100% after deductible
	Mental health and substance abuse: office and professional services	100% after deductible
	Vision exam (one exam every 12 months)	100% after deductible
Out-of-Network	Deductible for an individual	$5,200
	Deductible for a family	$10,400
	Plan pays/individual pays (co-insurance)	60%/40% after deductible
	Annual co-insurance maximum for an individual	$12,000 after deductible
	Annual co-insurance maximum for a family	$24,000 after deductible
	Wellness and preventive care	Not covered
	Hospital inpatient (including maternity)	60% after deductible
	Outpatient surgery	60% after deductible
	Emergency room services: for emergency care only	100% after in-network deductible
	Emergency room services: care for non-emergencies	60% after deductible
	Mental health and substance abuse: all services	60% after deductible
	Vision exam (one exam every 12 months)	60% after deductible

PRESCRIPTION DRUG PROGRAM[1]			
Retail	30-Day Supply	Generic	100% after deductible
		Preferred	100% after deductible
		Non-preferred	100% after deductible
Mail Order	90-Day Supply	Generic	100% after deductible
		Preferred	100% after deductible
		Non-preferred	100% after deductible
Specialty	30-Day Supply	Generic	100% after deductible
		Preferred	100% after deductible
		Non-preferred	100% after deductible

[1] The deductible is met by both medical and prescription drug expenses.

Maintenance drugs filled at retail will incur a $10 penalty after the second retail 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.

If a non-generic 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.

Note: This plan does not constitute "creditable coverage" for Massachusetts residents.

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Glossary of Terms

Co-insurance — The percentage of eligible claims you pay after you meet your deductible.

Co-insurance maximum, out-of-network — The most you will have to pay in a year in out-of-network co-insurance for covered benefits after you meet your out-of-network deductible.

Deductible (family) — This is the amount a family is required to pay before benefits begin. Once this amount is met, the plan will consider all family members to have met their deductibles. One individual cannot contribute more than the individual deductible amount. This is an embedded deductible.

Deductible (individual) — This is the amount an individual is required to pay before benefits begin. Once this amount is met, the plan will begin paying claims for that individual at the co-insurance level.

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 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 — Mail order is a service that allows you to refill recurring prescriptions (90-day supply) through an online pharmacy. You receive your prescriptions by mail.

Maximum out-of-pocket (medical and prescription) — The maximum out-of-pocket limit includes the deductible and co-insurance for eligible, in-network services. After the individual or family amount has been satisfied, the health plan covers all eligible, in-network health care expenses for the rest of the plan year.

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 plan costs.

Retail pharmacy benefits — This refers to filling your prescriptions at a participating network pharmacy. This approach is best for short-term prescriptions (up to 30-day). You could save money by filling recurring prescriptions via mail order (see above).

Specialist — Any physician not considered a primary care physician.

Specialty drug — Specific prescriptions used to treat complex, chronic or special health conditions.

Telemedicine — The use of telephone and/or live video technology in order to provide medical care.

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

Vision exam — Covers one annual eye exam per covered family member, which may include an eye health examination, dilation and/or refraction. Coverage does not include glasses or contact lenses (unless there has been a cataract extraction), eye surgery or retinal telescreening. See the *Preventive Care Schedule* for additional vision screening coverage for children when performed by a pediatrician or primary care physician as part of an annual well-child visit.

Wellness and preventive care — Refers to the services listed on the *Preventive Care Schedule*, which are covered at 100%, not subject to the deductible. The *Preventive Care Schedule* is based on services required under the Patient Protection and Affordable Care Act of 2010 (PPACA), as amended.

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 overview 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.

Note: A corresponding *Summary of Benefits and Coverage* was created to help consumers more easily understand their insurance 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 **1-888-98-GUIDE** (1-888-984-8433) Monday through Friday, between 7 a.m. and 6 p.m. CST.