Health Choice 3000 80/20

Schedule of Benefits

HIGHMARK®

An Independent Licensee of the Blue Cross and Blue Shield Association

Produced by GuideStone Financial Resources of the Southern Baptist Convention

Effective 1/1/2020

GuideStone®

Do well. Do right.®

IMPORTANT INFORMATION

Please be aware that the coverage made available hereunder may be prohibited or unadvisable in certain countries. GuideStone may be able to provide some general information or assistance in this regard, but GuideStone is not in a position to provide legal advice to employers or employees in such countries.

This Plan does not constitute "creditable coverage"
in the state of Massachusetts.

This Schedule of Benefits highlights the benefits available under the Plan. It does not tell You all the details about your Plan. Your Plan is made available by GuideStone Financial Resources of the Southern Baptist Convention, and the following details are in your Plan booklet:

- How to enroll in the Plan.
- When Plan coverage begins and ends.
- Typical Services and supplies the Plan covers.
- Limitations on any Covered Services and Supplies.
- Typical Services and supplies excluded from Plan coverage.
- How to file a claim for benefits under the Plan.
- Special meanings of some of the words used in the Schedule of Benefits.

The effective date of the Plan is January 1, 2020, however your effective date is determined by the date You enter the Plan. If You received medical Services or supplies before your effective date for this Plan, Claims for those Services or Supplies will be paid under the terms of the applicable plan in effect when the Claims were Incurred. Usually, a Claim is Incurred when a Covered Service or Supply is received by a Covered Person.

Important phone numbers

GuideStone Customer Relations: **1-844-INS-GUIDE** (1-844-467-4843)

Highmark Blue Cross Blue Shield..... **1-866-472-0924**

Blue Cross Blue Shield Provider Network: **1-800-810-BLUE** (1-800-810-2583)

Blue Cross Blue Shield Global Core (International Claims): ..... **1-800-810-2583** with AT&T USADirect access code
or 804-673-1177 (call collect outside the U.S.)
or Email: customerservice@bcbsglobalcore.com

Highmark Maternity Education and Support Program **(Baby BluePrints®)**: **1-866-918-5267**

Express Scripts: **1-800-555-3432**

Express Scripts (International Claims): ..... **1-800-497-4641** with AT&T USADirect access code
or collect (614) 421-8292

Teladoc: **1-800-Teladoc** (1-800-835-2362)

Vitals SmartShopper: **1-866-285-7475**

Important websites

www.GuideStone.org
www.bcbs.com
www.highmarkbcbs.com
www.bcbsglobalcore.com
www.teladoc.com/GuideStone
www.Express-Scripts.com

Schedule of Benefits

Benefits	In-Network Care	Out-of-Network Care
Deductible Individual Family	 $3,000 $5,000	 $5,000 $10,000
Payment level/Co-insurance[1] Excludes Co-payments	80% after Deductible until Maximum Out-of-Pocket limit is met; then 100%	50% after Deductible until Co-insurance and Deductible Out-of-Pocket limit is met; then 100% (based on Provider's Allowable Charge)
Maximum Out-of-Pocket limit[1] Medical and Prescription	$6,000 Individual $12,000 Family	N/A
Co-insurance and Deductible Out-of-Pocket limit	N/A	$25,000 Individual $30,000 Family
Lifetime Maximum	Unlimited	Unlimited
Physician office Visit (Primary Care)[2] Includes lab and X-ray Services	100% after $25 Co-payment	50% after Deductible
Specialist office Visit[2] Includes lab and X-ray Services	100% after $45 Co-payment	50% after Deductible
Retail Clinic office Visit[2] Includes lab and X-ray Services	100% after $25 Co-payment	50% after Deductible
Telemedicine	$0 Co-payment	N/A
Urgent Care	100% after $50 Co-payment	50% after Deductible
Ambulance	80% after Deductible	50% after Deductible
Autism Spectrum Disorders for dependent children Applied Behavior Analysis[3] Speech Therapy[4] Occupational Therapy[5] Physical Therapy[6]	80% after Deductible	50% after Deductible
Chiropractic treatment Maximum 12 Visits/Benefit Period	100% after $45 Co-payment	50% after Deductible
Diagnostic Services Lab, X-ray and other tests	80% after Deductible	50% after Deductible
Durable Medical Equipment	80% after Deductible	50% after Deductible
Emergency Room Services Emergency Care[7] Other than for Emergency Care	80% after $250 Co-payment $250 Co-payment, then 80% after Deductible	80% after $250 Co-payment $250 Co-payment, then 50% after Deductible
Home Healthcare Maximum 120 Visits/Benefit Period	80% after Deductible	50% after Deductible
Hospice	80% after Deductible	50% after Deductible
Hospital expenses Inpatient Outpatient	80% after Deductible 80% after Deductible	$500 Co-payment, then 50% after Deductible[8] 50% after Deductible

Benefits	In-Network Care	Out-of-Network Care
Infertility counseling and testing	80% after Deductible	50% after Deductible
Maternity	80% after Deductible	50% after Deductible
Medical/Surgical expenses	80% after Deductible	50% after Deductible
Mental Health and Alcohol/Drug Abuse Inpatient Office Visit	80% after Deductible 100% after $25 Co-payment	$500 Co-payment, then 50% after Deductible[8] 50% after Deductible
Organ transplants Blue Distinction Centers Other transplant services	 100% no Deductible 80% after Deductible	 50% after Deductible 50% after Deductible
Physical Therapy	80% after Deductible	50% after Deductible
Pre-authorization requirements	Network facility providers will obtain Pre-authorization of your Network Inpatient admission on your behalf	Performed by member Failure to Pre-authorize an Out-of-Network Inpatient admission will result in a 20% benefit reduction[8]
Skilled Nursing Facility care Maximum 120 days	80% after Deductible	50% after Deductible
Speech & Occupational Therapy	80% after Deductible	50% after Deductible
Vision Benefit One eye exam/Benefit Period	100% after $25 Co-payment	50% after Deductible
Wellness Benefit[9]	100% no Deductible	Not covered

1. Maximum Out-of-Pocket limit – Family Maximum Calculation; Family members meet only their Individual Maximum Out-of-Pocket limit and then their claims will be covered at 100%; if the family Maximum Out-of-Pocket limit has been met prior to their Individual Maximum Out-of-Pocket limit being met, their claims will be paid at 100%.
2. See Office Visit Co-payments in your Plan booklet for limitations.
3. Applied behavior analysis is available to dependent children through age 16.
4. Speech Therapy is available to dependent children to age six.
5. Occupational Therapy is available to dependent children through age 16.
6. Physical Therapy is available to dependent children through age 16.
7. Out-of-network emergency services are reimbursed at the in-network benefit level based on the local Blue Cross/Blue Shield licensee allowance (when available) or up to charges.
8. Member is required to contact Blue Cross Blue Shield Healthcare Management Services prior to a planned Out-of-Network Inpatient admission or within 48 hours of an admission to a Hospital as an Inpatient for Emergency Care. If this does not occur and it is later determined that all or part of the Out-of-Network Inpatient stay was not Medically Necessary and Appropriate, the patient will be responsible for payment of any costs not covered.
9. See the *Preventive Schedule* for information about the Wellness Benefit.

Outpatient Prescription Drug	Plan pays	You pay
Retail (up to 30-day supply)		
Generic	Cost over Co-payment	$15
Preferred	Cost over Co-payment	$50
Non-preferred	Cost over Co-payment	$75
Mail order (up to 90-day supply)		
Generic	Cost over Co-payment	$30
Preferred	Cost over Co-payment	$100
Non-preferred	Cost over Co-payment	$150
Diabetic supplies	Cost over Co-payment	$20
Preferred insulin	Cost over Co-payment	$75
Specialty drug (up to 30-day supply)		
Generic	Cost over Co-payment	$50
Preferred	Cost over Co-payment	$75
Non-preferred	Cost over Co-payment	$100

The participant pays the Co-payment or drug cost, whichever is less.

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.

Maintenance drugs filled at retail, other than Walgreens, 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.

Co-pays for certain specialty medications will be set to the maximum available manufacturer co-pay assistance. These co-pays will be paid by the manufacturer after the participant applies for co-pay assistance.

Preventive Immunization Comparison

The chart below shows the vaccines covered by Highmark and Express Scripts. Age limits may apply.

Highmark covers the vaccines if administered by a network provider at your doctor's office. Use your Highmark BCBS ID card in order to be covered by Highmark.

Express Scripts covers the vaccines if administered by a participating pharmacy. Not all contracted pharmacies will be able to give all covered vaccines at all times. Contact your participating pharmacy regarding vaccine availability and times for administration by a pharmacist. Use your Express Scripts ID card at the pharmacy in order to be covered by Express Scripts.

Vaccines covered at a network doctor's office or participating pharmacy
Chicken Pox (Varicella)
Diphtheria/Tetanus/Pertussis (DTaP/Td/Tdap)
H. Influenzae Type B (Hib)
Hepatitis A and B
Influenza
Measles/Mumps/Rubella (MMR)
Meningococcal
Pneumococcal
Polio (IPV)
Rotavirus
Shingles (Zoster)

The following vaccines are only covered by Express Scripts. Use your Express Scripts ID card at the pharmacy in order to be covered by Express Scripts.

Vaccines available only at a participating pharmacy
Japanese Encephalitis
Rabies
Typhoid
Yellow Fever

Preventive Medications

The plan pays for preventive care only when given by a network provider. To determine if a specific medication is covered under the wellness benefit, call Express Scripts at 1-800-555-3432. For over-the-counter medications purchased with a prescription from an in-network pharmacy, use your Express Scripts ID card.

Medication	Coverage
Aspirin	Coverage to persons age 45 years old for men (55 years for women) through age 79 years
Colonoscopy Preparation	Coverage to persons age 50 years old and older every 10 years, or earlier or more frequent for persons determined to be at a high risk for colon cancer
Fluoride	Coverage to persons through the age of 5 years old
Folic acid	Coverage to females through the age of 50 years old
Iron	Coverage to persons less than 1 year of age
Smoking cessation	Coverage to persons age 18 years old and older
Statins	Coverage of low to moderate dose statins for persons age 40 to 75 years old
Raloxifene **Tamoxifen**	Coverage for women without a cancer diagnosis who are determined to be at risk for breast cancer by their physician and meet certain criteria
Vitamin D supplement	Coverage to persons age 65 years old and older at risk for falls

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