Group Plans Health Choice 2000 Plus: GuideStone

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | Plan Type: PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.GuideStone.org/Summaries or by calling 1-888-98-GUIDE (1-888-984-8433).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network **$2,000** person **/** **$4,000** family. Out-of-network **$4,000** person **/** **$8,000** family. Doesn't apply to preventive care and co-pays.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For in-network **$4,000** person **/** family. For out-of-network **$10,000** person **/** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, deductibles and co-pays.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.highmarkbcbs.com or call 1-800-810-2583** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 co-pay/visit	50% co-insurance	Includes one comprehensive annual eye exam.
	Specialist visit	$35 co-pay/visit	50% co-insurance	-------------------none-------------------
	Other practitioner office visit	$35 co-pay for chiropractor	50% co-insurance for chiropractor	Limited to 20 visits per coverage period.
	Preventive care/screening/immunization	No charge	Not covered	See *Preventive Care Schedule* for covered services in-network. Travel immunizations covered at 100%. Abortive services and certain contraceptives are not covered.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	50% co-insurance	If performed in a primary care or specialist office, primary care or specialist co-pay applies.
	Imaging (CT/PET scans, MRIs)	20% co-insurance	50% co-insurance	-------------------none-------------------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	20% co-insurance	100% of drug cost with reimbursement at plan costs upon manual claim form submission.	$250 maximum for 30-day supply. $750 maximum for 90-day supply (mail-order). You must pay the difference in the cost between the preferred/non-preferred drug and its generic equivalent if available. Certain contraceptives are not covered.
	Preferred brand drugs	20% co-insurance		
	Non-preferred brand drugs	20% co-insurance		
	Specialty drugs	20% co-insurance		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	50% co-insurance	-------------------none-------------------
	Physician/surgeon fees	20% co-insurance	50% co-insurance	-------------------none-------------------

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% co-insurance after $100 co-pay	20% co-insurance after $100 co-pay	50% co-insurance out-of-network for non **Emergency Services.**
	Emergency medical transportation	20% co-insurance	50% co-insurance	If an emergency, pays at the in-network level and waives deductible.
	Urgent care	$25 co-pay/primary care visit	50% co-insurance	$35 co-pay/specialist visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	50% co-insurance	-------------------none-------------------
	Physician/surgeon fee	20% co-insurance	50% co-insurance	-------------------none-------------------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 co-pay	50% co-insurance	-------------------none-------------------
	Mental/Behavioral health inpatient services	20% co-insurance	50% co-insurance	-------------------none-------------------
	Substance use disorder outpatient services	$25 co-pay	50% co-insurance	-------------------none-------------------
	Substance use disorder inpatient services	20% co-insurance	50% co-insurance	-------------------none-------------------
If you are pregnant	Prenatal and postnatal care	20% co-insurance	50% co-insurance	-------------------none-------------------
	Delivery and all inpatient services	20% co-insurance	50% co-insurance	-------------------none-------------------
If you need help recovering or have other special health needs	Home health care	20% co-insurance	50% co-insurance	Maximum 120 days per year.
	Rehabilitation services	20% co-insurance	50% co-insurance	Age and visit limitations apply to certain conditions.
	Habilitation services	Not covered	Not covered	-------------------none-------------------
	Skilled nursing care	20% co-insurance	50% co-insurance	Maximum 120 days per year.
	Durable medical equipment	20% co-insurance	50% co-insurance	Rental or purchase option determined by Claims Administrator. Rental costs cannot exceed the total cost of purchase.
	Hospice service	20% co-insurance	50% co-insurance	-------------------none-------------------
If your child needs dental or eye care	Eye exam	$25 co-pay	50% co-insurance	-------------------none-------------------
	Glasses	Not covered	Not covered	-------------------none-------------------
	Dental check-up	Not covered	Not covered	See *Preventive Care Schedule* for exceptions.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture • Certain contraceptives • Cosmetic surgery • Dental care (Adult) • Elective abortion	• Experimental or investigational treatment • Hearing aids • Infertility treatment • Long-term care	• Private-duty nursing • Private hospital room • Routine foot care • Weight loss program

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery	• Chiropractic care — limited to 20 visits per coverage	• Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-98-GUIDE (1-888-984-8433). You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-866-472-0924 or visit www.highmarkbcbs.com.

Spanish Assistance (Asistencia en Español):

Para obtener asistencia en Español, llame al 1-888-98-GUIDE (1-888-984-8433).

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,340
- **Patient pays** $3,200

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,000
Co-pays	$30
Co-insurance	$1,020
Limits or exclusions	$150
Total	**$3,200**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,950
- **Patient pays** $2,450

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,000
Co-pays	$30
Co-insurance	$340
Limits or exclusions	$80
Total	**$2,450**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.