

# Personal Health Saver 7000 EPO

Effective January 1, 2023

The Personal Health Saver 7000 EPO is an HSA-qualified High Deductible Health Plan, eligible for use with a Health Savings Account (HSA).

PLAN FEATURES		
In-Network	Deductible for individual coverage	\$7,000 <sup>1</sup>
	Deductible for family coverage (aggregate deductible)	\$14,000 <sup>1</sup>
	Plan pays/individual pays (co-insurance)	100%/0% after deductible
	Maximum out-of-pocket (medical and prescription)	\$7,000/14,000
	Primary care or retail clinic visit/ specialist office visit (includes virtual visits)	0% after deductible
	Teladoc®	0% after deductible
	Wellness and preventive care (primary care/ specialist)	0% no deductible
	Hospital inpatient (including maternity)	0% after deductible
	Outpatient surgery	0% after deductible
	Emergency room services: for emergency care only	0% after deductible
	Emergency room services: care for non-emergencies	0% after deductible
	Urgent care	0% after deductible
	Outpatient services (CT scans, MRI, diagnostic)	0% after deductible
	Chiropractic services (12 visits annually)	0% after deductible
	Mental health/substance abuse: inpatient services	0% after deductible
	Mental health/substance abuse: office visit	0% after deductible
Vision exam (one exam every 12 months)	0% after deductible	
Out-of-Network	<b>EPO Plan design has no benefit out of network other than emergency services</b>	
	Emergency room services	0% after deductible
	All other non-emergency services	Not Covered

PRESCRIPTION DRUG PROGRAM <sup>1</sup>			
Retail	30-Day Supply	Generic	0% after deductible
		Preferred	0% after deductible
		Non-preferred	0% after deductible
Mail Order/ Walgreens	90-Day Supply	Generic	0% after deductible
		Preferred	0% after deductible
		Non-preferred	0% after deductible
		Diabetic supplies	0% no deductible
		Participating insulin	\$75 no deductible
Specialty	30-Day Supply	Generic	0% after deductible
		Preferred	0% after deductible
		Non-preferred	0% after deductible

The deductible is met by both medical and prescription expenses.

For family coverage, one individual cannot be responsible for more than the ACA limit of \$9,100.

If a non-generic drug is purchased when a generic drug 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.

A 90-day supply of maintenance drugs can be filled either by Walgreens or by mail order. Prices may vary.

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

Insulin copay applies to select insulin products whose manufacturers have chosen to participate in the Patient Assurance Program.



## Glossary of Terms

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

**Co-insurance and deductible out of pocket limit (out-of-network)** — The most you will have to pay in a year in out-of-network deductibles and co-insurance for covered benefits.

**Co-pay** — The fixed, up-front dollar amount you pay for certain covered expenses. Co-pay amounts apply after your in-network or out-of-network deductible and do not apply to your out-of-network co-insurance maximum.

**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. For family coverage, one individual cannot be responsible for more than the current IRS limit.

**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 Affordable Care Act of 2010 (ACA), 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](https://www.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. CST.