# BlueHPN 2000 Plus

GuideStone®

Effective 01/01/2027

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|---|---|---|
| IN-NETWORK | Deductible for individual coverage | $2,000 |
| | Deductible for family coverage (Embedded deductible) | $4,000 |
| | Plan pays/individual pays (co-insurance) after deductible | 100%/0% |
| | Maximum out-of-pocket (medical and prescription) | $5,750 individual/$11,500 family |
| | Primary care or retail clinic visit | $25 |
| | Specialist office visit (includes virtual visits) | $45 |
| | Virtual care services | $0 |
| | Wellness and preventative care (primary care/ specialist) | 0% no deductible |
| | Hospital inpatient (including maternity) | 0% after deductible |
| | Outpatient surgery (Center of Excellence: Carrum Health) | 0% no deductible |
| | Outpatient surgery facility (outside of Carrum Health) | 0% after deductible |
| | Emergency room services | $250 copay, then 0% |
| | Urgent care | $50 |
| | Outpatient services (Centers of Excellence: OneImaging) | 0% after deductible |
| | Outpatient services (outside of OneImaging) | 0% after deductible |
| | Outpatient PT/OT/ST (30 visit limit per therapy type; visit limit waived with mental health services diagnosis) | $45 |
| | Chiropractic services (12 visits annually) | $45 |
| | Mental health/substance abuse: inpatient services | 0% after deductible |
| | Mental health/substance abuse: office and virtual visit | $25 |
| | Vision exam (one exam every 12 months) | $25 |
| OUT-OF-NETWORK | Deductible for an individual | Not covered |
| | Deductible for a family | Not covered |
| | Plan pays/individual pays (co-insurance) | Not covered |
| | Co-insurance and deductible out of pocket limit for an individual | Not covered |
| | Co-insurance and deductible out of pocket limit for a family | Not covered |
| | Wellness and preventive care | Not covered |
| | Hospital inpatient (including maternity) | Not covered |
| | Outpatient surgery | Not covered |
| | Emergency Room Services | See In-Network Emergency Room Services |
| | Mental health/substance abuse: inpatient services | Not covered |
| | Mental health/substance abuse: office visit | Not covered |

## PRESCRIPTION DRUG PROGRAM[1]

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|---|---|---|---|
| RETAIL | 30-Day Supply | Generic | $15 |
| | | Preferred | $50 |
| | | Non-Preferred | $75 |
| | | | |
| MAIL ORDER/ RETAIL | 90-Day Supply | Generic | $30 |
| | | Preferred | $100 |
| | | Non-Preferred | $150 |
| | | Diabetic Supplies | $20 |
| | | Participating Insulin | $75 |
| | | | |
| SPECIALTY | 30-Day Supply | Generic | $50 |
| | | Preferred | $75 |
| | | Non-Preferred | $100 |

## Additional Plan Information

The participant pays the Co-payment or drug cost, whichever is less.
Maintenance drugs filled at retail, other than the member selected retail pharmacy(CVS or 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.
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 member selected retail pharmacy (Walgreens or CVS) or by mail order. Prices may vary.
Medical claims Incurred outside the United States where no network exists will be considered In-Network.
Accumulators are met by both medical and prescription expenses. Co-pays do not accumulate towards your deductible.
Co-pays for certain specialty medications will be set to the maximum available manufacturer Co-pay assistance. This Co-pay adjustment will only apply after deductible satisfaction if this is a qualified high deductible plan. These Co-pays will be paid by the manufacturer after the participant applies for Co-pay assistance and will not apply toward MOOP.
Insulin Co-pay applies to select insulin products whose manufacturers have chosen to participate in the Patient Assurance Program.
Non-urgent MRI and CT scan services must be scheduled through OneImaging. Bariatric procedures, certain spinal procedures, and knee and hip replacements must be scheduled through Carrum Health. This requirement does not apply to the Health Today plan, Medicare-coordinating plans, Global Core plans, and Cigna Healthcare International plans, or in the event of an approved exception.

## Glossary of Terms

**Coinsurance** — The percentage of eligible claims you pay after you meet your deductible.

**Coinsurance 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 coinsurance for covered benefits.

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

**Deductible (family) —** This is the amount a family is required to pay before benefits begin for services not covered by copays. 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 for services not covered by copays. Once this amount is met, the plan will begin paying claims for that individual at the coinsurance 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 coinsurance 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***.

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.

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