BlueHPN 3000 EPO

Effective January 1, 2023

	PLAN FEATURES	
In-Network	Deductible for an individual	$3,000
	Deductible for a family	$5,000
	Plan pays/individual pays (co-insurance)	80%/20%
	Maximum out-of-pocket (medical and prescription): individual/family	$6,000/$12,000
	Primary care or retail clinic visit co-pay/ specialist office visit co-pay (includes virtual visits)	$25/$45
	Teladoc® co-pay	$0
	Wellness and preventive care (primary care/ specialist)	100%
	Hospital inpatient (including maternity)	20% after deductible
	Outpatient surgery	20% after deductible
	Emergency room services: for emergency care only	$250 co-pay, then 20% (after deductible)
	Emergency room services: care for non-emergencies	$250 co-pay, then 20% (after deductible)
	Urgent care co-pay	$50
	Outpatient services (CT scans, MRI, diagnostic)	20% after deductible
	Chiropractic services co-pay (12 visits annually)	$45
	Mental health/substance abuse: inpatient services	20% after deductible
	Mental health/substance abuse: office visit co-pay	$25
	Vision exam co-pay (one exam every 12 months)	$25
Out-of-network	EPO Plan design has no benefit out of network other than emergency services	
	Emergency room services	$250 co-pay, then 20% (after deductible)
	All other non-emergency services	Not Covered

	PRESCRIPTION DRUG PROGRAM		
Retail	30-Day Supply	Generic	$15 co-pay
		Preferred	$50 co-pay
		Non-preferred	$75 co-pay
Mail Order/ Walgreens	90-Day Supply	Generic	$30 co-pay
		Preferred	$100 co-pay
		Non-preferred	$150 co-pay
		Diabetic supplies	$20 co-pay
		Participating insulin	$75 co-pay
Specialty	30-Day Supply	Generic	$50 co-pay
		Preferred	$75 co-pay
		Non-preferred	$100 co-pay

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

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.

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.

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 and will not apply toward MOOP.

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

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. Office visit co-pay amounts do not apply toward your in-network or out-of-network deductible or your out-of-network co-insurance maximum.

Deductible (family) — This is the amount a family is required to pay before benefits begin for services not covered by co-pays. 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 co-pays. 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, co-pays 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, including co-pays, 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 your plan's costs.

Primary care/retail clinic co-pay — The amount you pay for an office visit to a network retail clinic or primary care physician such as a pediatrician, general practitioner, family practitioner, internist or gynecologist.

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 on co-pays 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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