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GuideStone PPO Medical Plan Options

Prepared for: INTERNATIONAL STUDENTS INC #68438

Network: Blue Cross Blue Shield

Effective January 1, 2021

Medical Rates	Health Choice 500	Health Choice 1000	Health Choice 3000 70/30	Health Saver 3000	Value Health 5000
Employee only	$823.15	$740.83	$600.90	$617.36	$436.27
Employee + Spouse	$1,728.62	$1,555.74	$1,261.89	$1,296.46	$916.17
Employee + Child(ren)	$1,563.98	$1,407.58	$1,141.71	$1,172.98	$828.91
Employee + Family	$2,469.45	$2,222.49	$1,802.70	$1,852.08	$1,308.81

In-network Medical Benefits	Health Choice 500	Health Choice 1000	Health Choice 3000 70/30	Health Saver 3000	Value Health 5000
Annual deductibles *Individual / Family*	$500 / $1,000	$1,000 / $2,000	$3,000 / $5,000	$3,000 / $6,000 (aggregate)[1]	$5,000 / $10,000[1]
Medical & Prescription out of pocket maximum *Individual / Family (includes deductible)*	$4,750 / $7,500	$5,000 / $8,250	$6,000 / $12,000	$5,000 / $10,000 (aggregate)[2]	$7,950 / $15,800
Plan pays *(coinsurance)*	80%	80%	70%	90% after deductible	70%
Primary care / Specialty office visit	$25 / $45	$25 / $45	$25 / $45	You pay 10% after deductible	$0 / $70 (first 3 visits)[4]
Teladoc	$0	$0	$0	You pay 0% after deductible	$0
Vision Exam *(annual refractive exam)*	$25	$25	$25	You pay 10% after deductible	Not covered
Wellness visit *(per Preventive Care Schedule)*	100% no copay	100% no copay	100% no copay	100% no deductible	100% no copay
Hospital inpatient (including Maternity) *(after deductible)*	80%	80%	70%	90%	70%
Emergency room services *(deductible does not apply unless otherwise noted)*	80% after $250 copay	80% after $250 copay	70% after $250 copay	90% after $250 copay and deductible	70% after $300 copay and deductible
Urgent Care	$50 copay	$50 copay	$50 copay	You pay 10% after deductible	$120 copay (first 3 visits)[4]
Outpatient surgery facility *(after deductible)*	80%	80%	70%	90%	70%
Outpatient services (CT scan; MRI; Diagnostic) *(after deductible)*	80%	80%	70%	90%	70%
Chiropractic services (12 visits annually)	$45	$45	$45	You pay 10% after deductible	Not covered
Mental health / Substance abuse • Inpatient services *(after deductible)*	80%	80%	70%	90%	70%
• Office and professional services	$25	$25	$25	You pay 10% after deductible	$0
Lifetime maximum benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

[1] *Deductible is met by both medical and prescription drug expenses.*

[2] *In 2021, for family coverage, one individual cannot be responsible for more than $8,150*

[4] *Copay applies to first three visits. Deductible applies starting with fourth visit.*

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Prescription Drug Benefits		Health Choice 500	Health Choice 1000	Health Choice 3000 70/30	Health Saver 3000	Value Health 5000
Retail (30-day supply)	Individual deductible / Family deductible	NA / NA	NA / NA	NA / NA	In-network deductible applies	In-network deductible applies
	Generic drug	$15	$15	$15	You pay 10% after deductible	$15 (no deductible)
	Preferred drug[1]	$50	$50	$50	You pay 10% after deductible	$50 after deductible
	Non-preferred drug[1]	$75	$75	$75	You pay 10% after deductible	$75 after deductible
Mail Order (90-day supply)	Individual deductible / Family deductible	NA / NA	NA / NA	NA / NA	In-network deductible applies	In-network deductible applies
	Generic drug	$30	$30	$30	You pay 10% after deductible	$30 (no deductible)
	Preferred drug[1]	$100	$100	$100	You pay 10% after deductible	$125 after deductible
	Non-preferred drug[1]	$150	$150	$150	You pay 10% after deductible	$185 after deductible
Specialty (30-day supply)	Individual deductible / Family deductible	NA / NA	NA / NA	NA / NA	In-network deductible applies	In-network deductible applies
	Generic drug	$50	$50	$50	You pay 10% after deductible	You pay 30% after deductible
	Preferred drug[1]	$75	$75	$75	You pay 10% after deductible	You pay 30% after deductible
	Non-preferred drug[1]	$100	$100	$100	You pay 10% after deductible	You pay 30% after deductible

[1] *If a preferred or non-preferred drug is purchased when a generic is available, you must pay the generic copayment plus the difference between the cost of the preferred/non-preferred drug and the cost of its generic equivalent.*

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Out-of-Network Medical Benefits	Health Choice 500	Health Choice 1000	Health Choice 3000 70/30	Health Saver 3000	Value Health 5000
Annual deductibles *Individual / Family*	$1,000 / $2,000	$2,000 / $4,000	$5,000 / $10,000	$6,000 / $12,000 (aggregate)	$10,000 / $20,000
Co-insurance and deductible out of pocket limit *Individual / Family (includes deductible)*	$21,000 / $22,000	$22,000 / $24,000	$25,000 / $30,000	$22,000 / $42,000 (aggregate)	No Limit
Plan pays (*coinsurance*) *(after deductible, unless otherwise noted)*	60%	50%	50%	60%	50%
Primary care / Specialist office visit *(includes annual vision exam)*	60%	50%	50%	60%	50% (Vision exam not covered)
Wellness visits	Not covered	Not covered	Not covered	Not covered	Not covered
Hospital inpatient (including Maternity)	60% after $500 copay	50% after $500 copay	50% after $500 copay	60% after $500 copay	50% after $500 copay
Emergency room services [as determined by Highmark]					
• For emergency care only *(deductible does not apply unless otherwise noted)*	80% after $250 copay	80% after $250 copay	70% after $250 copay	90% after $250 copay and in-network deductible	70% after $300 copay and in-network deductible
• Other than for emergency care	60% after $250 copay	50% after $250 copay	50% after $250 copay	60% after $250 copay	50% after $300 copay
Outpatient surgery facility	60%	50%	50%	60%	50%
Outpatient services (CT scan; MRI; Diagnostic)	60%	50%	50%	60%	50%
Chiropractic services (12 visits annually)	60%	50%	50%	60%	Not covered
Mental health / Substance abuse					
• Inpatient services	60% after $500 copay	50% after $500 copay	50% after $500 copay	60% after $500 copay	50% after $500 copay
• Office and professional services	60%	50%	50%	60%	50%
Lifetime maximum benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

The GuideStone plans effective in 2021 comply with ACA regulations applicable to self funded church plans for 2021.