

Administration Manual for Employers

Group Plans

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HOW TO USE THIS MANUAL

PURPOSE

This manual is intended to help each Employer participating in the Group Plans effectively and efficiently administer the benefit plans offered to its Employees. Specific plans and coverage may vary by Employer and include some or all of the following options:

- Employee Term Life Plan
- Employee Optional Term Life Plan
- Spouse Term Life Plan
- Spouse Optional Term Life Plan
- Child Term Life Plan
- Employee Accidental Death and Dismemberment Plan
- Employee Personal Accident Plan
- Spouse Personal Accident Plan
- Employee Premier Long Term Disability Plan
- Employee Choice Long Term Disability Plan
- Employee Economy Long Term Disability Plan
- Employee Premier Short Term Disability Plan
- Employee Choice Short Term Disability Plan
- Employee Economy Short Term Disability Plan
- PPO Medical Plans (Health Today, Health Legacy, Health Choice 500, 1000, 2000, 3000, 5000, Health Saver 2600, Health Saver 2800, Health Saver 3000)
- Senior Plus Plan
- Senior Plan
- Care Basic Plan
- Care Plus Plan
- Premier Dental Care Plan
- Choice Dental Care Plan
- Guided Dental HMO Plan

HOW TO USE THIS MANUAL

This manual describes the important administrative provisions of these plans and sets forth the step-by-step procedures that each Employer must follow in order for GuideStone Financial Resources to properly record new Employees, make subsequent changes to master records and account for Employer payments.

This manual serves as a training tool for new administrative personnel who become responsible for the administration of the plans. The manual also serves as a reference guide for personnel who are already familiar with the operation of the plans.

This manual does not contain procedures which are specific for each Employer such as an Employer's internal procedures for reconciling payments against payroll records. We recommend that each Employer maintain a set of detailed internal procedures that operate in conjunction with the procedures outlined in this manual to effectively administer these plans.

ORGANIZATION AND CONTENTS

Many of the chapters contained in this manual are organized to present information on an "events" basis. For example, "How to Process Enrollments" describes what must be done to handle the enrollment "event." The "How to Process Terminations" chapter explains the information you should give an Employee leaving your employment as well as how and when you must communicate this information to GuideStone. Other chapters deal with medical claims and other claims "events." We think you will find this organization helpful in explaining what you must do when a particular event occurs.

A few of the chapters of the manual are not event-oriented, but contain important information about the plans and how they operate. For example, the manual contains a glossary of defined terms which are capitalized and used throughout this manual. It is important to be familiar with these terms and their definitions.

Also in this manual is a chapter entitled "How to Get Help." This chapter lists various kinds of information you may require for administration of the plan enabling you to identify a contact who can supply this information. Another chapter includes instructions for reordering forms by mail or downloading them through GuideStone Financial Resources Internet Web site.

REVISIONS

GuideStone Financial Resources reviews and makes revisions to this manual from time to time. The effective date of each page is in the lower left corner of the page, after the code "GROUP PLANS." While every effort is made to maintain accurate information in the manual, changes in policy that occur between revisions will not be reflected until the next revision date. Employers are typically notified by mail or

HOW TO USE THIS MANUAL

email of changes in policy in the interim and are responsible for administering their plans in accordance with the new policies.

Since this manual is maintained on the GuideStone Financial Resources Web site, hard copies are not provided.

As situations arise that are not covered by this manual, it is important to know where to get help. As a general rule, your questions or problems should be directed to the department at GuideStone Financial Resources responsible for handling that aspect of the Program, or you may call the Insurance Solutions and Services department. Some questions will need to be directed to an outside agency such as Highmark BCBS for medical plan benefit information or Medco Health for prescription drug information.

HOW TO GET HELP

This section helps you direct your questions and problems to the appropriate agency or individual. The following pages contain a listing of some areas to which these questions should be referred and a list of important phone numbers. Since personnel assignments may change, you may print the Important Numbers page in this section and use the blank lines to list the names of your usual contacts.

FOR INFORMATION OR QUESTIONS ON . . .

CONTACT . . .

- Age reduction and retirement - effect on benefits Insurance Operations, Group Plans
- Appeal of denied Medical benefits claims Insurance Operations, Claims Unit
Highmark BCBS
- Appeal of denied Dental Claims Cigna Dental
- Beneficiary designation Insurance Operations, Claims Unit
- Benefit Interpretation for medical Highmark BCBS
- Billing Statements Insurance Operations, Group Plans
- Claim submission procedures for Dental benefits Cigna Dental
- Claim submission procedures for PPO Medical Plans, Senior Plan or Senior Plus Plan, Care Basic Plan or Care Plus Plan Highmark BCBS
- Claim submission procedures for Term Life, Disability, Accidental Death & Dismemberment or Personal Accident benefits Insurance Operations, Claims Unit

HOW TO GET HELP

FOR INFORMATION OR QUESTIONS ON . . .

CONTACT . . .

- Conversion of Term Life coverage Insurance Operations, Group Plans
- Coordination of Benefits procedures for medical Highmark BCBS
- Eligibility of Employees or dependents for benefits Insurance Operations, Group Plans
- Enhanced Benefits provider verification PPO Member Services number listed on the ID card
- Enrollment procedures Insurance Operations, Group Plans
- ID cards - Request new dental ID cards Cigna Dental
- ID cards - Request new medical/prescription drug ID cards for PPO, Senior Plan or Senior Plus Plan, Care Basic Plan or Care Plus Plan Highmark BCBS (for medical)
Medco Health (for prescriptions)
- Leave of absence information Insurance Operations, Group Plans
- Plan Administration Insurance Operations, Group Plans
- Portability of Term Life coverage Insurance Operations, Group Plans
- Pre-authorization for PPO Medical Plans Highmark BCBS

HOW TO GET HELP

FOR INFORMATION OR QUESTIONS ON . . .

- Prescription drug information for PPO Medical Plans, Senior Plan or Senior Plus Plan, Care Basic Plan or Care Plus Plan
- Upgrading Employer coverage or adding new Employer benefits

CONTACT . . .

Medco Health

Insurance Solutions and Services

IMPORTANT NUMBERS

**GuideStone Financial Resources
phone numbers:**

**Main number:
1-888-98-GUIDE
(1-888-984-8433)**

**Internet Address:
www.GuideStone.org**

| Department | Contact | Email address | Phone number |
|--|----------------|----------------------|---------------------|
| • Insurance Operations, Group Plans | _____ | _____ | _____ |
| • Insurance Operations, Claims | _____ | _____ | _____ |
| • Insurance Solutions and Services | _____ | _____ | _____ |

Outside agencies:

| Agency | Internet Address | Phone Number |
|--|--|---------------------|
| • Highmark BCBS <ul style="list-style-type: none"> ○ Provider Search ○ Explanation of Benefits & Claims | www.highmarkbcbs.com | 1-866-472-0924 |
| • Medco Health | www.medco.com | 1-800-555-3432 |
| • Cigna Dental <ul style="list-style-type: none"> ○ Premier Dental Care Plan ○ Choice Dental Care Plan ○ Guided Dental HMO Plan | www.mycigna.com | 1-800-244-6224 |

ADMINISTRATIVE RESPONSIBILITIES

EMPLOYER RESPONSIBILITIES

- Explaining the Group Plans to new Employees.
- Offering new Employees who are eligible for Participation in Group Plans the opportunity to enroll in the Program's Plan(s) within 31 days of initial eligibility.
- Verifying that all Employees and dependents enrolled in Group Plans meet the eligibility rules for the Plan(s). Failure to adhere to the eligibility rules will result in the termination of coverage for the affected enrollee(s) and reimbursement to GuideStone, at its sole discretion, may be required for claims paid on behalf of ineligible enrollees.
- Offering enrollment in Contributory medical plans to Employees who previously declined coverage for themselves and/or their Eligible Dependents when they become eligible as Special or Late Enrollees.
- Enrolling Employees and submitting their enrollment forms to GuideStone Financial Resources.
- Distributing appropriate benefit materials to new participating Employees.
- Maintaining monthly earnings records for each participating Employee.
- Maintaining copies of Enrollment Forms, Beneficiary Designation Forms and other important papers relating to an Employee's Participation in the Program.
- Verifying the monthly billing statement and remitting the monthly payments due to GuideStone Financial Resources. Non-payment could result in termination of coverage.
- Submitting changes to GuideStone Financial Resources in a timely manner.
- Initial filing of Term Life, Personal Accident and Disability claims.
- Instructing Employees and Retirees about Medical and Dental claim filing procedures.
- Reporting changes that affect an Employee's or Retiree's group benefits or coverage status to GuideStone Financial Resources.
- Counseling Employees who are approaching retirement concerning the effect retirement will have on their coverage.
- Registering with and reporting to government agencies, when and if required.
- Providing GuideStone Financial Resources with Employee and Retiree information and any statistical data needed for GuideStone Financial Resources to properly administer the Program.
- Notifying Employees and Retirees of their rights and obligations under the Program.
- Maintaining the minimum Participation requirements of the Group Plans. If these requirements are no longer met, it must be reported to the Group Plans Account Administrator.

ADMINISTRATIVE RESPONSIBILITIES

GUIDESTONE FINANCIAL RESOURCES RESPONSIBILITIES

- Establishing and maintaining Employee and Retiree coverage records.
- Submitting the Group Plans administrative payments to the Claims Administrators.
- Providing Employers with technical administrative assistance and benefit plan information.
- Interpreting plan provisions.
- Serving as liaison on escalated claim situations.
- Preparing and distributing communication materials covering Program benefits and claim procedures.
- Coordinating the overall administration of the Program between participating Employers and the Claims Administrators.
- Designing and instituting Program benefits and administrative changes.
- Reviewing Program renewal terms and modifying rates, when applicable.
- Controlling all accounting, statistical and costing functions as they pertain to the financial success of the Program.

GENERAL ADMINISTRATIVE GUIDELINES

GENERAL INFORMATION

This chapter of the manual discusses many of the general plan provisions and administrative guidelines that apply to an Employer's Participation in Group Plans. This chapter does not discuss specific benefit provisions or coverage since this information will vary depending on plan elections made by each participating Employer. For specific benefit and coverage information, consult the Employee Booklets.

PLAN PARTICIPATION REQUIREMENTS

Minimum Participation Requirements

An Employer eligible to participate in Group Plans is:

- Any church, convention, board, agency, commission, organization or unit affiliated with the Southern Baptist Convention. Or, Non-Southern Baptist Convention churches and Evangelical ministries who are not in conflict with the Southern Baptist Convention; who
- On an on-going basis, maintains a minimum Participation requirement of 10 or more full-time Employees.

Note: The minimum Participation requirement applies to any new Employer effective January 1, 1994 and after and to all churches regardless of their effective date.

An Employer falling below the minimum Participation requirement shown above will be given until the January 1st following the end of a 12 month period to achieve the necessary Participation levels. The 12 month period begins on the first month the Employer fell below the minimum Participation requirement. If the Participation requirement is not met, coverage will automatically terminate for all Employees participating in Group Plans. If a Southern Baptist Convention Employer loses eligibility to participate in Group Plans, and coverage is terminated, participating Employees may have the option of transferring their Term Life, Accident, Medical, Dental, Short Term Disability and Long Term Disability coverage into GuideStone Financial Resources Personal Plans. If a Non-Southern Baptist Convention Employer loses eligibility to participate in Group Plans, and coverage is terminated, participating Employees may have the option of transferring their Term Life, Accident, Dental, Short Term Disability and Long Term Disability coverage into GuideStone Financial Resources Personal Plans. Medical coverage for Employees of a Non-Southern Baptist Convention Employer may not be transferred to Personal Plans. Employees who transfer into the Personal Plans will receive benefits and rates according to plan provisions of the Personal Plans.

An Employer falling below the minimum Participation requirement shown above will not be eligible to upgrade or add coverage until the Participation requirement has again been met. In order to transfer back to Group Plans from Personal Plans at a future date, an Employer must maintain a minimum of 10 full-

GENERAL ADMINISTRATIVE GUIDELINES

time employees in Personal Plans for six months. The Employer would then need to go through the group underwriting process and be approved in order to be eligible to transfer back to Group Plans.

Non-Contributory Plans

When the full cost of a plan is paid by an Employer (Non-Contributory plans), the same coverage must be provided to all eligible Employees with no individual selection with regard to any plans. **100% of all eligible Employees and dependents must participate** in Non-Contributory plans.

If Employee and/or dependent coverages are provided by an Employer on a Non-Contributory basis, and a new Employee and/or Eligible Dependent is not enrolled at the time of his initial eligibility, it will be treated as an administrative error. The Employee and/or Eligible Dependent will be enrolled as of the date of eligibility with the appropriate back charges.

Waiver of Medical and Dental

An Employee may waive out of Medical or Dental coverage when the coverage is paid 100% by the Employer. A Group Plans Waiver of Medical/Dental Coverage form must be completed, which can be located on the Web site at www.GuideStoneInsurance.org. The waiver allows the Employee to opt out of Non-Contributory medical and dental coverage. The following criteria apply in order for the waiver to be approved:

- A waiver may be used for the Employee, all dependents or the entire family.
- An Employee may waive coverage only if the Employee/dependent has medical/dental coverage elsewhere.
- If the Employee waives coverage, the Employee's dependents are not eligible for coverage.
- Employers may not offer any financial or other incentives in exchange for the Employee waiving coverage.
- The Employee who waives coverage does not count for the ten Employee minimum that the Employer must maintain to participate in Group Plans.
- The Employee/dependent may enroll in the medical plan later if the requirements for a special or late enrollee of the plan are met. See the "Special and Late Enrollment" section of this manual.
- The Employee/dependent may enroll in the dental plan at any time according to the guidelines for the effective date. The dental plan limits benefits for some initial periods of coverage.
- When a waiver form is submitted to GuideStone and approved, the date coverage will end will be determined according to the Rescission rules. Refer to the "How to Process Terminations" chapter.

GENERAL ADMINISTRATIVE GUIDELINES

Contributory Plans

If the Employer's Group Plans require Employees to pay a portion of the cost (Contributory plans), **75% of all eligible Employees must participate** in the plans. The Employer must pay at least 50% of the cost of any Contributory Employee coverage.

(Participation requirements and Employer contribution requirements do not apply to Employee and Spouse Personal Accident Insurance.)

If the Employer offers Medical or Dental benefits to Employees, the Employer must offer dependent coverage as well. At least **50% of all Eligible Dependents must participate** in the medical and dental plans. The Employer is not required to pay any of the cost of dependent coverage.

If Employee and/or dependent coverage is provided by an Employer on a Contributory basis, and a new Employee and/or Eligible Dependent is not enrolled within 31 days of the Eligibility Date, that Employee and/or Eligible Dependent must provide satisfactory Evidence of Good Health before Term Life or Disability coverage will become effective. The Employee and/or Eligible Dependent will not be able to enroll in a medical plan until the following January 1 unless Special Enrollment requirements are met. (See the Special and Late Enrollment section of this manual.)

Employees and Eligible Dependents can enroll in Premier Dental Care Plan, Choice Dental Care Plan or the Guided Dental HMO Plan at any time.

Eligible Employees

All Salaried, full-time Employees, (as defined by the Employer), that work at least the number of hours that the Employer requires to be considered a full-time Employee, but not less than 20 hours a week are considered eligible to participate in the Group Plans.

The following classes of Employees are not eligible for coverage under the plans:

- Temporary Employees
- Employees who work less than 20 hours per week

Waiting Period

This is the period of time an Employee must complete to be eligible for Group Plans coverage. An Employer may elect to have no Waiting Period. If an Employer elects to have a Waiting Period, the usual Waiting Period is one to three months of employment. The Waiting Period may be different for separate classifications of Employees. (See the Employee Classifications section of this chapter.) The Waiting Period may be waived in cases of a rehired Employee if he returns to work within one year of his original termination date or for an Employee transferring from another Employer with which the Employee had GuideStone Financial Resources coverage.

GENERAL ADMINISTRATIVE GUIDELINES

Employee Classifications

An Employer may designate classifications of Employees. Contribution arrangements, benefits and Waiting Periods may vary among these classifications. For example, an Employer may divide Employees into Administrative and Non-administrative classifications. The Employer may elect to offer dependent medical coverage on a Non-Contributory basis for Administrative Employees and on a Contributory basis for Non-administrative Employees. The Employer may also elect to have no Waiting Period for Administrative Employees and a one month Waiting Period before coverage becomes effective for Non-administrative Employees.

To protect against discrimination, the plans offered, the Waiting Period and any contribution requirements under the Employer's Program must be applied consistently and uniformly to all Employees within the same Employee classification.

Employers with 10 to 24 Employees are requested to limit the number of Employee classifications to two.

Dependent Coverage

An Employee is eligible for dependent coverage if one of these is true:

- The Employee has Employee Coverage under this Plan.
- The Employee used to have Employee Coverage under this Plan but is now covered under one of GuideStone Financial Resources plans for Medicare-eligible Employees, retirees and dependents.

Eligible Dependents under the Group Plans are:

- The spouse of the Employee
- The Employee's Child under age 26.
- The Employee's Child who was covered under the Plan and is incapacitated, provided the following requirements are met:
 - The Child must be developmentally disabled or physically handicapped and incapable of earning a living.
 - The Child must have been incapacitated when his or her Plan coverage would have ended because of age.
 - Proof of incapacitation must be sent to GuideStone Financial Resources at least 31 days before the Child's Plan coverage is scheduled to end.
 - Additional proof must be sent whenever asked to show that the Child is still incapacitated under this provision.

GENERAL ADMINISTRATIVE GUIDELINES

The Definition of “Child” under GuideStone Group Plans can be any of the following:

- An Employee’s or spouse’s natural (biological) child
- An Employee’s or spouse’s legally adopted child or a child placed in the home for adoption
- An Employee’s or spouse’s stepchild or foster child
- An Employee’s or spouse’s unmarried grandchild who resides with the Employee and is dependent on the Employee for support and maintenance
- A child for whom the Employee or spouse must provide health care by court order or order of a state agency authorized to issue National Medical Support Notices under federal law.
- A child for whom the Employee or spouse is a legal guardian or managing conservator.

The Employee’s spouse or child is not an Eligible Dependent while:

- On active duty in the armed forces of any country
- Covered for health care expenses under the Employer’s plan as an Employee. (No one can have both Employee Coverage and dependent Coverage under the Plan through the same Employer.)
- Eligible for Medicare and Medicare pays benefits before this Plan.

Incapacitated Children

The Term Life, Medical and Dental benefits of a child approved as fully incapacitated will **not** be terminated when the child reaches the maximum age for dependent coverage if the child continues to be incapacitated and provided coverage does not terminate for any other reason.

Generally, a child is considered fully incapacitated if he or she is unable to earn a living because of a developmental disability or physical handicap.

Proof that a child is fully incapacitated must be submitted to the Claim Administrator for approval 31 days prior to the date the child reaches age 26. The Claim Administrator may periodically request the Employee to submit subsequent proof of a child's incapacitating condition.

GENERAL ADMINISTRATIVE GUIDELINES

Plan Administrative Changes

Certain plan administration information and records on the operation of an Employer's Program must be accurately maintained by GuideStone Financial Resources Insurance Operations, Group Plans. This information includes:

- Employee Classifications
- Waiting Period
- Contributions required for Participation.

This information is determined by the Employer when they elect to participate in Group Plans and is maintained by GuideStone Financial Resources Insurance Operations, Group Plans.

To change any of the information listed above, contact GuideStone Financial Resources Insurance Operations, Group Plans, in advance of the change. You will be sent an Employer Acceptance Agreement on which to record the changes and the effective date of change. The completed Employer Acceptance Agreement should then be returned to GuideStone Financial Resources for the change to be processed and recorded in the Program's master records.

Refer all questions concerning Employee Classifications, Waiting Periods and contribution amount changes to GuideStone Financial Resources Insurance Operations, Group Plans.

IMPORTANT TERMS

This chapter contains some of the important terms that are used in connection with the Group Plans administration. These terms have a particular and definite meaning. It is important to become familiar with these terms and to know how to use them in connection with the Program operation.

| Terms | |
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| Active Disabled | An Employee who is disabled but is considered to have current employment status. See the Disabled Medicare Beneficiaries section of the “Basic Medicare” chapter of this manual for more details. |
| Allowable Expenses | The necessary and reasonable Medical and Dental benefits, part or all of which are covered by the benefit plans covering the claimant under the Program. |
| Annual Re-enrollment Period | The period each year when participating Employees and their Eligible Dependents may transfer between medical plans offered by the Employer. Or, for eligible Employees and their Eligible Dependents who did not elect to enroll in a GuideStone Financial Resources medical plan when they first became eligible, the period when the Employee or Eligible Dependent(s) may enroll as a Late Enrollee in a medical plan. Coverage becomes effective the January 1 following the request for Employers who have a standard renewal period. |
| Assignment | <p>With respect to medical and dental benefits – an election by an Employee to have benefits payable from the plan made directly to the provider of a service (the hospital, doctor, dentist, etc.).</p> <p>With respect to Term Life and Personal Accident benefits - the right exercised by an Employee, in which he or she delivers over to another individual all incidents of ownership of coverage, including the right to name or change a beneficiary.</p> |

IMPORTANT TERMS

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| Beneficiary | <p>The person or persons named by a participating Employee to receive the proceeds from the Term Life, Accidental Death and Dismemberment or Personal Accident benefit plans in the event of the Employee's death. If an Employee dies and does not have a valid beneficiary designation(s) on file with GuideStone Financial Resources, payment will be made in the following order:</p> <ul style="list-style-type: none"> • The estate of the deceased Employee • The Surviving Spouse • The surviving children, in equal shares • The surviving parents, in equal shares • The surviving sibling(s), in equal shares. |
| Care Basic Plan | <p>A Medicare coordinating plan offered to Employees, Retirees or covered dependents for whom Medicare is the primary payer of claims. The plan provides benefits for Medicare Part A services only and includes Part D prescription drug coverage with a Medicare-designed coverage gap.</p> |
| Care Plus Plan | <p>A Medicare coordinating plan offered to Employees, Retirees or covered dependents for whom Medicare is the primary payer of claims. The plan provides benefits for Medicare Part A and B services and includes Part D prescription drug coverage with a Medicare-designed coverage gap.</p> |
| Certificate of Creditable Coverage | <p>Certification provided to a Participant of a medical plan by the medical plan provider when coverage ends. The certificate may be used by the individual when enrolling into a new medical plan to reduce the Pre-existing Condition Limitation period of the new plan.</p> |

IMPORTANT TERMS

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| <p>Claim Administrator</p> | <ul style="list-style-type: none"> • Highmark Blue Cross Blue Shield® - for the PPO Medical Plans, Senior Plan and Senior Plus Plan, and Care Basic Plan and Care Plus Plan. • Cigna Dental – for the Premier Dental Care Plan, Choice Dental Care Plan and Guided Dental HMO Plan. • Provident Life and Accident Insurance Company, a part of Unum Provident Corporation – for the Personal Accident Plan • Unum Life Insurance Company of America – for the Term Life, Accidental Death and Dismemberment plans, and Long & Short Term Disability plans |
| <p>Conversion Privilege</p> | <p>An Employee's right to convert terminated group Term Life to individual direct payment policies administered by the Claim Administrator without being required to furnish Evidence of Good Health. Plan benefits must be converted and paid for within 31 days after group coverage stops.</p> |
| <p>Coordination of Benefits (COB)</p> | <p>The provision that guarantees that Employees receive all the benefits they should, but not more than the actual costs of the medical care received. If two or more group medical plans cover expenses, one of the plans is called "Primary" and the other(s) "Secondary". The primary plan will pay first and will pay the maximum benefit provided by the plan. The rules for determining the Primary and Secondary medical plan may be found in the Employee Booklet.</p> <p>Specifically, our Medical and Dental benefit plans will pay either benefit in full, or a reduced amount which, when added to the benefit paid by another plan, will equal 100% of the Allowable Expenses incurred by the claimant.</p> |
| <p>Co-payment</p> | <p>Under the Medical and Dental benefit plans, the part of the Allowable Expenses paid by the participating Employee.</p> |

IMPORTANT TERMS

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| Covered Dental Expenses | The usual charges of a dentist; supplies which are necessary for treatment of a dental condition, but only to the extent that such charges are within reasonable and customary fees for services and supplies customarily employed for treatment of that condition, and only if rendered in accordance with accepted standards of dental practice. |
| Covered Medical Expenses | The expenses for certain hospital and other medical services and supplies incurred by a claimant in connection with treatment of an injury or disease. |
| Creditable Coverage | For medical coverage, the amount of previous coverage (measured in months) used to reduce the pre-existing condition limitation period. |
| Deductible | The amount an Employee must pay each calendar year before benefits are payable under the PPO Medical Plans, the Premier Dental Care Plan or Choice Dental Care Plan. |
| Dental Health Maintenance Organization (DHMO) | A managed dental care plan offered by Employers to Employees who reside in a service area established by the dental insurance provider. Network providers must be used to receive benefits from the plan. The Guided Dental HMO Plan offered through Cigna Dental offers dental coverage through a Dental HMO plan. |
| Disability | <p>Short Term – Any sickness or injury that limits a covered Employee from performing the material and substantial duties of his/her regular occupation for a period of time established by the plan and the Employee has a 20% or more loss in weekly earnings. Some disabilities may not be covered.</p> <p>Long Term – For the initial period defined by the plan, any sickness or injury that limits a covered Employee from performing the material and substantial duties of his/her regular occupation and results in a 20% or more loss in monthly earnings. After the initial period, due to the same sickness or injury, the Employee is unable to perform the material and substantial duties of any gainful occupation for which he or she is reasonably fitted by education, training or experience. Some disabilities may not be covered.</p> |

IMPORTANT TERMS

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| Effective Date | The date the Employer enters Group Plans and the date an Employee's coverage begins under the Program. |
| Eligible Dependents | <ul style="list-style-type: none"> • Employee's spouse <ul style="list-style-type: none"> ○ A spouse is a person of the opposite sex to whom the Employee is married at the relevant time by a religious or civil ceremony effective under the laws of the state in which the marriage was contracted. • Employee's child under age 26 for medical and dental coverage. For child life coverage, the dependent must be at least 14 days old. • A Child is defined as: <ul style="list-style-type: none"> ○ An Employee's or spouse's natural (biological) child ○ An Employee's or spouse's legally adopted child or a child placed in the home for adoption ○ An Employee's or spouse's stepchild or foster child ○ An Employee's or spouse's unmarried grandchild who resides with the Employee and is dependent on the Employee for support and maintenance ○ A child for whom the Employee or spouse must provide health care by court order or order of a state agency authorized to issue National Medical Support Notices under federal law. ○ A child for whom the Employee or spouse is a legal guardian or managing conservator. • For Medical expenses - provided the newborn child is under 31 days old and incurs charges for treatment of a disease, injury or congenital abnormality. • Employee's Child who was covered under the Plan and is incapacitated. The Child must meet all of these rules: <ul style="list-style-type: none"> ○ The Child must be developmentally disabled |

IMPORTANT TERMS

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| | <p>or physically handicapped and incapable of earning a living</p> <ul style="list-style-type: none"> ○ The Child must have been incapacitated when his or her Plan coverage would have ended because of age ○ The Employee must send GuideStone Financial Resources proof of incapacitation at least 31 days before the Child's plan coverage is scheduled to end ○ The Employee must send additional proof whenever asked to show that the Child is still incapacitated under this provision. <p>The Term Life, Medical and Dental benefit of a fully incapacitated child will not be terminated when the child reaches the maximum age for dependent coverage if the child continues to be incapacitated and provided coverage does not terminate for any other reason.</p> |
| Eligibility Date | The date an Employee meets the requirements for Participation in the plans provided under the Group Plans. |
| Employee | A person employed by the Employer. |
| Employee Classification | The group or groups of Employees the Employer includes as being eligible for coverage under the Group Plans. All Employees of the Employer may belong to the same group or be divided into two or more groups such as "Administrative" and "Non Administrative," etc. To protect against discrimination, the plans offered, the Waiting Period and any contribution requirements under the Employer's Program must be applied consistently and uniformly to all Employees within the same Employee classification. Employers with 10 to 24 Employees are requested to limit the number of Employee classifications to two. |
| Employer | Any local church, convention, board, agency, commission, organization, or unit affiliated with the Southern Baptist Convention eligible to participate in a "church plan" as defined under the Employee Retirement Income Security Act (Erisa) of 1974, as amended. Or, any Non-Southern Baptist Convention churches and ministry organizations that are generally regarded as Evangelical ministries who are not in conflict with the Southern Baptist Convention. |

IMPORTANT TERMS

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| | Employers must continue to meet certain Participation requirements on an ongoing basis. See Plan Participation Requirements in the “General Administrative Guidelines” chapter of this manual for specific information. |
| Employer Acceptance Agreement (EAA) | A document that is used when an Employer enrolls in Group Plans or makes changes to their existing coverage. The document outlines Participation requirements, rates, benefits, terms and conditions, and other critical data and is signed by the Employer’s authorized representative. |
| Employer Access | An on-line service available to Employers at no cost. Allows Employers to view plan and filing information for their insurance program, make certain changes for Employees on-line, to submit other types of changes on-line, pay bills online, view payment history and run billing inquiries and reports. Employer Access is designed to save both time and money. |
| Employer Base Plan | Coverage elected by the Employer through Group Plans and provided or offered to Employees. |
| Enrollment Date | The date a new Employee meets the requirements for Participation in the plans provided under Group Plans and elects to enroll himself and his dependent(s) in the plan(s). For a Special Enrollee, the date the Employee and/or his eligible dependent(s) become eligible due to a Qualifying Event. For a Late Enrollee, the January 1 following the request for coverage for Employers who have a standard renewal period. |
| Expanded Ministry | Non-SBC churches and ministry organizations who are generally regarded as Evangelical ministries and who are not in conflict with the Southern Baptist Convention. |
| Group Plans | Group Plans |
| Health Care Provider | A physician, hospital, or medical facility that provides health care services. |
| Health Care Reform | A general term that encompasses the changes to healthcare plans resulting from passage of the 2010 Patient Protection and Affordable Care Act (PPACA). Examples of the changes include extending the maximum age for dependents to age 26 and removing pre-existing condition limitations for any Participant under the age of 19. |

IMPORTANT TERMS

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| HIPAA | Health Insurance Portability and Accountability Act of 1996 is a federal law signed by President Clinton on August 21, 1996. |
| Late Enrollee | An individual who requests enrollment in a medical plan more than 31 days after his initial eligibility. Coverage becomes effective on the January 1 following the request for Employers who have a standard renewal period. |
| Look Back Period | For medical coverage, the six month period of time prior to a new Employee's hire date that is used to determine pre-existing conditions. For a special or late enrollee, the date used for the look back period is the coverage effective date. |
| Medco Health | Administers the Home Delivery Pharmacy Service prescription drug program for prescription maintenance medications (drugs taken on an on-going basis) and the retail network pharmacy service (drugs taken on a short-term basis). |
| Medicare | Medical benefits provided by Social Security when a person reaches age 65 or is disabled. "Part A" is hospital coverage and pays for medical inpatient care and in some circumstances, post hospital services in a nursing facility or the patient's home. "Part B" is supplemental medical coverage (i.e., doctor's costs, outpatient hospital services, etc.) and other services and supplies not covered by "Part A" of Medicare. |
| Medicare Coordinating Plan | A medical plan designed to coordinate with Medicare and pay some medical and prescription drug costs not paid by Medicare. |
| MHPA | The Mental Health Parity Act of 1996 is a federal law enacted in 1996 affecting coverage limits for mental health benefits. |
| NMHPA | The Newborns' and Mothers' Health Protection Act of 1996 is a federal law enacted in 1996 which governs how long health plans must permit a mother and newborn to spend in the hospital following birth. |
| Non-Contributory Plans | Under these plans, the entire cost of coverage is paid by the Employer. Since no Employee contributions are required for Participation, all Employees and dependents meeting the eligibility requirements of the plans must be included for coverage. |

IMPORTANT TERMS

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| PAID Prescriptions, L.L.C. | A division of Medco Health – provides "acute" prescription drugs, taken on a short-term basis, with a small co-payment for each prescription filled at a participating pharmacy. |
| Participant | An Employee or Eligible Dependent who is enrolled in any plan(s) in Group Plans. |
| Participation | Membership in Group Plans. |
| Payment Management | A way of moving money electronically without the use of paper. The Employer may make a one-time payment online using Employer Access or set up a recurring monthly payment for their insurance billing. |
| Portability | A provision that allows Participants, with evidence of insurability, to continue Term Life and Accidental Death and Dismemberment coverage directly with the Term Life carrier at group rates when the coverage would otherwise end. |
| Post-Retirement | Coverage continued into retirement. |
| PPO Health Plans | Health Plans offered which may require an annual deductible and annual co-payment amount. PPO plans offered by Group Plans are: <ul style="list-style-type: none"> ○ Health Today, Health Legacy 200, Health Choice 500, 1000, 2000, 3000, 5000, Health Saver 2600, Health Saver 2800 and Health Saver 3000 ○ Senior Plan and Senior Plus Plan, Care Basic Plan and Care Plus Plan |
| Pre-Authorization | A determination made by Highmark BCBS of the medical necessity of a PPO Medical Plan Participant's admission to a hospital or treatment facility: Services include: <ul style="list-style-type: none"> ● Pre-authorization for inpatient hospital stays or inpatient treatment of substance abuse and mental illness. ● Pre-authorization is only a determination that an admission or procedure is medically necessary and does not guarantee automatic payment of claims. <p>Employees must comply with these provisions in order to receive maximum benefits under the medical plan. (See</p> |

IMPORTANT TERMS

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| | <p>Booklet for details.)</p> <ul style="list-style-type: none"> • Discharge Planning – This process keeps track of a hospitalized Participant’s recovery process. Medical review specialists contact the patient’s doctor to determine if an extension of stay is needed and works with the patient and his doctor to arrange for home health care, rehabilitation or other services when appropriate. |
| Pre-Existing Condition | For medical coverage, illnesses or injuries for which medical advice, diagnosis, care or treatment was recommended or received during the six months prior to the hire date of a new Employee or effective date of a current Employee. Pre-existing conditions do not apply to any Participant under the age of 19. |
| Pre-Existing Condition Limitation Period | For medical coverage, the 12-month period beginning with the hire date for new Employees or beginning with the coverage effective date for Special or Late Enrollees during which benefits for pre-existing conditions are limited or excluded. Pre-existing conditions do not apply to any Participant under the age of 19. |
| Preferred Provider Organization (PPO) | <p>A network of local physicians, hospitals and other health care providers who have agreed to provide quality health care at discounted prices. Under the PPO Medical Plans, Employees and their dependents have the option to access PPO providers and receive an increased level of benefits.</p> <p>Employees of Employers located outside the PPO service area may travel to a PPO service area and receive a higher level of benefits.</p> |
| Premium Waiver | If a participating Employee under age 60 becomes permanently and totally disabled, and has been totally disabled for nine months, Term Life, Accidental Death and Dismemberment and Personal Accident coverage may be continued, without payment of charges, during the period of disability, up to age 70. Proof of disability must be submitted to and approved by the Claim Administrator before the extension of coverage takes effect. |

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| <p>Pre-Treatment Review of Dental Benefits</p> | <p>A system that allows a Participant and his dental care provider to know in advance what estimated benefits would be payable under the Premier Dental Care Plan and Choice Dental Care Plan for a proposed course of treatment.</p> |
| <p>Protected Health Information (PHI)</p> | <p>Any information about an individual's health that reveals (or can be used as a reasonable basis to reveal) the identity of the individual. This information can relate to the past, present or future physical or mental health condition of an individual; information about the health care services provided to an individual; or payment for health care services provided to an individual.</p> |
| <p>Program</p> | <p>The coverage or benefits provided under Group Plans to a participating Employer and offered to the Employees of an Employer. The plans may differ among participating Employers, but may consist of the following coverage:</p> <ul style="list-style-type: none"> • Employee Term Life Plan • Employee Optional Term Life Plan • Accidental Death and Dismemberment Plan • Spouse Term Life Plan • Spouse Optional Term Life Plan • Personal Accident Plan (Employee & Spouse) • Child Term Life Plan • PPO Medical Plans (Health Today, Health Legacy 200, Health Choice 500, 1000, 2000, 3000, 5000, Health Saver 2600, Health Saver 2800 and Health Saver 3000) • Senior Plus Plan • Senior Plan • Care Plus Plan • Care Basic Plan • Premier Dental Care Plan • Choice Dental Care Plan • Guided Dental HMO Plan • Premier, Choice or Economy Long Term Disability Plans |

IMPORTANT TERMS

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| | <ul style="list-style-type: none"> • Premier, Choice or Economy Short Term Disability Plans. |
| Provider of Service | Any accredited medical facility, licensed physician, licensed qualified dentist or laboratory that provides medical services or supplies. |
| Qualifying Event | An event which allows an eligible Employee who elected not to enroll himself or his Eligible Dependent(s) in a GuideStone Financial Resources medical plan when he or his dependent(s) first became eligible, to enroll himself and/or his Eligible Dependent(s) in the plan as a Special Enrollee. |
| Reasonable and Customary | <p>Only the "Reasonable & Customary Charge" for a medical or dental service or supply is covered under the PPO Medical Plans, Premier Dental Care Plan and Choice Dental Care Plan. The plans cover the lesser of:</p> <ul style="list-style-type: none"> • The charge usually made by the provider who furnishes it, or • The customary charge made by those of similar professional standing in the same geographic area. |
| Rescission | Under the Health Care Reform rules, any retroactive cancellation (Rescission) of a Participant's medical coverage is prohibited except in certain situations: fraud or intentional misrepresentation of a material fact or non-payment of premiums. |
| Salary | <p>Salary means your gross annual income from services from Southern Baptist Employment, or approved Expanded Ministries group. It may include your total income just before taxes and before any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 403(b) annuity, Section 125 plan, or flexible spending account. It may include income actually received from bonuses, overtime pay, housing allowance or any other extra compensation, or income received from sources as last reported to GuideStone Financial Resources.</p> <p>Note: This Definition must be used uniformly for all Employees in determining amounts of Term Life coverage and Disability benefits.</p> |

IMPORTANT TERMS

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| Senior Plan | A Medicare coordinating plan offered to Employees, Retirees or covered dependents for whom Medicare is the primary payer of claims. The plan provides benefits for Medicare Part A services only. |
| Senior Plus Plan | A Medicare coordinating plan offered to Employees, Retirees or covered dependents for whom Medicare is the primary payer of claims. The plan provides benefits for both Medicare Part A and Part B services. |
| Service Area | The geographical area serviced by a PPO or Dental HMO. |
| Special Enrollee | An individual who enrolls in a medical plan after meeting Special Enrollment requirements. |
| Special Enrollment Requirement | When an individual is allowed to enroll himself and/or his dependents in a medical plan within the specified time frame of a Qualifying Event, such as acquiring a dependent through marriage, birth, adoption, or placement for adoption or loss of other coverage. |
| Surviving Spouse | The spouse who was a covered dependent on the Employee's Group Plan coverage and therefore eligible to continue certain coverage as a Surviving Spouse after the Employee's death. |
| Waiting Period | <ul style="list-style-type: none"> • The period of time an Employee must be employed in order to become eligible for benefits under the Program provided by the Employer; or • For the Premier Dental Care Plan and Choice Dental Care Plans, the period of time a Participant must be covered under the Plan before benefits are paid for certain services. |
| Waiver of Medical/Dental Coverage | A provision that allows an Employee to Waive out of Medical/Dental Coverage when the coverage is paid 100% by the Employer and certain requirements are met. |
| Waiver of Payment | A provision allowing an Employee who becomes totally disabled prior to age 60 to continue Term Life, Personal Accident and Accidental Death & Dismemberment coverage at no cost to the Employee up to age 70. See Premium Waiver. |

HOW TO PROCESS MONTHLY BILLING STATEMENTS

GENERAL INFORMATION

On approximately the 9th day of each month, GuideStone Financial Resources Insurance Operations, Group Plans will send you a billing statement for payments due under Group Plans. The statement will be for coverage in force during the next month. The statement shows the name and basic coverage rate information for each Employee participating in Group Plans. This coverage varies according to your particular Program.

The monthly billing statement must be **PAID AS BILLED**. Please do not make changes to the statement or adjust the charged amounts shown.

If a change should be made that affects Employee rates, **do not report changes with your payment**. Report changes to GuideStone Financial Resources Insurance Operations, Group Plans. If received by the 1st of the month, the change will be reflected on your **next** billing statement, along with any adjustment due.

Payment for the monthly charges due and the detachable portion of the recap page of your statement **should be received by GuideStone Financial Resources by the 1st of the month** for which coverage is being billed.

HOW TO PROCESS MONTHLY BILLING STATEMENTS

PAST DUE ACCOUNTS

Group Plans limits the number of months an account may remain in a past due status to two months. If your account becomes two months past due, you will be given until the end of the month to bring your account payments up-to-date. If GuideStone Financial Resources has not received payment by the end of the month, and no payment arrangements have been made, your group's coverage will be canceled. For example:

| Calendar | | |
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| Aug. 9 Current statement is created for September coverage. | Sept. 1 September payment is due. | |
| Sept. 9 Past due statement is created for September on the October billing statement. | Oct. 1 September and October payments are now due. Past Due Letter will be sent to the Employer. | Oct. 31 September and October payments must be received by GuideStone Financial Resources to avoid cancellation. |

DESCRIPTION OF PLAN NAMES

Listed below are descriptions of the plan names that appear on the Group Plans billing statement.

| Billing Code | Plan Description |
|--------------|---|
| ABASIC | Care Basic Plan for active Employees and their dependents |
| ABSR | Senior Plan for active Employees and their dependents |
| ABSR+ | Senior Plus Plan for active Employees and their dependents |
| AD&D | Employee Accidental Death and Dismemberment Plan |
| APLUS | Care Plus Plan for active Employees and their dependents |
| CHLTD | Choice Long Term Disability |
| CHSTD | Choice Short Term Disability |
| CLIFE | Child Term Life Plan |
| DENT | Combination Premier Dental, Choice Dental and Guided Dental HMO plans |
| DENTCH | Choice Dental Care Plan |
| DENTPR | Premier Dental Care Plan |
| DENTMO | Guided Dental HMO Plan |

HOW TO PROCESS MONTHLY BILLING STATEMENTS

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| DIS | Combination of Premier, Choice and Economy Long Term Disability Plans, Premier, Choice and Economy Short Term Disability Plans and Executive Long Term Disability Plan |
| ECLTD | Economy Long Term Disability |
| ECSTD | Economy Short Term Disability |
| ELIFE | Employee Term Life |
| EPAI | Employee Personal Accident Plan |
| EXC50 | Executive Choice 50 Long Term Disability |
| EXC70 | Executive Choice 70 Long Term Disability |
| EXP50 | Executive Premier 50 Long Term Disability |
| EXP70 | Executive Premier 70 Long Term Disability |
| HHC0500 | Highmark Blue Cross Blue Shield® Health Choice 500 |
| HHC1000 | Highmark Blue Cross Blue Shield® Health Choice 1000 |
| HHC2000 | Highmark Blue Cross Blue Shield® Health Choice 2000 |
| HHC3000 | Highmark Blue Cross Blue Shield® Health Choice 3000 |
| HHC5000 | Highmark Blue Cross Blue Shield® Health Choice 5000 |
| HHL0200 | Highmark Blue Cross Blue Shield® Health Legacy 200 |
| HDHP26 | Highmark Blue Cross Blue Shield® Health Saver 2600 |
| HDHP28 | Highmark Blue Cross Blue Shield® Health Saver 2800 |
| HDHP30 | Highmark Blue Cross Blue Shield® Health Saver 3000 |
| HH Medical | Combination of Highmark Blue Cross Blue Shield PPO Medical Plans: Health Choice 500, 1000, 2000, 3000, 5000, Health Legacy 200, Health Today, Health Saver 2600, Health Saver 2800 and Health Saver 3000 |
| HHT0080 | Highmark Blue Cross Blue Shield® Health Today |
| LTED | Economy Long Term Disability Plan (closed to new Participants) |
| LTSD | Standard Long Term Disability Plan (closed to new Participants) |
| OLIFE | Employee Optional Term Life |
| PLIFE | Post Retirement Life Plan (closed to new Participants) |
| PRLTD | Premier Long Term Disability Plan |
| PRSTD | Premier Short Term Disability Plan |
| RBASIC | |

HOW TO PROCESS MONTHLY BILLING STATEMENTS

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| | Care Basic Plan for retired or inactive Employees and their dependents |
| RETSR | Senior Plan for retired or inactive Employees and their dependents |
| RETSR+ | Senior Plus Plan for retired or inactive Employees and their dependents |
| RLIFE | Retiree Term Life Plan |
| RPLUS | Care Plus Plan for retired or inactive Employees and their dependents |
| SLIFE | Spouse Term Life Plan |
| SOLIFE | Spouse Optional Term Life Plan |
| SPAI | Spouse Personal Accident Plan |
| STED | Economy Short Term Disability Plan (closed to new Participants) |
| STSD | Standard Short Term Disability Plan (closed to new Participants) |
| WLIFE | Spouse Widow Term Life Plan |

BACK CREDITS

When a back credit is payable, it will appear on your monthly statement on the line below the appropriate coverage. A back credit would result if a termination of an Employee, dependent or product is reported and processed too late to be reflected in a current billing statement. The statement prepared for the next month would then reflect a credit due the Employer for the termination.

Note: Group Plans limits back credit to two billed months for retroactive changes.

BACK CHARGES

If notification of a change is delayed, a back charge to the effective date may appear on your monthly statement. When a back charge is due, it appears on the line below the appropriate coverage. Back charges may be billed for:

- Addition of new Employees or dependents
- Increase to existing coverage
- Addition of a new coverage.

COMPUTATION OF CHARGES

The basis for computing your monthly charges and credits is as follows:

Enrollments

- For new Employees and their Eligible Dependents whose coverage becomes effective on or before the 15th day of a month, a charge will be made for that month.

HOW TO PROCESS MONTHLY BILLING STATEMENTS

Example: Assume an Employee is hired August 6, and the Employer's Program has a one month Waiting Period before coverage becomes effective. Coverage becomes effective September 6, and charges are made for the month of September.

- For Participants whose coverage becomes effective on or after the 16th day of the month, there will be no charge for the month. The first charge for the coverage will be for the month following enrollment.

Example: Assume an Employee is hired August 20, and the Employer's Program has no Waiting Period. Coverage becomes effective August 20 but no charges are made for August. Charges will be reflected beginning on the Employer's September billing statement.

Terminations

- If the effective date of a termination is on or before the 15th of the month, no charge will be made for the month. Benefits will cease on the day after the last day worked (or the last day the Participant was eligible for coverage).

Example: Assume an Employee terminates employment on September 9. No charges are made for the Employee's coverage for the month of September. Benefits cease on September 10.

- If coverage is terminated on or after the 16th of the month, benefits will cease on the day after the last day worked (or the last day the Participant was eligible for coverage), and there will be a charge for the month.

Example: Assume an Employee's dependent with medical coverage reaches age 26 on September 22 and is no longer an Eligible Dependent. Charges are made for dependent medical coverage for the month of September but the dependent's medical coverage ceases on his 26th birthday.

Note: The effective date requested for termination of medical coverage may be adjusted to comply with Rescission rules. Refer to the "How to Process Terminations" chapter.

PROCEDURES FOR PROCESSING THE MONTHLY BILLING STATEMENT

Process the monthly billing statement as follows:

1. Review the name and coverage of each Employee listed on the statement. Pay particular attention to the following:
 - The Employee's monthly Salary (rounded up to the next whole dollar) is shown to the right of the Employee's Social Security Number.
 - Coverage for Term Life, Employee Optional Term Life, Spouse Term Life, Spouse Optional Term Life, Accidental Death & Dismemberment and Employee and Spouse Personal Accident are shown in terms of volume.
 - The charge for each plan is shown in the columns opposite the coverage amount.

HOW TO PROCESS MONTHLY BILLING STATEMENTS

- Employee monthly charges are summarized at the far right in the column headed "Total Charge."
 - Retroactive adjustments identify a "from" and "through" date for the time period of adjustment.
2. Review the Employer recap on the first page of the billing statement.
 - The recap summarizes the number of members covered and charges payable for each plan or plan category.
 - Adjustments, when necessary, are itemized by plan or plan category.
 3. Except for reporting Salary changes for **all** Employees, do not change or alter the Employee coverage and rate information. Changes received by the 1st of the month will appear on your next month's billing statement.

Report any discrepancies on a separate transmittal and send it promptly to:

Insurance Operations, Group Plans
GuideStone Financial Resources, SBC
2401 Cedar Springs
Dallas, TX 75201 - 1407

Note: Do not send payments to this address.

4. After the billing statement has been fully reviewed and any discrepancies noted on a separate transmittal, prepare a check (except for accounts using Employer Access Payment Management) for the "Total Amount Due" as shown on the recap page.
 - **Do not include payments for any other GuideStone Financial Resources plans or programs with your Group Plans payment.**
 - **Please pay as billed.** Do not deduct for terminated coverage. Appropriate credit will be reflected on the next month's billing statement.
 - Make the check payable to "GuideStone Financial Resources of the Southern Baptist Convention".
 - Payment is due by the 1st day of the month for which coverage is being billed.
5. Retain a copy of the billing statement in your permanent Group Plans file.
6. Send the original detachable portion of the recap page of the billing statement and a check (except for accounts using Employer Access Payment Management) for the total monthly payment due to the address on the return envelope enclosed with the billing:

Insurance Operations
GuideStone Financial Resources, SBC
P.O. Box 672073
Dallas, TX 75267-2073

Note: The above address is to be used only for payments.

PAYMENT MANAGEMENT

General Information

Payment Management is a way of moving money electronically without the use of paper. This type of bill payment will allow an Employer to pay for Group Plans coverage by authorizing money to be transferred from the Employer's checking or savings account each month as a recurrent payment or a one time payment.

Advantages of Payment Management

- Eliminates writing checks
- Saves time and money
- Increases the accuracy of payments
- Reduces the risk of lost checks

How to sign up for Payment Management

- Enroll using Employer Access by selecting the Insurance Billing tab or
- Call GuideStone Financial Resources toll free number, 1-888-984-8433, or your Group Plans Account Administrator, and request a Payment Management Draft Authorization form. This form may also be accessed by going to the GuideStone Financial Resources Web site at: www.guidestoneinsurance.org/FormsandFAQ/GroupForms.
 - Complete the authorization form and return it to GuideStone Financial Resources.
 - Once your financial institution is prepared to process scheduled monthly Payment Management transactions on the Employer's account, GuideStone Financial Resources will notify the Employer by mail of the date of the first transmission.
 - Continue to mail in the monthly payment until notified that Payment Management withdrawals have been established.
- Please contact your Group Plans Account Administrator for instructions if your account is past due.

How to edit Payment Management withdrawals

- Use Employer Access by selecting the Insurance Billing tab to edit Payment Management withdrawals or
- Contact your Group Plans Account Administrator.
- Please allow sufficient time when requesting a Payment Management change.

HOW TO PROCESS MONTHLY BILLING STATEMENTS

How to stop making Payment Management withdrawals

- Use Employer Access by selecting the Insurance Billing tab to stop Payment Management withdrawals or
- Call GuideStone Financial Resources toll free number to request a Payment Management Termination form. This form may also be accessed by going to the GuideStone Financial Resources Web site at www.guidestoneinsurance.org/FormsandFAQ/GroupForms.
 - Complete the form and return it to GuideStone Financial Resources.
 - Termination requests received less than 10 days prior to the debit processing date may not be completed before the next debit.
- Please allow sufficient time when requesting termination of Payment Management debits.

HOW TO PROCESS ENROLLMENTS

NEW EMPLOYEES

The Group Plans benefits provided by the Employer and any required Employee contributions should be fully explained to each new Employee. A sample of a suggested "Enrollment Checklist" that may help you in providing this information is shown in the Procedures section of this chapter.

Prompt enrollment is important. Enrollment Forms for new Employees should be completed at the time of hire and mailed or faxed promptly to GuideStone Financial Resources Insurance Operations, Group Plans. This assures that coverage will become effective on the first day of eligibility and avoids requiring the Employee to submit Evidence of Good Health at a later date or delay of coverage. (See the "How to Process Evidence of Good Health" chapter in this manual.)

Note: Delaying submission of enrollment forms for medical coverage can result in denial of coverage until the annual open enrollment period. For Employers with a standard renewal period, medical coverage would not be effective until the following January 1st.

ELIGIBLE EMPLOYEES

All **regular, full-time** Employees of the Employer are eligible for coverage, provided they meet the eligibility provisions of the plans.

The following classes of Employees are **not** eligible for coverage under the plans:

- Temporary Employees
- Employees who work less than 20 hours per week.

CONTRIBUTORY VS NON-CONTRIBUTORY PLANS

The Employer may elect to pay a part or all of the charges for these Employee benefits. The two funding approaches are outlined in the "General Administrative Guidelines" chapter of this manual. To summarize, the Employer chooses to offer each plan to its Employees in one of the following ways:

- **Non-Contributory Plan(s)** - The charges for coverage are paid entirely by the Employer. Employees and dependents that meet eligibility requirements must be enrolled in the plan(s). Coverage becomes effective on the date the Employee or dependent first becomes eligible. Employees **do not** contribute toward the cost of the Program.

HOW TO PROCESS ENROLLMENTS

- **Contributory Plan(s)** - The charges for coverage are paid by participating Employees, or jointly by Employer and covered Employees. Eligible Employees and dependents receive coverage if they elect to enroll in the plan(s) within 31 days of the Eligibility Date and agree to make contributions toward the cost of the Program. Employees **do** contribute toward the cost of coverage under Contributory plans.

Refer to the “General Administrative Guidelines” chapter of this manual for detailed Employee and dependent eligibility requirements.

WHEN EMPLOYEE COVERAGE BECOMES EFFECTIVE

The date coverage becomes effective depends on the length of the Waiting Period, if any, and whether the Employer's plans are Non-Contributory or Contributory.

Non-Contributory Plans – This coverage becomes effective on the Employee's Eligibility Date.

Contributory Plans – This coverage also becomes effective on the Employee's Eligibility Date if the date of signature on the completed Enrollment Form is within 31 days of the Employee's Eligibility Date. If the Enrollment Form is not signed within 31 days of the Employee's Eligibility Date:

- Life or Disability coverage will become effective when satisfactory Evidence of Good Health is approved. (See the "How to Process Evidence of Good Health" chapter in this manual.)
- Employees can enroll in Premier Dental Care, Choice Dental Care or the Guided Dental HMO Plans at any time.
- Employee Personal Accident or AD&D (Accidental Death & Dismemberment) coverage will become effective on the date the completed Enrollment Form is received. Employee Life coverage is a prerequisite for Accidental Death & Dismemberment coverage.
- The Employee Optional Term Life Plan requires completion of an Evidence of Good Health Enrollment Form. This coverage becomes effective when the Evidence of Good Health is approved by the Claim Administrator.

Note: If the Employee is away from work on the date coverage would normally become effective, Term Life, Accidental Death & Dismemberment, Dental, Disability and Personal Accident coverage will not become effective until the Employee returns to full-time work for one full day. This rule also applies to increases in coverage once an Employee is a Participant.

HOW TO PROCESS ENROLLMENTS

WHEN DEPENDENT COVERAGE BECOMES EFFECTIVE

Non-Contributory Plans – This coverage becomes effective on the Employee's Eligibility Date.

Contributory Plans – This coverage also becomes effective on the Employee's Eligibility Date if the date of signature on the completed Enrollment Form is within 31 days of the Employee's Eligibility Date. If it is not signed within 31 days of the Employee's Eligibility Date:

- Term Life coverage will become effective when satisfactory Evidence of Good Health is approved, provided the Employee is enrolled. (See the "How to Process Evidence of Good Health" chapter in this manual.)
- The Dependent cannot enroll in a medical plan until the Annual Re-enrollment period unless Special Enrollment Requirements are met. (See the "Special and Late Enrollment" chapter in this manual.)
- Dependents can enroll in the Premier Dental Care Plan, Choice Dental Care Plan or the Guided Dental HMO Plan at any time, provided the Employee is enrolled.
- Spouse Personal Accident coverage will become effective on the date the completed Enrollment Form is received, provided the Employee is enrolled.
- Spouse Optional Term Life coverage will become effective when the Evidence of Good Health Enrollment Form is approved by the Claim Administrator.

Note: Benefits for Child Term Life coverage do not begin before the 14th day of life.

REHIRED EMPLOYEES

A terminated Employee who is rehired within one year is eligible for waiver of the Waiting Period. A rehire occurring after one year of the date of termination should be treated as a new Employee. Re-enroll the Employee in either instance, according to the procedures shown for new Employees.

ENROLLMENT AND ORIENTATION

The Group Plans provided by the Employer should be explained in detail in the Employee's orientation. Once the coverage has been explained, have the Employee complete a Group Plans Enrollment Form and, if applicable, an Evidence of Good Health Enrollment Form.

To speed the actual enrollment process and help guarantee the accuracy of the basic data needed for record keeping, we recommend that you type the basic Employee and employment information on the

HOW TO PROCESS ENROLLMENTS

Group Plans Enrollment Form *before* you meet with the new Employee. See the Procedures section of this chapter for specific information and instructions.

ENROLLMENT PROCEDURES

1. Discuss the following with the new Employee:
 - The eligibility requirements of the plans and when coverage will become effective
 - The amount of the Employee's required contributions (if any) and how the payroll deduction amount is determined
 - When personal Employee and dependent status changes should be reported to you
 - The basic types of Term Life coverage beneficiary designations that may be used
 - The basic plan provisions and benefits provided by the plans
 - The Pre-authorization requirements and procedures of the medical plan, if applicable
 - The Pre-existing Condition limitations of the medical plan, if applicable, including the application of prior Creditable Coverage to the Pre-existing Condition Limitation Period
 - Home Delivery Pharmacy Service and Prescription Drug Program, if applicable.
 - The Waiting Periods of the Dental Plan, if applicable
 - The effect of retirement or termination of employment on Group Plans coverage

The suggested "Enrollment Checklist" shown on the next few pages may be copied and used when you discuss the basic provisions and coverage provided under the Employer's Group Plans.

HOW TO PROCESS ENROLLMENTS

ENROLLMENT CHECKLIST

Name of Employee _____

Social Security No. _____

Date of Full-Time Employment _____

Coverage Effective Date _____

Discuss each Employee benefit available to the new Employee at the time of hire. Be sure to cover the basic provisions of the plans, when benefits will become effective, and each election decision the Employee is eligible to make. Check off each box after the subject is discussed with the Employee.

Life and Accident Benefits

- Eligibility — Employee and dependent
- When coverage becomes effective
- Basic plan/provisions, as applicable
 - Employee Term Life
 - Employee Optional Term Life
 - Spouse Term Life
 - Spouse Optional Term Life
 - Child Term Life
 - Personal Accident benefits
 - Accidental Death and Dismemberment
- Claim filing procedures
- Rates, as applicable
- Life Portability and Conversion rights at termination

Medical Benefits

- Eligibility — Employee and dependent
- When coverage becomes effective
- Benefits of using a network provider
- Basic plans/provisions, as applicable
- Prescription drug program, if applicable
- Pre-authorization, if applicable
- Pre-existing condition limitations, including the application of prior creditable coverage to limitation period
- Claim filing procedures

HOW TO PROCESS ENROLLMENTS

- Rates, as applicable
- Continuation provision at termination, if applicable
- Separate Medical and Prescription Drug ID cards will be mailed within 10 working days of the enrollment being processed by GuideStone Financial Resources

Disability Benefits

- Eligibility — Employee
- When coverage becomes effective
- Basic plans/provisions, as applicable
- Rates, as applicable
- Claim filing procedures

Dental Benefits

- Eligibility — Employee and dependent
- When coverage becomes effective
- Basic plans/provisions, as applicable
- Rates, as applicable
- Waiting Periods, as applicable
- Claim filing procedures
- ID cards will be mailed by the Dental carrier

Process the Enrollment Form for the new Employee and give the Employee the following materials:

- Information on GuideStone Financial Resources and Claims Administrator's website for referencing Employee Booklets and PPO Providers
- Notice of Pre-existing Condition Limitations
- Notice of Special Enrollment Rights

Administrator: _____ Date of Orientation: _____

HOW TO PROCESS ENROLLMENTS

2. Complete the following information on a Group Plans Enrollment Form:

Section A General Information

- Employer Name and Number
- Name of Employee, Employee Date of Birth and Social Security Number
- Home Address, Daytime Telephone Number and Email Address
- Gender and Marital Status
- Employee Classification
- Monthly Salary
- Date of Full-Time Employment and Coverage Effective Date

Note: It is essential that the "Employee Classification" blank be completed if the Employer has more than one Employee classification.

Section B Benefit Election

- Indicate each product elected by the Employee and the coverage amount if applicable
- For Employee Optional Term Life election and Spouse Optional Term Life election, separate application is required

Note: If the Employee has Eligible Dependents and your dependent medical plan or dependent dental plan is Non-Contributory, then the Employee must be enrolled for family coverage.

Section C Participant and Dependent Information

- The name of the Participant and the Guided Dental HMO dental ID number, if applicable.
- The name, Social Security number, relationship, birth date, sex, and Guided Dental HMO dental ID number for any Eligible Dependent.

Section D Beneficiary Designation

- The name, relationship, birth date, Social Security number of the Employee's beneficiary for Life and Personal Accident coverage.

Section E Required Signatures

- Employee's signature and date signed
- Employer's signature and date signed

HOW TO PROCESS ENROLLMENTS

3. The following elections require submission of an Evidence of Good Health Form to the Claim Administrator for approval in addition to the Group Plans Enrollment form.
 - Employee Term Life offered by the Employer which exceeds four times the Employee's annual Salary
 - Employee Optional Term Life coverage
 - Spouse Optional Term Life coverage which exceeds the Employer's base plan
 - Employee Term Life, Spouse Term Life, Child Term Life or Disability coverage for Contributory plans when the Enrollment Form date of signature is more than 31 days past the date the Employee or dependent first became eligible for coverage.

See the "How to Process Evidence of Good Health" chapter of this manual.

4. If there are any omissions or questions, resolve them with the Employee before submitting the form.
5. Sign and date the enrollment form in Section E Required Signatures as the Employer Representative.
6. Request from the Employee a Certificate of Creditable Coverage from his or her prior group medical plan, if applicable.
7. Keep a file copy of all materials sent to GuideStone Financial Resources. For Employers covered by the Americans with Disabilities Act (ADA), regulations require Employee medical information to be kept in confidential files separate from regular personnel files. Always retain a copy of the Group Plans Enrollment Form if applicable.
8. Send the following completed material to GuideStone Financial Resources Insurance Operations, Group Plans:
 - Group Plans Enrollment Form
 - Certificate of Creditable Coverage from prior medical coverage, if applicable
9. If applicable, have the Employee send the Evidence of Good Health Form to GuideStone Financial Resources Insurance Operations, Group Plans.

(HIPAA) HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

GENERAL INFORMATION

Under specific circumstances, Special and Late Applicant provisions may apply for Employees and/or Eligible Dependents who do not enroll in a medical plan offered by the Employer within 31 days of their first eligibility. These provisions may allow the Employee and/or Eligible Dependent(s) to enroll in the medical plan at a later date if he or she qualifies as either a Special Enrollee or Late Enrollee. These provisions apply only to medical coverage offered on a Contributory basis. For Non-Contributory medical coverage, all eligible Employees and dependents must enroll in the medical plan effective on the first date of eligibility.

Special and Late Applicant provisions are applicable to active full-time Employees and their Eligible Dependents **for medical coverage only**. Evidence of Good Health is not required for medical coverage as a Special or Late Enrollee. When an Employee or any of the Employee's Eligible Dependents meet Special Enrollment requirements, the Employee and any Eligible Dependents may be enrolled in medical coverage effective on the date of the Qualifying Event. Special Enrollment is not limited to the dependent who meets the requirement. Employee coverage is a prerequisite for dependent coverage (See the "How to Process Enrollments" chapter of this manual for details on enrolling an Employee.)

SPECIAL ENROLLEES

A Special Enrollee is an individual who meets the Special Enrollment Requirement of either acquiring a dependent(s) or reaching the end of other medical coverage due to loss of eligibility.

As a Special Enrollee, these individuals are permitted to enroll in a Group Plans Medical Plan within 60 days of the Qualifying Event due to loss of eligibility, or 60 days due to acquisition of a dependent. Special Enrollees, who are age 19 or over, are subject to a 12-month Pre-existing Condition Limitation, less any Creditable Coverage. The Pre-existing Condition Limitation does not apply to any Special Enrollee who is under the age of 19.

Dependent Addition

To qualify as a Special Enrollee due to the acquisition of a dependent, the Employee and/or his Eligible Dependent(s) must meet one of the following requirements:

- Marriage
- Birth
- Adoption

(HIPAA) HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

- Placement for adoption
- Loss of Medicaid or CHIP due to eligibility (documentation required)
- Becomes eligible for premium assistance under Medicaid or CHIP (documentation required)

Request for medical coverage must be submitted within 60 days of the Qualifying Event. If approved, coverage will become effective on the date of the Qualifying Event.

Loss of Other Health Care Coverage

To qualify as a Special Enrollee due to the loss of other health care coverage, the Employee and/or Eligible Dependent(s) must have been covered by other group coverage that ceased within the last 60 days of the request for coverage in Group Plans. Prior group coverage must have ceased for one of the following reasons:

- Company out of business
- Termination of employment
- Layoff
- End of COBRA eligibility
- Retirement
- Death
- Divorce

If an Employee and/or Eligible Dependent(s) elect to enroll in the Employer's Medical Plan as a Special Enrollee, follow the procedures for Special and Late Enrollment in this chapter.

Request for Medical coverage must be submitted within 60 days of the loss of other medical coverage. If approved, coverage will become effective on the day following the termination of the prior group plan coverage. Special enrollees, age 19 and over, are subject to a 12 month Pre-existing Condition Limitation, less any creditable coverage. The Pre-existing Condition Limitation does not apply to any Special Enrollee who is under the age of 19.

Note: Loss of eligibility does not include a loss due to failure of the individual to pay premiums on a timely basis or termination of coverage for cause, such as making a fraudulent claim.

LATE ENROLLEES

A Late Enrollee is an Employee or Eligible Dependent who does not enroll in a Group Plans medical plan during his or her initial eligibility period and does not qualify as a Special Enrollee. These individuals are permitted to enroll in a Group Plans medical plan during the Annual Re-enrollment Period which for

(HIPAA) HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Employers with a standard renewal period is each January 1. Late Enrollees, age 19 and over, are subject to a 12-month Pre-existing Condition Limitation, less any Creditable Coverage. The Pre-existing Condition Limitation does not apply to any Late Enrollee who is under the age of 19.

If an Employee and/or Eligible Dependent(s) elect to enroll in the Employer's Medical Plan as a Late Enrollee, follow the procedures for Special and Late Enrollment in this chapter. For Employers with a standard renewal period, medical coverage for the Employee and/or Eligible Dependents will become effective on the January 1 following submission of the application.

PROCEDURES FOR SPECIAL AND LATE ENROLLMENT

1. Discuss the following with the Employee who is enrolling himself and/or his Eligible Dependent(s) in a medical plan as Special or Late Enrollees:
 - The eligibility requirements of the medical plan and when coverage will become effective
 - The amount of the Employee's required contributions and how the payroll deduction amount is determined
 - When personal Employee and dependent status changes should be reported to you
 - The basic plan provisions and benefits provided by the medical plan
 - The Pre-authorization Requirements and procedures of the medical plan, if applicable
 - The Pre-existing Condition Limitations of the medical plan, if applicable, including the application of prior Creditable Coverage to the limitation period
 - Medco Health Home Delivery Pharmacy Service and Retail Network Pharmacy Service, if applicable.

The suggested Enrollment Checklist in the "How to Process Enrollments" chapter of this manual may be copied and used when you discuss the basic provisions and coverage provided under the Employer's Group Plans.

2. Have the Employee complete a Special and Late Applicant Form for Health Care Coverage as follows. If the Employee is not currently on your Group Plans bill with other products, a Group Plans Enrollment Form **must** accompany this form for enrollment. (See the "How to Process Enrollments" chapter of this manual.)
 - Complete the following information:
 - Employer Name and Employer Number
 - Name of Employee, Social Security number
 - Employee Address, Employee Telephone Number
 - Indicate the person(s) for whom the coverage is being requested.

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- From the choices listed on the enrollment form, indicate the reason coverage is being requested and the date of the Qualifying Event, if applicable. For Late Enrollees at Employers with a standard renewal period, coverage will become effective on the January 1 following the application.
 - For each dependent requesting coverage, indicate:
 - Dependent's Name, Social Security Number and Date of Birth
 - Relationship to Employee
 - Sex
 - Have the Employee and the Employer's Authorized Representative sign and date the form. Application must be made within 60 days of the Qualifying Event due to loss of eligibility, or 60 days due to acquisition of a dependent.
3. Attach a Certificate of Creditable Coverage from prior health care plan, if applicable.
 4. Give the Employee a packet which includes:
 - Information on GuideStone Financial Resources and Claims Administrators' Web sites for referencing Employee Booklets and PPO Providers.
 - The appropriate Employee Booklet if access is not available on the Web site
 - Notice of Pre-existing Condition Limitations, if PPO Medical Plans
 5. Keep a file copy of all materials sent to GuideStone Financial Resources. For Employers covered by the Americans with Disabilities Act (ADA), regulations require Employee medical information to be kept in confidential files separate from regular personnel files.
 6. Send the following completed material to GuideStone Financial Resources Insurance Operations, Group Plans:
 - Special and Late Applicant Enrollment Form for Health Care Coverage
 - Group Plans Enrollment Form, if applicable
 - Certificate of Creditable Coverage from prior medical coverage, if applicable.

Note: Under no circumstances should the Special and Late Applicant Form for Health Care Coverage be sent directly to the Claim Administrator.

PROTECTED HEALTH INFORMATION (PHI)

PHI that GuideStone Financial Resources handles

- Medical reasons for declines on applications
- Detailed medical information that claims has access to
- Medical information that Claims Appeals Committee members use
- Any correspondence from members containing medical information on themselves or on a covered individual
- Medical information on applications

How the Plan will use Members information

The Plans may use, share or disclose Protected Health Information without authorization from the member to pay medical benefits, operate the Plan or in connection with treatment by a health care provider covered by HIPAA. In addition, the Plans may use or disclose members information in other special circumstances described in the Notice (Privacy practices of health plans) which GuideStone Financial Resources sends to all members who enroll in a Medical Plan. To review this Notice or obtain a copy, go to GuideStone Financial Resources Web site or call your Account Administrator in Group Plans.

Authorization to Disclose PHI

The plans require written authorization for the use or disclosure of a members' Protected Health Information for any other purpose. A PHI Disclosure Form #8010 should be completed and returned to Group Plans. This form can be located at GuideStone Financial Resources Web site, or you can call your Group Plans Account Administrator to request the form.

Withdrawal of Authorization for (PHI) Disclosure

The individual has the right to withdraw their authorization at any time. A Withdrawal of Authorization for PHI Disclosure form #8111 needs to be completed and returned to Group Plans. This form can be located at GuideStone Financial Resources Web site, or you can call your Group Plans Account Administrator to request the form.

HOW TO PROCESS EVIDENCE OF GOOD HEALTH

GENERAL INFORMATION

The Claim Administrator reserves the right to accept or decline any medical information supplied in connection with Evidence of Good Health. When evidence is requested and found acceptable, plan coverage becomes effective on the date it is approved by the Claim Administrator.

WHEN EVIDENCE OF GOOD HEALTH IS REQUIRED

Evidence of Good Health may be required in connection with Life and Disability coverage under the Employer's Program and to upgrade Medicare Coordinating Plans. Evidence of Good Health is required in the following situations:

- If an Employee or an Employee's Eligible Dependent(s) does not enroll for Contributory life or disability plans offered by the Employer within 31 days of the date first eligible to participate, Evidence of Good Health is required before coverage becomes effective. See the Employee Booklet for specific information regarding plan coverage that may require Evidence of Good Health under the Employer's Program.
- Evidence of Good Health is required of the Employee who requests reinstatement of Contributory life or disability coverage previously discontinued.
- Evidence of Good Health is required for any amount of Employee Term Life offered by the Employer that exceeds four times the Employee's annual Salary.
- Evidence of Good Health is required for retirees or inactive Employees or their covered dependents that are enrolled in the Senior Plan and want to upgrade to the Senior Plus Plan or that are enrolled in the Care Basic Plan and want to upgrade to the Care Plus Plan.
- Evidence of Good Health will be required in connection with Optional Term Life coverage for the following reasons:
 - Initial enrollment or requested increase in Employee Optional Term Life coverage
 - Initial enrollment or requested increase in Spouse Optional Term Life coverage which exceeds the Employer's base plan
 - Coverage increases due to Salary increases when it has been at least two years from the last date the Employee provided satisfactory Evidence of Good Health
 - Cumulative increases in coverage due to Salary increases that exceed 15% of the amount of coverage from the last date the Employee provided satisfactory Evidence of Good Health
 - Cumulative increases in coverage due to Salary increases that exceed \$50,000 from the last date the Employee provided satisfactory Evidence of Good Health.

WHEN EVIDENCE OF GOOD HEALTH IS NOT REQUIRED

Evidence of Good Health is not required in the following situations:

- Since Employees are covered automatically for all Non-Contributory plans made available by the Employer, Evidence of Good Health is not required in connection with these plans.
- No Evidence of Good Health is required for the Personal Accident or Accidental Death and Dismemberment Plans.
- No Evidence of Good Health is required in connection with coverage in any dental plan. Employees and Eligible Dependents can enroll in the Premier Dental Care, Choice Dental Care, or the Guided Dental HMO Plans at any time.
- No Evidence of Good Health is required for an active Employee or his covered dependent(s) in connection with coverage in a medical plan. An employee or dependent who requests coverage in a Contributory medical plan more than 31 days after initial eligibility will be ineligible to enroll in the medical plan until the Employer's annual re-enrollment (which is usually January 1 following the request) unless Special Enrollment Requirements are met. (See the "Special and Late Enrollment" chapter of this manual.)

PROCEDURES FOR COMPLETING THE EVIDENCE OF GOOD HEALTH

Process Evidence of Good Health Form as follows:

1. Employer's Authorized Representative completes Section A
 - **Section A: Employer Information.** Provide the following information:
 - Employer name
 - Employer telephone and fax number
 - Employer account number
 - Employer address
 - Employer email address
 - Employee classification
 - Employee's total monthly Salary
 - Employment status
 - Sign and date the form confirming that the Employee is actively working or retired.
2. Assist the employee in completing sections B and C of the form, if needed.
 - **Section B: Employee Information.** Have the Employee complete the following:
 - Employee name
 - Employee Social Security number

HOW TO PROCESS EVIDENCE OF GOOD HEALTH

- Employee birth date
- Employee email address
- Employee home telephone number
- Employee address
- Employee gender
- Employee marital status
- **Section C: Coverage Options.** Have the Employee check only the coverage for which he is applying and provide the following information:
 - Basic Term Life coverage, if applicable, including:
 - Employee Basic Term Life coverage currently in force, and,
 - Employee Basic Term Life coverage amount for which application is being made.
 - Employee Optional Term Life Coverage, if applicable, including:
 - Times Annual Salary amount for which application is being made,
 - Optional Term Life coverage currently in force, and,
 - Optional Term Life coverage amount for which application is being made.
 - Total Term Life amount requested (Employee Basic Term Life and Employee Optional Term Life combined)

(Note: Employee Basic Term Life and Employee Optional Term Life combined coverage amount cannot exceed the lesser of eight times the annual Salary or the standard plan maximum of \$750,000.)

- Spouse Basic Term Life coverage, if applicable
 - Spouse Basic Term Life coverage currently in force, and,
 - Spouse Basic Term Life coverage amount for which application is being made.
- Spouse Optional Term Life Coverage, if applicable, including:
 - Spouse Optional Term Life coverage currently in force, and,
 - Spouse Optional Term Life coverage amount for which application is being made.
- Total Spouse Term Life amount requested (Spouse Basic Term Life and Spouse Optional Term Life combined)

Note: Spouse Term Life must be in \$5,000 increments. Spouse Basic Term Life and Spouse Optional Term Life combined coverage amount cannot exceed 50% of the combined total of Employee Basic Term Life and Employee Optional Term Life coverage, up to the standard plan maximum of \$250,000.

HOW TO PROCESS EVIDENCE OF GOOD HEALTH

- Child Term Life coverage, if applicable
- Disability coverage, if applicable
- Economy Long Term Disability
- Choice Long Term Disability
- Premier Long Term Disability
- Economy Short Term Disability
- Choice Short Term Disability
- Medicare Primary Coverage upgrade, if applicable
- **Section D: Beneficiary Designation.** If application is for Employee Term Life or Employee Optional Life coverage, have the Employee complete the beneficiary designation including:
 - Full name
 - Relationship to Employee
 - Birth Date
 - Social Security Number of primary and, if applicable, contingent beneficiary.

Note: See the “How to Change a Beneficiary” chapter of this manual for guidelines for naming a beneficiary.

3. After completing Section A give the Evidence of Good Health Form and a GuideStone Financial Resources return envelope to the Employee. Instruct the Employee to complete sections B – G.
 - The Employee should then send the completed Evidence of Good Health Form to GuideStone Financial Resources Insurance Operations, Group Plans. Under no circumstance should the Evidence of Good Health Form be sent directly to the Claim Administrator.

Note: Because of privacy regulations under the Health Insurance Portability and Accountability Act (HIPAA), it would be prudent to avoid copying an Employee’s personal medical information.

- **Section E: Applicant and Dependent Information**
 - The Employee should complete questions 1 and 2. Only family members who are requesting coverage should be listed.
 - The Employee should provide the address(es) of any Eligible Dependent(s) who is applying for coverage and does not reside with the Employee.
- **Section F: Applicant and Dependent Medical Information**
 - The Employee should complete questions 1 and 2.

HOW TO PROCESS EVIDENCE OF GOOD HEALTH

- **Section F: Part I**
 - The Employee should complete questions 1 through 6 on all persons who are requesting coverage.
 - For any "yes" answers to question 1 or 2, complete item 3 of Section F.
 - **Section F – Part II**
 - The Employee should complete questions 7 – 55 on all persons who are requesting coverage.
 - **Section F – Part III**
 - The Employee should complete this section if any questions were checked in Part II.
 - **Section F – Part IV**
 - The Employee should complete on any person that is requesting coverage.
 - **Section G: Applicant and Dependent Authorization**
 - The Employee (and spouse, and children age 18 and over, if applicable) must read, then sign and date the statement, on both pages where indicated.
4. When the Employee has completed the health information, the Employee should make a copy of the entire application for his or her records and return the form directly to GuideStone Financial Resources Group Plans:
- Insurance Operations, Group Plans
GuideStone Financial Resources
2401 Cedar Springs Rd
Dallas, TX 75201-1407
5. Group Plans coordinates the processing of Evidence of Good Health with the Claim Administrator. If the Claim Administrator requires additional medical information, they will contact your Employee and furnish specific instructions for the data required.
6. The Insurance Operations, Group Plans will notify you when the evidence is approved or declined and inform you of the effective date for the approved coverage.
- When Evidence of Good Health has been approved, inform the Employee of the date coverage becomes effective.
 - Declination notices from the Claim Administrator are sent directly to the Employee, stating the reason for declination.

HOW TO PROCESS CHANGES

GENERAL INFORMATION

Employee personal data changes affecting employment status and/or coverage elections should be recorded and reported to GuideStone Financial Resources as soon as possible.

This chapter of the manual explains how the following changes should be processed and reported to GuideStone Financial Resources Insurance Operations, Group Plans.

| | |
|---------------------------------|--|
| <p>Personal Data</p> | <ul style="list-style-type: none"> • Name changes • Salary changes • Marital status changes • Employee address changes |
| <p>Coverage Status</p> | <ul style="list-style-type: none"> • Adding or dropping coverage (Contributory and Non-Contributory) • Increasing or decreasing coverage • Attainment of age 65 during active service (does not need to be reported by the Employer) • Dependent changes |
| <p>Employment Status</p> | <ul style="list-style-type: none"> • Employee classification changes • Temporary / part-time to regular, full-time • Regular, full-time to temporary / part-time |
| <p>Transfers</p> | <ul style="list-style-type: none"> • Between medical or dental plans offered by the Employer • To or from another participating Employer |

HOW TO PROCESS CHANGES

This chapter of the manual covers changes only. See other manual chapters, as indicated below, for information and procedures for processing new Employees, terminations, Beneficiary changes, etc.

| TYPE OF ACTIVITY | MANUAL CHAPTER |
|---|-----------------------------|
| Enrolling New Employees | How to Process Enrollments |
| Terminating Employees | How to Process Terminations |
| Beneficiary Changes | How to Change a Beneficiary |
| Retiring Employees | Leaving Active Employment |
| Leave of Absence | Leaving Active Employment |
| Continuation During Unemployment | How to Process Terminations |
| Medical/Dental Continuation After Termination | How to Process Terminations |

When changes occur that require the completion and submission of a Group Plans Employer Change Report, report the change and its effective date immediately. **Do not** send changes with the monthly billing statement.

Certain types of changes may be made online through Employer Access. See the “Employer Access” chapter in this manual for further information.

PERSONAL DATA CHANGES

Name Changes

If an Employee's name changes because of marriage, divorce, court order, etc., report the change in the Employee Information section of the Employer Change Report by checking the name change box.

Salary Changes

Salary adjustments, whether increases or decreases, should be reported in the Types of Changes section of the Employer Change Report. Complete the “Effective date of change” field, check whether the Salary change is an increase or decrease, and indicate the new Salary.

Salary changes that affect all Employees may be noted on the Employer's monthly billing statement. The effective date of change must be included. The Salary changes should be sent to GuideStone Financial Resources Insurance Operations, Group Plans.

HOW TO PROCESS CHANGES

Coverage and rates resulting from Salary changes will be adjusted effective the date the change is received by GuideStone Financial Resources. This could result in a billing adjustment for any Salary changes received. If the effective date is in the future, that is the date that will be used.

Note: It is important that you notify Group Plans of Salary changes in a timely manner. Since most Term Life, Accidental Death & Dismemberment and Long & Short Term Disability plan coverage amounts are based on an Employee's current Salary, failure to notify Group Plans of a change could result in a decreased level of benefits for your Employees. Payment of any claim or benefits will be determined by the last earnings reported to GuideStone Financial Resources, provided the reported effective date is prior to the date the claim was incurred.

Marital Status Change

If an Employee's marital status changes due to marriage, divorce, etc., report the change in the Types of Changes section of an Employer Change Report. Check the marital status box to indicate the type of change. Use the provided blank to provide details concerning the change. Also, remind the Employee to review existing Beneficiary designations and medical or dental dependent coverage status for possible changes. Explain the Employee's Special Enrollment Rights for Medical coverage due to a Life-changing Event, if applicable.

Address Changes

If an Employee's home address changes, report the change in the Employee Information section of the Employer Change Report. Check the change of address box to indicate type of change.

A change of address may affect your Employee's eligibility in the Guided Dental HMO Plan. Moving out of the DHMO service area may cause a Participant to become ineligible for the plan.

COVERAGE STATUS CHANGES

Adding Contributory Coverage

If provided under your Program, Employees may elect to add or reinstate coverage, except medical coverage, at any time. Reinstatement of discontinued medical coverage can be made only during the Annual Re-enrollment Period which is usually the January 1 following the request unless Special Enrollment Requirements are met. (See the Special and Late Enrollment section in the "HIPAA" chapter of this manual.) Late Term Life or Disability plan elections require Evidence of Good Health before coverage becomes effective. (See the "How to Process Evidence of Good Health" chapter of this manual.)

HOW TO PROCESS CHANGES

The addition of Accidental Death & Dismemberment, Dental and/or Personal Accident coverage should be reported in the Types of Changes section of the Employer Change Report. The "Effective date of change" field should show the date the coverage should be added. The effective date will be the date the request is received at GuideStone Financial Resources unless a future date is indicated in the "Effective date of change" field. Indicate in the Product Changes section which product is being added and the volume of the coverage, if applicable. If a dependent is also being added to the product, the dependent information and product changes sections on the second page of the form would also need to be completed.

Note: Employee Term Life coverage is a prerequisite for Accidental Death & Dismemberment coverage.

Dropping Contributory Coverage

An Employee may drop a Contributory coverage at any time. Termination of a plan should be submitted on an Employer Change Report. Indicate in the Types of Changes section the reason for the requested termination. The "Effective date of change" field should show the requested date coverage should be terminated. If medical coverage is being terminated, the "Employee paid through date" must be completed. Credit is limited to a maximum of 2 billed months. Evidence of Good Health is required of the Employee who requests reinstatement of Contributory Life or Disability coverage previously discontinued.

Note: The effective date requested for termination of medical coverage may be adjusted to comply with Rescission rules. Refer to the "How to Process Terminations" chapter.

Adding Non-Contributory Coverage

When Group Plans are provided for Employees and Eligible Dependents on a Non-Contributory basis, all eligible Employees and their Eligible Dependents are automatically covered. The rules concerning delayed application for coverage and the requirements for Evidence of Good Health **do not apply** to Non-Contributory plans. Report the addition on the Employer Change Report in the same manner as adding Contributory coverage. GuideStone Financial Resources adjusts the coverage, and charges are reflected on the monthly billing statement being prepared at the time notice of the change is received. If notification of a change is delayed, a back charge to the effective date may appear on your monthly billing statement.

Dropping Non-Contributory Coverage

For coverage that is Non-Contributory, 100% Participation of all eligible Employees and their Eligible Dependents is required. Non-Contributory coverage may not be terminated as long as the Employee and/or dependent(s) are eligible for coverage unless the Employee elects to waive medical/dental coverage. (See Waiver of Medical/Dental in the "General Administrative Guidelines" chapter of this manual.)

HOW TO PROCESS CHANGES

Note: When a child reaches the limiting age of a life, medical or dental plan, coverage terminates on the date the dependent no longer meets the definition of an Eligible Dependent. (See Eligible Dependents in the "Important Terms" chapter of this manual.)

Increasing or Decreasing Coverage

Increases or decreases in Term Life, Accidental Death and Dismemberment and Long-Term Disability coverage due to a Salary change are automatically processed when the Salary change is reported to GuideStone Financial Resources Insurance Operations, Group Plans.

An increase or decrease in Personal Accident coverage (if applicable to the Employer's Program) is processed **only when the change is requested** by the Employer. An Employer Change Report should show the newly elected Personal Accident amount (in increments of \$25,000) and should be completed and submitted to GuideStone Financial Resources Insurance Operations, Group Plans.

An increase in Employee Optional Term Life coverage due to an increase in Salary is automatically processed when a Salary increase is reported to GuideStone Financial Resources. There may be instances where satisfactory Evidence of Good Health will be required before an increase in the Employee Optional Term Life coverage will be effective. (Evidence of Good Health is always required to increase Spouse Optional Term Life coverage. See the "How to Process Evidence of Good Health" chapter of this manual.) The multiple of annual rate of basic earnings for Employee Optional Term Life may be reduced upon request, but increased only by satisfying Evidence of Good Health subject to approval by the Claim Administrator.

When an Employee becomes eligible for additional amounts of Term Life coverage, and the coverage is provided on a Contributory basis but the Employee prefers to decline the additional amount, have the Employee complete an Employee's Refusal of Increase in Amount of Optional and/or Contributory Life Insurance form. Send the form to GuideStone Financial Resources Insurance Operations, Group Plans and retain a copy of the form.

Note: The Employee should be aware that if additional Term Life coverage is refused and then requested at a later date, the additional amount will not become effective until satisfactory Evidence of Good Health has been provided.

All Employees must participate in the Term Life coverage plan according to the schedule chosen by the Employer. Refusal of increases of coverage applies **only** to Employees who have had an increase in Salary that affects their existing amount of Optional Term Life coverage and those whose Term Life coverage is Contributory.

HOW TO PROCESS CHANGES

Note: If Employee Term Life coverage decreases, Spouse Term Life coverage will be reduced, if necessary, not to exceed 50% of the Employee Term Life Plan and Employee Optional Term Life Plan combined.

Attainment of Age 65 during Active Service

When an active Employee or spouse attains age 65, certain changes are made that directly affect benefit plan coverage. These changes are made automatically by GuideStone Financial Resources Insurance Operations, Group Plans.

- Employee Term Life coverage is reduced by 35% or to \$20,000, whichever is greater, on the January 1 following attainment of age 65. If the coverage amount prior to reduction is \$20,000 or less, no reduction in coverage will be made.
- Accidental Death and Dismemberment coverage is reduced by 35% or to \$20,000, whichever is greater, on the January 1 following attainment of age 65. If the coverage amount prior to reduction is \$20,000 or less, no reduction in coverage will be made.
- Personal Accident coverage is reduced by 35% on the January 1 following attainment of age 65.
- Spouse Personal Accident coverage is reduced by 35% on the January 1 following the Employee's attainment of age 65.
- Employee Optional Term Life coverage is reduced by 35% on the January 1 following attainment of age 65.
- Spouse Term Life coverage will be reduced, if necessary, not to exceed 50% of the Employee Term Life Plan and Employee Optional Term Life Plan combined.
- Term Life, Accidental Death and Dismemberment, Personal Accident and Employee Optional Term Life are rounded to the next highest \$1,000 of coverage after the reduction is taken, provided it is not an increment of \$1,000. (i.e. A \$101,000 Term Life amount would reduce to \$65,650, which would round to \$66,000.) Spouse Personal Accident is rounded to the next \$500 of coverage after the reduction is taken provided it is not an increment of \$500.
- A Participant who is actively working and turns 65 can convert the amount of coverage lost to individual life policies directly with Unum.
- Medical coverage may be affected if the Employee or spouse is eligible for Medicare. A Medicare Coordinating Plans Enrollment Form will be requested if medical coverage will be affected. (See the "Basic Medicare Information" chapter of this manual.)

Note: See the "Leaving Active Employment" chapter of this manual for specific information concerning changes in Program coverage that occur at retirement.

HOW TO PROCESS CHANGES

Dependent Additions or Terminations

The addition or termination of an Employee's dependent coverage should be reported to GuideStone Financial Resources Insurance Operations, Group Plans.

Changes in dependent coverage should be reported using the Employer Change Report. In the Types of Changes section, the "Effective date of change" field should show the date the change occurred and the appropriate box should be checked to indicate the type of change needed. The dependent information and product changes sections on the second page of the form would also need to be completed. If the Employee is adding a dependent to medical coverage due to a Life-changing Event, a Special and Late Applicant Enrollment Form for Health Care Coverage is required in place of the Group Plans Change Report.

Contributory Plans – Employees may add coverage for newly acquired dependent(s) without Evidence of Good Health, as long as the change is reported within 60 days. If the change is reported more than 60 days beyond the dependent's original Eligibility Date:

- Evidence of Good Health must be submitted and approved by the Claim Administrator before Term Life coverage becomes effective.
- The newly acquired dependent(s) will be eligible to apply for medical coverage during the Annual Re-enrollment Period which is usually for the following January 1.

Note: Each dependent child must be individually identified in order to be covered under the Child Term Life plan. Even when the monthly rate for Child Term Life coverage for an Employee's dependent(s) was established prior to the birth of a child, adoption, or placement in the home, to add a new dependent, an Employer Change Report must be completed with the new dependent's name, date of birth, Social Security number and coverage election. The change report should be sent to GuideStone Financial Resources within 60 days of the birth of the child. Evidence of Good Health will be required for the newborn enrolling more than 60 days after initial eligibility, regardless of whether other dependent children are already enrolled in the plan.

Non-Contributory Plans – Coverage for newly acquired dependent(s) is automatic; however, the change must be reported to GuideStone Financial Resources. The rules concerning late application for dependent coverage and Evidence of Good Health requirements do not apply to Non-Contributory plans.

If notification of a change is delayed, a back charge to the Effective Date may appear on your monthly billing statement.

HOW TO PROCESS CHANGES

Eligible Dependents can enroll in the Premier Dental Care Plan, Choice Dental Care Plan or the Guided Dental HMO Plan at any time. The effective date will be the date the request is received at GuideStone unless a future date is indicated in the effective date field.

Dependent Medical/Dental coverage may be waived if certain requirements are met. (See Waiver of Medical/Dental in the "General Administrative Guidelines" chapter of this manual.)

EMPLOYMENT STATUS

Employee Classification Changes

When an Employee's reclassification results in a change of plan coverage, the change must be reported to GuideStone Financial Resources Insurance Operations, Group Plans.

If an Employee's classification changes, report the change in the Types of Changes section of an Employer Change Report. Check the class box to indicate the type of change. Use the provided blank to provide details concerning the change.

Example: Change from Administrative to Non-Administrative

Temporary / Part-Time to Regular, Full-Time

When an Employee changes from a temporary or part-time position to a regular, full-time position, all Program benefits become available to the Employee and the Employer may waive the Waiting Period.

The Program benefits should be explained and the Employee should complete a Group Plans Enrollment Form and, if applicable, an Evidence of Good Health Form. The date of employment on the form(s) should reflect the date the Employee becomes regular, full-time. (See the "How to Process Enrollments" chapter of this manual.)

Regular, Full-Time to Temporary / Part-Time

When an Employee changes to temporary or part-time status, all Program benefits terminate. However, the Employee has the right to apply for Portability or Conversion of any Term Life coverage to individual direct payment policies administered by the Claim Administrator. (See the "How to Process Terminations" chapter of this manual.)

If an Employee has a change of employment status, report the change in the Types of Changes section of an Employer Change Report. Complete the date the Employee's employment status changed in the "Effective date of change" field and indicate the change as "Terminate Employee". If medical coverage is

HOW TO PROCESS CHANGES

being terminated, the "Employee paid through date" must be completed. Use the "Other" field to explain the change. Credit is limited to a maximum of 2 billed months.

Note: The effective date requested for termination of medical coverage may be adjusted to comply with Rescission rules. Refer to the "How to Process Terminations" chapter.

TRANSFERS

Employees Transferring Between Medical Plans during Annual Re-Enrollment Period

During the Annual Re-enrollment Period, which is usually effective each January 1 for a standard renewal, covered Employees may elect to transfer between medical plans offered by the Employer. Employees and/or Eligible Dependents who did not enroll in a Group Plans medical plan during their initial 31-day eligibility period may also elect to enroll in a plan at this time as a Late Enrollee. (See the Special and Late Enrollment section in the "HIPAA" chapter of this manual.) The Employer will be notified each year of the time period in which re-enrollment applications will be accepted.

If an Employee elects to transfer between medical plans offered by the Employer, have the Employee complete an Employee Annual Change Request indicating his or her new plan election(s). Submit the form to GuideStone Financial Resources Insurance Operations, Group Plans during the Annual Re-enrollment Period. For an Employer with a standard renewal period, the new medical plan election will become effective on the January 1 following submission of the application.

Employees Transferring To or From another Participating Employer

When an Employee already covered under the Group Plans transfers from another Employer to a new Employer, the Employee must complete a new Group Plans Enrollment Form and, if applicable, an Evidence of Good Health Form. (See the "How to Process Enrollments" chapter of this manual.)

The Employer may waive the Waiting Period for coverage provided there is no break in coverage and the request is made within 31 days of the eligibility date. However, the Waiting Period must be observed for coverage requested more than 31 days after their eligibility date, or if there has been a break in coverage.

If an Employee transfers to another participating Employer, indicate the change as a "Terminate Employee" in the Types of Changes section on the Employer Change Report. Indicate the termination date in the "Effective date of change" field. Use the "Other" field under Termination Reasons to indicate the Employee's new Employer.

PROCEDURES FOR PROCESSING CHANGES

Process changes as follows:

1. An Employer Change Report must be completed and sent to GuideStone Financial Resources Insurance Operations, Group Plans as soon as one of these changes occurs.
 - a) Personal data change
 - b) Coverage status change
 - c) Employment status change
 - d) Transfers out of the Employer's Program
2. Be sure to include the effective date of the change, the date through which medical premiums have been paid if medical coverage is terminating and to sign and date the form.
3. Retain a copy of the Group Plans Change Report form in the Employee's permanent personnel file.
4. Send the completed Employer Change Report to the following address:

GuideStone Financial Resources
Insurance Operations, Group Plans
2401 Cedar Springs
Dallas, TX 75201 – 1407

HOW TO PROCESS A CHANGE OF BENEFICIARY

GENERAL INFORMATION

A Beneficiary for coverage is named on a new Employee's Group Plans Enrollment Form. To change Beneficiaries, a Beneficiary Designation Form must be completed and submitted to GuideStone Financial Resources Insurance Operations, Group Plans.

COMMON BENEFICIARY DESIGNATIONS

The following pages contain a list of the most frequently used Beneficiary designations and examples of how these designations should be worded:

| Type of Beneficiary | Examples of Wording to be Used |
|---|---|
| One Beneficiary | Mary Jones, wife (if not related to Employee, show as "friend"). |
| Estate | Estate. |
| Two Beneficiaries (Equal Shares) | John Jones and Mary Jones, father and mother, in equal shares or the survivor, if any. |
| Three or More Beneficiaries (Equal Shares) | John Jones, Peter Jones and Martha Jones, brothers and sister, in equal shares or the survivors or survivor, if any. |
| Children (Equal Shares) | John Jones, Peter Jones and Martha Jones, the insured's children, if living at the time of the insured's death, in equal shares or the survivors or survivor, if any. |
| Minor Child | Preferred method is to set up a testamentary trust to provide for the minor child. Note: If a minor child is the Beneficiary, and proper legal guardianship or trust is not established, payment of claims to the minor child may be delayed. |
| One Secondary Beneficiary | Lois Jones, wife, if living, otherwise, Herbert Jones, son. |
| More Than One Secondary Beneficiary | Lois Jones, wife, if living; otherwise, Herbert Jones, Alice Jones and Ann Jones, son and daughters, in equal shares, or the survivors or survivor, if any. |
| Children as Secondary Beneficiaries | Lois Jones, wife, if living; otherwise, John Jones, Peter Jones and Mary Jones, the insured's children, if living at the time of the insured's death, in equal shares, or the survivors or survivor, if any. (See Minor Child above.) |
| Trustee | (Company or Individual's Name) Trustee, in one sum, under Trust Agreement dated (insert date). A Trust Agreement must be in existence. |

DESIGNATIONS THAT SHOULD NOT BE USED

The Beneficiary designation of each Employee should be carefully checked to determine if it correctly reflects the Employee's intent. Certain designations cannot legally be used. To avoid complications at death, an organization or endowment should not be named unless it is a legal entity (has a legal existence as a corporation or trust).

An Employee may name their church/Employer as their beneficiary. The beneficiary designation should include the legal name of the Employer, tax payer identification number, address and phone number.

ADDITIONAL CONSIDERATIONS

All Beneficiary designations as shown on the Group Plans Enrollment Form and Beneficiary Designation Form should be carefully reviewed, keeping the following points in mind:

- The Employee's designation must be legible. If you cannot read a Beneficiary's name on the form, request that a new form be completed.
- Provide full name of each child designated as a Beneficiary. (See Minor Child on previous page.)
- The Beneficiary's name must always be shown in full, (i.e., Mary Jones, not Mrs. John Jones), and the date of birth, Social Security number and the relationship of the Beneficiary to the Employee must be stated.
- If the Beneficiary designated is **not** related to the Employee, the relationship should be shown as "friend."
- In an effort to improve legibility, the Beneficiary section must not contain erasures, mark-throughs, or white-outs.
- The Group Plans Enrollment Form and the Beneficiary Designation Form enable Employees to name different Beneficiaries for Term Life and Personal Accident benefits.

Note: When you have a question about the exact wording or the acceptability of a Beneficiary designation, refer your question immediately to GuideStone Financial Resources Insurance Operations, Claims Unit.

BENEFIT ASSIGNMENTS

With the consent of the Claim Administrator, the Term Life and Personal Accident plans under the Group Plans allow Employees to execute gift and value assignments of all incidents of ownership in their plan benefits. For further information concerning coverage assignments, contact GuideStone Financial Resources Insurance Operations, Claims Unit.

PROCEDURES FOR CHANGING A BENEFICIARY

Process a change in an Employee's Beneficiary for Term Life, Employee Optional Term Life and/or Personal Accident coverage as follows:

1. Give the Employee a Beneficiary Designation Form to complete.
 - The Employee *must* provide the full name, relationship, date of birth and Social Security number of the Beneficiary.
 - The Employee may designate a secondary Beneficiary in the event the primary Beneficiary designated is deceased at the point of benefit claim.
2. When an Employee returns a completed Beneficiary Designation Form, review the form to make sure all information has been properly and legibly completed.
3. Send the completed Beneficiary Designation Form to GuideStone Financial Resources Insurance Operations, Group Plans.
4. Retain a copy of the form in the Employee's permanent personnel file.

Note: Contact an Employee whose marital status has changed to determine whether the Beneficiary designation(s) should be changed.

HOW TO PROCESS TERMINATIONS

GENERAL INFORMATION

You are responsible for providing information to terminating Employees or in case of the Employee's death, the Surviving Spouse or dependents, of the effects of termination on the Employee's plan benefits. (See the "Leaving Active Employment" chapter of this manual for information regarding an Employee who is leaving active employment due to leave of absence, disability or retirement.) You should meet with each terminating Employee to discuss how leaving work or voluntary termination of Contributory coverage will affect the Employee's plan benefits. The "Termination Checklist" in this chapter has been developed to help you cover the items that should be discussed with a terminating Employee. Each item on the checklist is covered in detail in this chapter.

Termination of coverage occurs when:

- The Employee requests the termination of a coverage that is Contributory.
- The Employee terminates employment.
- The Employee or dependent is no longer in an eligible class. This may apply to all or part of the Employer's benefits Program.
- The dependent no longer meets the plan's definition of an Eligible Dependent as defined in the "Important Terms" chapter of this manual.
- Contributions cease for the coverage.

Medical and Dental coverage may continue for a specified period of time after termination of coverage if certain requirements are met. (See the "Continuation of Coverage" section of this chapter.)

DETERMINING THE DATE OF TERMINATION

It is vital that you notify GuideStone of terminations as soon as possible, but no later than within 31 days of the decision to terminate coverage. GuideStone is unable to terminate coverage more than 31 days prior to the date of notification except in certain situations: fraud or intentional misrepresentation of a material fact or non-payment of premiums. Until notification, the Employer will continue to be responsible for premiums billed for the affected Employee.

Note: In all cases, credits are limited to two billed months.

Medical

- Rescission rules prohibit Employers from retroactively terminating medical coverage for which an Employee has pre-paid. Basically, if an Employee contributes toward the cost of medical coverage, that coverage cannot be terminated prior to the date through which the coverage is paid.

HOW TO PROCESS TERMINATIONS

Example: If an Employee has paid for coverage through November 30th, the termination date for the coverage may not be prior to November 30th, even if you notify GuideStone of the desire to terminate coverage prior to that date (ex: November 12th).

- For Employees whose Employer pays for the cost of medical coverage, coverage will be terminated as of a current or future date. However, if there is an administrative delay in the termination notification, coverage may be terminated up to 31 days prior to the date of notification.

Example 1: The Employee terminated employment on November 11 and notification was received by GuideStone on November 30. The date coverage will be terminated is November 11.

Example 2: The Employee terminated employment on November 11 and notification was received by GuideStone on January 30. The date coverage will be terminated is December 30th, 31 days prior to the date of notification.

- When requesting termination of coverage, you will be responsible for providing GuideStone with both the last day worked and the date through which the coverage has been paid for by the Employee.

Dental, Disability, Accident and Term Life

- For loss of eligibility, coverage will terminate the date of the loss of eligibility.

Example: The Employee lost eligibility when employment terminated on October 16th and notification was received by GuideStone on November 8th. The date coverage will be terminated is October 16th.

- For all other termination requests, coverage will terminate as of the date of notification to GuideStone. If there is an administrative delay in the termination notification, coverage may be terminated up to 31 days prior to the date of notification.

Example: The Employee requests that Contributory life coverage be terminated on October 16th but notification was not received by GuideStone until November 30th. The date coverage will be terminated is October 30th.

CONTINUATION OF COVERAGE

In some cases, special provisions allow an Employee or Eligible Dependent to continue coverage for a specified amount of time when his or her coverage would normally terminate due to one of the following events: (See the chart in this chapter outlining provisions and requirements for continuation of specific coverage.)

- Employee's termination
- Employee's loss of coverage due to reduced number of hours worked
- Employee's death

HOW TO PROCESS TERMINATIONS

- Elimination of eligible class of Employees
- Loss of dependent child status
- Divorce or legal separation from the Employee

The continuation options available to the Employer include the following. The Medical/Dental Continuation Provision is an optional provision that the Employer may or may not elect to offer to Employees or their dependents. All other provisions should be offered to all Employees and dependents when applicable.

- Medical/Dental Continuation Provision (MCP/DCP), optional
- Continuation of Insurance Eligibility (CIE) (applies to SBC Employers/Employees only)
- Portability of Term Life coverage
- Conversion of Term Life coverage
- Continuation of coverage for Surviving Spouse and dependents.

If the Employer elects to offer a severance package to a terminating Employee, any continuation of insurance coverage through GuideStone Financial Resources must follow the provisions of MCP/DCP or CIE. Coverage for an Employee on a severance package will cease on the last day of work unless a continuation option is selected.

Note: Due to Section 4980B of the Internal Revenue Code, GuideStone Financial Resources medical plans are exempt from COBRA. Section 4980B concerns the failure to satisfy continuation coverage requirements of group health plans. According to Section 4980B (d), there is an exemption for Employers with fewer than 20 Employees, governmental plans, or church plans within the meaning of Section 414 (e). The medical plans offered by GuideStone Financial Resources meet the definition of church plan under Section 414 (e).

President Obama signed a stimulus package on February 17, 2009 that included a new COBRA subsidy. As a “church plan” under the Internal Revenue Code, GuideStone’s medical programs are exempt from COBRA. While GuideStone does offer a medical continuation program with provisions similar to COBRA, congress did not include church plans in the subsidy.

Medical/Dental Continuation Provision (MCP/DCP)

The Medical/Dental Continuation Provision (MCP/DCP) is an optional provision that the Employer may choose to offer to Employees or dependents whose medical or dental coverage would otherwise terminate. **The MCP/DCP is available only if the Employer has chosen this provision and has formally notified GuideStone Financial Resources of the election.**

The MCP/DCP allows continuation of medical and/or dental coverage only. All other coverage will terminate on the date the Employee and/or dependent becomes ineligible under the Group Plans. If the

HOW TO PROCESS TERMINATIONS

Employer offers the MCP/DCP, an individual whose medical and/or dental coverage would normally terminate may elect to continue his or her current medical and/or dental coverage after the date he or she would normally become ineligible for coverage under Group Plans. Medical and/or dental coverage may continue under the MCP/DCP for a period of up to 18 or 36 months, dependent upon the reason for termination. (See “Length of Continuation Period” section below). Only dependents who are participating in the program prior to becoming ineligible for coverage are eligible for Participation in the MCP/DCP.

Evidence of good health is not required for the continuation of medical coverage through the MCP, however, application must be made within 60 days of the date the Employee or dependent becomes ineligible for coverage through Group Plans.

Length of Continuation Period

Coverage under the MCP/DCP may continue for up to 18 months for Employees or their dependents that become ineligible for coverage due to:

- Termination of the Employee’s employment
- Loss of coverage due to the reduction in the number of hours the Employee works
- Elimination of the eligible class of Employees to which the Employee belongs.

Coverage under the MCP/DCP may continue for up to 36 months for Employees’ covered dependents who become ineligible for coverage due to:

- Divorce or legal separation from the Employee
- Loss of dependent child status (e.g. children who reach the maximum age limit under the plan).

Coverage under the MCP/DCP will terminate at the first to occur of:

- End of the 18 or 36 month period
- The Participant becomes covered as an Employee or dependent under another group medical/dental plan
- The Participant ceases to make necessary payments to the Employer
- The Participant becomes eligible for Medicare
- The group plan terminates for all Employees of the Employer.

Note: The effective date requested for termination of medical coverage may be adjusted to comply with Rescission rules. Refer to the Determining the Date of Termination section in this chapter.

HOW TO PROCESS TERMINATIONS

Payment of Charges

When an Employee and/or Eligible Dependent(s) elect to continue medical and/or dental coverage through the MCP/DCP, the monthly charges for the medical and/or dental coverage will continue at the same rate as for an active Employee. Charges will continue to be billed on the Employer's monthly billing statement. It is the responsibility of the Employer to collect payment for the charges from the Participant and submit payment along with the regular monthly payment.

When only a dependent is applying for the MCP/DCP, a separate monthly charge will be made on your monthly billing statement for the dependent.

Continuation of Insurance Eligibility (applies to SBC Employers/Employees only)

Continuation of Insurance Eligibility (CIE) is a provision that the Employer should offer to all terminating Employees who are actively seeking full-time denominational employment with a church or agency affiliated with the Southern Baptist Convention.

CIE allows continuation of medical, Term Life, dental and AD&D coverage at the Employee's current coverage volume for a period of up to 12 months after the date he or she becomes ineligible for coverage under Group Plans. Disability and personal accident coverage and any other coverage that the terminating Employee does not elect to continue will terminate on the date the Employee becomes ineligible under Group Plans.

Employee Participation in CIE is a prerequisite for dependent coverage. Only dependents who are participating in the program prior to the Employee's termination are eligible for Participation in CIE.

Evidence of good health is not required for the continuation of coverage through CIE, however, application must be made within 60 days of the date the Employee becomes ineligible for coverage through Group Plans.

Length of Continuation Period

Coverage under CIE may continue for up to 12 months for Employees and their dependents that become ineligible for coverage due to the termination of the Employee's employment.

Coverage under CIE will terminate at the first to occur of:

- End of the 12 month period
- The Participant accepts another denominational position in the Southern Baptist Convention
- The Participant ceases to make necessary payments to the Employer

HOW TO PROCESS TERMINATIONS

- The Participant becomes eligible for Medicare
- The group plan terminates for all Employees of the Employer.

Note: The effective date requested for termination of medical coverage may be adjusted to comply with Rescission rules. Refer to the Determining the Date of Termination section in this chapter.

Payment of Charges

When an Employee elects to continue coverage through CIE, the monthly charges for coverage will continue at the same rate as for an active Employee. Charges will continue to be billed on the Employer's monthly billing statement. It is the responsibility of the Employer to collect payment for the charges from the Participant and submit payment along with their regular monthly payment.

Portability of Term Life and Accidental Death and Dismemberment (AD&D) Coverage

Portability is a feature of Term Life Coverage that enables Employees to continue their Term Life and, if applicable, Optional Term Life and AD&D coverage, to direct payment policies with the Life Claim Administrator at group rates when coverage under Group Plans terminates. In addition, Spouse Term Life, Spouse Optional Life, and Child Term Life, under certain conditions, may be continued. Portability coverage is available to dependents only if the Employee elects Portability coverage.

To continue Term Life and AD&D coverage through the Portability option, an Employee and his covered dependents must provide Evidence of Good Health to the Term Life carrier. An individual is not eligible for the portability option if he or she has a medical condition which has a material effect on life expectancy.

Coverage under the Portability option may be continued up to the lesser of five times the Participant's Salary or the coverage amount lost. The Employee and the Employee's Eligible Dependent(s), if applicable, must make application within 31 days following the date he or she becomes ineligible for coverage through Group Plans. If an Employee wants to continue Term Life and AD&D coverage under the Portability option, the Employee must send a completed Life Insurance Election of Portability Coverage form to the Life Claim Administrator.

If a Participant is ineligible for Portability of Term Life coverage, or if his or her Portability coverage terminates, he or she may be eligible for Conversion of Term Life coverage. Conversion is not available for AD&D.

HOW TO PROCESS TERMINATIONS

Portability of Term Life and AD&D is permitted when:

- Term Life and AD&D coverage is lost due to termination of employment.
- Term Life and AD&D coverage is reduced due to the plan's retirement reduction provision.
- Term Life and AD&D coverage is lost due to elimination of eligible class of Employees.

Payment of Charges

The Employee must pay the full charge directly to the Term Life Claims Administrator for the Term Life and AD&D policy(ies) under the Portability option. The Employer makes no payment toward the charges for these policies. The charges will not appear on the Employer's monthly billing statement.

Rates for Portability coverage are not the same as Group Plans rates.

Conversion of Term Life Coverage

Group Plans enables Employees to convert their Term Life and, if applicable, Optional Term Life coverage, to individual direct payment policies when coverage under the plans terminates. In addition, Spouse Term Life, Spouse Optional Life, and Child Term Life, under certain conditions, may be converted to direct payment policies.

Term Life coverage may be converted in any amount up to and including the amount lost, to any of the standard conversion contracts offered by the Life Claim Administrator, without evidence of good health. The Employee or Eligible Dependent must make application within 31 days following the date he or she becomes ineligible for coverage through Group Plans. (Or within 31 days of the date the Employee or dependent is declined for Portability of his or her Term Life coverage, if applicable.) If an Employee wants to convert Term Life coverage, the Employee must send a completed Life Insurance Conversion Notification of Conversion Privilege form to the Life Claims Administrator.

The conversion policy will not contain Accidental Death and Dismemberment or other supplemental benefits. The charges will be based on the type of policy and amount of coverage selected by the individual, the class of risk to which he or she belongs, and the individual's age on the effective date of the conversion policy. Charges are not based on group rates and could be significantly higher than the Participant's coverage under the Group Plans.

Term Life Conversion is permitted when:

- Term Life coverage is lost due to termination of employment.
- Term Life coverage is reduced due to age or the plan's retirement reduction provision.

HOW TO PROCESS TERMINATIONS

- Term Life coverage is lost due to elimination of eligible class of Employees.
- Dependent Term Life is lost due to loss of dependent eligibility.

Note: The amount of Term Life coverage in force as an active Employee is payable if death occurs within the 31-day period allowed for conversion. This amount is payable whether actual application was made or the first premium was paid for the conversion policy. The 31-day period begins on the Employee's termination date as reported to GuideStone Financial Resources.

Payment of Charges

The Employee must pay the full charge directly to the Term Life Claims Administrator for converted Term Life policy(ies). The Employer makes no payment toward the charges for these policies. The charges will not appear on the Employer's monthly billing statement.

Note: Rates for Conversion coverage are not the same as Group Plans rates.

Continuation of Coverage for a Surviving Spouse and Dependents

In the event of an Employee's death, the Surviving Spouse and other dependents enrolled in the plan prior to the Employee's death may continue Term Life, Medical and Dental coverage. In order to establish the proper records, a completed Group Plans Enrollment Form should be submitted on behalf of the Surviving Spouse and Eligible Dependents using the Surviving Spouse's Social Security number and date of birth. When only children of a deceased Employee are continuing coverage (no Surviving Spouse coverage), use the name and date of birth of the oldest Eligible Dependent on the enrollment form(s). If the Surviving Spouse and/or Eligible Dependent(s) are continuing Term Life coverage after the Employee's death, a new beneficiary designation **must** be made on the new enrollment form.

Evidence of good health is not required for the continuation of coverage as a Surviving Spouse or dependent, however, application must be made within 90 days of the date of the Employee's death.

HOW TO PROCESS TERMINATIONS

Length of Continuation Period

Coverage as a Surviving Spouse or dependent may continue indefinitely but will terminate at the first to occur of:

- Spouse or dependent becomes eligible under another group plan
- Dependent no longer meets the Program definition of an Eligible Dependent
- Spouse or dependent ceases to make necessary payments to the Employer
- The group plan terminates for all Employees of the Employer.

Payment of Charges

The monthly charges for coverage for a Surviving Spouse and dependents will continue at the same rate as for an active Employee. The Surviving Spouse will be set up as Employee on the Employer's monthly billing statement. It is the responsibility of the Employer to collect payment for the charges from the Surviving Spouse and submit payment along with the regular monthly payment.

HOW TO PROCESS TERMINATIONS

COVERAGE CONTINUATION PROVISIONS

| FEATURES | MEDICAL/ DENTAL CONTINUATION PROVISION (MCP/DCP) | CONTINUATION OF INSURANCE ELIGIBILITY (CIE) (applies to SBC Employers/ Employees only) | SURVIVING SPOUSE AND/OR DEPENDENT COVERAGE AFTER EMPLOYEE'S DEATH |
|--|---|---|--|
| Qualifying Events for Employee to Continue Coverage | <ol style="list-style-type: none"> 1. Termination of employment (except in the case of "gross misconduct") 2. Loss of coverage due to reduced number of hours worked 3. Elimination of Eligible Class of Employees | <p>Same as Medical/Dental Continuation Provision. Additionally, the Employee must be actively seeking full-time SBC employment</p> | <p>Not Applicable</p> |
| Qualifying Events for Dependent(s) to Continue Coverage | <ol style="list-style-type: none"> 1. Termination of the Employee's employment 2. Employee's loss of coverage due to reduced number of hours worked 3. Divorce or legal separation from the Employee 4. Loss of dependent child status (i.e., children who reach limiting age under the plan, marriage) | <p>Employee's coverage is being continued according to CIE provisions</p> | <p>Death of Employee</p> |
| Requirement for Continuation | <p>Employee or dependent must have been enrolled in the plan prior to termination of coverage</p> | <ol style="list-style-type: none"> 1. Employee and dependent(s) must have been enrolled in the plan prior to Employee's termination 2. Employee coverage is a prerequisite for dependent coverage to be continued | <p>Surviving Spouse and other dependent(s) must have been enrolled in the plan prior to Employee's death</p> |

HOW TO PROCESS TERMINATIONS

| FEATURES | MEDICAL/ DENTAL CONTINUATION PROVISION (MCP/DCP) | CONTINUATION OF INSURANCE ELIGIBILITY (CIE) (applies to SBC Employers/ Employees only) | SURVIVING SPOUSE AND/OR DEPENDENT COVERAGE AFTER EMPLOYEE'S DEATH |
|---|---|--|--|
| Continued Benefits for Employee and Dependent(s) | Medical/Dental | Term Life, AD&D, Medical, Dental | Term Life, Medical, Dental |
| Enrollment | <p>1. Employee or dependent must sign an application to continue coverage within 60 days of the date coverage would otherwise terminate</p> <p>2. Loss of dependent eligibility will result in an enrollment separate from the Employee</p> | Employee must sign an application to continue coverage within 60 days of the date coverage would otherwise terminate | Spouse or dependent must provide an Enrollment Form to continue coverage within 90 days of the date coverage would otherwise terminate |
| Payment of Charges | Employer is responsible for collecting payments from the former Employee or dependent and remitting payment to GuideStone Financial Resources on a monthly basis along with the Employer's regular payment | Same as Medical/Dental Continuation Provision | Employer is responsible for collecting payments from the spouse or dependent and remitting them to GuideStone Financial Resources on a monthly basis along with the Employer's regular payment |
| Length of Continuation Period | <p>1. 18 months for Employees and dependent(s) in the event of termination of employment or loss of coverage due to a reduction in number of hours worked</p> <p>2. 36 months for all other "dependent" categories</p> | 12 months | Indefinitely |

HOW TO PROCESS TERMINATIONS

| FEATURES | MEDICAL/ DENTAL CONTINUATION PROVISION (MCP/DCP) | CONTINUATION OF INSURANCE ELIGIBILITY (CIE) (applies to SBC Employers/ Employees only) | SURVIVING SPOUSE AND/OR DEPENDENT COVERAGE AFTER EMPLOYEE'S DEATH |
|--|--|---|--|
| Events that Terminate Coverage | <ol style="list-style-type: none"> 1. Employee or dependent ceases to make necessary payments 2. Employee or dependent becomes covered as an Employee under any group plan 3. The individual becomes eligible for Medicare coverage 4. Former spouse of an Employee remarries and becomes covered as a dependent under any group plan 5. The group plan terminates for all Employees 6. End of continuation period | Same as Medical/Dental Continuation Provision | <ol style="list-style-type: none"> 1. Spouse or dependent ceases to make necessary payments 2. Spouse or any other dependent becomes eligible for benefits under any group plan 3. A dependent no longer meets the Program definition of a dependent 4. Dependent coverage is discontinued for the eligible class in which the Employee was a member 5. The group plan terminates for all Employees |
| Portability/ Conversion Option – when Continuation ceases | No portability or conversion option for PPO Medical/Dental Plans. | <p>Conversion for Life coverage must be requested within 31 days of termination of coverage, provided requirements are met. Portability is not available.</p> <p>Portability for AD& D coverage must be requested within 31 days of termination of coverage, provided requirements are met. Conversion is not available.</p> <p>No portability/conversion for PPO Medical/Dental plans.</p> | <p>Conversion for Life coverage must be requested within 31 days of termination of coverage, provided requirements are met. Portability is not available.</p> <p>No portability/conversion for PPO Medical/Dental plans.</p> |

HOW TO PROCESS TERMINATIONS

CERTIFICATE OF CREDITABLE COVERAGE FOR MEDICAL

When an Employee or dependent terminates medical coverage through Group Plans, a Certificate of Creditable Coverage will be issued to the Employee and/or covered dependent(s). A Certificate is also issued when an Employee and/or covered dependent(s) elects to continue medical coverage through the Medical/Dental Continuation Provision (MCP/DCP) or Continuation of Insurance Eligibility (CIE).

Certification of coverage extends to each covered person, not just the Employee. Group Plans provides a consolidated certificate covering all members of the same family when information is identical for each individual or separate certificate when the information is different. Group Plans will provide certificates to a third party at the covered individual's request.

Note: Certificates will be provided at the request of the individual for up to 24 months after the coverage ceases or after a continuation period ends.

A Certificate of Creditable Coverage may be used by an individual when enrolling in a new medical plan. The Certificate may reduce the Pre-existing Condition Limitation Period of the new plan. An individual should retain the Certificate of Creditable Coverage for 24 months after termination of coverage for use in providing evidence of prior coverage.

HOW TO PROCESS TERMINATIONS

TERMINATION CHECKLIST

Name of Employee _____

Social Security No. _____

Date of Full-Time Employment _____

Date of Termination _____

Discuss with the Employee the effects of termination on benefits and the date that coverage under the Employer's plan stops. Check off each box after the subject has been discussed or the material listed has been given to the terminating Employee.

- Date all benefits stop
- Notice of Continuation Provisions (if applicable)
- Term Life coverage Portability and Conversion provisions and application process
- Certificate of Creditable Coverage for Medical

Administrator: _____

Date Interviewed: _____

TERMINATION PROCEDURES

Process terminations as follows:

1. The Employee should be told what effect leaving active employment will have on the Employee's plan benefits. The "Termination Checklist" located on the previous page can help you to provide this information. Be sure to cover the following points:
 - The date coverage under the plans terminates
 - Continuation Provisions, if applicable
 - Term Life coverage Portability and Conversion provisions
 - Certificate of Creditable Coverage for medical

2. If the Employee wants to continue Term Life and Accidental Death and Dismemberment (AD&D), if applicable, coverage under the Portability provision, a Life Insurance Election of Portability Coverage form must be completed and returned to the Term Life Claim Administrator.

Note: If an Employee submits an application for Portability coverage, and Portability coverage is denied, the Term Life Claim Administrator will contact the Employee concerning the Conversion option.

The Employer should complete the following information on the Portability coverage application:

- Company Name – GuideStone Financial Resources, SBC
- Plan Number - 552580
- Division Number – 001 unless a different 3 digit number appears on your life booklet in the upper right hand corner.
- Date Coverage Ended
- Reason
- Current Life Amount – The Employee's current volume of life coverage. Also include the current volume of spouse and/or dependent coverage if the Employee wants to convert that coverage.
- Employer Signature
- Date

The Employee should complete the remainder of the application and mail it to the Term Life Claim Administrator at the address on the top of the form. Emphasize that application for Portability coverage must be made **within 31 days** of the date coverage terminates through Group Plans.

HOW TO PROCESS TERMINATIONS

3. If the Employee is ineligible to continue Term Life coverage under the Portability provision because of health problems, a Life Insurance Conversion Notification of Conversion Privilege form should be completed and returned to the Term Life Claim Administrator.

The Employer should complete the following information on the conversion coverage application:

- Company Name – GuideStone Financial Resources, SBC
- Plan Number/Division Number – 552580 001
- Employee’s Name, Social Security Number and Date of Birth – include this information even if the application is for dependent coverage.
- Dependent Name, Social Security Number and Date of Birth – this should be completed only if a dependent is applying for coverage. A separate application must be completed for the Employee and each dependent.
- Group life insurance benefits were – indicate either “terminated” or “reduced”
- Date of termination or reduction
- Amount of coverage lost
- Was the Employee disabled on the date of termination or reduction?
- Employer Signature
- Date

The Employee should complete the remainder of the Conversion coverage application and mail it along with the first month’s premium to the Term Life Claim Administrator at the address on the top of the form. (Rates are included in the application.)

4. Complete the Employer Change Report indicating the termination of the Employee. Be sure to include the effective date of the change, the date through which medical premiums have been paid if medical coverage is terminating and to sign and date the form.
5. If the Employee and/or his Eligible Dependents wish to continue coverage through the Medical/Dental Continuation Provision (MCP/DCP), if offered by the Employer, or the Continuation of Insurance Eligibility (CIE), complete the applicable continuation form in addition to Employer Change Report.
6. Retain a copy of the Group Plans Employer Change Report and the continuation form, if applicable, for your permanent file.
7. Send the Employer Change Report and if applicable, the continuation form to the following address:

GuideStone Financial Resources
Insurance Operations, Group Plans
2401 Cedar Springs
Dallas, TX 75201-1407

HOW TO PROCESS TERMINATIONS

8. If the terminating Employee is not continuing coverage through MCP/DCP or CIE, remove copies of the Employee's Enrollment Form and change forms from the active enrollment file. Place this material in the file kept for terminating Employees. These records should be held for a minimum of five years from the date the Employee terminates.

LEAVING ACTIVE EMPLOYMENT

GENERAL INFORMATION

You are responsible for telling an Employee what will happen to plan benefits and to the benefits of covered dependent(s) when an Employee leaves active employment status. The various conditions that constitute leaving active work status are listed below:

- Leave of absence
- Disability leave
- Retirement

The effects on an Employee's plan benefits in the event of death, resignation or discharge are described separately under the chapter "How to Process Terminations."

LEAVE OF ABSENCE

If an Employee is granted a leave of absence, coverage under Group Plans, *with the exception of Disability*, may continue up to 12 months, provided monthly payment of charges continues on the Employer's billing. Responsibility for payment is at the Employer's discretion. An Employer Change Report must be completed and sent to GuideStone Financial Resources Insurance Operations, Group Plans within 31 days of the date the leave of absence begins. The change report should include the date the leave of absence begins, as well as the date the Employee is expected to return to active employment.

At the end of the 12-month period, or at any time before that date when monthly billing payments are discontinued, the Employee may elect to continue Term Life coverage as direct payment policies through the Life Claims Administrator. (See the Portability of Term Life Coverage and Conversion of Term Life Coverage sections of the "How to Process Terminations" chapter in this manual.)

DISABILITY LEAVE

Verification of Disability Status

In order to continue Participation in the Group Plans during a period of disability, an Employee's disability status must be verified through one of the following sources:

- The Employee is approved to receive disability benefits under a Group Plans Disability Plan or another long term disability plan;

LEAVING ACTIVE EMPLOYMENT

- The Employee is approved for Waiver of Payment for a GuideStone Financial Resources Term Life Plan and/or Employee Personal Accident Plan;
- The Employee is approved for Social Security disability benefits;

Some coverage under the Group Plans may be continued when an Employee becomes disabled. Some coverage has Waiver of Payment provisions; others require that charges continue to be paid. Some coverage is continued for specified periods of time while others are continued until the Employee attains age 65 or age 70. In some situations, the Employee may be considered retired. Contact your Group Plans Account Administrator for information regarding coverage for any disabled Employee.

When Disability Ends

An Employee may be approved for disability status indefinitely or for a specific time period. The Employee is eligible to continue Participation in Group Plans only during the period of disability. When an Employee's disability cannot be verified (see the Verification of Disability Status section of this chapter), he is no longer eligible for coverage under Group Plans as a disabled Participant. (When a Participant's disability benefits cease but Waiver of Payments continues, the Participant is still considered to be disabled and may continue coverage in Group Plans.) When a Participant reaches the end of the time period for which his disability status was approved, he may:

- Return to work, if no longer disabled;
- Continue coverage through the Medical/Dental Continuation Provision (MCP/DCP) for 18 months if the Employer offers the program or through Continuation of Insurance Eligibility (CIE) for 12 months and the Participant is otherwise eligible; (See the Continuation of Coverage section of the "How to Process Terminations" chapter in this manual.)
- Continue coverage as a Retiree if the Participant is over age 55 and is considered by his Employer to be retired, and the Employer offers retiree coverage. (See the Retirement at Age 55 or Older section of this chapter.)

If coverage is not continued through one of the above provisions, all coverage will terminate.

The Employee has the option of continuing Life coverage according to Portability or Conversion privilege as a direct payment plan with the Term Life Claim Administrator when he or she is no longer eligible to continue coverage under Group Plans (See the Portability of Term Life Coverage and Conversion of Term Life Coverage sections of the "How to Process Terminations" chapter of this manual.)

RETIREMENT BEFORE AGE 55

Group Plans benefits terminate on the date of retirement for those Employees who retire prior to age 55. These Employees have the option of continuing Life coverage according to Portability or Conversion privilege as a direct payment plan with the Term Life Claim Administrator. (See the Portability of Term Life Coverage and Conversion of Term Life Coverage sections of the "How to Process Terminations" chapter of this manual.)

RETIREMENT AT AGE 55 OR OLDER

For Group Plans coverage purposes, retirement age is considered age 55 or older.

- A dependent is eligible for coverage under the retired Employee's medical, dental and term life plans only if the dependent was enrolled in the plan(s) at the time of the Employee's retirement.
- Charges will continue to be billed on the Employer's monthly statement. It is the responsibility of the Employer to collect payment for the charges from the Participant and submit payment along with the Employer's regular payment.
- These Employees may be eligible to continue the amount of Term Life coverage lost due to reduction through a direct payment policy with the Term Life Claims Administrator. (See the Portability of Term Life Coverage and Conversion of Term Life Coverage sections of the "How to Process Terminations" chapter of this manual.)
- A retiree's eligibility for coverage is based on the Employer's continued Participation in the plan.

LEAVING ACTIVE EMPLOYMENT

Retired Employees in this age group and their covered dependents are eligible for Group Plans coverage as summarized below.

| PLAN BENEFIT | EFFECT OF RETIREMENT ON COVERAGE |
|---|--|
| Medical | If the Employer offers retirement benefits, medical coverage may continue for the retired Employee and spouse, if eligible, until each reaches age 65. At age 65, the Employee and/or spouse must select a Medicare coordinating plan if he or she wants to continue medical coverage under Group Plans. Coverage is then offset by the benefits provided by Medicare. A Senior Plans Enrollment Form is required to enroll. The effective date of coverage will depend on the date the form is received and the plan chosen. |
| Dental | Dental coverage terminates upon the Employee's retirement unless the Employer has elected to offer continuation of Dental coverage into retirement. |
| Disability | Coverage terminates upon Employee retirement. |
| Employee Term Life Coverage | If the Employer offers retirement benefits, coverage is reduced upon Employee retirement. The amount of standard coverage is limited to a maximum of \$20,000 in multiples of \$5,000. The amount of coverage may not increase following the Employee's election at retirement. The Employee has the option of continuing the amount of Term Life coverage lost due to retirement according to Portability or Conversion privilege as a direct payment plan with the Term Life Claim Administrator when he or she is no longer eligible to continue coverage under Group Plans. (See the Portability of Term Life Coverage and Conversion of Term Life Coverage sections of the "How to Process Terminations" chapter of this manual.) |
| Employee Optional Term Life Coverage | If the Employer offers retirement benefits, coverage is reduced or terminated upon Employee retirement. The combined total of both the Employee Term Life coverage and Employee Optional Term Life coverage is limited to a maximum of \$20,000 in multiples of \$5,000. The amount of coverage may not increase following the Employee's election at retirement. The Employee has the option of continuing the amount of Employee Optional Term Life Coverage lost due to retirement according to Portability or Conversion privilege as a direct payment plan with the Term Life Claim Administrator when he or she is no longer eligible to continue coverage under Group Plans. (See the Portability of Term Life Coverage and Conversion of Term Life Coverage sections of the "How to Process Terminations" chapter of this manual.) |

LEAVING ACTIVE EMPLOYMENT

| | |
|--|---|
| Term Life Coverage for Dependents | <p>Coverage may continue for the retired Employee's eligible spouse and children. Spouse coverage will be reduced, if necessary, not to exceed 50% of the total amount of Employee Term Life and Employee Optional Term Life coverage elected at retirement. The minimum Spouse Term Life amount is \$5,000.</p> <p>The Employee has the option of continuing the amount of Term Life Coverage for dependents lost due to retirement according to Portability or Conversion privilege as a direct payment plan with the Term Life Claim Administrator when he or she is no longer eligible to continue coverage under Group Plans. (See the Portability of Term Life Coverage and Conversion of Term Life Coverage sections of the "How to Process Terminations" chapter of this manual.)</p> |
| Personal Accident Coverage | Coverage terminates upon Employee retirement. |
| Accidental Death and Dismemberment Coverage | Coverage terminates upon Employee retirement. |

PROCEDURES FOR PROCESSING AN EMPLOYEE LEAVING ACTIVE EMPLOYMENT

Process changes as follows:

1. The Employee should be told what effect leaving active employment will have on the Employee's plan benefits. Be sure to cover the following points:
 - The plans that may be continued and how long they may be continued provided any required charges are paid.
 - The date Disability coverage terminates.
 - How medical benefits are affected by Medicare.
 - The reduction or termination of Term Life coverage due to retirement.
 - Employee and Dependent Term Life coverage Portability and/or Conversion rights.
2. If applicable, give the Employee a Life Insurance Election of Portability Coverage form and/or a Life Insurance Conversion Notice of Conversion Privilege form.

If the Employee wants to continue his or her Life coverage or dependent life coverage under the Portability or Conversion privilege, the appropriate Life Insurance Election of Portability Coverage form and/or a Life Insurance Conversion Notice of Conversion Privilege form must be completed and returned to the Life Claims Administrator.

Note: Emphasize that Term Life Portability or Conversion rights must be exercised *within 31 days of the date employment terminates.*

LEAVING ACTIVE EMPLOYMENT

3. Complete the Employer Change Report. A change report must be completed and sent to GuideStone Financial Resources Insurance Operations, Group Plans when an Employee leaves active employment. Be sure to include the effective date of the change, the date through which medical has been paid if medical coverage is terminating and to sign and date the form.
4. In addition, a Senior Plans Enrollment Form should be completed if the Employee is:
 - Retiring from active employment, and
 - Continuing medical coverage, and
 - The Employee and/or a covered dependent are age 65 or older, and
 - The Employee and any covered dependent are not currently enrolled in a Medicare coordinating plan.

The effective date of coverage will depend on the date the form is received and the plan chosen. It is critical that all requested information and signatures are completed on the form including the Employer Tax ID number and the Medicare Claim number.

5. Retain a copy of the Employer Change Report and the Medicare Coordinating Plans Election Form, if applicable, for your permanent file.
6. Send the completed Employer Change Report and the Medicare Coordinating Plans Election Form, if applicable, to the following address:

GuideStone Financial Resources
Insurance Operations, Group Plans
2401 Cedar Springs
Dallas, TX 75201

LIFE, PERSONAL ACCIDENT AND DISABILITY CLAIMS

GENERAL INFORMATION

Notify GuideStone Financial Resources Insurance Operations when a claim for benefits under any of the following plans occurs:

- Employee, Spouse and Child Term Life Plans
- Long and Short Term Disability Plans
- Employee and Spouse Personal Accident Plans
- Accidental Death and Dismemberment (AD&D) Plan

GuideStone Financial Resources Insurance Operations will send you the necessary claim forms and instructions concerning how to file a claim for benefits.

TAX WITHHOLDING FROM DISABILITY PAYMENTS

The Claim Administrator is required to withhold FICA taxes from disability benefit payments made during the six calendar months following the month in which the Employee last worked. Unum matches the amount withheld by the Claim Administrator.

The Claim Administrator may also, at the Employee's request, withhold Federal Income Tax (FIT) from disability benefit payments. If this tax is withheld, the Claim Administrator will report it on the Form W-2 on which it reports any FICA withheld. The percent of disability payments subject to FIT taxation is the same as the percent of the cost of disability coverage paid by the Employer. For example, if 100% of the cost of disability coverage is paid by the Employer, then 100% of the disability benefit payment is subject to FIT. However, if 100% of the cost of disability coverage is paid by the Employee, then the disability benefit payment is not subject to FIT. If a portion of the cost of disability coverage is paid by both the Employer and Employee, the portion of the disability benefit payment subject to FIT is the percentage of the cost of disability coverage paid by the Employer. In addition, the Claim Administrator will match the FICA tax that is normally paid by the Employer.

Procedures

The Employer will periodically receive from the Claim Administrator a Disability Detailed Tax Report of disability payments which are subject to FICA taxation.

HOW TO PROCESS MEDICAL AND DENTAL CLAIMS

GENERAL INFORMATION

Medical and dental coverage offers Employees and their Eligible Dependents protection against costly medical and dental bills and expenses. Specific details are outlined in the Employee Booklet for each plan. Refer to the Booklet for specific plan coverage.

This chapter of the manual gives you general information about how claims will be processed under the PPO Medical Plans, Senior Plus and Senior Plans and the Care Plus and Care Basic Plans as well as the Premier, Choice, and Guided dental plans.

The plans have been designed to simplify your involvement with claims processing. However, the administrative success of the plans may depend to a large degree on how well your Employees are informed on the benefits of the plans and the proper procedures for filing a claim. Your responsibilities include the following:

- Explaining to Employees the benefits provided by the plans
- Explaining to Employees the procedures for filing a claim
- Distributing to Employees the Plan Booklet, and information regarding Preferred Provider Organization (PPO) and Dental Health Maintenance Organization (DHMO) provider networks, as applicable.

Note: For your convenience all of our booklets are online at www.GuideStoneInsurance.org.

IMPORTANT REMINDERS

The following points should be discussed with Employees prior to the time they actually receive health care services.

- Explain the plan benefits including the required Pre-authorization guidelines if applicable. Refer the Employee to the appropriate Medical Booklet.
- Explain the home delivery service and retail features of the Prescription Drug Program.
- If a Participant has given the health care provider permission to submit a claim, the Participant **should not** file the claim himself. Duplicate filing increases the administrative costs of handling claims and results in denied and pended claims. If the Participant is not sure whether or not the provider has submitted a claim, he should ask the provider before filing the claim. Participants may view their claims online for the PPO Medical Plans at www.highmarkbcbs.com.

HOW TO PROCESS MEDICAL AND DENTAL CLAIMS

- For the Senior Plus and Senior Plans and the Care Plus and Care Basic Plans, once Medicare has processed the claim, Medicare should file the claim with the Claim Administrator or Employees can forward their itemized bills and copies of their Medicare Explanation of Benefits form to the Claim Administrator for processing.
- If the patient has other group coverage that is primary, a copy of the primary group coverage explanation of benefit payment and the itemized statement must be submitted with the claim.
- Canceled checks and cash register receipts are not acceptable when filing a claim.
- The Participant's ID card will contain information regarding the PPO network, including a phone number to verify participating providers. PPO physicians and facilities may also be located through the Highmark Blue Cross Blue Shield® at www.bcbs.com. PPO Network information does not apply to Participants enrolled in the Senior Plus Plan, Senior Plan, Care Plus Plan and Care Basic Plan. If Internet access is not available, provider information may be obtained by calling the Claim Administrator at the number listed in the "How To Get Help" chapter of this manual.
- Since providers may discontinue Participation in PPO networks at any time, it is important for Participants to verify a provider's continued Participation by calling the number on the medical ID card each time he receives services.
- Group Plans also provides health care coverage for Employees and Eligible Dependents while they are outside of the United States. (See the International Claims section of this chapter for details.)
- Dental benefits are paid for covered services received in a foreign country only in the case of an emergency.

PRE-AUTHORIZATION GUIDELINES FOR MEDICAL PLANS

Highmark BCBS administers GuideStone Financial Resources Pre-authorization programs for inpatient hospital stays covered by the PPO Medical Plans. Pre-authorization is a determination that a Participant's admission to a hospital or treatment facility is medically necessary. Refer to "Healthcare Management Services" section of the Booklet for specific guidelines or contact the Claims Administrator, by calling the phone number on the back of the Participant's medical ID card.

Pre-authorization Procedure

Whenever a Participant's Health Care Provider recommends hospitalization, the Participant should call the Claims Administrator, listed on the back of the Participants Medical ID card, 7 to 10 days prior to the date of admission. If the hospitalization is an emergency, the Participant must call within 48 hours after the start of the emergency admission. If inpatient treatment of substance abuse or mental illness is recommended, the Participant must call the toll-free number before treatment begins.

HOW TO PROCESS MEDICAL AND DENTAL CLAIMS

Before a Participant calls for Pre-authorization, the Participant will need to have the following information. Some of the information should be obtained from the Health Care Provider.

- Patient's name, birth date, and relationship to Employee
- Employee's name, Social Security number, address, and telephone number
- Employer's name
- Reason for hospitalization
- Doctor's name, address and telephone number
- Name, address, and telephone number of hospital or place of surgery or treatment

The Claim Administrator's medical review specialist will discuss the request for hospitalization, or inpatient mental health or substance abuse treatment with the Participant. In many cases, the medical review specialist will confirm the medical necessity for hospitalization, over the telephone. If there is a question about the medical necessity for hospitalization, or more information is needed, the medical review specialist will discuss this with the Health Care Provider or his designated staff. If the Participant disagrees with the Claim Administrator's decision, the Participant or his Health Care Provider can request another review.

Note: Obtaining a Pre-authorization does not guarantee that the plan will pay benefits. Pre-authorization is only a determination that a Participant's admission to a hospital is medically necessary. All terms and conditions of the plan must be met.

Reduction of Benefits

If a Participant does not call the Claim Administrator within the specified time limits, benefits for services that require Pre-authorization will be reduced:

- If a Participant does not obtain a Pre-authorization for an inpatient hospital stay, including hospitalization for treatment of mental illness or substance abuse, the reduction will be applied to all hospital inpatient stay charges.
- If a Participant calls to request Pre-authorization after he has been admitted to the hospital, including hospitalization for treatment of mental illness or substance abuse, the reduction will be applied to all hospital inpatient stay charges incurred up to the date a hospital admission review is obtained.
- If the Claim Administrator denies a Participant's request for a Pre-authorization, the plan will not pay any of the charges for the hospital stay or for the listed procedure or service.

Refer to the "Healthcare Management Services" section of the Booklet and the Schedule of Benefits for specific guidelines.

FILING A MEDICAL CLAIM

PPO Medical Plans

PPO Medical Plans Participants must submit a claim to the Claim Administrator within one year from the end of the year following the date of service. These steps should be followed when filing a claim:

1. When a Participant goes to a Health Care Provider, the Participant should show the provider his or her medical ID card with the Claim Administrator's phone number and mailing address on it.
2. If the Employee files the claim, he should mail the provider's itemized statement to the address listed on the medical ID card.

If the provider files the first claim, the provider should mail an itemized statement for the services to the address listed on the medical ID card, or the provider may submit the claim electronically to the Claim Administrator.

3. The Employee should retain complete copies of *all* claim submissions so that in the event a claim is lost, the Employee will be prepared to re-submit the claim.
4. An Explanation of Benefits may be sent to the Employee when charges include anything other than an office visit copayment. Unless benefits have been assigned, medical plan payments for each claim submitted will be sent to the Employee.
5. After reviewing the explanation of benefits received in connection with a paid claim, if the Employee suspects that the payment is in error, the Employee should contact the Claim Administrator's claim office at the Member Services number on the medical ID card.
6. After four weeks, if the Participant's claim has not been paid or acknowledged, the Employee should contact the Claim Administrator's claim office at the number on the medical ID card to determine the status of the claim. Claim information may also be accessed through Highmark Blue Cross Blue Shield's website www.highmarkbcbs.com.

Senior, Senior Plus, Care Basic and Care Plus Plans

Claims for the Senior Plus, Senior, Care Plus and Care Basic Plans are filed just as they are for the PPO Medical Plans. (See the PPO Medical Plans section of this chapter for details.) However, since Medicare is the primary payer of benefits, the claims should first be filed with Medicare. Once Medicare has paid its portion of the claim, Medicare should electronically file with the Claim Administrator or the claim may be submitted to the Claim Administrator along with Medicare's explanation of benefits.

PRE-TREATMENT REVIEW OF DENTAL BENEFITS

Whenever the estimated cost of a recommended dental treatment plan exceeds \$300, the treatment plan should be submitted to the Claim Administrator for review before treatment begins.

Note: Obtaining a Pre-treatment Review of Dental Benefits does not guarantee that the plan will pay benefits. All terms and conditions of the plan must be met.

HOW TO PROCESS MEDICAL AND DENTAL CLAIMS

Pre-Treatment Review Procedure

To obtain a Pre-treatment Review of Dental Benefits, the dental care provider should prepare a treatment plan and send it to the Claim Administrator before any dental services are performed. The treatment plan should:

- List the recommended dental services
- Show the charge for each dental service
- Be accompanied by supporting pre-operative x-rays and any other appropriate diagnostic materials.

The Claim Administrator will notify the Employee and the attending dental care provider of the benefits payable based upon the treatment plan.

FILING A DENTAL CLAIM

Premier and Choice Plans

Premier and Choice Dental Plan Participants must submit a claim to the Dental Claim Administrator within 90 days of the date the claim is incurred. These steps should be followed when filing a claim:

1. When a Participant goes to a dental care provider, the Participant should present his or her Dental Plan ID Card to the provider.
2. Either the Participant or the Dental Care Provider should complete an American Dental Association approved claim form, or you can download a dental claim form from Cigna's web site, www.cigna.com.
3. The Employee should retain complete copies of *all* claim submissions so that in the event a claim is lost, the Employee will be prepared to re-submit the claim.
4. The Employee or dental care provider should submit the claim form within 90 days of the date the claim is incurred to:

Cigna Healthcare
P.O. Box 188037
Chattanooga, TN 37422-8037

5. An Explanation of Benefits will be sent to the Employee. Unless benefits have been assigned, dental plan payments for each claim submitted will be sent to the Employee.
6. After reviewing the explanation of benefits received in connection with a paid claim, if the Employee suspects that the payment is in error, the Employee should contact the Claim Administrator's claim office at **1-800-244-6224**.
7. After four weeks, if the Participant's claim has not been paid or acknowledged, the Employee should contact the Claim Administrator's claim office at **1-800-244-6224** to determine the status of the claim.

HOW TO PROCESS MEDICAL AND DENTAL CLAIMS

Note: Whenever the estimated cost of a recommended dental plan treatment exceeds \$300, the dental treatment plan should be submitted to the Claim Administrator for review before treatment begins. The treatment plan should be accompanied by supporting preoperative x-rays and any other appropriate diagnostic materials as requested by the Claim Administrator. (See the Pre-treatment Review for Dental Benefits section of this chapter.)

Guided DHMO Dental Plan

To receive benefits from the Guided DHMO Dental Plan contracted or approved dental care providers *must* be used. No claim forms are necessary to receive benefits. Participants pay only a copay for dental care services received from their selected plan dentist or from a plan specialist for services that the plan dentist is unable to provide. No referral is needed from the selected plan dentist in order to obtain services from a plan specialist. (Refer the Employee to the Certificate of Insurance issued by the Claim Administrator for detailed benefit information.)

PRESCRIPTION DRUG PROGRAM

The prescription drug program for the PPO Medical Plans, Senior Plus, Senior, Care Plus and Care Basic Plans is administered by Medco Health Solutions Inc., provider of the Home Delivery Pharmacy Service, and administrator of the retail pharmacy program.

Participants enrolled in any of the PPO Medical Plans or Senior Plus, Senior, Care Plus and Care Basic Plans will receive a separate prescription drug ID card from Medco Health.

Home Delivery Program

For prescription medications used on a regular basis, the Home Delivery Pharmacy Service offered through Medco Health provides the highest level of benefits. Your Employees should receive a Home Delivery Prescription Drug form and envelope from Medco Health when they enroll in the PPO Medical Plans, Senior Plus, Senior, Care Plus or Care Basic Plan.

To get a prescription filled through the **Home Delivery Pharmacy Service**:

1. A Participant should ask his doctor to prescribe a 90-day supply of the needed medication, plus refills, if appropriate. The physician's name and daily dosage should be clearly indicated on the prescription.

HOW TO PROCESS MEDICAL AND DENTAL CLAIMS

2. The Participant can call Medco Health's toll free number, **1-800-555-3432** or download and print the Medco Health Home Delivery Pharmacy order form. Participants should then mail the prescription with the correct co-payment in a completed mail order envelope to the following address:

Medco Health Rx Services
P.O. Box 650322
Dallas, TX 75265-0322
3. Or, a Participant can ask his Health Care Provider to call **1-888-EASYRX1** (1-888-327-9791) for instructions on how the Health Care Provider can fax the prescription.
4. Medco Health Rx Services will process the order upon receipt and will return the medication(s) to the Participant, via U.S. Mail or UPS, along with re-ordering instructions for future prescriptions or refills, if applicable.
5. When it is time for a refill, the Participant should mail his refill slip and co-payment in the special order envelope provided with the initial prescription or call Medco Health at **1-800-555-3432** to use the automated refill system. A Participant can also request refills through Medco Health's Internet Web site at www.medco.com.

Retail Program

The retail drug program is for prescription medications used on a short-term basis. When an Employee enrolls in a PPO Medical Plan, Senior Plus, Senior, Care Plus or Care Basic Plan, the Employee will receive a prescription drug ID card(s) that can be used to obtain prescription medications at a local pharmacy. A participating pharmacy should be used to receive maximum benefits for prescription drugs. A Participant does not have to file a claim form for prescriptions filled at a participating pharmacy.

A list of participating pharmacies can be found at Medco Health's Internet Web site, www.medco.com, or by calling **1-800-555-3432**.

To get a prescription filled at a **participating pharmacy**:

1. A Participant should present his prescription drug ID card and prescription(s) to the pharmacist at a local participating pharmacy. Eligibility for benefits will be confirmed via a computerized system.
2. The pharmacist will tell the Participant the correct co-payment amount that he is responsible for paying.

To get a prescription filled at a **non-participating pharmacy**:

1. When a Participant uses a non-participating pharmacy, a claim may be filed through Medco Health Solutions, Inc., and *a reduced benefit will be paid*.
2. The Participant is responsible for 100% of the price of the prescription at the time of purchase.

HOW TO PROCESS MEDICAL AND DENTAL CLAIMS

3. The Participant should complete a claim form, which provides direct reimbursement for prescriptions that were purchased at a non-participating pharmacy, and return the form along with the prescription receipt(s) to the address following address:

Paid Prescriptions, L.L.C.

P.O. Box 14711

Lexington, KY 40512

A claim form *must* accompany the prescription receipt(s) and can be obtained by calling Member Services at **1-800-555-3432**. Reimbursement will be made usually within 21 days from the date the claim form is received. Reimbursement will be the cost of the drug at a participating pharmacy less the co-pay and deductible, if applicable.

4. The Participant should keep complete copies of all claim submissions. In the event a claim is lost, the Participant will be prepared to re-submit claims.

INTERNATIONAL CLAIMS

International Medical Claims

The PPO Medical Plans provide coverage for Participants even while outside of the United States. GuideStone Financial Resources recommends that a Participant traveling to a foreign country call the Claim Administrator before leaving the country to discuss the best way to file foreign claims. While in a foreign country, PPO medical Participants should always call the BlueCard Worldwide Program at 1-800-810-2583 before receiving any routine inpatient or outpatient care. The Participant may also call the BlueCard Worldwide Program to help locate a doctor or hospital or access medical assistance services.

The Senior Plus, Senior, Care Plus and Care Basic Plans do not pay benefits for services received outside the United States. Refer to the Basic Medicare Information Chapter for further information.

To receive benefits for covered medical services received in a foreign country, a PPO Medical Plan Participant should follow these steps:

1. Your Employee may have to pay medical expenses in full when services are received. Usually benefits cannot be assigned to a foreign Health Care Provider. The Participant should obtain a receipt in English from the health care provider clearly indicating:
 - Health care provider's name
 - Diagnosis
 - Date of service
 - Type of service(s) rendered
 - Charge amount for each service in American dollars.

HOW TO PROCESS MEDICAL AND DENTAL CLAIMS

2. The Employee or Health Care Provider should submit claims to the address on the medical ID card within 12 months of the date the claim is incurred.
3. Medical plan payments and an explanation of benefits for each claim submitted will be returned to the Employee.
4. After reviewing the explanation of benefits received in connection with a paid claim, if the Employee suspects that the payment is in error, the Employee should contact the Claim Administrator's claim office at the number on the medical ID card.
5. After four weeks, if the Participant's claim has not been paid or acknowledged, the Employee should contact the Claim Administrator's claim office at the number on the medical ID card to determine the status of the claim. Claim information may also be accessed through Highmark Blue Cross Blue Shield's Web site at www.highmarkbcbs.com.

International Prescription Drug Claims

Participants residing and working outside the United States will have access to a toll-free Customer Service support number for international prescription drug claims. The number is 1-800-497-4641 with AT&T access code or collect at 1-614-421-8292.

To file a claim, participants should follow these steps:

1. Fill out the Medco Claim Form and attach detailed receipts. Receipts must contain the following information:
 - Date Prescription filled
 - Name and address of pharmacy
 - Doctor name or ID number
 - NDC number (drug number)
 - Name of drug and strength
 - Quantity and day's supply
 - Prescription number
2. The participant should send the claim to Medco via mail to the following address. Medco will only accept claim forms via mail.

Medco Health Solutions

P.O. Box 14711

Lexington, KY 40512

HOW TO PROCESS MEDICAL AND DENTAL CLAIMS

International Dental Claims

The Premier, Choice, and Guided DHMO Dental Plans pay benefits for covered services received in a foreign country only in the case of an emergency. (Refer the Employee to the Certificate of Insurance issued by the Claim Administrator for detailed benefit information.)

BASIC MEDICARE INFORMATION

GENERAL INFORMATION

Medicare is a two-part federal health insurance program: Hospital insurance benefits (Part A) and medical insurance benefits (Part B).

- A person age 65 or over and eligible for monthly Social Security benefits is eligible for Part A Medicare. A person is automatically enrolled in Part A if Social Security benefits are being received.
- Part B Medicare is available to all citizens living in the U.S. who are age 65 or older. Retired Employees and dependent spouses age 65 and over must enroll and remit premiums to receive Part B Medicare.
- A person less than age 65 who has been entitled to Social Security disability benefits for 24 months may also obtain Medicare benefits (both Part A and Part B). Medicare determines when a disabled person is entitled to Medicare benefits.

Note: Congress passed a law in 1997 that made many changes in the Medicare program. The law includes a section called Medicare+Choice that, starting in 1999, allowed more private insurance companies to offer coverage to people with Medicare. This Medicare program allows for more choices among Medicare health plans. For more information, call 1-800-MEDICARE (1-800-633-4227), or visit www.medicare.gov on the Internet.

For a person who is eligible for Medicare, generally, Medicare is the secondary payer when:

- All or some of the charges incurred are payable under an auto or liability insurance policy.
- Medical benefits are provided to a working person age 65 or over (or the working person's spouse who is age 65 or over) through an Employer's group health plan. This applies only to Employers with 20 or more Employees since these Employers cannot claim exemption to Medicare Secondary Payer Rules.
- The charges are incurred by a disabled Medicare beneficiary who is covered as an "active" Employee under a Large Group Health Plan as defined by the Centers for Medicare and Medicaid Services (CMS). Any Employer in Group Plans is considered a Large Group Health Plan regardless of the number of Employees.

MEDICARE ENROLLMENT

Retired Employees and dependent spouses over age 65 automatically receive Medicare Part A coverage at no cost when they enroll for Social Security retirement benefits. Retired Employees and dependent spouses over age 65 must enroll and make payments in order to receive Medicare Part B coverage.

BASIC MEDICARE INFORMATION

The Medicare Part B enrollment period begins on the first day of the third month before an individual becomes eligible for Medicare (usually age 65) and continues for seven months. If the Employee does not enroll for Medicare Part B at any time during his initial enrollment period, he will not have another chance to enroll until the next general enrollment period. A general enrollment period is held each year from January 1 to March 31 and if the Employee enrolls during this period, he will not be able to get Medicare until July of that year. The Employee may also be charged a premium surcharge for late enrollment.

Note: It is extremely important for individuals to enroll in Medicare Part B when they become eligible to elect this coverage. The Employer group health plan will coordinate benefits as if Medicare Part B is in effect even if the individual does not enroll in Medicare Part B. Therefore, the Employer group health plan will pay no benefits for type B charges if the Participant is not enrolled in Part B. If Medicare does not pay, GuideStone Financial Resources plan does not pay.

GUIDESTONE FINANCIAL RESOURCES MEDICARE COORDINATING PLANS

Medical benefits under Group Plans change when an Employee or dependent spouse becomes eligible for Medicare benefits and Medicare is determined to be the primary payer. An Employee, Retiree or any covered dependent for whom Medicare becomes the primary payer of benefits must transfer from his or her current medical plan to a GuideStone Financial Resources Medicare Coordinating Plan if he or she wants to continue medical coverage through GuideStone Financial Resources.

- GuideStone Financial Resources Medicare Coordinating Plans coordinate with Medicare and are designed to cover some of the expenses that Medicare allows but does not pay in full.
- GuideStone Financial Resources Medicare Coordinating Plans pay benefits based on Medicare approved amounts. Services or supplies not covered by Medicare, and charges above the Medicare approved amount are not covered under the plans and are the responsibility of the Participant.
- All medical expenses covered under Medicare, but not paid in full, can be considered under GuideStone Financial Resources Medicare Coordinating Plans up to the maximum allowed under the plans.

DETERMINATION OF PAYER OF BENEFITS

Medicare Secondary Payer (MSP) rules determine how Medicare and GuideStone Financial Resources pay medical benefits for the following two groups:

- Participants, age 65 or older, who are currently employed; and/or
- Covered spouses, age 65 or older, of Participants who are currently employed.

BASIC MEDICARE INFORMATION

MSP rules state that, for the two groups named above, GuideStone medical plans will be the “primary” payer of medical claims for Employers with a total of 20 or more Employees on the payroll for any 20 or more calendar weeks in the current or preceding calendar year. The condition is met as long as the total number of individuals on the Employer’s payroll for the week adds up to at least 20 regardless of the number of Employees who actually work or who are expected to report for work on a particular day. If an Employer does not meet this condition, Medicare will be the “primary” payer of medical claims, and the cost of medical coverage may be lower for the two groups named above.

An “Employee” is anyone who has been carried on the payroll, whether currently working or not, and will include all full-time and part-time Employees; any Employee receiving disability benefits from which FICA taxes are withheld; and any ministers. To determine if your Employer is subject to MSP rules: List the number of Employees on the payroll during each week in the current calendar year and previous calendar year. Count the number of weeks in each year in which the Employer had 20 or more Employees on the payroll on any given day. If, in the preceding year or in the current year (viewed independently), you have 20 or more weeks with 20 or more Employees on the payroll, you are not exempt from the MSP rules.

The Employer must notify the Insurance Operations, Group Plans of eligibility for the MSP exemption by submitting a completed Exemption Form for Medicare Secondary Payer Rules. The Employer's medical coverage will then pay secondary to Medicare for the two groups named above.

Anyone in these two groups must transfer from their current Group Plans medical plan to a GuideStone Financial Resources Medicare Coordinating Plan. Under the Medicare Coordinating Plan, Participants will file claims with Medicare first. Once Medicare processes their claims, Medicare should file with the Claims Administrator or Employees can forward their itemized bills and copies of their Medicare Explanation of Benefits Form to the Claim Administrator for processing. If the Employer qualifies for the MSP exemption now, but the number of Employees increases to 20 or more for each day in each of 20 or more calendar weeks in the current or preceding calendar year, the group coverage must revert to paying primary to Medicare at the end of the 20th week. Please notify the Insurance Operations, Group Plans if this happens so that charges may be adjusted to accurately reflect required coverage.

Generally, if the Employer has 20 or more Employees, but falls below that number during a calendar year, the Employer does not become exempt from Medicare Secondary Payer rules immediately. Medicare rules require that the Employer's group coverage continue to pay primary to Medicare for the remainder of that calendar year and all of the following year.

Note: There are severe penalties imposed by the Centers for Medicare and Medicaid Services (CMS) for noncompliance with Medicare Secondary Payer Provisions.

DISABLED MEDICARE BENEFICIARIES

For disabled beneficiaries, the Coordination of Benefits Contractor (“COBC”) for Centers for Medicare and Medicaid Services (CMS), is responsible for determining when Medicare becomes the primary payer of benefits. The test of whether Medicare is primary or secondary is whether the coverage of the disabled Medicare beneficiary under a Large Group Health Plan is by virtue of the “current employment status” of either the beneficiary or a member of the beneficiary’s family.

Since disabled Medicare beneficiaries are usually not engaged in active work, CMS has established guidelines for use in determining whether coverage under a Large Group Health Plan is by virtue of the Employee’s or dependent’s “current employment status” for purposes of the primary/secondary payer rules.

Generally, an Employee will be considered to have “current employment status” (and Medicare will be secondary payer):

1. If the person is actively working as an Employee, is the Employer (including a self-employed person), or is associated with the Employer in a business relationship; or
2. The individual is not actively working and is receiving disability payments from the Employer that are subject to FICA tax, or would be subject to FICA tax were the Employer not exempt from such tax under the Internal Revenue Code (the first six months of disability benefits are subject to FICA tax); or
3. If the person is not actively working but **all** of the following are true:
 - The person retains employment rights in the industry (e.g., is furloughed, temporarily laid off or on sick leave; is a teacher or seasonal worker who does not work year-round);
 - The person has not had their employment terminated by the Employer;
 - The person has not been receiving disability benefits from an Employer for more than six months; and
 - The person is not receiving Social Security disability benefits

If an Employee does not meet the conditions required to have “current employment status,” then Medicare is primary on the basis of disability. Please see the following section for Procedures.

BASIC MEDICARE INFORMATION

Procedures for Processing Disabled Medicare Beneficiaries

When a disabled Employee becomes eligible for Medicare benefits due to his or her disability:

- Forward to GuideStone Financial Resources a copy of the disabled Employee's Health Insurance Claim Number (HICN) identification card for disability and a Group Plans Senior Plan Enrollment Form indicating the Employee's choice for a Medicare coordinating plan. This form is required to enroll in a Medicare coordinating plan.
- The Employee's Group Plans records will be updated to reflect Medicare as the primary payer of benefits with an effective date based on when the form was received and the plan chosen.
- The Employee's current Group Plans medical plan will be terminated the day before the effective date of the Medicare coordinating plan.

It is imperative you send GuideStone Financial Resources a copy of the disabled Employee's HICN identification card and the Group Plans Senior Plan Enrollment Form as soon as possible. A delay in sending the identification card to GuideStone Financial Resources could result in incorrect payment of claims.

Note: Effective in 1996, disabled individuals diagnosed with End Stage Renal Disease (ESRD) generally become Medicare primary beginning with the 33rd month after the month in which the individual starts a regular course of dialysis. This applies even if the individual is eligible for Medicare due to age or another disability.

BASIC MEDICARE INFORMATION

**GUIDELINES FOR ORDER OF BENEFIT DETERMINATION WITH
MEDICARE UNDER THE GROUP PLANS MEDICAL PLANS**

| CLAIMANT | | EMPLOYER'S GROUP HEALTH PLAN | MEDICARE |
|------------------------------|---|------------------------------|----------|
| ACTIVE EMPLOYEES | Active Participant age 65 and over employed by an Employer with 20 or more Employees | First | Second |
| | Active Participant age 65 and over employed by an Employer with less than 20 Employees (MSP exempt) | Second | First |
| SPOUSES OF ACTIVE EMPLOYEES | Spouse age 65 and over and Employer has 20 or more Employees | First | Second |
| | Spouse age 65 and over and Employer has less than 20 Employees (MSP exempt) | Second | First |
| RETIRED EMPLOYEES | Retired Employee under age 65 | First | N/A * |
| | Retired Employee age 65 and over | Second | First |
| SPOUSES OF RETIRED EMPLOYEES | Spouse, age 65 and over, of retiree under age 65 | Second | First |
| | Spouse, age 65 and over, of retiree age 65 and over | Second | First |
| | Spouse, under age 65, of retiree under age 65 | First | N/A * |
| | Spouse, under age 65, of retiree age 65 and over | First | N/A * |
| DISABLED EMPLOYEES | Disabled "active" Employee, entitled to Medicare | First | Second |
| | Disabled Employee entitled to Medicare and not an "active" Employee as determined by Medicare | Second | First |
| DISABLED SPOUSES | Disabled spouse of "active" Employee, entitled to Medicare | First | Second |
| | Disabled spouse entitled to Medicare of retired Employee | Second | First |
| SURVIVING SPOUSES | Surviving spouse, age 65 and over | Second | First |
| | Surviving spouse, under age 65 | First | N/A* |

*Not entitled until age 65

MEDICARE BENEFITS OUTSIDE THE UNITED STATES

Medicare Primary Participants traveling outside the United States

Medicare benefits are not available to a Participant eligible for Medicare when medical expenses are incurred outside the United States, except in case of an emergency. **GuideStone Financial Resources Medicare Coordinating Plans do not pay benefits for health care services received outside of the United States** since these plans cover only those expenses covered by Medicare.

Medicare Primary Participants living outside the United States

If a Participant is eligible for Medicare and lives outside of the United States, he should enroll in the Group Plans PPO Medical Plans. The Participant will may need to pay in full for medical expenses received outside of the United States since benefits usually cannot be assigned to a foreign provider. The Participant should obtain a receipt clearly indicating the following information:

- Name of the licensed practitioner
- Diagnosis
- Date of service
- Type of service(s) rendered
- Amount charged for each service

The Participant should have the receipt translated into English and the charges converted into U.S. currency values on the date of service. The Participant can seek guidance from the nearest American Embassy to find a licensed practitioner or assistance with translating a medical bill.

The Participant should file the claim with the Claim Administrator. If benefits are not covered by Medicare, the Claim Administrator will process the eligible charges as though the Participant had full coverage with the Claim Administrator.

MEDICARE PART D

Beginning January 1, 2006, individuals eligible for Medicare are also eligible for a Medicare-approved prescription benefit, also known as Medicare Part D. GuideStone will make available Medicare Coordinating Plans that incorporate the benefits of the new Medicare legislation. GuideStone Participants will not need to purchase a Part D plan elsewhere as the prescription benefits included in our Medicare Coordinating Plans meet or exceed the minimum standard established for Part D coverage.

BASIC MEDICARE INFORMATION

Note: If a Participant chooses to get Part D coverage elsewhere, they will become ineligible for the Medicare Coordinating Plans that GuideStone currently makes available (except in the instance of qualifying for the low-income subsidy).

Low Income Subsidy

The Low Income Subsidy is a feature of the Medicare Part D legislation that will allow those Medicare Participants who meet specific eligibility and income criteria to receive prescription drug benefits at a discounted rate or free of charge.

Contact CMS for the current eligibility requirements for the Low Income Subsidy at 1-800-Medicare or www.medicare.gov.

Participants who qualify for this subsidy will be given an opportunity to enroll in the Medicare Coordinating Plan without the prescription benefits included.

EMPLOYER ACCESS

GENERAL INFORMATION

Employer Access is an on-line service designed to help you maintain and access information regarding your retirement and insurance accounts.

Currently available features for Insurance include:

- Account Maintenance/Inquiry
 - Provides access to existing Employees to make personal data changes
 - Provides access to existing Employees to make Salary changes
 - Provides access to existing Employees to submit changes for:
 - Adding a dependent
 - Adding a product
 - Terminating an Employee
 - Terminating a dependent
 - Terminating a product
 - Provides access to submit an enrollment for a new Employee
 - Employer Annual Election and Re-enrollment Tracking
 - Available for annual re-enrollment (usually October through December)
 - Allows online Employer election of plans for the next plan year
 - Provides information on Employees' plan election for the next year
 - Employees may be accessed either individually by inputting their Social Security number or by selecting from a list of all Employees
- Insurance Billing
 - Provides access to view and pay the most recent bill
 - Provides access to billing history
 - Allows download of billing to an Excel file
 - Allows one-time payment of bill and creation of automatic monthly payments
- Employer Reports
 - Allows an Employer to run various reports such as:
 - New Employees (within a date range)
 - Dependents losing eligibility
 - Participants turning age 65

EMPLOYER ACCESS

- Employees on continuation
 - Allows an Employer to schedule regular reports with email notification when report is ready
- Claims Information
 - Provides access to links for claim filing information for the various plans
 - A new browser page will open when a link is chosen
 - It is not necessary to log back into Employer Access when the page is closed unless the session expires
- Plan Booklets
 - Provides access to links to plan booklets
 - A new browser page will open when a link is chosen
 - It is not necessary to log back into Employer Access when the page is closed unless the session expires
- Providers/Vendors Sites
 - Provides access to links for GuideStone vendors and providers
 - A new browser page will open when a link is chosen
 - It is not necessary to log back into Employer Access when the page is closed unless the session expires
- Forms
 - Provides access to PDFs (Portable Document Format) for forms used to administer Group Plans
 - It is not necessary to log back into Employer Access when the page is closed unless the session expires

NOTE: By using this program, you agree to adhere to eligibility rules for Employees and dependents and that failure to do so could result in termination of their coverage and reimbursement to GuideStone.

Getting Access

You may register your Employer for the Employer Access Program on the GuideStone website. Click Employer Login from the homepage, www.GuideStone.org. In the Log in box, click the Register Employer with Employer Access link.

EMPLOYER ACCESS

You may also complete the Letter of Agreement and Designation of Employer Access Program Administrator forms and have them signed by an authorized officer of the Employer. Once GuideStone Financial Resources receives this information, your authorization will be established and your designated administrator can access the Employer's account.

Call Customer Relations at **1-888-98-GUIDE** (1-888-984-8433), or your Group Plans Account Administrator to request the above forms. You may also find these forms on the Group Plans forms page at www.guidestoneinsurance.org/FormsandFAQ/GroupForms in the Miscellaneous section.

You will use the same User ID and Password for Employer Access as you use for personal online services. If you are not a current Participant with a User ID and Password, when you sign onto Employer Access for the first time, click 'Register Now' and follow the online directions.

PROCEDURES FOR USING EMPLOYER ACCESS

Logging On

1. Click Employer Login from the home page, www.GuideStone.org
2. Log in with User ID and Password
3. If this is your first time to log in to GuideStone's website, you will need to click Create ID/Password.

Address Changes

1. Follow above steps 1-2 for Logging On
2. Click Employees
3. Click an Employee from the Employee list, or enter the Employee SSN in the Search By: box.
4. Click the Contact Info tab.
5. Click the Edit button.
6. Make necessary changes.
7. Click Save.

Salary Changes

1. Follow above steps 1-2 above for Logging On
2. Click Employees
3. Click Update Salaries
4. Type in New Salary Effective Date (must be the current date or a future date in the format of mm-dd-ccyy)
5. Place the cursor in the New Monthly Salary to the right of the Employee whose Salary is changing
6. Type in the new monthly Salary in the blank provided
 - a) **DO NOT** use decimal points or cents.
 - b) The Salary must be rounded up to the next dollar amount. Example: Salary is \$1,502.35, input 1503.
 - c) The Salary may not be zero.
7. Continue inputting Salaries in the same manner for other Employees if applicable
8. Click Update once all Salaries have been input.

Submission of Changes for Adding or Terminating an Employee, Dependent or Product

Employer Access also provides for online submission to Group Plans of changes that need to be made to existing Employees and new Employees that need to be enrolled. This method of online submission may be used in place of mailing or faxing a paper form to Group Plans.

In order to submit a change online, follow the directions in the Logging In section of this chapter. Then click on the Employees tab. To enroll a new Employee, you may choose Add Employee from this screen. To make other changes, choose an Employee from the Employee list or provide the Employee's SSN in the Search By: box. Select the applicable change from the list and proceed through the self-explanatory screens. The type of information required to be input will vary by the type of Maintenance Function selected. Once the change has been submitted, notification will be sent to Group Plans who will process the change the same as if a paper form had been received.

If Add Employee is selected, the system will move through a series of self-explanatory screens that will require personal data, dependent information and plan elections be input. Once the change has been submitted, notification will be sent to Group Plans who will process the change the same as if a paper form had been received.

For additional assistance with using Employer Access, contact your Group Plans Account Administrator.

FLEXIBLE SPENDING ACCOUNT

GENERAL INFORMATION

Flexible benefit plans, often called “cafeteria plans” or “section 125 plans” allow Employees to pay out-of-pocket costs with pre-tax dollars. These accounts are completely Employee-funded, meaning Employers cannot make direct contributions. An Employee decides how much he or she wants to contribute to the FSA for a period of one calendar year plus a three-month grace period. After this time frame, the Employee loses any money left in the account.

FSA funds can be used to pay for qualified health care expenses including premiums and out-of-pocket medical, dental and vision expenses. FSA’s also allow Employees to pay for child care expenses with pre-tax dollars.

GuideStone has an endorsed arrangement with Employee Benefits Corporation (EBC) to provide flexible spending accounts. The Employer must have Medical or Dental coverage thru GuideStone Financial Resources to be eligible.

1. Employers must establish flexible benefit plans for their Employees. Employees may choose to participate through the Employer plan. No individual plans are available.
2. Plans may take between 30 and 60 days to set up, depending on the choices Employers make.
3. Employers can set up plans any time in the year.

You can get more information about flexible benefit plans by calling EBC at **1-800-346-2126**, or through their Web site at www.ebcflex.com.

ADMINISTRATIVE FORMS

ABOUT THIS SECTION

For your convenience, this section contains information on how you can get forms and booklets online, and information on the most commonly used forms.

Forms and Booklets

Most forms and booklets may be downloaded through GuideStone Financial Resources Internet Web site at www.GuideStoneInsurance.org. When accessing forms through the Web site, be sure to select only **Group Plans** forms.

Forms may be found on the Web site by clicking on: Insurance, Forms & FAQs, Group Plans Forms.

Booklets may be found on the Web site by clicking on: Insurance, Forms & FAQs, Plan Booklets.

If Internet access is not available or you prefer to order forms by telephone, contact your Group Plans Account Administrator for assistance.

Commonly Used Forms

- Group Plans Enrollment form -To enroll a new Employee, or enroll a current Employee who is not on your billing.
- Waiver of Medical and/or Dental Coverage, Group Plans - Must be completed to waive (decline) Employer paid medical or dental coverage when the Employee has other coverage.
- Employer Change Report, Group Plans - To make changes to current Employees' coverage, such as: termination of employment, Salary change, add a dependent, terminate a dependent, change in current coverage.
- Special and Late Applicant Enrollment Form for Health Care Coverage, Group Plans - To add medical coverage after the Employee's or dependent's initial eligibility period has passed. Add coverage mid-year (Special Enrollment) with a qualifying event, or at open enrollment (Late Enrollment) without a qualifying event
- Senior Plan Enrollment Form, Group Plans - Required for enrollment when the Participant is Medicare primary with GuideStone coverage secondary.
- Employee/Retiree – Senior Plans Termination Form, Group Plans - Required for termination from one of our Senior or Care Plans.
- Evidence of Good Health Application, Group Plans -Application to apply for life and disability coverage when underwriting is required.

ADMINISTRATIVE FORMS

- Request for Medical and/or Dental Continuation, Group Plans (MCP/DCP) - To continue medical or dental coverage when an Employee or dependent is no longer eligible due to termination of employment, reduction in number of hours working, divorce or legal separation, loss of dependent child status.
- Request for Continuation of Insurance Eligibility, Group Plans (CIE) -To continue life, AD&D, medical and dental coverage after termination when the Employee is seeking other Southern Baptist employment. (Available for Southern Baptist groups only).

ID Cards

- Medical and Prescription ID cards for the PPO Medical Plans, Senior Plus Plan, Senior Plan, Care Plus Plan and Care Basic Plan may be ordered through the numbers listed in the “How to Get Help” chapter of this manual.
- ID cards for the Premier, Choice or Guided Dental Plan may be ordered from Cigna at the numbers listed in the “How to Get Help” chapter of this manual.