

Group Plans

Care Basic Plan



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1. Your booklet

A. Introduction

Thank You for choosing this Plan from GuideStone Financial Resources of the Southern Baptist Convention (GuideStone). This is your booklet for the Group Care Basic Plan (Plan). GuideStone sponsors the Plan and your Employer offers the Plan to its employees and retirees.

Some words and phrases in this booklet, such as “Plan,” have special meanings. We call these words and phrases “defined terms.” Usually, these defined terms are capitalized. The **Definitions** section at the end of this booklet gives the meanings of these defined terms.

Other organizations help the Plan serve You:

- **Highmark Blue Cross Blue Shield® (Highmark)**, the Claims Administrator for the medical Plan, administers payment of Claims, but has no liability for the funding of the benefit plan.
- **Medco Health Solutions, Inc. (Medco Health)** and its affiliates, is the Claims Administrator for Outpatient retail pharmacy and home delivery Prescription Drugs.

This booklet tells You about Plan benefits beginning January 1, 2009. Claims for medical Services You received before January 1, 2009 will be paid under the terms of the plan in effect when the Claims were Incurred. Usually, a Claim is Incurred when a Medicare Eligible Expense is received by a Covered Person.

B. Important phone numbers

GuideStone Customer Relations: **1-888-98GUIDE (984-8433)**

Blues On Callsm: **1-888-BLUE428**

Highmark Blue Cross Blue Shield (Highmark): **1-866-472-0924**

Medco Health Solutions, Inc. (Medco Health): **1-866-544-2976**

Medicare: **1-800-Medicare**

C. Important Web sites

www.GuideStone.org

www.highmarkbcbs.com

www.medco.com

www.medicare.gov

2. Benefit summary

The **Benefit summary** summarizes many of your Plan benefits. This booklet discusses your benefits in more detail. Please read it carefully to understand the Plan's limitations and exclusions. Please do not rely only on this **Benefit summary** to understand the Plan.

Care Basic Plan

Part A Services

(Medicare Eligible Expenses)

Plan Pays

You Pay¹

Hospital Stays

Semi-private room and board,
general nursing and other
Hospital Services and supplies.

\$400 toward Part A Deductible
Part A Copayments for days 61-150
100% after 150 days

Remainder of Part A Deductible
Nothing after 60 days

Skilled Nursing Facility Care

Nothing

All costs not covered by Part A

Post-Hospital Home Health Care

Nothing

All costs not covered by Part A for
services and durable medical equipment

Hospice Care

Nothing

All costs not covered by Part A

Blood

Nothing

All costs not covered by Part A

Part B Services

(Medicare Eligible Expenses)

Plan Pays

You Pay¹

Medical Services and supplies

Physicians' Services, Inpatient and Outpatient
medical and surgical Services and supplies,
physical and speech therapy, diagnostic tests,
durable medical equipment and other Services.

No coverage for
Part B Services

All costs not covered by Part B

Clinical Laboratory Service

No coverage for Part B Services

All costs not covered by Part B

Home Health Care

No coverage for Part B Services

All costs not covered by Part B

¹ Member pays 100% of any charges that are not covered by Medicare or that are above the Medicare approved amount.

Outpatient Prescription Drug Program

- Refer to your Evidence of Coverage plan document.
www.GuideStoneInsurance.org/~/-/media/Insurance/HealthMaterials/2009/MedcoEvidenceOfCoverage%20pdf.ashx

Limitations

Benefits will not be paid for confinement, treatment, or Service that Medicare does not pay a part of, nor for the confinement, treatment, or Service not covered in the **Benefit summary**.

This Plan combined with Medicare and any other group medical coverage will not pay more than your covered health care expenses.

3. Who is eligible

A. Employee Coverage — coverage for employees and retirees

You are eligible for Employee Coverage under the Plan if You are an Eligible Employee or Eligible Retiree and not covered under any other group medical benefit plan offered by your Employer.

You are an Eligible Employee if:

- You are age 65 or older, eligible for Medicare, and an active full-time employee (as defined by your Employer) earning wages from an Employer that offers Plan coverage to one or more Covered Classes of employees;
- You work at least the number of hours that your Employer requires to be considered a full-time employee, but not less than 20 hours a week;
- Your Employer has fewer than 20 employees on the payroll as counted in accordance with applicable Medicare requirements;
- You have completed your Employer's waiting period, if any;
- You are in a Covered Class of employees to whom your Employer offers Plan coverage; or
- You are disabled and eligible for Medicare.

You are an Eligible Retiree if:

- You are a retiree who was working full-time (as defined by your Employer) when You retired from service;
- You were covered under that Employer's health plan when You retired;
- That Employer now offers Plan coverage to one or more Covered Classes of retirees;
- You are in a Covered Class of retirees to whom that Employer offers Plan coverage;
- You are age 65 or older and eligible for Medicare.

Covered Classes are groups of employees or retirees to whom your Employer offers Plan coverage. Your Employer may put employees into groups based on such things as job position, work hours per week, earnings or other factors. Your Employer also may put retirees into groups based on such things as years of service, age at retirement and other factors. Your Employer decides which groups of employees or retirees are Covered Classes under the Plan.

Your Employer may offer Plan coverage to some, but not to all groups of employees or retirees. Also, some Employers who offer coverage to one or more groups of employees may not offer plan coverage to retirees.

If You work for or retire from more than one Employer that offers the Plan, You must choose through which Employer You want to have Employee Coverage. You can't have double Employee Coverage or both Employee Coverage and Dependent Coverage under the Plan.

When Coverage begins tells You how to enroll.

B. Dependents Coverage

Many Employers offer Dependents Coverage. If You have Employee Coverage under this Plan, your dependents may be eligible for Dependents Coverage under this Plan or another plan (if the dependent is not eligible for Medicare) offered by your Employer. Ask your Employer if Dependents Coverage is available.

To get Dependents Coverage, You must have Employee Coverage under this Plan or another GuideStone sponsored medical plan.

Your Eligible Dependent under this Plan is:

- Your Spouse who is eligible for Medicare.
- Your unmarried Child who is disabled, dependent on You for support and maintenance, and is eligible for Medicare.

Your Child means:

- Your natural (biological) Child.
- Your legally adopted Child or a Child placed in your home for adoption.
- A Child living with You and dependent on You for support and maintenance. This may be:
 - Your stepchild.
 - Your foster Child.
 - Your grandchild.
- A Child for whom You 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 You are legal guardian or managing conservator.

C. If two Covered Persons want to cover the same dependent Child

Your Child can't be covered under the Plan as a dependent of two Covered Persons working or retired from the same Employer. You and your Spouse may both have medical coverage through the same Employer and both have Employee Coverage under a GuideStone sponsored medical plan. If so, You must decide which of You will carry the Child as a dependent under his or her coverage. You also have to tell your Employer what You decide.

D. Exceptions — dependents not eligible

There are exceptions to the rules for dependent eligibility. Your Spouse or Child is not an Eligible Dependent under this Plan if he or she:

- Is on active duty in the armed forces of any country.
- Already has Employee Coverage under this Plan or another GuideStone sponsored medical plan through your Employer. (No one can have both Employee Coverage and Dependents Coverage through the same Employer.)

When coverage begins tells You how to enroll your Eligible Dependents.

4. When coverage begins

A. Enrolling yourself

It is important for You to enroll early. To enroll for Employee Coverage, You must:

- Be eligible for coverage.
- Give your Employer a signed enrollment form within 31 days after You first become eligible.
- Pay any required contributions.

If You do all these things at the right time, You will be covered on the date you are eligible.

B. Enrolling your dependents

Enroll your dependents when You enroll. Most Employers offer Dependents Coverage to their employees. If your Employer offers this coverage, this is what You must do to enroll your Eligible Dependents:

- Enroll yourself for Employee Coverage.

- Give your Employer a signed enrollment form within 31 days after You first become eligible that lists your Eligible Dependents.
- Pay any required contributions.

If You do all these things at the right time, your Dependents Coverage will begin when your Employee Coverage begins. Any Eligible Dependents You do not enroll when You enroll yourself for Employee Coverage may be late enrollees. This means that their coverage will be delayed.

Dependents not enrolled in Medicare may be eligible for coverage under another plan offered by your Employer.

C. Late enrollees (for active employees)

Your Eligible Dependents will be late enrollees if You:

- Do not enroll them when they first become eligible.
- Do not meet one of the special enrollment requirements described below.

For late enrollees:

- Coverage will not begin until January 1 following the date You enroll.
- The Plan may delay coverage for any Pre-existing Sickness or Injury.

D. Special enrollment requirements (for active employees)

If your family status changes. You can enroll your Spouse and any other Eligible Dependents in this Plan as special enrollees if any one of these qualifying events happens:

- Marriage.
- Birth of a newborn.
- Adoption or placement of a Child in your home for adoption.

If any one of these events happens, **You must enroll your Eligible Dependents promptly.** To do so, You must:

- Enroll them within 60 days after the event.
- Pay any required contributions.

If You do both of these things at the right time, the Plan or another GuideStone medical plan (if they qualify) will cover You and the Eligible Dependents You enroll from the date of the marriage, birth, adoption or placement in the home for adoption.

E. Adding dependents to coverage (for non-active members)

If your family status changes, You can enroll your new dependent in this Plan if any one of these qualifying events happens:

- Marriage.
- Birth of a newborn.
- Adoption or placement of a child in your home for adoption.

If any one of these events happens, **You must enroll your new dependent promptly.** To do so, You must:

- Enroll them within 60 days after the event.
- Pay any required contributions.

If You do both of these things at the right time, the Plan or another GuideStone medical plan (if they qualify) will cover You and the Eligible Dependents You enroll from the date of the marriage, birth, adoption or placement in the home for adoption. If you do not do these things at the right time, your dependents may be late enrollees.

F. Dropping dependents from coverage

You can drop a dependent from your coverage at any time. This can happen if there is a death or divorce or your Child stops being eligible because of age. You must tell your Employer promptly about the change.

G. Making enrollment changes

Report all enrollment changes promptly so that You and your Eligible Dependents become covered as soon as possible. Also, a change in coverage could make your contributions to the Plan higher or lower. If You do not report a change promptly, You may pay higher contributions than necessary. The Plan will not refund these excess payments.

Your Employer has the forms You need to enroll or to make any changes in coverage.

5. When coverage ends

A. End of Employee Coverage

Your Employee Coverage will end when any one of these things happens:

- GuideStone or your Employer stops offering the Plan.
- You are no longer eligible for Medicare.
- Required contributions are not paid when due.
- You become enrolled in any Medicare Part D plan other than the low-income subsidy plan.

B. End of Dependents Coverage

Your dependents will lose coverage if any one of these things happens:

- Your Spouse or Child is no longer an Eligible Dependent.
- GuideStone stops offering the Plan.
- Your Spouse or Child is no longer eligible for Medicare.
- Your Employer stops offering Dependents Coverage.
- Required contributions are not paid when due.

C. Continued coverage for Covered Dependents after your death

If You die while covered under the Plan, your Covered Dependents may continue their Plan coverage. This continued coverage will end when any one of these things happens:

- Your dependent is no longer an Eligible Dependent.
- Your dependent becomes eligible for benefits under any other medical plan.
- The Plan stops offering Dependents Coverage.
- GuideStone or your Employer stops offering medical plans.
- Required contributions are not paid when due.

D. How to obtain a certificate of creditable coverage

Certificates of creditable coverage are written documents provided by this Plan to show the type of coverage a person had (e.g., employee only, employee plus Spouse, etc.) and how long the coverage lasted. Under federal law, most group health plans must

provide these certificates automatically when a person's coverage terminates. However, if a plan does not give You a certificate, You have the right to request one. Certificates apply both to plan members and to dependents.

This Plan will automatically give You a certificate after You lose coverage under the Plan. One will also be provided for your dependents when we have reason to know that your dependents are no longer covered.

In addition, the Plan will provide a certificate for You (or your dependents) upon request if You make the request within two years (24 months) after your coverage terminates. Contact GuideStone Customer Relations at **1-888-984-8433** to request a certificate of creditable coverage.

6. Member services

Good health care is more than just Physician Visits. It's also the service that supports your care. Whether it's for help with a Claim or a question about your benefits, You can call the toll-free member service number on the back of your Medical ID Card or log onto the Highmark Web site, www.highmarkbcbs.com and connect to My BlueLink. A Highmark member service representative will help You with any coverage inquiry. Representatives are trained to answer your questions quickly, politely and accurately.

A. Blues On Callsm

From My BlueLink page at www.highmarkbcbs.com, click on "Blues On Call" or dial the 24-hour toll free number, **1-866-472-0924** to speak with a specially trained Registered Nurse. Your call will be kept strictly confidential.

Blues On Callsm addresses your total health care needs rather than focusing on one specific disease, condition or Sickness through interaction with both the patient and the Physician. Blues On Callsm promotes the philosophy of shared decision-making by helping You work with your Physicians in the task of choosing treatment options that take into account your values and preferences. Blues on Callsm provides You with health care support Services, including assistance in the self-management of certain health conditions. You have 24-hour access, seven days a week, to health information and personalized support for health decisions.

Support Services may include:

- Assessment of your functional and health status, including co-morbidities, risk factors, motivation and confidence in managing your health, and receptivity for change;
- Assessment of your knowledge of your particular condition and your understanding and adherence to the recommendations and instructions of your health care Provider;
- Education and training on health-related topics that can be helpful in improving your overall health status, such as appropriate diet and nutrition, smoking cessation and exercise; and
- Ongoing monitoring (coaching) to optimize your health status, ensuring adherence to the Physician's treatment plan, identifying and addressing barriers that prevent or hinder adherence to the Physician's treatment plan, and assessing the need for case management services.

B. Highmark Web site

Visit the Highmark Web site at www.highmarkbcbs.com for a world of information, interactive tools and Services. As a Blue Cross Blue Shield member, You have access to health and wellness information, user-friendly Services related to your health care coverage, and valuable tools for managing your own health and well-being on My BlueLink, your personal Web page. Simply go to the Web site and log onto My BlueLink.

Here You can:

- Customize the content of your pages, including health and wellness content and links to other sites.
- Access a variety of Services related to your Blue Cross Blue Shield coverage, order a Medical ID Card or Claim form, investigate a Claim, or find a Physician.

- Access valuable health resources including Blues On Callsm. You can look up any medical topic in the Healthwise Knowledgebase[®], a comprehensive health information resource containing more than 28,000 pages of current medically accurate health information. You can also complete the personal wellness profile, which helps You identify your personal health risks and set goals to improve your wellness.
- Access “Healthy Living” page for fitness tools, calculators, personal wellness profile and more.

Highmark also keeps You informed through a quarterly newsletter, *Looking Healthward*. This newsletter contains new product updates as well as a wide variety of health and preventive care articles and “stay healthy” tips.

7. Outpatient Prescription Drug program

A. Overview

Medco Health Solutions, Inc. administers the Plan’s Outpatient Prescription Drug program. **Please see your Evidence of Coverage plan document that describes your prescription drug benefits.**

8. How to file a Claim

These rules explain how to apply for payment of Plan benefits. Either You or your Covered Dependent can file a Claim under these procedures. To be considered, a claim must be filed within one year from the end of the year following the date of service.

These rules do not apply to Claims for Outpatient Prescription Drugs. Those rules are described in your **Evidence of Coverage plan document**.

A. Filing claims

Medical care Providers (Physicians and Hospitals) file all Medicare Claims for you. Medicare pays your provider before your Plan coverage pays benefits. You need to inform your Provider of your Medicare and your Plan coverage by presenting both identification cards at the time of your treatment.

If your Provider informs Medicare of your Plan coverage, Medicare sends the Claims Administrator your itemized Claim and a copy of your Medicare Explanation of Benefits. The Claims Administrator will pay your Providers directly and will send an explanation of benefits statement to You.

If your Provider does not inform Medicare of your Plan coverage, (for example, your Medical ID Card was not presented at the time of Service) Medicare will not forward your Claim to the Claims Administrator. It then becomes your responsibility, and You will need to send a copy of your itemized claim and your Medicare Explanation of Benefits to the Claims Administrator for processing.

B. Explanation of benefits statement

Once your Claim is processed, You will receive an explanation of benefits (EOB) statement. The statement lists: the provider’s charge, Allowable Charge, Copayment, Deductible and Coinsurance You are required to pay; total benefits payable; and total amount You owe.

If a Claim cannot be processed due to incomplete information, the Claims Administrator will send a written explanation prior to the expiration of the 30 calendar days. You are then allowed up to 45 calendar days to provide all additional information requested. The Claims Administrator will render a decision within 15 calendar days of either receiving the necessary information or upon expiration of 45 calendar days if no additional information is received.

In actual practice, benefits under the Plan may be processed and paid within a few days after the Claims Administrator receives completed proof of the expense. If a Claim cannot be paid, the Claims Administrator will promptly explain why.

C. Appeal of payment, denial and review

You may request an appeal of a Claim denial by written request to the Claims Administrator within 180 calendar days of receipt of notice of the denial. The Claims Administrator will make a full and fair review of the Claim. The Claims Administrator may require additional information to make the review. The Claims Administrator will notify the claimant in writing of the appeal decision within 60 calendar days of receiving the appeal request.

After exhaustion of the first appeal process, a second appeal may be requested. The second appeal must be requested in writing within 45 days of the denial of the first appeal. Written comments, documents, records, and other information relating to the Claim for benefits may be supplied to the Claims Administrator. The Claims Administrator will make a determination within 60 calendar days of request for a second appeal. However, if the appeal cannot be processed due to incomplete information, the Claims Administrator will send a written explanation of the additional information that is required or an authorization for the claimant's signature so information can be obtained from the Provider. Failure to comply with the request for additional information could result in declination of the appeal. A determination will be made and notification of the outcome will be provided within 60 calendar days of the receipt of all necessary information to properly review the appeal request.

If the Claims Administrator does not pay your Claim after it has gone through all levels of its own appeal process, it will send You a final denial letter. This letter will tell You how to appeal your Claims denial to the Plan. You cannot file an appeal with the Plan until You receive the final denial letter from the Claims Administrator.

If You decide to appeal your Claim to the Plan, You must send a written appeal within 60 days of the Claims Administrator's final denial letter. Your appeal should include:

All the reasons why your Claim should not be denied.

Any information that You wish to have the Plan consider in reviewing the appeal. You may send in any new or additional information that You think might affect the Claim review.

Send this appeal to:

Claims
Insurance Operations Department
GuideStone Financial Resources of the Southern Baptist Convention
2401 Cedar Springs Rd.
Dallas, Texas 75201-1498

The claims department will review your appeal. If the information You send clearly shows that You should receive Plan benefits, the claims department will reverse the Claim denial and notify You of the decision.

If your appeal does not clearly show that You should receive Plan benefits, the claims department may ask for additional information, either from You or from others. The claims department will send your appeal and all the related information to the Plan's claims appeals committee for review. The committee also may ask You or other sources for additional information. The committee will make a final decision based on all the information it receives.

The committee will decide your appeal within 60 days after You file your appeal with the Plan. This review can take up to 120 days if special circumstances make it impossible for the committee to complete the review within 60 days. If this happens, You will be notified of the delay within the first 60 days. Once the committee completes its review, it will send You a letter about its decision. This letter will tell You the specific reasons for the final decision. It will also tell You about the Plan provisions that the committee relied on to make its decision.

The committee has complete discretion when it decides any appeals. Its decision is final and binding.

For purposes of this section, "claimant" means You, your dependent, or legal representative.

D. Legal action

Legal action for a Claim may not be started before the appeal procedures have been exhausted. Further, no legal action may be started later than two years after proof is required to be filed.

E. Facility of payment

The Plan will normally pay all benefits to You. However, if the claimed benefits result from a dependent's Sickness or Injury, the Plan may make payment to the dependent. Also, in the special instances listed below, payment will be as indicated. All payments so made will discharge the Plan to the full extent of those payments.

- If payment amounts remain due upon your death, those amounts may, at the Plan's option, be paid to your estate, Spouse, Child, parent, or provider of medical and dental Services.
- If the Plan believes a person is not legally able to give a valid receipt for a benefit payment, and no guardian has been appointed, the Plan may pay whoever has assumed the care and support of the person.

F. Medical examinations

The Plan may have the person whose expense is the basis for claim examined by a Physician. The Plan will pay for these examinations and will choose the Physician to perform them.

G. Plan's right to recover overpayments

If the Plan pays You or someone else more than it should have paid for any reason, it has the right to be repaid for these overpayments.

The Plan may recover the overpayments from:

- The person to or for whom the Plan paid the excess amount.
- Insurance companies.
- Other organizations.

The Plan also has the right to be repaid the reasonable cash value of any benefits it provides in the form of Service.

9. General information

A. Right to amend or terminate the Plan

GuideStone can terminate the Plan at any time for any reason. Your Plan benefits will end if this happens.

GuideStone also can change any or all of the provisions of the Plan at any time and for any reason. It does not have to notify You first. Any change may cause your benefits to be different than those described in this booklet.

B. Church plan

The Plan is intended to be a "church plan" as defined in the Employee Retirement Income Security Act of 1974, as amended (ERISA), and the Internal Revenue Code. Because it is a church plan, many legal requirements that apply to most other health care plans do not apply to this Plan. For example, this Plan does not have to follow the COBRA Continuation Coverage requirements.

C. Plan is not an employment contract

The Plan is not an employment contract. Enrollment in the Plan does not give You any right to continued employment with your Employer.

D. Choice of law

If You or anyone else brings an action against the Plan, the laws of the State of Texas will apply.

E. Relation among parties affected by the Plan

All health care Providers, including Hospitals, are independent contractors to GuideStone. No health care Provider works for GuideStone either as an employee or agent. No GuideStone employee works for any health care Provider, either as an employee or agent. That means that each health care Provider You go to is responsible to You for the Services and supplies it provides to You. GuideStone is not responsible for providing You with any Services and supplies. Nor is it responsible for any Services and supplies You receive from any health care provider.

F. Plan discretion

GuideStone has complete discretion to construe or interpret all provisions, to determine eligibility for benefits, and to determine the type and extent of benefits, if any, to be provided. GuideStone decisions in such matters shall be controlling, binding, and final. In any action to review any such decision by GuideStone, GuideStone shall be deemed to have exercised its discretion properly unless it is proved that GuideStone has acted arbitrarily and capriciously.

10. Your confidential medical information

A. Collecting information

We rely on information from You and your Covered Dependents to operate the Plan. Generally, You give this information when You enroll and when You file claims.

The Claims Administrator may also collect information about You from other sources. The Claims Administrator needs this information to process claims. For example, your coverage may have limits on it that depend on your salary or job class. The Claims Administrator would get that information from GuideStone.

B. Disclosing information to others

The provisions of this section are intended to comply with the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations promulgated thereunder, as they may be amended from time to time (collectively, "HIPAA") and, in particular, the rules under HIPAA pertaining to the privacy of Individually Identifiable Health Information set forth in 45 C.F.R. Subtitle A, Part 164, Subpart E, as it may be amended from time to time (the "Privacy Rule"). This section shall supersede any provisions of the Plan to the extent those provisions are inconsistent with this section. Each capitalized term used in this section that is not otherwise defined in the Plan shall have the meaning ascribed to it under HIPAA.

- (1) Required Uses and Disclosures of PHI. Except as otherwise set forth herein, GuideStone (hereafter Plan Sponsor) shall be required to use and disclose Protected Health Information (PHI) received from the Plan or any Health Insurance Issuer providing benefits under the Plan, as follows:
 - (a) for disclosure to the Secretary of Health and Human Services, when required by the Secretary for its investigation or determination of the compliance of the Plan with the Privacy Rule;
 - (b) for disclosure to a Plan Participant, Spouse or Covered Dependent of that Individual's PHI upon the Individual's written request or in appropriate response to an exercise by the Plan Participant, Spouse or Covered Dependent of any other of his or her individual rights with respect to PHI, all in accordance with the requirements of the Privacy Rule;
 - (c) for purposes of the Plan Administration functions set forth in paragraphs 3 and 4 of this section 9(B), or as otherwise required by HIPAA; and
 - (d) for use or disclosure to other persons, as required by applicable law other than HIPAA, provided that nothing in this paragraph (1)(d) shall permit or require the use by or disclosure of PHI to the Plan Sponsor to the extent such disclosure is prohibited by HIPAA.

- (2) **Permitted Uses and Disclosures of PHI.** Except as otherwise set forth herein, the PHI received from the Plan or any Health Insurance Issuer providing benefits under the Plan shall be permitted to be used and/or disclosed as follows:
- (a) by persons handling Plan operations and claims, members of the claims appeals committee, customer relations, legal services, executive management, actuarial and financial services, and marketing support for Treatment, Payment or Health Care Operations including but not limited to, eligibility, enrollment, provider verification of enrollment, internal verification of enrollment, qualified medical child support orders, dis-enrollment, employee contributions, participating employer contributions, payment of cost of coverage, payment of continuation of benefits, precertification, predetermination concurrent review, case management, centers for high risk procedures, claim adjudications, claim payments, claim status benefit determinations, medical necessity reviews, review of claim appeals, informal employee assistance, coordination of benefits, third party liability, stop loss claims, audit reports, claims audits, administration audits, information systems controls, legal/compliance audits, financial audits, establishment of the Plan, underwriting and actuarial valuations, amending the Plan, network development, terminating the Plan, selection of vendors, and any other activity that would constitute Treatment, Payment or Health Care Operations, provided that, to the extent required by administrative rules under the Plan or applicable law, such use or disclosure is made pursuant to and in accordance with a valid consent under the Privacy Rule;
 - (b) pursuant to and in accordance with a valid authorization under the Privacy Rule;
 - (c) by persons handling Plan operations and claims for wellness, prevention and disease management including but not limited to, voluntary medical examination, health profiles, screening, alternatives for financial incentive, disease management evaluation and disease management programs;
 - (d) by persons handling Plan operations and claims, auditing, customer relations, legal services, executive management, actuarial and financial services, and marketing support for other benefits and benefit plans including but not limited to short term or long term disability, workers' compensation, AD&D and life insurance;
 - (e) by persons handling human resources, Plan operations and claims for employment purposes including but not limited to, FMLA leave, return to work clearance or limitations, substance abuse policy, and required physical examinations;
 - (f) by persons handling Plan operations and claims, customer relations, legal services, and executive management for response to inquiries including but not limited to complaints and grievances, an Individual's own information, requests from the U.S. Department of Health and Human Services or U.S. Department of Labor, a public health agency or any other government agency, a subpoena or due diligence request and due diligence;
 - (g) by persons handling Plan operations and claims, and marketing support for other miscellaneous reasons including but not limited to Internet Web site communications, marketing, fundraising, research, and on-site medical staff needs;
 - (h) by persons handling human resources, corporate medical staff, information systems, mailroom/fax delivery, research and product development, legal services, finance, accounting, and audit for Plan and other purposes; and
 - (i) as otherwise permitted by, and in compliance with, HIPAA; provided that nothing in this section 9(B)(2) shall permit or require the disclosure of PHI to the Plan Sponsor to the extent such disclosure is prohibited by HIPAA.
- (3) **Requirements of Plan Sponsor.** The Plan Sponsor shall:
- (a) not use or disclose PHI received from the Plan or any Health Insurance Issuer providing benefits under the Plan, other than for Plan Administration, or as otherwise required by law;
 - (b) ensure that any agent (including a subcontractor) to whom the Plan Sponsor provides PHI received from the Plan or any Health Insurance Issuer providing benefits thereunder, agrees to the same restrictions and conditions with respect to PHI as apply to the Plan Sponsor under this section 9(B)(3);
 - (c) not use or disclose PHI received from the Plan or any Health Insurance Issuer providing benefits under the Plan, for employment-related actions and decisions or in connection with any employee benefit plan or benefit provided by the Plan Sponsor other than the Plan or a health benefit provided under the Plan;

- (d) report to the Plan or Health Insurance Issuer providing benefits thereunder, as applicable, any use or disclosure of PHI received from the Plan or Health Insurance Issuer providing benefits under the Plan, that is inconsistent with the uses or disclosures required or permitted under this section 9(B)(3) and of which the Plan Sponsor becomes aware;
- (e) make the PHI of a Plan Participant, Spouse or Covered Dependent available to that Individual, upon the Individual's written request, in accordance with the requirements of the Privacy Rule;
- (f) incorporate amendments of PHI of a Plan Participant, Spouse or Covered Dependent as and to the extent required by the Privacy Rule;
- (g) make available to a Plan Participant, Spouse or Covered Dependent upon the Individual's written request, the information necessary to provide an accounting of the disclosures of PHI as and to the extent required by the Privacy Rule;
- (h) make the Plan Sponsor's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan or any Health Insurance Issuer providing benefits under the Plan, available to the Secretary of Health and Human Services for determinations as to the compliance of the Plan with HIPAA;
- (i) if feasible, return or destroy all PHI received from the Plan or any Health Insurance Issuer providing benefits under the Plan, that the Plan Sponsor maintains and retains no copies thereof; or, if such return or destruction is not feasible, limit further uses and disclosures of PHI to the purposes that make the destruction or return infeasible; and
- (j) ensure that the requirements set forth in paragraph (4)(b) and (c) below are satisfied with respect to PHI.

(4) Access to Protected Health Information.

- (a) **Minimum necessary.** Except as to a use or disclosure of information related to the treatment of an Individual, when using or disclosing PHI or when requesting PHI from another entity, the Plan or any individual acting on behalf of the Plan, must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure or request. Adherence to policies established by the Plan Sponsor with respect to the use, disclosure, or request of PHI shall be deemed to constitute such an effort unless the circumstances otherwise require.
- (b) **Access.** Access to and use of PHI shall be limited to individuals who perform functions relating to Plan Administration on behalf of or in connection with the Plan, as described in sections 9(B)(1) and (2) above, with respect to the performance of such functions. Other individuals or classes of individuals may be furnished with access to PHI with respect to functions that they are performing on behalf of or in connection with the Plan pursuant to a designation by the Plan Sponsor.
- (c) **Non-compliance.** If the Plan Sponsor becomes aware of any issues relating to non-compliance with the requirements of this section 9, the Plan Sponsor shall undertake an investigation to determine the extent, if any, of such non-compliance; the individuals, policies, or practices responsible for the non-compliance; and appropriate means for curing or mitigating the effects of non-compliance and preventing such non-compliance in the future. Any individual who is determined by the Plan Sponsor to be responsible for such non-compliance, shall be subject to disciplinary action, as determined by the Plan Sponsor, in its sole discretion, including but not limited to, one or more of the following:
 - Required additional training and education with respect to the use or disclosure of or access to PHI.
 - Reprimand.
 - Suspension of access to PHI or other diminution of duties or privileges.
 - Removal from position or termination.

(5) **Certification of Plan Sponsor.** The Plan or any Health Insurance Issuer providing benefits thereunder shall disclose PHI to the Plan Sponsor and to the individuals described in section 9(B)(2) above only if the Plan Sponsor has certified that the Plan has been amended to incorporate the provisions of this section 9(B)(5) and that it agrees with the restrictions and other rules set forth in section 9(B)(3).

(6) **Authorized Representative.** The Plan shall recognize an individual who is the authorized representative of a Plan Participant, Spouse or Covered Dependent as if the individual were the Plan Participant, Spouse or Covered Dependent himself or herself,

provided that the Individual has designated the authorized representative in accordance with the procedures established by the Plan Sponsor.

- (7) **Action by the Plan Sponsor.** The Plan Sponsor may act as prescribed in this section 9 or may delegate, in writing and in its sole discretion, any and all of its functions under this section 9 to the Privacy Officer or other officer or employee, or to a group of officers or employees of the Plan Sponsor. The Plan Sponsor or such delegate shall have the authority to establish rules and prescribe forms and procedures for performing its functions hereunder.
- (8) **Action by member.** For additional information or to contact the Plan Sponsor, You may call GuideStone's toll free number at **1-888-984-8433** or contact them at *HIPAAPrivacyContact@GuideStone.org*.

11. Definitions

A. Words with special meanings

This section tells You the special meanings of many words and phrases used in this booklet. Sometimes there is a more detailed discussion of a particular word or phrase in another section in this booklet. If that happens, the definition should tell You what other section discusses that word or phrase.

Sometimes the definition of a word or phrase has another word or phrase in it that also has a special meaning. Look in **Definitions** for the special meanings. Here's an example: The definition of Accident has the word Injury in it. If You look at the definition of Injury, You will see its special meaning.

Accident. An unforeseen and unplanned event that causes an Injury.

Ambulance Service. A Facility Other Provider licensed by the state which, for compensation from its patients, provides local transportation by means of a specially designed and equipped vehicle used only for transporting the Sick and Injured.

Ambulatory Surgical Facility. A Facility Other Provider, with an organized staff of Physicians, which is licensed as required by the state, has the required certificate of need, and which, for compensation from its patients:

- Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
- Provides treatment by or under the supervision of Physicians and nursing Services whenever the patient is in the facility;
- Does not provide Inpatient accommodations; and
- Is not, other than incidentally, a facility used as an office or clinic for the private practice of a Professional Provider.

Anesthesia. The administration of a regional or rectal anesthetic or the administration of a drug or other anesthetic agent by injection or inhalation, the purpose and effect of which is to obtain muscular relaxation, loss of sensation or loss of consciousness.

Average Wholesale Price. The published cost of a drug product to the wholesaler.

Benefit Period. The specified period of time during which charges for Covered Services must be Incurred in order to be eligible for payment by the Plan. A charge shall be considered Incurred on the date a Covered Person receives the Service for which the charge is made. A Benefit Period is a calendar year or a Plan year as designated by your Employer.

Blues On CallSM (Health Education And Support Program). A program administered by the Plan's designated agent through which a Covered Person receives health education and support Services, including assistance in the self-management of certain health conditions.

Certified Registered Nurse. A Certified Registered Nurse anesthetist, Certified Registered Nurse practitioner, certified enterostomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse, or certified clinical nurse specialist, certified by the State Board of Nursing or a national nursing organization recognized by the State Board of Nursing. This excludes any registered professional nurses employed by a health care facility, as defined in the Health Care Facilities Act, or by an anesthesiology group.

Child. Your unmarried Child, including:

- Your natural (biological) Child.
- Your legally adopted Child or a Child placed in your home for adoption.
- A Child living with You and dependent on You for support and maintenance. This may be:
 - Your stepchild.
 - Your foster Child.
 - Your grandchild.
 - A Child for whom You must provide health care by court order.
 - A Child for whom You are legal guardian or managing conservator.

Chiropractor. A licensed Chiropractor performing Services within the scope of such licensure.

Claim. A request for the payment or reimbursement of the charges or costs associated with a Covered Service.

Claims Administrator. For medical coverage, Highmark Blue Cross Blue Shield.

Clinical Laboratory. A medical laboratory licensed where required, performing within the scope of such licensure, and is not affiliated or associated with a Hospital or Physician.

Coinsurance. The percentage of eligible expenses You and the Plan share. The exact Coinsurance depends on the Plan provisions. Your Coinsurance will be the Covered Services which must be paid by You. See the **Benefit summary**.

Copayment. The amount You pay for Covered Services or for drugs You purchase through the **Outpatient Prescription Drug program**.

Covered Class. A class of employees or retirees who are eligible for Plan coverage. These are the Covered Classes under this Plan:

- Active full-time employees earning wages from a church or ministry organization working at least 20 hours per week.
- Retired employees who meet the Employer's criteria.

Covered Dependent. An Eligible Dependent who becomes covered under the Plan. See **When You become covered**.

Covered Member. An Eligible Employee or Eligible Retiree who becomes covered under the Plan. See **When You become covered**.

Covered Percent/Covered Percentage. The percentage of Eligible Expenses that the Plan pays. The Covered Percent is not the same for all Eligible Expenses. See the **Benefit summary**.

Covered Person. An Eligible Employee, Eligible Retiree or Eligible Dependent who becomes covered under the Plan. See **When You become covered**.

Covered Service. A Service for which benefits will be provided when rendered by a Provider. See the **Benefit summary**.

Custodial Care. Care provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting his or her activities of daily living and which is not primarily provided for its therapeutic value in the treatment of a Sickness, disease, bodily Injury, or condition. Multiple non-skilled nursing Services/non-skilled rehabilitation Services in the aggregate do not constitute Skilled Nursing Services/Skilled Rehabilitation Services. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparing special diets and supervising the administration of medications not requiring Skilled Nursing Services/Skilled Rehabilitation Services provided by trained and licensed medical personnel.

Deductible. A specified dollar amount of liability for Covered Services that must be Incurred by a Covered Person before the Plan will assume any liability for all or part of the remaining Covered Services.

Dependents Coverage. Plan coverage for your Eligible Dependents. See **Who is eligible**.

Developmental Disability. A dependent Child's substantial handicap which:

- Results from mental retardation, cerebral palsy, epilepsy, or other neurological disorder; and
- Is diagnosed by a Physician as a permanent or long-term continuing condition.

Diagnostic Service. Procedures ordered by a Professional Provider because of specific symptoms to determine a definite condition or disease.

Durable Medical Equipment. Items which can withstand repeated use; are primarily and customarily used to serve a productive medical purpose; are generally not useful to a person in the absence of Sickness, Injury or disease; are appropriate for use in the home and do not serve as comfort or convenience items.

Eligible Dependent. Your Eligible Dependents are:

- Your Spouse who is eligible for Medicare.
- Your unmarried Child who is disabled, dependent on You for support and maintenance, and is eligible for Medicare.

Eligible Employee. You are an Eligible Employee if:

- You are age 65 or older, eligible for Medicare, and an active full-time employee (as defined by your Employer) earning wages from an Employer that offers Plan coverage to one or more Covered Classes of employees; and
- You work at least the number of hours that your Employer requires to be considered a full-time employee, but not less than 20 hours a week; and
- You have completed your Employer's waiting period, if any; and
- You are in a Covered Class of employees to whom your Employer offers Plan coverage; or
- You are disabled and eligible for Medicare

Eligible Retiree. You are an Eligible Retiree if:

- You are a retiree who was working full-time (as defined by your Employer) when You retired from service; and
- You were covered under that Employer's health plan when You retired; and
- That Employer now offers Plan coverage to one or more Covered Classes of retirees; and
- You are in a Covered Class of retirees to whom that Employer offers Plan coverage; and
- You are age 65 or older and eligible for Medicare.

Emergency Accident Services. The initial treatment of bodily Injuries resulting from an Accident.

Emergency Medical Services. The initial treatment of a sudden onset of a medical condition with acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in:

- Permanently placing the patient's health in jeopardy; or
- Causing other serious medical consequences; or
- Causing serious impairment to bodily functions; or
- Causing serious and permanent dysfunction of any bodily organ or part.

Emergency transportation and related emergency Services provided by a licensed Ambulance Service shall constitute an Emergency Care Service.

Emergency Room Services. Treatment or Service provided through the emergency room of a Hospital. This includes facility charges, emergency room Physician and other Provider charges associated with treatment or Services.

Employee Coverage. Plan coverage for Eligible Employees and Eligible Retirees. See **Who is eligible.**

Employer. A church or ministry organization that is eligible to utilize products and Services made available by or through GuideStone Financial Resources of the Southern Baptist Convention and offers Plan coverage to its Eligible Employees and Eligible Retirees.

Facility Other Provider. An entity other than a Hospital which is licensed, where required, to render Covered Services. Facility Other Providers include:

- Alcohol Abuse Treatment Facility.
- Ambulance Service.
- Ambulatory Surgical Facility.
- Birthing Facility.
- Day/Night Psychiatric Facility.
- Drug Abuse Treatment Facility.
- Freestanding Dialysis Facility.
- Freestanding Nuclear Magnetic Resonance Facility.
- Magnetic Resonance Imaging Facility.
- Home Health Care Agency.
- Home Infusion Therapy Provider.
- Hospice.
- Outpatient Alcohol Abuse Treatment Facility.
- Outpatient Drug Abuse Treatment Facility.
- Outpatient Physical Rehabilitation Facility.
- Outpatient Psychiatric Facility.
- Psychiatric Hospital.
- Rehabilitation Hospital.
- Skilled Nursing Facility.

Facility Provider. A Hospital or Facility Other Provider, licensed where required, to render Covered Services.

Family Coverage. Coverage for the member and one or more of the member's dependents.

Freestanding Dialysis Facility. A Facility Other Provider licensed and approved by the appropriate governmental agency which, for compensation from its patients, is primarily engaged in providing dialysis treatment, maintenance or training to patients on an Outpatient or home-care basis.

Freestanding Nuclear Magnetic Resonance Facility/ Magnetic Resonance Imaging Facility. A Facility Other Provider which, for compensation from its patients, is primarily engaged in providing, through an organized professional staff, nuclear magnetic resonance/magnetic resonance imaging scanning. These facilities do not include Inpatient beds, medical or health-related Services.

Full-Time Student. Your dependent Child attending a school that has a regular teaching staff, curriculum and student body and who:

- Attends school on a full-time basis, as determined by the school's criteria; and
- Is dependent on You for principal support.

Generally Accepted. Treatment or Service that:

- Has been accepted as the standard of practice according to the prevailing opinion among experts as shown by (or in) articles published in authoritative, peer-reviewed medical and scientific literature; and
- Is in general use in the medical or dental community; and
- Is not under continued scientific testing or research as a therapy for the particular Injury or Sickness which is the subject of a Claim.

GuideStone. GuideStone Financial Resources of the Southern Baptist Convention.

Health Care Extender. An allied health practitioner who is delivering medical Services under the direction and supervision of a Physician. Direction and supervision means the Physician co-signs any progress notes written by the Health Care Extender or there is a legal agreement that places overall responsibility for the Health Care Extender's Services on the Physician.

Home Health Care Agency. A Facility Other Provider or Hospital program for home health care, licensed by the state and certified by Medicare which, for compensation from its patients:

- Provides skilled nursing and other Services on a visiting basis in the patient's home, and
- Is responsible for supervising the delivery of such Services under a plan prescribed by the attending Physician.

Home Infusion Therapy. The administration of Medically Necessary and Appropriate fluid or medication via a central or peripheral vein to patients at their place of residence.

Home Infusion Therapy Providers. A Facility Other Provider which has been accredited by the Joint Commission on Accreditation of Healthcare Organizations and Medicare, if appropriate, and is organized to provide infusion therapy in the home to patients at their place of residence.

Hospice. A Facility Other Provider, licensed by the state, which, for compensation from its patients, is primarily engaged in providing palliative care to terminally ill individuals.

Hospice Care. A program which provides an integrated set of Services and supplies designed to provide palliative and supportive care to terminally ill patients and their families. Hospice Services are centrally coordinated through an interdisciplinary team directed by a Physician.

Hospital. A duly licensed Provider that is a general or special Hospital which has been approved by Medicare, the Joint Commission on Accreditation of Healthcare Organizations, or the American Osteopathic Hospital Association which, for compensation from its patients:

- Is primarily engaged in providing Inpatient diagnostic and therapeutic Services for the diagnosis, treatment and care of Injured and Sick persons by or under the supervision of Physicians, and
- Provides 24-hour nursing Services by or under the supervision of Registered Nurses.

Immediate Family. Your Spouse, Child, stepchild, parent, brother, sister, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, son-in-law, grandchild, grandparent, step-parent, step-brother or step-sister.

Incurred. A charge is considered Incurred on the date You receive the Service or supply for which the charge is made.

Individual Treatment Plan. A plan that has specific goals and objectives for the patient that is appropriate to both the patient and the program's treatment method.

Infusion Therapy. The administration of Medically Necessary and Appropriate fluid or medication via a central or peripheral vein.

Injury. A trauma to the body caused by an outside source.

Inpatient. A person who is a registered bed patient in a Facility Provider and for whom a room and board charge is made.

Inpatient Stay Charges. Covered Services by a Hospital for room, board, and general nursing Services.

Inpatient Treatment Plan. A plan that has specific goals and objectives for the patient that is appropriate to both the patient and the program's treatment method.

Licensed Practical Nurse (LPN). A nurse who has graduated from a formal practical nursing education program and who is licensed by the appropriate state authority.

Maximum. The greatest amount payable by the Plan for Covered Services and Supplies. This could be expressed in dollars, number of days, or number of Services for a specified period of time.

- **Program Maximum** - the greatest amount payable by the Plan for Covered Services.
- **Benefit Maximum** - the greatest amount payable by the Plan for a specific Covered Service.

Medicaid. A federal program providing grants to states for medical assistance programs (Title XIX of the United States Social Security Act).

Medical Care. Professional Services rendered by a Professional Provider or Professional Other Provider for the treatment of a Sickness or Injury.

Medical Identification Card (Medical ID Card). The currently effective card issued to You by the Claims Administrator.

Medicare. The programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Medicare Eligible Expenses. Expenses covered by Medicare to the extent recognized as reasonable and medically necessary by Medicare.

Mental Illness. An emotional or mental disorder characterized by a neurosis, psychoneurosis, psychopathy, or psychosis without demonstrable organic origin.

Non-Participating Pharmacy. A licensed and registered pharmacy, which is not a Participating Pharmacy.

Nurse-Midwife. A licensed Nurse-Midwife. Where there is no licensure law, the Nurse-Midwife must be certified by the appropriate professional body.

Optometrist. A licensed Optometrist performing Services within the scope of such licensure.

Outpatient. A patient who receives Services while not confined as an Inpatient.

Outpatient Physical Rehabilitation Facility. A Facility Other Provider which, for compensation from its patients, is primarily engaged in providing Services for physical rehabilitative therapy on an Outpatient basis.

Participating Pharmacy. A licensed and registered pharmacy which has a pharmacy service agreement with Medco Health .

Pharmacy Identification Card (Pharmacy ID Card). The currently effective card issued to You by Medco Health.

Physical Handicap. A dependent Child's substantial physical or mental impairment which:

- Results from Injury, accident, congenital defect, or Sickness; and
- Is diagnosed by a Physician as a permanent or long-term dysfunction or malformation of the body.

Physical Therapist. A licensed Physical Therapist. Where there is no licensure law, the Physical Therapist must be certified by the appropriate professional body.

Physician. A person who is a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.), licensed and legally entitled to practice medicine in all of its branches, perform Surgery and dispense drugs.

Physician Visit. A face-to-face meeting between a Physician or Physician's staff and a patient for the purpose of Medical Care or Services.

Plan. The Group Care Basic Plan. This booklet describes the Plan.

Podiatrist. A licensed Podiatrist performing Services within the scope of such licensure.

Prescriptions Drugs. Any drugs or medications ordered by a Professional Provider by means of a valid prescription order, bearing the federal legend: Caution: Federal law prohibits dispensing without a prescription, or legend drugs under applicable state law and

dispensed by a licensed pharmacist. Also included are prescribed injectable insulin and disposable insulin syringes, as well as compounded medications, consisting of the mixture of at least two ingredients other than water, one of which must be a legend drug.

Professional Other Provider. A person or entity other than a Facility Provider or Professional Provider who is licensed, where required, to render Covered Services as prescribed by a Professional Provider within the scope of such licensure or under the supervision of a Professional Provider within the scope of such licensure. Professional Other Providers include:

- Occupational Therapist.
- Respiratory Therapist.

Professional Provider. A person or practitioner licensed where required and performing Services within the scope of such licensure. The Professional Providers are:

- Audiologist.
- Physical Therapist.
- Certified Registered Nurse.
- Physician.
- Chiropractor.
- Podiatrist.
- Clinical Laboratory.
- Psychologist, Licensed Social Worker or Master Level Therapist.
- Dentist.
- Speech-Language Pathologist.
- Nurse-Midwife.
- Optometrist.

Protected Health Information (PHI). PHI is any information about your health that reveals (or can be used as a reasonable basis to reveal) your identity. This information can relate to your past, present or future physical or mental health conditions; information about the health care Services provided to You; or payment for health care Services provided to You.

Provider. A Facility Provider, Professional Provider, Professional Other Provider licensed where required and performing within the scope of such licensure.

Psychiatric Hospital. A Facility Other Provider approved by the Joint Commission on Accreditation of Healthcare Organizations or by the American Osteopathic Hospital Association which, for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic Services for the Inpatient treatment of Mental Illness. Such Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing Services are provided under the supervision of a Registered Nurse.

Psychologist. A licensed Psychologist. When there is no licensure law, the Psychologist must be certified by the appropriate professional body.

Registered Nurse (RN). A nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program) and is licensed by the appropriate state authority.

Rehabilitation Hospital. A Facility Other Provider approved by the Joint Commission on Accreditation of Healthcare Organizations or by the Commission on Accreditation of Rehabilitation Facilities or certified by Medicare which, for compensation from its patients, is primarily engaged in providing Skilled Rehabilitation Services on an Inpatient basis. Skilled Rehabilitation Services consist of the combined use of medical, social, educational, and vocational Services to enable patients disabled by Sickness or Injury to achieve the

highest possible level of functional ability. Skilled Rehabilitation Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing Services are provided under the supervision of a Registered Nurse.

Service(s). Treatment rendered by a Facility Provider, Professional Provider or Professional Other Provider to a Covered Person for a Covered Service.

Sickness. Any disorder or disease of the body or mind. This includes pregnancy, miscarriage or childbirth.

Skilled Nursing Facility. A Facility Other Provider approved by the state and certified by Medicare, which, for compensation from its patients, is primarily engaged in providing Skilled Nursing Services on an Inpatient basis to patients requiring 24-hour Skilled Nursing Services but not requiring confinement in an acute care general Hospital. Such care is rendered by or under the supervision of Physicians. A Skilled Nursing Facility is not, other than incidentally, a place that provides:

- minimal care, custodial care, ambulatory care, or part-time care Services, or
- care or treatment of Mental Illness, Alcohol Abuse, Drug Abuse or pulmonary tuberculosis.

Skilled Nursing Services/Skilled Rehabilitation Services. Services which have been ordered by and under the direction of a Physician and are provided either directly by or under the supervision of a medical professional, e.g., Registered Nurse, Physical Therapist, Licensed Practical Nurse, Occupational Therapist, Speech Pathologist or Audiologist with the treatment described and documented in the patient's medical records. Unless otherwise determined in the sole discretion of the Plan, Skilled Nursing Services/Skilled Rehabilitation Services shall be subject to the following:

- The Skilled Nursing Services/Skilled Rehabilitation Services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge, and skills of a qualified licensed medical professional and must be such that the care could not be performed by a non-medical individual instructed to deliver such Services.
- The Skilled Rehabilitation Services must be provided with the expectation that the patient has restorative potential and the condition will improve materially in a reasonable and generally predictable period of time. Once a maintenance level has been established or no further progress is attained, the Services are no longer classified as skilled rehabilitation and will be considered to be Custodial Care.

The mere fact that a Physician has ordered or prescribed a therapeutic regimen does not, in itself, determine whether a Service is a Skilled Nursing Service or a Skilled Rehabilitation Service.

Spouse. A person of the opposite sex to whom You are married at the relevant time by a religious or civil ceremony effective under the laws of the state in which the marriage was contracted.

Supplier. An individual or entity that is in the business of leasing and selling Durable Medical Equipment and supplies. Suppliers include, but are not limited to, the following: Durable Medical Equipment Suppliers, vendors/fitters, prosthetic Suppliers, pharmacy/Durable Medical Equipment Suppliers.

Surgery.

- The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other procedures;
- The correction of fractures and dislocations; and
- Usual and related pre-operative and post-operative care.

Therapy Service. The following Services ordered by a Professional Provider to promote the recovery of the patient.

- **Radiation Therapy** - the treatment of disease by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes.
- **Chemotherapy** - the treatment of malignant disease by chemical or biological antineoplastic agents.

- **Dialysis Treatments** - the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body through hemodialysis or peritoneal dialysis. Dialysis treatment includes home dialysis.
- **Physical Therapy** - the treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, Injury, or the loss of a body part or parts.
- **Respiration Therapy** - the introduction of dry or moist gases into the lungs for treatment purposes.
- **Occupational Therapy** - the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.
- **Speech Therapy** - the treatment for the correction of a speech impairment resulting from disease, Surgery, Injury, or previous therapeutic processes.
- **Infusion Therapy** - treatment by means of Infusion Therapy when performed by, furnished by and billed by a Facility Provider.
- **Cardiac Rehabilitation** - the physiological and psychological rehabilitation of patients with cardiac conditions through regulated exercise programs.

Visit(s). A patient's physical presence at a location designated by the Hospital, Facility Other Provider, Professional Provider or Professional Other Provider for the purpose of providing Covered Services.

You. An Eligible Employee or Eligible Retiree. Sometimes "You" means both the member and his or her Covered Dependents. The booklet will tell You when this is the case.



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