GuideStone®

Group Plans Administration Manual

Medical | Dental | Life | Accident | Disability

WE'RE HERE FOR YOU!

Thank you for choosing GuideStone Financial Resources® as your employee benefits provider. We're committed to bringing you value while supporting ***your values***.

This *Group Plans Administration Manual* provides detailed instructions to guide you in the day-to-day management of your plans. Because specific plan benefits can vary from organization to organization, we recommend that each employer also maintains a set of detailed internal procedures to supplement the procedures outlined here.

While this manual is designed to serve as a general guide for administering your plan, remember there will likely be situations and circumstances that are not specifically addressed. In these instances, it is best to consult your GuideStone Group Plans administrator to bring ***clarity and direction***.

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SECTION 1:
GUIDESTONE CONTACT INFORMATION

With GuideStone®, your team of experts is just one phone call or email away. They have specialized knowledge of your ministry and stand ready to respond quickly.

GUIDESTONE GROUP PLANS CONTACTS:

Plans with 2–24 participants
(214) 720-2640
Insurance.CSS1@GuideStone.org

Plans with 25–49 participants
(214) 720-2645
InsuranceCSM@GuideStone.org

Plans with 50 or more participants
(214) 720-2650
Insurance.CSL@GuideStone.org

SECTION 2:
VENDOR CONTACT INFORMATION

We work with multiple providers so that you can offer the best quality coverage to your employees. When you need fast answers to questions about an employee's claims or your coverage details, it is best to contact the provider directly. Remember, if you are requesting claim information on behalf of an employee, GuideStone must have an *Authorization for Disclosure of Protected Health Information (PHI)* form on file before we can discuss the employee's claim.

Refer to the list below to find the information you need.

GUIDESTONE VENDORS:

Highmark BCBS (medical coverage)
Benefits questions: 1-866-472-0924
Hospital or facility admissions: 1-800-452-8507
HighmarkBCBS.com
Claim form
ID card, group number and mobile access information

Express Scripts (prescription drug coverage)
Member Services: 1-800-555-3432
Express-Scripts.com
Claim form
ID card, group number and mobile access information

Teladoc (telemedicine provider)
1-800-835-2362
Teladoc.com/GuideStone

Cigna (dental coverage)
Customer Service: 1-800-CIGNA24 (1-800-244-6224)
MyCigna.com
ID card, group number and mobile access information

Cigna Global (international medical coverage)
Customer Service: 1-800-441-2668
(Outside the USA, via ATT + Access) (302) 797-3100
Cigna Global website
Claim form

Unum (life, accident and disability coverage)
Claim submission process questions:
Contact your Group Plans administrator
Questions about claim service: 1-800-858-6843
Life claim service: 1-800-445-0402

GUIDESTONE EXPERIENCED VENDORS:

Employee Benefits Corporation (Health Reimbursement Arrangement administrator)
P.O. Box 44347
Madison, Wisconsin 53744-4347
Customer Service: 1-800-346-2126 or (608) 831-8445, Monday–Friday, 8 a.m.–5 p.m. CST
Fax: (608) 831-4790
Secure upload: *ebcflex.com*

ACSIA Partners (long-term care plans)
Customer Service: 1-877-LTC-4478 (1-877-582-4478)
ltcGuideStone.com

Davis Vision (eye care plans)
Customer Service: 1-800-999-5431
davisvision.com

MinistryWorks (payroll and reporting service)
Customer Service: 1-866-215-5540
MinistryWorks.com

SECTION 3:
PARTICIPATION GUIDELINES

Regular Groups (groups with five or more employees)

EMPLOYER GUIDELINES

- The employer must be eligible to participate in a church plan.
- The employer must pay at least 50% of the cost of any contributory employee medical coverage.
- Employers who require employees to pay a portion of the coverage costs must have 75% of all eligible employees participating in their plan.
- Medical or dental benefits offered to employees must be offered to dependents 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 toward dependent coverage.
- Employers must have at least five employees participating in their disability coverage.
- The number of employee classifications for these groups may depend on the employer size and products offered. The employer's requirements for each class should be clearly outlined by the employer and applied without discrimination to each employee within a given class.
    - Employers should note that a reduction in hours or a change in job role may affect an employee's classification, thereby affecting his or her eligibility for products.

EMPLOYEE ELIGIBILITY GUIDELINES

- The employee must be classified as active and full time (as defined by the employer), earning wages from an employer that offers plan coverage to one or more covered classes of employees.
- The employee must work the number of hours required by the employer to be considered a full-time employee. That number must be at least 20 hours per week.
- The employee must complete the employer's waiting period (if any) before enrolling in coverage.
- The employee is a part of a covered class of employees to whom the employer offers plan coverage.
- The employee must be a U.S. citizen or possess a valid work permit as verified by the employer.

FAILURE TO MAINTAIN MANDATORY GROUP SIZE PARTICIPATION REQUIREMENTS

GuideStone understands that situations, such as unexpected employee turnover, may cause a group to fall below the minimum required group size. You will not automatically be dropped from group coverage if this occurs.

PROBATIONARY PERIOD GUIDELINES

Employers who fall below the minimum participation requirements for three consecutive months will retain coverage and be allotted a nine-month probationary period to bring their group size back to the appropriate participation levels.

- The total 12-month process period will be calculated beginning the first month the employer falls below the minimum participation requirement.
- Employers are required to maintain their coverage at pre-probationary levels.
- No upgrades to existing products or new products may be added until required participation levels have been met and sustained for a minimum of six months.
- If the employer resumes participation levels, coverage will continue uninterrupted.
- If the employer resumes participation levels, but subsequently falls below minimum requirements, the 12-month probation period restarts from the date that participation levels dropped below requirements.
- If the participation requirement is not met after the 12-month period, coverage will automatically terminate for all employees participating in each of the affected products.

If an employer's coverage is terminated due to their inability to maintain the required number of participants to qualify for group coverage, the remaining individuals may be transferred to Personal Plans coverage. Employees may have the option of transferring their term life, accident, medical, dental and long- and short-term disability coverage into similar coverage offered by GuideStone Personal Plans. Please note that Personal Plans medical coverage is only available to employees who work for an employer with fewer than 100 employees.

An employer will have the opportunity to transfer coverage back to Group Plans by increasing their required number of participants and maintaining that number for a specified amount of time. The time period may vary depending on the affected products and the size of your group. Your Group Plans administrator can provide details.

Micro Groups (groups with two to four employees)

If your church, ministry or nonprofit has two to four full-time enrolling employees, you're eligible for GuideStone Group Health, Dental, Term Life and Accident plans for Micro Groups.

EMPLOYER GUIDELINES

- The employer must be eligible to participate in a church plan.
- Micro Groups may have one employee classification.
- The effective date for new Micro Groups is the first day of the month the employer chooses to begin offering coverage.
- The renewal date for all coverage is January 1, regardless of initial enrollment date.
- Micro Groups may choose one core medical plan.
- Life and accident products are available to SBC and non-SBC groups.

EMPLOYEE ELIGIBILITY GUIDELINES

Employees who meet the following criteria may enroll in a GuideStone Micro Groups plan:

- The employee must be classified as active and full time (as defined by the employer), earning wages from an employer that offers plan coverage to one or more covered classes of employees.
- The employee must work the number of hours required by the employer to be considered a full-time employee. That number must be at least 20 hours per week.
- The employee must complete the employer's waiting period (if any) before enrolling in coverage.
- The employee must be a part of the covered class of employees to whom the employer offers plan coverage.
- The employee must be a U.S. citizen or possess a valid work permit as verified by the employer.

PRODUCT GUIDELINES

Medical

- Micro Groups may choose one core medical plan.
- A minimum of two covered employees is required.
- Employers must contribute 100% of the cost of medical coverage for employees.
- 100% of eligible employees must enroll in the plan. Employees that waive coverage because they are (1) Medicare-primary or (2) covered on a spouse's plan are not counted toward the number of eligible employees.
- All active employees working the required number of hours set by the employer (but not less than 20 hours) are considered eligible employees.

Dental coverage

- A minimum of two covered employees is required at initial enrollment.
- Employers are not required to make a minimum contribution toward the cost of coverage.

Term life

- A minimum of two covered employees is required for term life and AD&D coverage.
- Employers must contribute 100% of the cost for employee coverage.
- Dependent coverage may be paid by the employee or the employer.
- Covered employees must also be enrolled in medical coverage at initial enrollment.
- Standard age rates apply for Employee, Spouse and Child Term Life coverage.
- Employee and dependent life coverage will only be issued on a guarantee basis in one of these two increments:
    1. $20,000 Employee Term Life Plan
       $10,000 Spouse Term Life Plan
       $10,000 Child Term Life Plan
    2. $10,000 Employee Term Life Plan
       $5,000 Spouse Term Life Plan
       $10,000 Child Term Life Plan
- Optional Term Life is available. Applicants are required to submit an *Evidence of Good Health Application* to obtain this coverage.

Accident

- Employers must pay 100% of the cost for Employee AD&D coverage when it is offered.
- AD&D coverage requires 100% employee participation.
- Supplemental AD&D coverage may be offered at either the employer or employee's expense.

FAILURE TO MAINTAIN MANDATORY GROUP SIZE PARTICIPATION REQUIREMENTS

GuideStone understands that situations, such as unexpected employee turnover, may cause a group to fall below the minimum required group size. You will not automatically be dropped from group coverage if this occurs. You will have the opportunity to increase your employee participation to at least two participants. The **Probationary Period Guidelines** are detailed under the **"Regular Groups"** heading of this section.

SECTION 4:
BENEFIT ELIGIBILITY

EFFECTIVE DATES FOR COVERAGE

The effective date of coverage for new hires is the employee's official hire date (typically the employee's first day of work) unless the employer imposes a waiting period for coverage.

- If there is a waiting period for coverage, the effective date will be calculated based on the guidelines provided by the employer.
- The waiting period imposed by the employer must be compliant with the current guidelines under the Affordable Care Act (ACA), which prohibits waiting periods longer than 90 calendar days for medical coverage.

Employers should use the online Employer Access Program (EAP) or submit a *Group Plans Enrollment Form* to enroll employees during the employee's first 31 days of eligibility.

Employers may use the *Group Plans New Employee Checklist* as a guide when completing new enrollments.

CONTRIBUTORY VS. NON-CONTRIBUTORY COVERAGE

Contributory coverage is coverage for which an employee contributes toward the cost of coverage for himself/herself and/or eligible dependents.

- Dental and supplemental accident coverage can be added anytime outside of the 31-day window of initial eligibility without underwriting.
- Life and disability coverage applicants are required to submit an *Evidence of Good Health Application* if adding coverage outside of the 31-day window of initial eligibility.
- Employees may also add medical coverage outside the 31-day window of initial eligibility if there is a special enrollment event or if they do so during the employer's annual re-enrollment period.
- Contributory coverage can be dropped at any time; however, the ACA's rescission rules prohibit retroactive termination of medical coverage unless it is being canceled due to non-payment, fraud or an intentional misrepresentation of material fact.

Learn more about rescission rules on our Health Care Reform web page and in the "Health Care Reform" section of this online manual, which begins on page 32.

Non-contributory coverage is coverage for which the employer contributes the entire cost of coverage for the employee and/or the employee's dependents.

- Employers offering non-contributory coverage must enroll all employees and their dependents who meet the eligibility requirements.
- Medical and dental coverage may be rejected only with a signed *Waiver of Medical and/or Dental Coverage Group Plans* form.

- Life and accident products may not be waived if coverage is non-contributory.
- Non-contributory coverage must be added within 31 days of the employee's initial date of eligibility. Coverage will become effective on the date of initial eligibility.

DEPENDENT ELIGIBILITY

Eligible dependents include:

- The spouse of an employee
- Children up to age 26

  The definition of "your child" includes:

  - Your and/or your spouse's biological child
  - Your and/or your spouse's legally adopted child or a child placed in your home for adoption
  - Your and/or your spouse's stepchild or foster child
  - Your and/or your spouse's grandchild who is dependent on you for support and maintenance
  - A child for whom you or your spouse must provide health care by court order or order of state agency authorized to issue National Medical Support Notices under federal law
- Incapacitated children of any age, who meet the following requirements:
  - You and/or your spouse must be the legal guardian or managing conservator for the incapacitated child.
  - The child must be developmentally disabled or physically handicapped and incapable of earning a living.
  - The child must be incapacitated when his or her plan coverage would have ended because they turn 26.
  - You must provide GuideStone with proof of the child's disability or physical handicap at least 31 days before your child's regular coverage is scheduled to end. This is normally during the month before their 26th birthday.
  - You must provide additional proof whenever asked to show that your child is still incapacitated.

SPECIAL ENROLLMENT EVENTS

The Health Insurance Portability and Accountability Act (HIPAA) requires that active employees in a group health plan be given the opportunity to enroll themselves and/or eligible dependents in health care coverage outside of the annual enrollment period after experiencing certain life events.

There are three categories of special enrollment events:

1. Dependent acquisition
2. Loss of other coverage
3. Employee or dependent becomes eligible for premium assistance under Medicaid or CHIP

AN EMPLOYEE HAS 60 DAYS FROM THE DATE OF THE SPECIAL ENROLLMENT EVENT TO ADD COVERAGE.

The coverage effective date for an enrollment or plan change due to the acquisition of a dependent is the date that the special enrollment event occurred (e.g., adoption date, marriage date, etc.). The effective date for a special enrollment event due to loss of coverage is the first day following the loss of other coverage.

If an employee is adding coverage due to becoming eligible for Medicaid or CHIP premium assistance that helps pay for a group health plan, the coverage effective date will be the date that GuideStone receives the appropriate documentation.

LIST OF SPECIAL ENROLLMENT EVENTS

Dependent additions

- Marriage
- Birth
- Adoption
- Placement in the home for adoption
- Becoming legal guardian

Loss of other coverage

- Employer contributions for employee or dependent coverage are terminated
- COBRA eligibility expires
- Coverage terminates due to loss of eligibility
- Employee death
- Divorce
- Termination of employment
- Layoff
- Retirement (if the employer does not offer health coverage to retirees)
- Legal separation (must provide a court order to GuideStone Legal Services)
- Reduction in work hours
- Employee reclassification leading to the loss of eligibility for coverage
- Dependent eligibility ends due to age
- Employee or dependent loss of eligibility for Medicaid or CHIP
- Employee no longer resides, lives or works in the HMO service area
- Medicaid or CHIPRA eligibility ended
- If local laws require an international employee to purchase benefits in the country in which they are serving; therefore, the employee waives coverage with the Group Plans employer. The employee will be eligible to add coverage through GuideStone Group Plans upon losing that foreign coverage when they return stateside.
- Termination of a plan on the health care exchange

The following do not constitute loss of eligibility of other coverage:

- Failure to pay premiums on a timely basis
- Termination for cause
- Making a fraudulent claim
- Intentional misrepresentation
- Voluntarily dropping health care exchange coverage to enroll in GuideStone coverage
- Significant increase in the costs of non-GuideStone coverage

Employers should use the online EAP or the *Special Enrollment Form for Medical Coverage* to enroll in coverage after experiencing a HIPAA special enrollment event.

COVERAGE FOR SURVIVING DEPENDENTS

In the event of an employee's death, GuideStone allows the surviving spouse and his or her eligible dependents to continue the Spouse Term Life, Spouse Optional Term Life, Child Term Life, and medical and dental coverage that were in place prior to the employee's death. A surviving spouse has 60 days following the employee's death to elect to continue coverage.

A surviving spouse has the option to continue coverage for:

- Himself/herself only
- Dependent children only
- Both himself/herself and any dependent children

Important notes about coverage for surviving spouses:

- The surviving spouse and children do not have HIPAA special enrollment rights.
- The surviving spouse and children may change plans during annual re-enrollment.
- The addition of a dependent child is allowed if the surviving spouse was pregnant at the time of the employee's death. In this case, the child must be added within 60 days of his or her birth date.
- Additional dependents such as a new spouse or a new child cannot be added to surviving spouse coverage.
- The surviving spouse and/or child will remain on the employer's bill. It is the employer's responsibility to make payment arrangements with the surviving spouse.

SECTION 5:
OPTIONS FOR CONTINUATION OF COVERAGE

Your ministry may be used to offering COBRA to your employees; however, GuideStone offers "church plans" as defined in section 414(e) of the *Internal Revenue Code* (the Code). Church plans are not subject to COBRA because of an exemption found at Code section 4980B(d)(3). Although not subject to COBRA, GuideStone understands the need for continuation after certain losses of coverage. Therefore, GuideStone offers the following coverage in its place:

- Medical Continuation Provision (MCP) for participants who wish to retain GuideStone Group Plans medical coverage after their coverage ends
- Dental Continuation Provision (DCP) for participants who wish to retain GuideStone Group Plans dental coverage after their coverage ends

Both continuation plans are optional and may be offered at the employer's discretion at the time the employer enrolls in GuideStone coverage or at a later date with a written request signed by the employer's decision maker. The cost of coverage will remain the same while on continuation, unless the employee changes their coverage options.

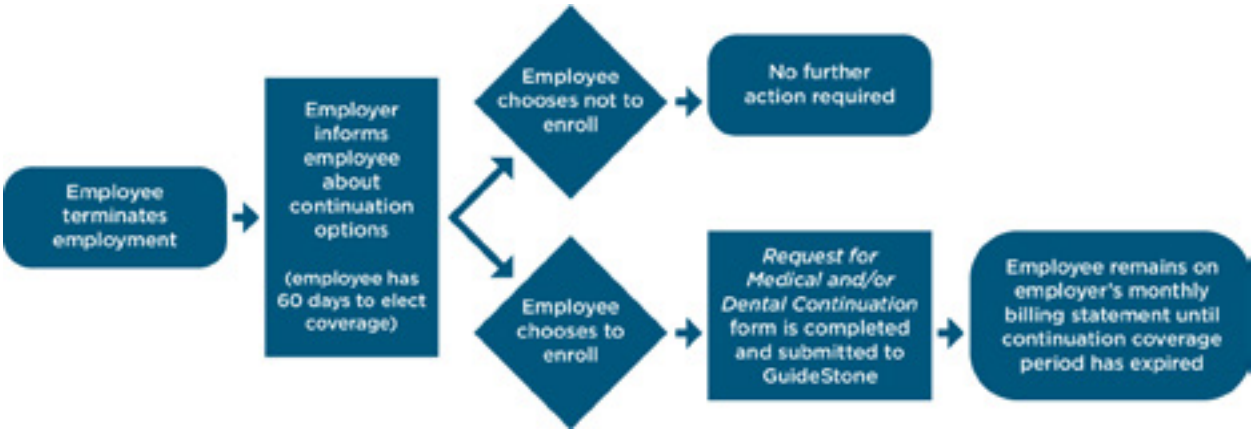
The employee must choose whether to continue coverage at the time of termination or loss of eligibility. There is no option for retroactive continuation.

Details about MCP and DCP are highlighted in the chart below:

MCP and DCP	
Eligibility	• Coverage must be made available to all employees. • Continuation coverage may be denied if the employee is terminated for misconduct.
Duration of continuation period	Up to 18 months for: • Termination of employment • Loss of coverage due to reduction in hours • Elimination of eligible class of employees Up to 36 months for: • Divorce or legal separation from employee • Loss of dependent child status (children who reach the maximum age limit under the plan) Medical continuation coverage will terminate if an employee becomes actively employed and eligible for benefits at another ministry eligible for GuideStone coverage or becomes Medicare-eligible.
Products that can be continued	• Medical coverage • Dental coverage
How to enroll	Complete the *Request for Medical and/or Dental Continuation*

Both continuation plans are optional and may be offered at the employer's discretion at the time the employer enrolls in GuideStone coverage or at a later date by submitting a written request to your GuideStone relationship manager. An employer cannot offer continuation coverage for an employee if the employee is terminated due to gross misconduct.

Below is a simple outline of GuideStone's continuation process:



NOTICE TO EMPLOYEES ABOUT CONTINUATION OPTIONS

GuideStone does not send any communication to employees after we receive the employee's termination notice. Employers are responsible for informing their employees about their options to continue coverage after separation of employment. Employees have 60 days from the date of termination to elect continuation coverage. Coverage will be backdated to the employee's termination date so that there is no break in coverage.

BILLING

Employees on continuation will remain on their employer's billing statement and be charged the same monthly rate. Employers are responsible for collecting payments from employees on continuation. Because it may be more difficult to collect payments from employees that are on continuation coverage, employers should keep in mind that they have the discretion to create their own payment terms with separated employees. If an employer wishes to charge employees an additional amount for continuation coverage, they should seek appropriate counsel to determine the allowable administration premium that can be passed on to employees since this is not a COBRA plan.

ADMINISTERING CONTINUATION COVERAGE

Employers that have used COBRA administrators in the past may continue to use these administrators for your continuation coverage through GuideStone.

Although employers are ultimately responsible for tracking the expiration dates for employees' continuation coverage, GuideStone has several tools and practices in place to make tracking this process easier. Employers who are enrolled in the EAP may run a continuation report using the "Reporting" tab on their dashboard. This report shows employees currently on continuation. Also, if there has not been a termination request submitted by the employer, GuideStone sends a notice of termination of coverage letter to employees approximately three months before their continuation coverage is set to expire.

SPECIAL CONSIDERATIONS WHEN TRANSFERRING FROM TRADITIONAL COBRA COVERAGE TO A GUIDESTONE CONTINUATION PLAN

Employers new to GuideStone have the option to transfer their COBRA-covered employees to GuideStone's continuation coverage. Unlike traditional COBRA coverage, GuideStone does not allow the continuation period to be extended due to disability or a subsequent qualifying event that occurs after initial enrollment. Employees that had extended coverage periods under COBRA provisions may be affected if they transition to GuideStone's continuation coverage. For example, if an employee was granted a 29-month coverage period under prior COBRA coverage due to a disability, the maximum coverage period allowed through GuideStone would be up to 18 or 36 months from the day the employee first enrolled in COBRA coverage, depending on the reason for COBRA enrollment.

EMPLOYEES WHO BECOME ELIGIBLE FOR OTHER GUIDESTONE COVERAGE

Employees must switch to their current employer's plan when eligible. An employee's continuation coverage will terminate if they become an active employee of another ministry eligible for GuideStone coverage. This rule does not apply if the employee, although actively employed, is not eligible to enroll in their current employer's health plan.

The chart below outlines some key differences between COBRA coverage and continuation:

	COBRA	Continuation
Sources of law	The Consolidated Omnibus Budget Reconciliation Act	Self-funded church plans are not subject to ERISA and are therefore not required to offer COBRA
Initial notice and election notice	Must be supplied by the plan administrator	Must be provided by the employer
Cost of coverage	Up to 102% of the cost of plan or 150% in case of disability	GuideStone does not charge an additional amount
Extension of coverage period	Coverage period may be extended due to disability or subsequent special enrollment events	Coverage period cannot be extended for any reason
Offering coverage	May be required by law	Employers may elect to participate

SEVERANCE

Group Plans does not make allowances for coverage that is part of a severance package. However, the employer may offer a severance package of their own design, and Group Plans coverage may be included by offering continuation via MCP/DCP. Continuation will begin the day following the employee's termination date.

LIFE AND AD&D PORTABILITY AND CONVERSION

Portability and conversion allow a plan participant to continue life and AD&D coverage when their coverage terminates or is otherwise changed due to certain events. The coverage will be offered directly through the carrier, rather than as an employee benefit.

It is the employer's responsibility to inform employees of their options regarding portability and conversion of their coverage when they leave your organization.

Please reference the chart on the next page to learn more about your options for portability and conversion of life insurance and the portability of AD&D insurance. Remember, AD&D insurance is not available for conversion.

See chart on next page »

Question	Portability	Conversion
When is a participant eligible?	• Retirement • Employee termination • Employee's work hours drop below minimum requirement • Loss of coverage due to transfer from Group Plans to Personal Plans or vice-versa Application for coverage must be received within 31 days of loss of coverage.	• Retirement • Age 65 reduction in benefit amount • Employee termination • Dependent loses eligibility • GuideStone terminates coverage with vendor who supplies coverage • Hours drop below minimum requirement • Continuation ends Application for coverage must be received within 31 days of loss of coverage.
Premiums	Premiums are typically lower than converted coverage.	Premiums are typically higher than coverage obtained by portability.
Policy provisions	• Coverage offered is term life insurance that does not gain cash value. • Life premium rates are based on age and increase every five years. • You may increase coverage for you and your dependents (subject to plan provisions and approved evidence of insurability). • The maximum coverage is $750,000 for all Unum Life and AD&D coverage combined.	• Coverage offered is a whole life policy or a single premium convertible one-year term life policy, which may gain cash value. • Premiums remain the same for the duration of the policy. • You may only have up to, but not exceeding, the amount you had under your group plan.

Fill out the application for *Term Life Insurance Election of Portability Coverage* or the *Life Insurance Notification of Conversion Privilege* form.

There are state-specific forms for:

- District of Columbia
- Florida
- Massachusetts
- New Hampshire

- Iowa
- Kentucky
- Maine
- Maryland
- New York
- North Carolina
- Ohio
- Virginia

If your employee resides in one of these states, your Group Plans administrator can provide you with one of these forms.

SECTION 6:
BILLING

STATEMENTS

Employers are billed for coverage one month in advance. Statements are scheduled to arrive mid-month for the following month's coverage. For example, you will receive the billing statement for October's coverage around September 15.

PAYMENTS

Payments are due by the first of the month for which the coverage is being billed. For example, payment for the October coverage is due October 1.

ENROLLMENTS AND TERMINATIONS

It is important to always pay your statement as billed. Do not make deductions or additions for terminated or newly added coverage. Timely reporting of coverage changes is encouraged so that they may be reflected accurately on the corresponding month's billing statement. Changes should be submitted prior to the first of each month to ensure that the changes will be reflected on the current billing statement.

Enrollments

- When coverage is added for an employee and/or their eligible dependent(s) on or before the 15th day of a month, the employer will be charged for the full month of coverage.
- When coverage is added for an employee and/or their eligible dependent(s) on or after the 16th day of the month, the employer will not be charged for the full month of coverage. Billing for that coverage will begin the following month.

Terminations

- If the effective date for termination of coverage for an employee and/or an eligible dependent(s) is on or before the 15th of the month, you will not be charged for the full month of coverage.
- If the effective date for a termination of coverage for an employee and/or an eligible dependent(s) is on or after the 16th of the month, you will be charged for the full month of coverage.

BILLING CREDITS

Employers are limited to a maximum credit of two billed months for coverage terminations. For example, if an employer has been billed for September and October's coverage and submits a termination request for an employee with an effective date of August 14, the employer will receive a credit for September and October's coverage only.

MAKING PAYMENTS

Recurring or one-time payments may be made online at GuideStone's EAP.
Payments may be mailed to:

GuideStone Financial Resources
P.O. Box 672073
Dallas, Texas 75267

SECTION 7:
MEDICARE

MEDICARE OVERVIEW

Medicare is a federal health insurance program for individuals age 65 and older, individuals younger than age 65 with certain disabilities, and those with End-Stage Renal Disease (ESRD) regardless of their age.

Medicare consists of three parts:

Part A (hospital insurance) — Part A provides coverage for services such as care in a skilled nursing facility, inpatient hospital stays, hospice and some home health services.

Eligible employees are encouraged to enroll in Medicare Part A. This coverage comes at no additional cost to the employer or the employee and will serve as secondary coverage to GuideStone's PPO plan until the employee retires.

Part B (medical insurance) — Part B provides coverage for services such as doctor's visits and outpatient care. Part B may also cover expenses not covered under Part A for some services and supplies related to physical and occupational therapy and home health care.

Employees that do not sign up for Part B when they are first eligible may incur a late penalty that will result in a permanent increase in their Part B premium. This rule generally does not apply if an employee was covered under a group health plan.

Medicare has special enrollment periods for enrolling in Part B when an employee retires and Medicare becomes their primary medical provider. This means that active, Medicare-eligible employees with medical coverage may delay Part B enrollment, without penalty, until they retire.

Part D (prescription drug coverage) — Medicare Part D helps cover Medicare-approved prescription benefits. Part D prescription drug coverage must be purchased through private companies. Beneficiaries are able to choose a drug plan from a provider and pay a monthly premium for the coverage.

Medicare beneficiaries may incur a late enrollment penalty (LEP) if:

- There is a continuous period of 63 days or more at any time after the end of the individual's Part D initial enrollment period during which the individual was eligible to enroll, but was not enrolled in a Medicare Part D plan
- Was not covered under any creditable prescription drug coverage

Creditable prescription drug coverage is defined as coverage that meets Medicare's minimum standards, since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Individuals may incur this penalty regardless of whether they are an active or retired employee. The Part D enrollment penalty is discussed in further detail in the "Creditable Coverage" section of this chapter.

HOW BECOMING MEDICARE-ELIGIBLE AFFECTS YOUR MEDICAL COVERAGE

All active employees (including disabled employees that have an active employment status) will remain on their employer's PPO coverage once they reach the age of Medicare eligibility. Employees will not be eligible to enroll in a GuideStone Medicare-coordinating plan until they are retired or are otherwise categorized as inactive employees.

A spouse's eligibility for GuideStone Medicare-coordinating coverage is based on the employee's employment status.

- The spouse of an active employee may only be enrolled in that employee's GuideStone PPO coverage offered through his or her employer.
- The spouse of an inactive or retired employee may only be enrolled in a GuideStone Medicare-coordinating plan.

An employee with plans to retire once they become Medicare-eligible must enroll in a Medicare-coordinating plan to continue receiving GuideStone medical coverage.

The "Retirement" section of this manual contains information about how to enroll in a Medicare-coordinating plan.

DISABLED MEDICARE BENEFICIARIES

For disabled beneficiaries, the Coordination of Benefits Contractor (COBC) at the Centers for Medicare and Medicaid Services (CMS) is responsible for determining when Medicare becomes the primary payer of benefits.

The CMS reviews the "current employment status" of either the beneficiary or a member of the beneficiary's family to determine if and when Medicare will become the primary payer of medical benefits for a disabled individual who is covered by a large group health plan.

Generally, an employee will be considered to have "current employment status" (and Medicare will be secondary payer) if:

- The individual **is actively working** as an employee, is the employer (including a self-employed person) or is associated with the employer in a business relationship.
- 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).
- The individual is **not actively working** but all of the following are true:
  - The individual 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 individual has not had their employment terminated by the employer.
  - The individual has not been receiving disability benefits from an employer for more than six months.
  - The individual 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.

More details are provided in the next section.

PROCEDURES FOR PROCESSING DISABLED MEDICARE BENEFICIARIES

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

1. Complete a *Termination of Coverage* form to discontinue the employee's PPO coverage and a *Group Plans Medicare-Coordinating Plans Packet* form to enroll the employee in their choice of Medicare-coordinating plan. A copy of the disabled employee's Health Insurance Claim Number (HICN) identification number is also needed in order to complete the form.
2. GuideStone will update the employee's Group Plans records to reflect Medicare as the primary payer of benefits effective on the day the employee became eligible for Medicare benefits due to disability.
3. The employee's current Group Plans medical coverage will be terminated. The individual's Medicare-coordinating plan will become effective on the day the employee became eligible for Medicare benefits due to his or her disability.

It is imperative that you send GuideStone a copy of the disabled employee's HICN identification number and the *Termination of Coverage* form as soon as possible. A delay in sending the identification number to GuideStone could result in incorrect payment of claims.

Disabled individuals diagnosed with ESRD generally become Medicare-primary beginning on the 30th day of the month following 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.

CREDITABLE COVERAGE

The CMS defines "creditable coverage" as prescription drug benefits that are expected to pay as much, on average, as the standard Medicare prescription drug coverage benefit. It is important that Medicare-eligible employees are made aware of the creditable or non-creditable status of the medical plan they choose. If they choose a non-creditable plan and stay on that plan for 63 days or more past the final date of their initial Medicare-qualifying enrollment period, they will be subject to the LEP, which will lead to a permanent increase in their monthly premiums.

> The LEP is 1% of the national base beneficiary premium for each full, uncovered month that a person was eligible to join Medicare Part D and chose not to do so. The national base beneficiary premium usually increases from year to year, so the penalty paid by the beneficiary would be adjusted accordingly. The LEP is permanent, and the individual will be subject to this penalty as long as they have Medicare prescription drug coverage.

A participant may owe an LEP if they didn't join a Medicare drug plan when they were first eligible for Medicare Part A and/or Part B, and:

- They didn't have other prescription drug coverage that met Medicare's minimum standards.
- They had a break in coverage of at least 63 days.

GuideStone will notify Medicare-eligible employees of the creditable status of their plans on the following occasions:

- Annually in October of each plan year
- Upon enrollment in a Medicare-coordinating plan regardless of age or enrollment in a PPO plan at age 65 or older
- Three months before the participant turns age 65

If an employee is Medicare-eligible and enrolled in a non-creditable plan, they need to know what steps they can take to avoid accruing any further penalties. Please review *How to Avoid a Medicare Part D (Prescription Drug) Penalty* so that you may discuss options with the employee.

Visit *Medicare.gov* for more information about Medicare.

SECTION 8:
RETIREMENT

When an employee retires, it is important to educate them on how their insurance coverage is affected. Individuals may continue Employee Term Life, Spouse Term Life, dental and medical coverage during retirement if they were enrolled in the coverage prior to retirement and the retiree coverage is offered by their employer. The employee may keep retiree coverage as long as the cost of coverage continues to be paid by either the retiree or the employer and the employer continues to offer the coverage as part of their benefits package.

In the event that the employer elects not to offer retiree coverage, participants may be able to gain access to retiree coverage through GuideStone Personal Plans.

DENTAL

The dental plan coverage for retired employees will remain the same once they transition to retirement. The employee and any eligible dependents will continue to access their plan benefits using the same dental ID card and plan information that were issued prior to the employee's retirement.

LIFE COVERAGE

- A retired employee may have a maximum amount of $20,000 in retiree life coverage.
- A covered spouse is limited to coverage up to one-half of the amount of coverage carried by an employee. This means that Spouse Term Life coverage cannot exceed $10,000 during retirement.
- If an employer does not offer life coverage to its retirees or the employee would like to maintain the full amount of coverage in effect prior to retirement, the employee may use the portability option and transition any lost coverage to a private policy through Unum. Please review the chapter on "Options for Continuation of Coverage" for more information about this option.
- If an employer does not offer retiree life coverage, the employee may be eligible to obtain $20,000 in retiree life coverage through GuideStone Personal Plans.

ACCIDENT COVERAGE

Accident coverage is not available to retirees. An individual's accident coverage will automatically terminate at retirement.

MEDICAL COVERAGE

Medicare-eligible employees will become Medicare-primary once they retire, and their GuideStone PPO coverage will terminate. It is important that employers prepare their retiring employees for the transition to Medicare by taking the following steps:

1. Ensure the employee is informed as to whether their current prescription coverage is classified as creditable coverage by Medicare Part D. Employees should receive correspondence from GuideStone approximately three months before their 65th birthday that advises them if their prescription coverage is creditable or non-creditable.

2. Submit a *Termination of Coverage* form and be sure to complete Section E to confirm products that will be continued in retirement.
3. Ensure that retiring employees who want to participate in a GuideStone Medicare-coordinating plan enroll in the plan for which they are eligible and best fits their needs. Also ensure that the employee and any eligible dependents are enrolled in Medicare Part A and Part B if they are enrolling in a Medicare-coordinating plan that includes Part B coverage. Medicare-eligible employees may enroll in Medicare anytime while still covered by their group health plan. Beneficiaries will be assigned an HICN by CMS once they enroll in Medicare, and this information is needed before they can enroll in one of GuideStone's plans.
4. The employee should complete and submit the *Group Plans Medicare-Coordinating Plans Packet* form to GuideStone by the 20th of the month prior to their desired month of enrollment. All Medicare-coordinating plans become effective on the first day of the month. Employees should keep this fact in mind when planning their retirement date.

Find *Summaries of Benefits and Coverage* (Summaries), benefit overviews and plan booklets for GuideStone's Medicare-coordinating plans at *GuideStoneInsurance.org/FormsandFAQ/PlanBooklets*.

SECTION 9:
COVERAGE CHANGES FOR LIFE AND ACCIDENT PRODUCTS FOR EMPLOYEES TURNING AGE 65

There are important changes to employees' Term Life and AD&D products that begin on the January 1 following their 65th birthday.

Group Term Life and AD&D Plans are designed primarily to provide a financial safety net for employees' families during their most crucial income-earning years. Similar to other plans in the industry, GuideStone's Group Term Life and AD&D Plans reduce by 35% on January 1 following their 65th birthday.

For example, an individual who is actively at work with $100,000 in life insurance would retain $65,000 in coverage upon turning 65.

However, coverage will not be reduced to less than $20,000.

Likewise, the Employee Supplemental Accidental Death & Dismemberment coverage for an employee with $50,000 would be reduced to $33,000 on January 1 following an employee's 65th birthday.

Employees affected by these changes have the option of converting lost Group Term Life and AD&D Plans coverage to a personal policy with GuideStone's life insurance provider, Unum. Please reference the chapter on "Options for Continuation of Coverage" for more information on this process.

Please reference the quick reference chart *Employee Turning 65 Years of Age* as a guide for changes to life and accident coverage that take place January 1 following an employee's 65th birthday.

See chart on next page »

Employee Turning 65 Years of Age

A guide for GuideStone Group Plans employers **for non-medical products**

Will the employee continue working or retire?

Employee continues working

Inform employee of the following coverage changes and options:

- Employee Term Life Plan, AD&D and Employee Supplemental AD&D coverage will reduce by 35% effective January 1 after reaching age 65.
- Spouse Term Life Plan coverage may reduce, if necessary, not to exceed 50% of the combined total of Employee Term Life and Employee Optional Life plans.
- Spouse Supplemental AD&D coverage will reduce to 50% of the Employee Supplemental AD&D coverage.
- Inform employee of options for converting lost life coverage.

Employee retires

Inform employee of the following coverage changes and options:

- AD&D, Employee Supplemental AD&D and disability coverage is terminated.
- Employee may retain $20,000 in retiree life coverage if it is offered by the employer and the employee is eligible. Employee may also retain a maximum of $10,000 in spouse life coverage.
- Inform employee of option to port or convert lost life coverage.
- Employee may retain dental coverage if it is offered by the employer and the employee is eligible.

Employee Turning 65 Years of Age

A guide for GuideStone Group Plans employers **for medical products**

Employee continues working

Employer PPO coverage will be primary.

- Employee remains on PPO coverage.
- Inform employee whether their PPO prescription coverage is creditable toward Medicare Part D.
- If employee's current plan is not creditable, employee has the opportunity to change to a creditable plan if offered by their employer.

Employee retires

Medicare coverage will be primary.

- Inform employee whether their PPO prescription coverage is creditable toward Medicare Part D.
- PPO medical plan will terminate.
- Confirm employee has enrolled in Medicare Part B if the employee plans to enroll in a Medicare-coordinating plan with Part B coverage.
- Employee can enroll in a Medicare-coordinating plan offered by their employer by completing the Medicare enrollment form (included in *Medicare-Coordinating Plans Packet*) and submitting it to GuideStone by the 20th day of a given month in order for coverage to be effective the first day of the following month.

Note: If a Medicare-coordinating plan is not offered in Group Plans, the employee may be eligible to enroll in coverage through Personal Plans.

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SECTION 10:
EMPLOYER ACCESS PROGRAM OVERVIEW

Employer Access Program (EAP) is an online tool designed to ease your administrative duties by providing you with a web-based alternative to access and manage the day-to-day tasks associated with your insurance account. Use EAP to enroll new participants, add dependents, terminate products and generate reports.

HOW DO YOU SIGN UP?

1. Visit the EAP.
2. Register your organization.
3. Add and delete authorized users as appropriate for your administrative needs.

Because EAP contains personal and confidential information about your employees, only individuals with a legitimate business need should have access to the program.

SECTION 11:
HEALTH CARE REFORM

The passage of the ACA brought significant changes in the way that health care coverage is administered. GuideStone has a dedicated Health Care Reform page to provide you with the most pertinent information regarding health care reform and its implications on your ministry.

Although it is important to familiarize yourself with all of the information, there are some distinct provisions of the law that are especially impactful to the administration of your GuideStone plan. These provisions are discussed below:

RESCISSION

Rescission, as it relates to health care reform, is the retroactive revocation or termination of health care coverage by a group health plan or a health insurance issuer. If an employee contributes toward the cost of medical coverage for himself/herself and/or an eligible dependent, that employee's prepaid coverage cannot be terminated prior to the date through which the coverage is paid.

For example, if an employee has paid for coverage through November 30, then coverage cannot be terminated prior to November 30, even if you notify GuideStone of the desire to terminate coverage prior to that date (e.g., November 12).

When you process a termination request for medical coverage using EAP or the *Termination of Coverage* request form or online through EAP, you are required to enter the paid-through date. This is simply the last date of coverage for which the employee has paid for himself/herself and/or eligible dependent(s). Providing an accurate paid-through date will ensure that your medical coverage is properly terminated.

If medical coverage is fully paid by the employer, it is permissible to terminate coverage as of a current date or a future date.

There may be instances where employee coverage is paid for by the employer, while dependent coverage is paid by the employee. When this situation occurs, the coverage is wholly treated as employee paid and termination of prepaid coverage is prohibited.

Timely notification to GuideStone for terminations of medical coverage is important because we are unable to terminate coverage more than 31 days prior to the date of notification.

EXCEPTIONS TO THE RESCISSION RULE

There are limited circumstances under which employee coverage can be rescinded:

- The covered individual commits a fraudulent act as prohibited under the terms of the insuring agreement.
- The covered individual makes an intentional misrepresentation of material fact as prohibited under the terms of the insuring agreement.
- The coverage is canceled for non-payment of charges.

EMPLOYER MANDATE

The Employer Shared Responsibility (employer mandate) requires organizations classified as applicable large employers (ALEs) to provide affordable, minimum-value health coverage to full-time employees or be subject to stiff penalties.

> The ACA defines ALEs as those who employ on average at least 50 full-time employees, including full-time equivalent employees, during a calendar year. The IRS defines full-time employees as those working on average 30 hours per week or more.

Use GuideStone's part-time and full-time equivalent employee calculator to determine if your organization is considered an ALE and thereby subject to the employer mandate.

> All of GuideStone's medical plans qualify as minimum essential coverage (MEC) as required for compliance under the ACA.

CONTROLLED GROUPS

Controlled groups are commonly owned entities that are recognized as a single employer under the ACA.

All employees in a controlled group must be counted during the process of determining if your ministry meets the definition of an ALE. As an ALE, your ministry would be subject to the employer mandate provision of the ACA, meaning that you would be required to offer health care coverage to your employees.

Generally, for churches and qualified church-controlled organizations (QCCOs):
A controlled group will exist among organizations able to sponsor a church plan and therefore be treated as a single employer if:

1. One organization provides (directly or indirectly) at least 80% of the operating funds for the other organization during the preceding taxable year of the recipient organization

and

2. There is a degree of common management or supervision between the organizations so that the organization providing the operating funds is directly involved in the day-to-day operations of the other organization.

Recognizing if your organization and its affiliated entities are a controlled group is important because:

- Controlled groups must count all employees in each organization as one group when determining if they qualify as an ALE.
- Non-controlled groups may count employees in each entity separately and use that count to determine if the individual entity is an ALE.

An example of a controlled group would be a pregnancy crisis center that is financially supported (at least 80%) by a church and the church staff are directly involved in the day-to-day operations of the pregnancy crisis center.

GuideStone's *Controlled Group Fact Sheet* provides guidance for determining if your organization's commonly owned entities qualify as a controlled group.

REIMBURSEMENT VEHICLES

Barring certain rare exceptions, the ACA prohibits reimbursement to an employee for purchasing health coverage in the individual marketplace.

Employers face stiff penalties, as much as $100 per employee, per day, for each violation of this provision with a maximum penalty of $36,500 per year, per employee.

To learn more about how your ministry is impacted by the provision, visit the Reimbursement Vehicles page of GuideStone's Health Care Reform website.

CODE SECTIONS 6055 AND 6056 REPORTING REQUIREMENTS

Sections 6055 and 6056 were added to the *Internal Revenue Code* to detail new reporting requirements under the ACA. These reporting requirements became effective in 2016 for the 2015 calendar year.

GuideStone will report details about your employees' health care coverage to both the IRS and to each individual employee who is enrolled in a GuideStone medical PPO plan. ALEs are required to meet the reporting requirements under Section 6056.

Employers can access a *Covered Persons Report* in EAP, which may provide helpful data for reporting that is required of ALEs.

Please review the *Health Plan Information Reporting* fact sheet and the chart on the next page for more information on required reporting under Code Sections 6055 and 6056.

ACA REPORTING

Form	Sender	Recipient	Report Details
Form 1095-B Health Coverage	GuideStone	Participants	This form reports to responsible individuals (participants) the months for which they and their dependents were enrolled in minimum essential coverage (MEC) at GuideStone during the reporting period. Participants and dependents will be identified by Social Security number or date of birth and name. These forms assist participants with their tax reporting. Copies of these will accompany *Form 1094-B* to the IRS.
Form 1094-B Transmittal of Health Coverage Information Returns	GuideStone	IRS	This form is used to transmit to the IRS copies of *Form 1095-B* and reports the total number of *Form 1095-Bs* included in the batch.
Form 1095-C Employer-Provided Health Insurance Offer and Coverage	Applicable large employer (ALE)	Employees of ALEs	This form reports to an ALE's employees any offers of coverage made by the employer, the employee's share of the lowest-cost monthly premium for self-only minimum value coverage and, for 2015, whether a safe harbor applies. It will include the employer's contact information and Employer Identification Number. This form assists participants with their tax reporting. Copies of these will accompany *Form 1094-C* to the IRS.
Form 1094-C Transmittal of Employer-Provided Health Insurance Offer and Coverage Returns	Applicable large employer (ALE)	IRS	This form is used to transmit to the IRS copies of *Form 1095-C* and reports the total number of *Form 1095-Cs* included in the batch.
ACA Covered Persons Report	GuideStone	Employers	This summary information will provide employers a list of the months of coverage for employees and dependents enrolled in a MEC plan at GuideStone during the reporting period. This summary is for informational purposes only but may be useful to ALEs as they fulfill their reporting responsibilities.

SECTION 12:
DISTRIBUTING REQUIRED NOTICES

Federal law requires that certain legal notices regarding insurance rights and coverage be distributed to employees:

- At the time of hire
- At initial enrollment in a health plan
- During re-enrollment

Reference the chart on the next page to view these notices and the times they should be distributed. Employers should furnish employees with any of these forms upon request.

See chart on next page »

Hire date: Please distribute these forms to new employees enrolling in Preferred Provider Organization (PPO) or HSA-qualified High Deductible Health Plans:

Notice	When Required	Delivery Format	Notes
Summary of Benefits and Coverage	Provide to all new hires.	Provide a paper copy. Electronic copies may only be distributed according to Department of Labor (DOL) criteria.**	Employers must also provide to employees when coverage changes (including dependent additions and HIPAA special enrollment events), upon the employee's request and when material modifications are made in the coverage. Reference the *Distribution Instructions Summary of Benefits and Coverage (Summary)*.
Benefit Overview	Provide to all new hires.	Provide a paper or electronic copy.	Distribution is not legally required at the noted times; however, it is recommended as a courtesy to employees.
Notice of Exchanges & Coverage Options	Provide to all new hires within 14 days of their start date.	Provide a paper copy.	
Group Plans Notice of Special Enrollment Rights	Provide to new hires at or before the time the employee is initially offered the opportunity to enroll in the plan.	Provide a paper copy. Electronic copies may only be distributed according to Department of Labor (DOL) criteria.**	This notice must also be provided to eligible employees who choose not to enroll in a GuideStone health plan. The notice below must also be supplied to those enrolled in an international medical plan: *International Group Plans Notice of Special Enrollment Rights*.
CHIPRA Required Notice for Your Employees	Provide to all new hires.	Provide a paper copy. Electronic copies may only be distributed according to Department of Labor (DOL) criteria.**	The notice below must also be supplied to any employees enrolled in an international medical plan: International version: *CHIPRA Required Notice for Your Employees*

Medical plan enrollment: Please distribute this form to employees at the time of enrollment in PPO or HDHP coverage:

Notice	When Required	Delivery Format	Notes
HIPAA Notice of Privacy Practices for Protected Health Information	Provide at initial enrollment.	Provide a paper copy.	Supply this notice to employees and their dependents at enrollment and upon request. The notice below must also be supplied to any employees enrolled in an international medical plan: International version: *HIPAA Notice of Privacy Practices for Protected Health Information*

Medicare-coordinating enrollment: Please distribute these forms to employees at the time of enrollment in a Medicare-coordinating plan:

Notice	When Required	Delivery Format	Notes
Group Plans Medicare-Coordinating Plans Packet	Provide at initial enrollment.	Provide a paper copy.	Provide at initial enrollment.
HIPAA Notice of Privacy Practices for Protected Health Information	Provide at initial enrollment.	Provide a paper copy.	Supply this notice to the employee and their dependents at enrollment and upon request.

Re-enrollment: Please distribute these forms at the time of re-enrollment for PPO or HDHP coverage:

Notice	When Required	Delivery Format	Notes
Summary of Benefits and Coverage	Provide at re-enrollment.	Provide a paper copy. Electronic copies may only be distributed according to Department of Labor (DOL) criteria.**	Reference the *Distribution Instructions Summary of Benefits and Coverage (Summary)*.
Benefit Overview	Provide at re-enrollment.	Provide a paper or electronic copy.	Distribution is not legally required at the noted times; however it is recommended as a courtesy to employees.

HIPAA Notice of Privacy Practices for Protected Health Information	Provide at re-enrollment.	Provide a paper copy or information on how the employee may obtain an electronic version of the document.	Supply this notice to the employee and any dependents at enrollment and upon request. The notice below must also be supplied to any employees enrolling in an international medical plan: International version: HIPAA Notice of Privacy Practices for Protected Health Information
CHIPRA Required Notice for Your Employees	Provide at re-enrollment.	Provide a paper copy. Electronic copies may only be distributed according to Department of Labor (DOL) criteria.**	This notice must also be supplied to any employees enrolled in an international medical plan: International version: CHIPRA Required Notice for Your Employees

Re-enrollment in No Rx Medicare-coordinating plans: Please distribute these forms at the time of re-enrollment for No Rx Medicare-coordinating plans:

Notice	When Required	Delivery Format	Notes
Summary of Benefits and Coverage	Provide at re-enrollment.	Provide a paper copy. Electronic copies may only be distributed according to Department of Labor (DOL) criteria.**	Reference the Distribution Instructions Summary of Benefits and Coverage (Summary).
Benefit Overview	Provide at re-enrollment.	Provide a paper or electronic copy.	Distribution is not legally required at the noted times; however, it is recommended as a courtesy to employees.

HIPAA Notice of Privacy Practices for Protected Health Information	Provide at re-enrollment.	Provide a paper copy or information on how to obtain an electronic copy.	All active employees and their dependents must be informed of how they can obtain a copy of this notice.
CHIPRA Required Notice for Your Employees	Provide at re-enrollment.	Provide a paper copy. Electronic copies may only be distributed according to Department of Labor (DOL) criteria.**	

Medicare-coordinating re-enrollment: Please distribute these forms at the time of re-enrollment in a Medicare-coordinating plan:

Notice	When Required	Delivery Format	Notes
Medicare-Coordinating Plans Summary and Disclosure Statement	Provide at re-enrollment.	Provide a paper copy.	
HIPAA Notice of Privacy Practices for Protected Health Information	Provide at re-enrollment.	Provide a paper copy or information on how to obtain an electronic copy.	All active employees and their dependents must be informed of how they can obtain a copy of this notice.

** DEPARTMENT OF LABOR (DOL) ELECTRONIC NOTICE CRITERIA

Please consult the specific DOL criteria and rules at *29 CFR Part 2520.104b-1*. Generally, the DOL allows electronic distribution of these forms if the forms are prepared and furnished in a manner to ensure actual receipt by the employees (all participants in the health plan). The DOL requires that:

- Your system for furnishing the form must result in actual receipt of the form, and you should periodically confirm the delivery of the forms (e.g., using return receipts, identifying undeliverable messages or otherwise confirming receipt of transmitted information).
- You must protect the employee's confidentiality by incorporating into your electronic information system measures designed to preclude unauthorized receipt of or access to the employee's information.
- For forms provided in a DOL-mandated format (e.g., the Summary), you are not permitted to change the format.
- You must forward the form with a statement that explains the document's significance and the employee's right to a paper copy.

Electronic distribution can be made to employees with work-related computer access and employees who have affirmatively consented to receive electronic notices. Specifically, provided the above criteria are met:

- You may make an electronic disclosure to an employee who has the ability to access documents at any location where the employee reasonably could be expected to perform employment duties and whose access to your electronic information system is an integral part of those employment duties.
- You may make an electronic disclosure to an employee who does not have work-related computer access only if you receive affirmative consent from that employee. Note that the DOL requires specific, detailed consent for disclosures made over the internet or other electronic communication network. Generally, prior to consenting, the employee must be given a clear and conspicuous statement describing the processes for giving consent, withdrawing consent and accessing forms in the future. Additionally, if you change your software or hardware requirements for accessing these forms, you must provide a new statement and request new consent from the employee.

Note: There are several health plan notices that GuideStone is not required to provide to enrollees. This occurs when the notice requirements are included under Title 1 of ERISA. While GuideStone health plans are not subject to the Title 1 of ERISA notice requirements, GuideStone medical plans still provide the required level of coverage.

SECTION 13:
RE-ENROLLMENT

The annual re-enrollment period is a designated time of year when employers are given the opportunity to evaluate and make changes to their medical and dental coverage offerings for the upcoming plan year.

All changes will take effect January 1 of the following year.

During this time, eligible employees and/or their dependent(s) may enroll in medical coverage for the first time, transfer coverage to another plan offered by their employer or drop medical coverage.

Although dental coverage can be added or dropped at any time throughout the plan year, the annual re-enrollment period is the only time that a participant may transfer to another dental plan without experiencing a HIPAA special enrollment event.

Enrollment or changes to products such as life, accident and disability are not included in the annual re-enrollment process.

Below is a timeline for important dates and events during the re-enrollment process.

March–August
Insurance Plans will call employers to discuss renewal strategies.

Mid-September to October
Employers will receive a second phone call from Insurance Plans to discuss the content of the renewal rates and employers' insurance election plans for the upcoming year.

Mid-November
Employee plan elections and coverage should be finalized and submitted to Insurance Plans.

Beginning of October
Employers will receive renewal materials via EAP that will contain the following information:

- *Employer Annual Election Form*
- *Employee Annual Change Request*
- Brochure with plan changes and summary information for all available plans
- Rates booklet

End of October
Employers will submit plan decision.

January 1
Your plan year starts and plan changes take effect.

RE-ENROLLMENT TIPS

Re-enrollment can be a hectic time of year for employers. Following the tips below can save valuable time during the re-enrollment process.

- No action needs to be taken for employees who are not making changes to their coverage. Their current coverage options will simply roll forward to the upcoming year.
- If an employee has already submitted a waiver form to GuideStone for themselves and/or eligible dependent(s), it is not necessary to submit a new waiver form at re-enrollment.
- If an employee is enrolling in GuideStone coverage for the first time, please submit a *Group Plans Enrollment* form rather than the *Employee Annual Change Request* form so that all of the pertinent information may be captured.
- Employers should meet with their committees to confirm plan elections before mid-October.
- Employers that are terminating any product coverage are required to provide GuideStone with written notice at least 30 days prior to the effective date of termination.

SECTION 14:
EMPLOYER ADMINISTRATIVE RESPONSIBILITIES

Below is a list of key responsibilities employers should perform to ensure the successful administration of their Group Plans coverage with GuideStone.

- Explain Group Plans coverage options to new employees.
- Ensure that employees who are eligible for participation enroll in a plan within 31 days of eligibility.
- Verify that all employees and dependents enrolled in Group Plans meet the eligibility rules for the plans in which they are enrolled. Failure to adhere to the eligibility rules may result in the termination of coverage for the affected enrollee(s), and employers may be required to reimburse GuideStone for claims paid on behalf of ineligible enrollees.
- Offer enrollment in medical plans to employees who previously declined coverage for themselves and/or their eligible dependents when they become eligible due to a special enrollment event.
- Distribute appropriate benefit materials to new participating employees.
- Report any salary changes to GuideStone in a timely manner if the employee is enrolled in a salary-based product (salary changes cannot be backdated).
- Maintain copies of forms and other important plan documents relating to an employee's participation in the plan.
- Verify the monthly billing statement and remit monthly payments to GuideStone. Non-payment will result in termination of coverage.
- Submit benefit changes to GuideStone in a timely manner.
- Insure timely filing of term life, personal accident and disability claims for employees and their eligible dependents.
- Report changes that affect a participant's group benefits or coverage status to GuideStone in a timely manner.
- Counsel employees about the benefit coverage and changes that accompany retirement.
- Provide GuideStone with participant information and any statistical data needed to properly administer your plans.
- Notify plan participants of their rights and obligations.
- Maintain the minimum participation requirements of the Group Plans. If these requirements are no longer met, the change must be reported to the Group Plans Support Team.
- Distribute required notices to employees as required by law for the administration of health plans.

SECTION 15:
HELPFUL LINKS

GuideStone's Health Care Reform resources are designed to help you understand how the ACA impacts your ministry.

Health Care Reform Web Page

Affordable Care Act Overview

U.S. Department of Health & Human Services

VENDORS

GuideStone works with several high-quality health care providers to bring you well-rounded, benefit-rich coverage. When your organization or one of your employees has a question regarding a claim, or they need something the vendor can provide, it's more efficient to work directly with the vendor.

Highmark/ Blue Cross Blue Shield

Cigna Global Medical Coverage

Cigna Dental

Express Scripts

PLAN ADMINISTRATION

Managing the day-to-day details of your plan can be easier with these tools.

GuideStone Employer Access

Employer Tools

Employer Forms

Plan Booklets

SECTION 16:
PROTECTED HEALTH INFORMATION

Protected health information (PHI) is defined as information used, created or transmitted as a result of health plan operations that can identify an individual.

As a covered entity under the Health Insurance Portability and Accountability Act (HIPAA), GuideStone is required to take precautionary measures to protect the PHI of employees and their dependents who participate in our plans.

GuideStone will avoid disclosing more information than is minimally necessary to perform our duties and will ensure that the appropriate steps are taken to disclose the minimum amount of PHI necessary to accomplish a particular use or disclosure, as required under HIPAA.

For all uses and disclosures of an individual's PHI, other than those required by law or for treatment, payment or health care operations of the GuideStone health plan, HIPAA requires GuideStone to obtain a valid written or oral authorization from the individual. Read GuideStone's *HIPAA Notice of Privacy Practices for Protected Health Information* for more information.

To ensure the protection of employees, we ask that employers take safety measures when communicating PHI to GuideStone.

Below are some precautions you can take to protect the PHI of your employees:

- Password protect documents containing PHI that are sent via email. A password to the document may be sent in a separate email.
- When sending documents that contain the PHI of multiple participants via postal mail, put each participant's information in a separate, labeled and sealed envelope. This helps protect the individual PHI of each employee. The separate envelopes may be mailed together in one large package or envelope.
- When faxing documents, be sure to confirm the appropriate fax number and recipient name before sending. Always include a coversheet so that confidential information is not clearly visible to those passing by.

SECTION 17:
IMPORTANT TERMS

Allowed amount — Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference.

Beneficiary (life insurance) — The person or persons named by a participant to receive the proceeds from the term life, AD&D or supplemental AD&D plans in the event of the employee's death.

Beneficiary (Medicare) — A recipient of Medicare benefits.

Co-insurance — The percentage of eligible claims you pay after you meet your deductible.

Co-insurance maximum, out-of-network — The most you will have to pay in a year in out-of-network co-insurance for covered benefits after you meet your out-of-network deductible.

Contributory coverage — Coverage for which an employee contributes a portion or the entire amount of the cost of coverage for either himself/herself, eligible dependent(s) or both.

Conversion — An employee's right to convert terminated group term life coverage to an individual direct-payment policy with GuideStone's term life provider, Unum.

Coordination of benefits — The process by which claim payments are made when a plan participant is covered by more than one plan. One of the plans will be considered primary and the other would be deemed secondary. The primary plan would pay first, and the secondary plan may pay an additional benefit according to the details of its coverage plan. GuideStone's rules for determining primary and secondary coverage can be found in the medical and dental plan booklets.

Co-pay — The fixed, up-front dollar amount you pay for certain covered expenses. Office visit co-pay amounts do not apply toward your in-network or out-of-network deductible or your out-of-network co-insurance maximum.

Creditable coverage — Prescription coverage that meets or exceeds the standard prescription drug coverage provided by Medicare Part D.

Deductible (individual) — This is the amount an individual is required to pay before benefits begin for services not covered by co-pays. Once this amount is met, the plan will begin paying claims for that individual at the co-insurance level.

Dental Health Maintenance Organization (DHMO) — A managed dental care plan available to employees that reside in a service area established by a dental insurance provider. Network providers must be used to receive benefits from the plan.

Eligibility date — The date an employee meets the requirements for participation in coverage offered by his or her employer.

Emergency care — Medical services from the Emergency department of a hospital to evaluate a medical condition that, in the absence of immediate medical attention, would place the health of

the individual in serious jeopardy, cause serious impairment to bodily functions or cause serious and permanent dysfunction to any bodily organ or part.

Employee classification — A categorization of employees based on criteria defined by an employer. Job title and job function are typical characteristics used by employers to establish employee classifications.

Generic — A bioequivalent to the brand-name drug made available to the public after the patent has expired on the brand-name drug. The generic version is usually less expensive than the brand-name drug.

Health care reform — A general term that encompasses the changes to health care administration resulting from the passage of the Affordable Care Act (ACA).

In-network — Health care services received from a provider in a PPO network.

Long-term disability — After the initial period, as defined by your plan, a sickness or injury that limits an employee from performing the material and substantial duties of their regular occupation and results in 20% or more loss in the employee's indexed monthly earnings due to that same sickness or injury.

Mail order — Mail order is a service that allows participants to refill recurring prescriptions (90-day supply) through an online pharmacy. Participants receive their prescriptions by mail.

Maximum out-of-pocket (MOOP) (medical and prescription) — The maximum out-of-pocket limit includes the total of the deductible, co-pays and co-insurance for eligible, in-network services. After the individual or family amount has been satisfied, the health plan covers all eligible, in-network health care expenses, including co-pays, for the rest of the plan year.

Medicare-coordinating plan — A medical plan designed to coordinate with Original Medicare coverage and pay some medical and prescription drug costs not paid by Medicare.

Network provider — A doctor, hospital or other health care facility that has entered into a contract to provide medical services or supplies at agreed-upon rates to participants and their dependents who are covered by the plan.

Non-contributory coverage — Coverage for which the entire cost is paid by the employer for either an employee, eligible dependent(s) or both.

Non-preferred drugs — A list of prescribed medications that are not on the plan's formulary.

Non-preferred provider — A provider who does not have a contract with your health insurer or plan to provide services to you. Participants will pay more to see a non-preferred provider. Participants should check their policy to see if their providers are contracted with their health insurance or plan or if their health plan has a tiered network requiring them to pay more to see some providers.

Paid-through date — The last date for which an employee has contributed or paid the full cost of medical coverage for himself/herself or an eligible dependent(s).

Participant — A person enrolled in any plan coverage offered by GuideStone.

Portability — A provision that allows participants, with evidence of insurability, to move terminated Group Term Life and AD&D Plans coverage to an individual direct payment policy with Unum.

PPO health plan — A health plan that provides savings for participants who use doctors, hospitals and other health providers that are a part of the plan's network.

Preferred drugs — Also known as formulary drugs, this is a list of commonly prescribed, brand-name medications that are selected based on their clinical effectiveness and opportunities to help control your plan's costs.

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

Protected health information (PHI) — Information that can identify an individual, which is used or created as a result of health plan operations.

Rescission — As it relates to health care reform, rescission is the retroactive revocation or termination of a person's medical coverage, and it is prohibited except in certain situations, including intentional misrepresentation of material fact, fraud or non-payment of charges.

Retail pharmacy benefits — This refers to filling prescriptions at a participating network pharmacy. This approach is best for short-term prescriptions (up to 30-day). Participants could save money on co-pays by filling recurring prescriptions via mail order (see above).

Short-term disability — A sickness or injury that limits an employee from performing the material and substantial duties of his or her regular occupation and results in a 20% or more loss in weekly earnings due to the same sickness or injury.

Special enrollment event — A provision under the Health Insurance Portability and Accountability Act (HIPAA) that allows active employees in a group health plan to enroll themselves and/or eligible dependents in health care coverage outside of the annual enrollment period after experiencing certain life events.

Specialist — Any physician not considered a primary care physician.

Specialty drug — Specific prescriptions used to treat complex, chronic or special health conditions. One retail fill is allowed after which mail order is required.

Summary of Benefits and Coverage **(Summary)** — A provision of the health care reform law that provides a government-created template that all insurance companies and self-funded plans must follow to provide a summary of the benefits and coverage of their health plans to the participants of their plans.

Surviving spouse — A spouse that was covered on a deceased employee's coverage at his or her time of death and is thereby eligible to continue certain coverage after the employee's death.

Telemedicine — The use of telephone and/or live video technology in order to provide medical care.

Urgent care — Treatment at an urgent care facility for the onset of symptoms that require prompt medical attention.

Vision exam — Covers one annual eye exam per covered family member, which may include an eye health examination, dilation and/or refraction. Coverage does not include glasses or contact lenses (unless there has been a cataract extraction), eye surgery or retinal telescreening. See the *2017 Preventive Schedule* for additional vision screening coverage for children when performed by a pediatrician or primary care physician as part of an annual well-child visit.

Waiting period — The period of time an employee must be employed in order to become eligible for benefits under the program provided by the employer.

Wellness and preventive care — Refers to the services listed on the *2017 Preventive Schedule*, which are covered at 100%, not subject to the deductible. The 2017 *Preventive Schedule* is based on services required under the Affordable Care Act of 2010 (ACA).