

Group Plans

Care Plus Plan



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Intended for GuideStone Participant Use Only

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Intended for GuideStone Participant Use Only

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 Plus 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 mail order Prescription Drugs.

This booklet tells You about Plan benefits beginning January 1, 2011. Claims for medical Services or supplies You received before January 1, 2011 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)**

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

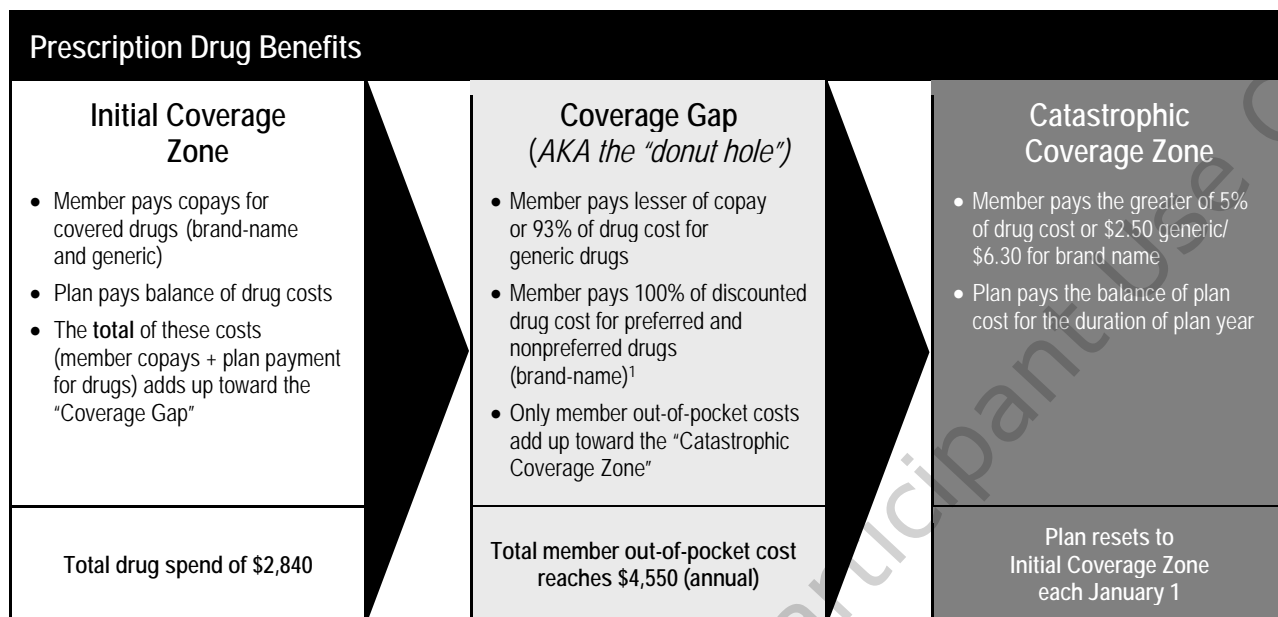
The **Benefit summary** summarizes many of your Plan benefits. This booklet discusses your benefits in more detail. Please read it carefully to understand the Plan's limitations and exclusions. Please do not rely only on this **Benefit summary** to understand the Plan.

Care Plus Plan

Medical Plans			
Part A services (as defined by Medicare)	Medicare pays	Care Plus plan pays	You pay ¹
Hospital stays: <ul style="list-style-type: none"> Semi-private room and board General nursing Other hospital services and supplies 	<ul style="list-style-type: none"> 100% days 1-60 Costs over \$283/day for days 61-90 Costs over \$566/day for days 91-150 (lifetime reserve days) 	<ul style="list-style-type: none"> 50% of Part A deductible (for every benefit period)² \$283/day for days 61-90 \$566/day for days 91-150 (lifetime reserve days); 100% after reserves are depleted All costs after 150 days 	50% of the Part A deductible ²
Skilled nursing facility care	<ul style="list-style-type: none"> 100% days 1-20 Costs over \$141.50/day for days 21-100 	Not a covered benefit	<ul style="list-style-type: none"> \$141.50/day for days 21-100 100% after 100 days
Part B services (as defined by Medicare)	Medicare pays	Care Plus plan pays	You pay ¹
Medical services & supplies: <ul style="list-style-type: none"> Doctors' services Inpatient and outpatient medical and surgical services/supplies Physical and speech therapy Diagnostic tests Durable medical equipment and other services 	80% of Medicare-approved amounts for covered services	Remaining 20% of Medicare-approved amounts for covered services	<ul style="list-style-type: none"> \$162 (Part B deductible)³
Diagnostic clinical laboratory service	100% of Medicare-approved amount for covered services	Not a covered benefit (Medicare covers at 100%)	Costs above Medicare-approved amounts or services not covered by Medicare

1. You are responsible for 100% of any charges not covered by Medicare or that are above the Medicare-approved amount.
2. You must pay 50% of the Part A deductible for every benefit period, which begins when you are admitted and ends when you have not received hospital or skilled nursing facility treatment for 60 days in a row.
3. You pay the Part B deductible once a year.

Summary



¹ Members will actually pay 50% of brand drug cost after a discount from the pharmaceutical manufacturer. The discounted amount will be charged at the pharmacy. The full retail cost of the drugs will still apply to getting out of the donut hole even though 50% was paid for by the pharmaceutical manufacturers.

Prescription Drug Copays:					
		Quantity (days' supply)	34	60	90
Retail Pharmacy	Generic ¹		\$8	\$16	\$24
	Preferred		\$35	\$70	\$105
	Non-Preferred		\$60	\$120	\$180
	Specialty Drug		\$50	\$100	\$150
	Generic ¹		\$6	\$11	\$16
Mail Order	Preferred		\$24	\$45	\$70
	Non-Preferred		\$40	\$80	\$120
	Specialty Drug		\$50	\$100	\$150
	Generic ¹		\$6	\$11	\$16

¹ Generic drug copays apply in both the Initial Coverage Zone and the Coverage Gap.

- Refer to your Evidence of Coverage plan document for further explanation.

<http://www.guidestoneinsurance.org/~media/Insurance/HealthMaterials/2010/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; 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
- Your Employer has fewer than 20 employees on the payroll as counted in accordance with applicable Medicare requirements; 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.

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.

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 Child who is disabled and is eligible for Medicare.

Your Child means:

- Your or Your Spouse's natural (biological) Child.
- Your or Your Spouse's legally adopted Child or a Child placed in your home for adoption.
- Your or Your Spouse's stepchild or foster Child.
- Your or Your Spouse's grandchild who is dependent on you for support and maintenance.
- 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. If You do not do these things at the right time, your dependents may be late enrollees.

If you lose coverage under another health plan, You can enroll after the initial 60-day period if You have been covered under either:

- COBRA Continuation Coverage, but the continuation period ended.
- Other group health care coverage that ended either because the Employer stopped making contributions or because eligibility ended due to age, legal separation, divorce, death, termination of employment or reduction in your work hours.

But You can enroll only if:

- Your prior group health care coverage was not terminated for cause (such as making a fraudulent claim or an intentional misrepresentation) or for late payment of contributions.

- You give your Employer a completed enrollment form no later than 31 days after the other health coverage ended.

If You meet all of these rules, your Plan coverage will begin on the first day after the other coverage ends. You may also enroll your Eligible Dependents under these special enrollment requirements, if they had other group health coverage and meet all of the other rules.

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.

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. Important Notice Requirement

You must report changes to coverage eligibility for You and Your covered dependants immediately. Failure to report could be interpreted as fraud or intentional misrepresentation as provided by the federal healthcare reform law known as the Patient Protection and Affordable Care Act (“PPACA”). GuideStone has adopted policies and procedures incorporating PPACA guidance. You may make unnecessary contribution payments that may not be refundable in accordance with those policies and procedures, and your coverage may be subject to rescission.

D. 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.
- The Plan stops offering Dependents Coverage.
- GuideStone or your Employer stops offering medical plans.
- Required contributions are not paid when due.

E. 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, **1-866-472-0924** or log onto the Highmark Web site, www.highmarkbcbs.com. A Highmark member service representative will help You with any coverage inquiry. Representatives are trained to answer your questions quickly, politely and accurately.

A. Highmark Web site

Highmark Blue Cross Blue Shield wants to help You have a greater hand in your health. Visit the Highmark Web site at www.highmarkbcbs.com for a world of information, interactive tools and Services. As a Blue Cross Blue Shield PPO participant, You have access to health and wellness information, user-friendly Services related to your PPO health care coverage, and valuable tools for managing your own health and well-being.

Here You can:

- Access a variety of Services related to your Blue Cross Blue Shield PPO coverage, order a Medical ID Card or Claim form, investigate a Claim, or find a Physician.
- Access valuable health resources. 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.
- Access fitness tools, calculators, a personal wellness profile that helps You identify your personal health risks and set goals to improve your wellness, and more.

Whether You want to evaluate your health and wellness, make better lifestyle choices, look at the advantages and disadvantages of various treatment options for a specific condition, or you're ready to improve your lifestyle, Highmark has the tools and resources to make it easier for you to take control of your overall health.

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. Claim and Appeal Procedure

This "Claim and Appeal Procedure" section is intended to comply with the applicable requirements of the Patient Protection and Affordable Care Act and the regulations and guidance issued thereunder. GuideStone reserves the right to change these claim and appeal procedures at any time as required or permitted by applicable law.

See **Appendix A** for the complete section on Claim and Appeal Procedures.

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.

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. Using Information and 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 and security of Individually Identifiable Health Information set forth in 45 C.F.R., Parts 160, 162 and 164, as 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 the "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 10(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 authorization under the Privacy Rule and provided further that The Genetic Information Nondiscrimination Act (“GINA”) prohibits the Plan from using or disclosing a PHI that is genetic information for underwriting purposes.;

- (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) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan (except with respect to enrollment and disenrollment information, Summary Health Information and PHI disclosed pursuant to an authorization) and ensure that any agents (including subcontractors) to whom it provides such Electronic PHI agree to implement reasonable and appropriate security measures to protect such information; and
- (j) report to the Plan any Security Incident of which it becomes aware; and

(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 10(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 10(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 10(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 10, 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.
 - In addition, an individual has a right to receive notice of a breach involving the individual's PHI, to the extent required by law

- (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 10(B)(2) above only if the Plan Sponsor has certified that the Plan has been amended to incorporate the provisions of this section 10(B)(5) and that it agrees with the restrictions and other rules set forth in section 10(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 10 or may delegate, in writing and in its sole discretion, any and all of its functions under this section 10 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. . Additional information is included in the Plan's Notice of Privacy Practices which may be accessed at:
http://www.guidestoneinsurance.org/~media/Insurance/PlanManagement/8008_HIPAAPrivacy%20pdf.ashx

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.

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

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 and Supplies 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 or supply for which the charge is made. A Benefit Period can be a calendar year or Plan year as determined by your Employer.

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. 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 and Supply.

Claims Administrator. . For eligibility claims, GuideStone. For medical benefits, Highmark Blue Cross Blue Shield. For prescription drug benefits, Medco Health Solutions, Inc. See Section 8 Claim and Appeal Procedure.

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 and Supplies which must be paid by You. See the **Benefit summary**.

Concurrent Care Claim. – A Claim after the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments that involves a reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments or any request by You to extend the course of treatment beyond the period of time or number of treatments.

Copayment. The amount You pay for Covered Services and Supplies 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 and Supply. A Service or supply for which benefits will be provided when rendered by a Provider or Supplier. 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 and Supplies that must be Incurred by a Covered Person before the Plan will assume any liability for all or part of the remaining Covered Services and Supplies.

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 Child who is disabled 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 Care. With respect to an Emergency Medical Condition –

- A medical screening examination from the emergency department of a Hospital and ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and
- Any further medical examination and treatment necessary to stabilize the patient. For this purpose, "to stabilize" means to provide such medical treatment of the Emergency Medical Condition as may be reasonably necessary to assure that no material

deterioration of the condition is likely to result from or occur during the discharge or other transfer of the patient from the Hospital.

Emergency transportation and related emergency Services provided by a licensed Ambulance Service shall constitute Emergency Care. Emergency Care shall not include treatment for an occupational Injury for which benefits are provided under any Workers' Compensation Law or any similar Occupational Disease Law.

Emergency Medical Condition. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that it could reasonably be expected that the absence of immediate medical attention would:

- Place the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Cause serious impairment to bodily functions; or
- Cause serious and permanent dysfunction of any bodily organ or part

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.
 - Clinical Laboratory.
 - 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.

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.

Independent Review Organization (“IRO”). An accredited by URAC or a similar nationally-recognized accrediting organization that will conduct external reviews in accordance with the procedures described in the “Claim and Appeal Procedure” section.

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.

Licensed Social Worker. A licensed Social Worker. Where there is no licensure law, the licensed Social Worker must be certified by the appropriate professional body.

Master Level Therapist. A provider with a current Master’s Degree in a recognized clinical discipline including Social Work, Psychology, or Counseling.

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 and Supplies.
- **Benefit Maximum** - the greatest amount payable by the Plan for a specific Covered Service and Supply.

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.

Occupational Therapist. A licensed Occupational Therapist. Where there is no licensure law, the Occupational Therapist 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 or supplies 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 Plus Plan. This booklet describes the Plan.

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

Prescription 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.
- Certified Registered Nurse.
- Chiropractor.
- Dentist.
- Licensed Practical Nurse.
- Licensed Social Worker.
- Master Level Therapist.
- Nurse-Midwife.
- Optometrist.
- Physical Therapist.
- Physician.

- Podiatrist.
- Psychologist.
- Speech-Language Pathologist.

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.

Rescission. A cancellation or discontinuation of coverage that has a retroactive effect, except to the extent attributable to non-payment of premiums, fraud or intentional misrepresentation.

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

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 or supplies 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.

URAC. A nationally recognized accrediting organization.

Urgent Care. Treatment at an urgent care facility for the on-set of symptoms that require prompt medical attention. Benefits will be determined according to the schedule of benefits for the level of Service provided.

Urgent Review. A HMS review that must be completed sooner than a prospective review in order to prevent serious jeopardy to a patient's life or health or the ability to regain maximum function, or in the opinion of a Provider with knowledge of a patient's medical

condition, would subject the patient to severe pain that cannot be adequately managed without treatment. Whether or not there is a need for an Urgent Review is based upon the HMS administrator's determination using the judgment of a prudent layperson who possesses an average knowledge of health and medicine. See also Section 8. Claim and Appeal Procedure.

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.

Intended for GuideStone Participant Use Only

Appendix A: Claim and Appeal Procedures

A. Internal Claims and Appeals

1. Eligibility

Eligibility and participation in the Plan is discussed in Sections 3 and 4. Who is Eligible. If You apply for coverage under the Plan or to change an election under the Plan and are denied, then You have the right to appeal this denial. All appeals involving eligibility must be submitted in writing to GuideStone, which is the Claims Administrator for appeals relating to eligibility. To be considered, the appeal must be filed with GuideStone within 180 days from the date You applied for coverage under the Plan or to change an election under the Plan. Your appeal should be sent to:

Senior Manager Customer Service
Insurance Operations Department
GuideStone Financial Resources
2401 Cedar Springs Rd.
Dallas, Texas 75201-1498

Two levels of appeal are allowed. GuideStone will decide the first level of appeal and provide You with written notice of its decision within 30 days of receipt of the written request for an appeal. If the request does not include sufficient information for GuideStone to make an intelligent decision, You will be notified of the need to provide additional information prior to the end of the 30-day period. You will have at least 45 days to respond to this request. If your first level appeal is denied, You will be given a reasonable period of time specified in the denial notice, not to exceed 180 days, to appeal such decision to the second level of appeal. Any second level of appeal will be decided within 30 days of its receipt. GuideStone's decision on the second level of appeal will be final and binding.

2. Medical Benefits or Prescription Drugs

a. How to File a Claim

How You file a Claim for benefits depends on whether the Claim involves a Claim for medical benefits or prescription drugs, as further described below. In addition, different claims procedures apply depending on whether the Claim is an Urgent Care Claim, Pre-Service Claim, Post-Service Claim or Concurrent Care Claim. See "Claim" in the "Definitions" section for additional information about each type of Claim.

Medical Benefits Claims

If You receive Services from a Network Provider, You will not have to file a Claim.

If You receive Services from an Out-of-Network Provider, You may be required to file the Claim yourself. To be considered, a Claim must be filed (by You or the Network or Out-of-Network Provider) within one year from the end of the year in which the date of Service occurs. All Claims involving medical benefits should be directed to Highmark Blue Cross Blue Shield, the Claims Administrator for the medical component of the Plan, at the following address:

Highmark Blue Cross Blue Shield
P. O. Box 1210
Pittsburgh, PA 15230-1210

Claim forms are available at: www.guidestone.org; Select Insurance, Forms & FAQs, Claims

Except for Urgent Care Claims, your Claim must be in writing on the required claim form. Urgent Care Claims may be oral or in writing on the required claim form. The required claim form is available from GuideStone, Highmark member services or the Highmark Web site. Make sure all information is completed properly, and then sign and date the form. Attach all itemized bills to the claim form and mail everything to the address on the form. Multiple Services for the same family member can be filed with one claim form. However, a separate Claim form must be completed for each person. Itemized bills must include the following information:

- The name and address of the Service Provider;
- The patient's full name;

- The date of Service;
- The amount charged;
- The diagnosis or nature of Sickness or Injury;
- For Durable Medical Equipment, the Physician's certification and date of rental or purchase;
- For Ambulance Service, the total mileage.

You must submit originals, so You will want to make copies for your records. Once your Claim is received by Highmark, itemized bills cannot be returned.

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. You are responsible for paying the Out-of-Network Provider the charges You incurred, including any difference between what You were billed and what the Plan paid.

Prescription Drug Claims

All Claims involving prescription drugs should be directed to Medco Health Solutions, Inc., the Claims Administrator for the prescription drug component of the Plan. Claims for reimbursement of prescription drug costs must be filed within one year from the end of the year in which the expenses were incurred. You may submit a Post-Service Claim if You are asked to pay the full cost of the prescription drug when You fill it and You believe that the Plan should have paid for it or You believe that the Copayment amount was incorrect. In addition, if a pharmacy (retail or home delivery) fails to fill a prescription that You have presented and You believe that it is covered under the Plan, You may submit a Pre-Service Claim. All Claims involving prescription drugs must be made to Medco Health Solutions, Inc. at the following address:

Medco Health Solutions, Inc.
P. O. Box 650322
Dallas, TX 75265-0322

Claim forms are available at: www.medcohealth.com

b. Timing of Initial Claim Decision

Once a Claim is submitted, the appropriate Claims Administrator will review the Claim and make a decision. Claims will be decided within different time frames depending on the nature of the Claim, as described below. If You do not receive a notice of the decision of the Claim within the applicable time period provided below, You will be deemed to have exhausted the claim and appeal process available under the Plan and shall be entitled to an external review or to pursue any available remedies under applicable law, such as judicial review.

Urgent Care Claim: If your Claim involves urgent care, You or your authorized representative will be notified of the Plan's initial decision on the Claim, whether adverse or not, as soon as possible, taking into account the medical exigencies. For Claims filed prior to July 1, 2011, the Claims Administrator must notify You of the decision no more than 72 hours after receiving the Claim. For Claims filed on or after July 1, 2011, the Claims Administrator must notify You of the decision no more than 24 hours after receiving the Claim. If the Claim does not include sufficient information for the Claims Administrator to make an intelligent decision, You or your representative will be notified within 24 hours after receipt of the Claim of the need to provide additional information. You will have at least 48 hours to respond to this request. The Claims Administrator then must inform You of its decision within 48 hours of the earlier of receiving the additional information or the end of the end of the period You are given to provide the additional information.

Pre-Service Claim: If your Claim is for a pre-service authorization, the Claims Administrator will notify You of its initial determination, whether adverse or not, as soon as possible, but not more than 15 days from the date it receives the Claim. This 15-day period may be extended by the Claims Administrator for an additional 15 days if the extension is required due to matters beyond the Claims Administrator's control. You will have at least 45 days to provide any additional information requested of You by the Claims Administrator.

Post-Service Claim: If your Claim is a Post-Service Claim, You are entitled to receive a written notice from the Claims Administrator, within 30 days of filing your Claim, telling You whether your Claim is to be allowed in whole or in part, or denied. If special circumstances require a period of more than 30 days to decide your Claim, this time limit may be extended

by an additional 15 days, and You will be notified of the extension within 30 days after You have filed your Claim. You will also have at least 45 days to provide any additional information requested by the Claims Administrator.

Concurrent Care Claim: If You have been approved to receive an ongoing course of treatment over a period of time or number of treatments, any termination or reduction will be considered a Concurrent Care Claim denial. The Claims Administrator will notify You of a reduction or termination of concurrent care benefits as soon as possible, but in any event early enough to allow You to have an appeal decided before the applicable benefit is reduced or terminated. The Claims Administrator will decide any Concurrent Care Claim that involves urgent care to extend or continue a course of treatment beyond the initial period of time or number of treatments within 24 hours if the Claim is received at least 24 hours prior to the expiration of the approved treatment. No extensions are permitted. The Claims Administrator will decide any non-urgent Concurrent Care Claims to extend or continue a course of treatment beyond the initial period of time or number of treatments in accordance with the Pre-Service Claim or Post-Service Claim rules, as appropriate.

c. Claim Denial

If your Claim is denied, in whole or in part, You will receive a written notice of the Plan's decision. This notice will include:

- The specific reason(s) for the denial, which, effective July 1, 2011, must include the denial code, the meaning of this code, and the standard, if any, that was used in denying the claim;
- The specific Plan provision(s) on which the denial is based;
- Any additional information needed to make your application for benefits acceptable and the reason this information is necessary;
- The procedure for requesting a review and the time limits applicable to such procedures, including a statement of your right to an external review;
- If an internal rule, guideline, or protocol was relied upon to determine a Claim, either a copy of the actual rule, guideline, or protocol, or a statement that the rule, guideline, or protocol was relied upon to determine the Claim will be provided to You free of charge upon request;
- If the decision is based on medical necessity or experimental treatment or a similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination based on the terms of the Plan and your medical circumstances, or a statement that You can receive the explanation free of charge upon request;
- In the case of an Urgent Care Claim, an explanation of the expedited claim review procedure. The Claims Administrator may notify you of a decision involving urgent care orally within the required timeframe and follow-up with a written or electronic notice no later than three days after the notification; and
- Effective July 1, 2011, information sufficient to identify the Claim involved, including the date of service, the health care provider, the Claim amount (if applicable), the diagnosis code, the treatment code, and the corresponding meanings of these codes;
- Effective July 1, 2011, information about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who can assist You with internal claims and appeals and external review processes.

d. Internal Appeal Procedure

If You disagree with the initial claim decision, there is a review procedure You, your beneficiary or authorized representative must follow. Under this procedure You can get a review of your benefit decision. You must also follow this procedure to appeal any rescission of coverage. A rescission is a retroactive termination of coverage for a reason other than your failure to timely pay required premiums for coverage. A rescission is permitted if You (or an individual seeking coverage on your behalf) performs an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact.

All appeals must be made to the Claims Administrator pursuant to the procedure described in the denial letter (see the "Claims Administrators" section below). The Plan generally requires two levels of internal appeal. If, after exhausting two levels of appeals, You are not satisfied with the final determination, You are entitled to request an external review of your Claim unless the Claim relates to your eligibility under the Plan. If your Claim involves urgent care or an ongoing course of treatment, You may be entitled to an expedited external review at the same time as the internal appeals process. See the "External Review" section below for additional

information. Any questions about the process for requesting review should be addressed to the Claims Administrator (see the "Claims Administrators" section below).

Here is some relevant information about the internal appeal procedure:

- You must submit a written request to the Claim Administrator for the review of the denial in accordance with the procedures set forth in the notice of denial;
- You will be given reasonable access to, and copies of, all documents relevant to the Claim, free of charge;
- You will be permitted to review the Claim file and to present evidence and testimony;
- If any new or additional evidence is considered, relied upon, or generated by the Plan (or at the direction of the Plan) or if the Plan's decision is based on a new rationale, then You will be provided with such evidence or rationale, free of charge, as soon as possible and sufficiently in advance of the date by which the Plan is required to decide the final appeal (in order to provide You with a reasonable opportunity to respond prior to such date);
- You may submit documents, issues and comments in writing - these will be reviewed even if they were not considered in the initial claim determination;
- You may have your Claim reviewed by a health care professional retained by the Claims Administrator if the denial was based on a medical judgment (this individual will not have participated in the initial denial); and
- You may request and be provided with the identification of any medical or vocational experts whose advice was obtained on behalf of the Claims Administrator in connection with the Claim, even if this advice was not relied upon;
- If your appeal involves reducing or terminating an ongoing course of treatment, the Plan will provide continued coverage during the internal appeal process; and
- Effective July 1, 2011, if the Plan fails to strictly adhere to all the requirements of the internal claim and appeal procedures set forth above, You will be deemed to have exhausted the internal claim and appeal procedures and may initiate an external review (as described below) and pursue any remedies available under applicable law, such as a judicial review.

The review of a Claim denial during the internal appeal will be conducted by a Plan fiduciary who will not be the individual who made the initial adverse benefit determination, nor the subordinate of such individual. This fiduciary will not give deference to the initial Claim denial or initial appeal decision. A review decision on your appeal must be made according to the following timetable:

Urgent Care Appeals - If an Urgent Care Claim is denied, one level of appeal is allowed. You will be given 180 days to appeal. Urgent care appeals may be submitted orally or in writing. Any urgent care appeals received will be decided within 72 hours of receipt, and You will be provided written or electronic notification of the appeal determination. Extensions beyond this time period will not be permitted.

Pre-Service Appeals - If a Pre-Service Claim is denied, two levels of appeal are allowed.

- First Level: You will be given 180 days to file a first level appeal. The first level of appeal will be decided within 15 days of its receipt. Extensions beyond this time period will not be permitted.
- Second Level: If your Claim is denied on the first level of appeal, You will be given a reasonable period of time specified in the denial notice, not to exceed 180 days, to appeal such decision to the second level of appeal. Any final second level of appeal will be decided within 15 days of its receipt. Extensions beyond this time period will not be permitted.

Post-Service Appeals - If a Post-Service Claim is denied, two levels of appeal are allowed.

- First Level: You will be given 180 days to file a first level appeal. The first level of appeal will be decided within 30 days of its receipt. Extensions beyond this time period will not be permitted.
- Second Level: If your claim is denied on the first level of appeal, You will be given a reasonable period of time specified in the denial notice, not to exceed 180 days, to appeal such decision to the second appeal level. Any final second level of appeal will be decided within 30 days of its receipt. Extensions beyond this time period will not be permitted.

Concurrent Care Appeals - Any concurrent care appeal to extend or continue a course of treatment beyond the initial period of time or number of treatments will be decided in accordance with the rules for appealing Urgent Care, Pre-Service or Post-Service Claims set forth above, as applicable. Urgent concurrent care appeals may be oral or in writing.

e. Internal Appeal Denials

If your Claim is denied during the first or second level of appeal, in whole or in part, the written notice of the Plan's decision will include:

- The specific reason(s) for the decision, which, effective July 1, 2011, must include the denial code, the meaning of this code, the standard, if any, that was used in denying the Claim, and a discussion of the decision;
- The specific Plan provision(s) on which the denial is based;
- A statement that you are entitled to have access to, and copies of, all documents relevant to your Claim free of charge;
- A description of your right to initiate a second level of internal appeal (if applicable) and your right to bring an external review;
- If an internal rule, guideline, or protocol was relied upon to determine a Claim, either a copy of the actual rule, guideline, or protocol, or a statement that the rule, guideline, or protocol was relied upon to determine the Claim and will be provided to You free of charge upon request;
- If the decision is based on medical necessity or experimental treatment or a similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination based on the terms of the Plan and your medical circumstances, or a statement that You can receive the explanation free of charge upon request;
- A statement informing You that other voluntary alternative dispute resolution options, such as mediation, may be available;
- Effective July 1, 2011, information sufficient to identify the Claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code, the treatment code, and the corresponding meanings of these codes.
- Effective July 1, 2011, information about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to assist You with internal claims and appeals and external review processes.

f. Conflicts of Interest

All claims and appeals will be decided fairly and impartially. That means that the Plan will not make any decisions affecting the person(s) involved in deciding your Claim (such as decisions relating to hiring, compensation, termination, or promotion) based on the likelihood that that person will deny your Claim.

B. External Review

1. Eligibility for an External Review

If, after exhausting all available internal appeals, You are not satisfied with the final determination, You may request an external review in accordance with the procedures set forth in the denial notice. You must satisfy the following requirements to be eligible for an external review:

- You must have been covered under the Plan at the time the health care item or service was requested or provided, as applicable;
- The adverse benefit determination must not relate to your failure to satisfy the requirements for eligibility under the terms of the Plan;
- You must exhaust the Plan's internal claim and appeal procedures (described above) unless You qualify for an expedited external review as described below or unless the Claim is incurred on or after July 1, 2011 and these procedures are deemed exhausted as a result of the Plan's failure to strictly adhere to the internal claim and appeal procedures described above; and

- You must provide all the information and forms required to process an external review.

2. Timing for Filing an External Review

If You are eligible for an external review, You must file a request for external review within four months after the date You receive a final denial notice. If there is no corresponding date four months after You receive notice, then the request must be filed by the first day of the fifth month following the date You receive notice. For example, if You receive a final denial notice on October 30, You must file your external review request by March 1 (because there is no February 30). If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next business day.

3. Expedited External Reviews

You are entitled to request an expedited external review under the following circumstances:

- If the Claim involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life, health, or ability to regain maximum function, You may request an expedited external review after the initial claim denial or after a denial on either level of appeal; or
- If the Claim concerns an admission, availability of care, continued stay, or health care item or service for which You received emergency services, but have not been discharged from a facility, You may request an expedited external review after the denial of the Claim after a denial on the final level of internal appeal.

4. External Review Procedure

Within five business days following the date of receipt of your external review request (or immediately after receiving your request for expedited external review), the Claims Administrator must complete a preliminary review to determine whether You are eligible for an external review. Within 1 business day after completing the preliminary review (or immediately upon completing the preliminary review of a request for an expedited external review), the Plan must provide You with a written notification with the following information:

- If the request is complete but the Claim is not eligible for external review, the notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).
- If the request is not complete, the notification will describe the information or materials needed to make the request complete and the Plan must allow You to submit this information or material within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

All timely-filed requests that are eligible for an external review will be assigned to a properly accredited independent review organization (“IRO”). In order to remove any bias and ensure independence, the Claims Administrators for the medical and prescription drug components of the Plan will each contract with at least 3 IROs on behalf of the Plan and will incorporate an independent, unbiased method for assigning claims to the IROs. The IRO will not be eligible for any financial incentives based on the likelihood that it will support the denial of benefits.

After the Claim is assigned to the IRO, the IRO will send You a written notice stating that the Claim is eligible and has been accepted for external review and a statement permitting You to submit additional information in writing within 10 business days of the date You receive such notice. The IRO is not required to accept additional information after 10 business days.

The Plan must provide the IRO with the documents and information considered in the Claim or appeal denial within 5 business days after the date the IRO is assigned the Claim (or in the case of an expedited external review, the Plan must provide this information electronically, by telephone, by facsimile, or some other expeditious method). If the Plan fails to do so, the IRO may reverse the denial of your Claim. The Claims Administrators will provide the IRO with the documentation. GuideStone will also receive a copy of documentation sent to an IRO for medical benefits appeals.

If You submit any additional information to the IRO, the IRO must forward it to the Claims Administrator within 1 business day of receipt of the additional information. The Claims Administrator must then reconsider the denial of your Claim or appeal that is the subject of the external review. The reconsideration will not delay the external review. If the Claims Administrator decides to reverse its decision based on the additional information, the Claims Administrator must notify You and the IRO within 1 business day of such decision and the external review may be terminated.

The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will not be bound by any decisions or conclusions reached during the Plan's internal claim and appeal process. The IRO will utilize legal experts where appropriate to make coverage determinations under the Plan. In addition to the documents and information provided, the IRO may consider the following information in reaching a decision to the extent it is available and appropriate:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Plan, You or your treating provider;
- The terms of the Plan;
- Appropriate practice guidelines, which must, at a minimum, include applicable evidence-based standards;
- Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
- The opinion of the IRO's clinical reviewer(s) after considering relevant information described above.

5. External Review Decisions

The IRO must provide You with written notice of its decision within 45 days after it receives your request for external review. In the case of an expedited external review, the IRO must provide notice of its decision as quickly as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives your request for expedited external review. If the notice is not in writing, the IRO must provide You with written notice within 48 hours after providing notice of its decision. The written notice for all decisions must include the following:

- A general description of the reason for the external review request, including information identifying the Claim (including the date(s) of the Service, the health care provider, the Claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
- The date the IRO received the assignment to conduct the external review and the date of the IRO's decision;
- The evidence or documentation the IRO considered in reaching its decision;
- The principal reason or reasons for the IRO's decision, including its rationale and any evidence-based standards that were relied upon in making the decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to You;
- A statement that judicial review may be available to You; and
- Current contact information, including a phone number, for any applicable office of health insurance consumer assistance or ombudsman.

The IRO must maintain records of all Claims and notices associated with the external review for 6 years following its decision. These records will be made available upon request for examination by You, the Plan, or State or Federal oversight agencies, except where such disclosure would violate State or Federal privacy laws.

If the IRO reverses the Claim or appeal denial, the Plan must immediately provide You coverage or payment for the Claim.

C. Exhaustion of Review Remedies

You must properly file a Claim for benefits, and complete all steps in the appeal process described in this section before seeking a review of your Claim for benefits in a court of law. The decision of the IRO shall be the final decision of the Plan. After the IRO makes its final decision, You may seek judicial remedies in accordance with your rights. No legal action may be started more than two years after a Claim is required to be filed under the terms of the Plan.

D. Effect of Decisions

GuideStone, the Claims Administrators, and the applicable IRO have the power, including, without limitation, discretionary power, to make all determinations that the Plan requires for its administration, and to construe and interpret the Plan whenever necessary to carry out its intent and purpose to and to facilitate its administration, including, but not by way of limitation, the discretion to grant or deny claims for benefits under the Plan. All such rules, regulations, determinations, constructions and interpretations made by GuideStone, the Claims Administrator, and the applicable IRO will be conclusive and binding.

E. Claims Administrators

Below is contact information for each of the Claims Administrators for the Plan:

Eligibility Appeals

Senior Manager Customer Service
Insurance Operations Department
GuideStone Financial Resources
2401 Cedar Springs Rd.
Dallas, Texas 75201-1498
888-984-9833

Medical Benefits Appeals

Highmark Blue Cross Blue Shield
P. O. Box 1210
Pittsburgh, PA 15230-1210
866-472-0924

Prescription Drug Appeals

Medco Health Solutions, Inc.
P. O. Box 631850
Dallas, TX 75063-0030
Attn: Appeals
800-555-3432

F. 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.
- Benefits payable to a Network Provider will be paid directly to the Network Provider on behalf of You or a dependent.
- Benefits payable to a Transplant Network Provider will be paid directly to the Provider.

G. Medical Examinations

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

H. 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.

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