Senior No Rx Plan

Group Plans

Produced by GuideStone Financial Resources of the Southern Baptist Convention

Effective January 1, 2021

IMPORTANT INFORMATION

Please be aware that the coverage made available hereunder may be prohibited or unadvisable in certain countries. GuideStone may be able to provide some general information or assistance in this regard, but GuideStone is not in a position to provide legal advice to employers or employees in such countries.

This is not a Medicare supplement plan.

This Plan coordinates with Original Medicare

Original Medicare is primary to this Plan.

1. Your booklet

A. Introduction

Thank You for choosing this Plan from GuideStone Financial Resources of the Southern Baptist Convention (GuideStone). This document constitutes your Group Senior Plan (Plan). The GuideStone Plan is made available to eligible employers for their 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 the payment of Claims, but has no liability for the funding of the Plan benefits.

This booklet tells You about Plan benefits beginning January 1, 2021. Claims for medical Services You received before your current Plan effective date 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:	**1-844-INS-GUIDE** (1-844-467-4843)
Highmark Blue Cross Blue Shield (Highmark):	**1-866-472-0924**
Medicare:	**1-800-Medicare** (1-800-633-4227)

C. Important websites

www.GuideStone.org
www.highmarkbcbs.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.

Senior No Rx Plan

MEDICAL BENEFITS			
Part A services Hospital services per benefit period (as defined by Medicare)	**Medicare pays**	**Senior Plan pays**	**You pay[1]**
Hospital stays Semi-private room and board General nursing Other hospital services and supplies	• 100% days 1-60 • Costs over $352/day for days 61-90 • Costs over $704/day for days 91-150 (lifetime reserve days)	• 50% of Part A deductible (for every benefit period) • $352/day for days 61-90 • $704/day for days 91-150 (lifetime reserve days) • 100% after reserve days are depleted • All costs after 150 days	• 50% of the Part A deductible
Blood • First three pints • Additional amounts	• Nothing • 100%	• Nothing	• 100% • Nothing
Skilled nursing facility care	• 100% days 1-20 • Costs over $176/day for days 21-100	• Nothing	• $176/day for days 21-100
Hospice Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill, and you elect to receive these services	• All but very limited co-pay/ co-insurance for outpatient drugs and inpatient respite care	• Nothing	• Co-pay/ co-insurance for outpatient drugs and inpatient respite care

[1] You are responsible for 100% of any charges not covered by Medicare Part A or that are above the Medicare Part A approved amount.

Part B services Medical services per calendar year (as defined by Medicare)	Medicare pays	Senior Plan pays	You pay[1]
Preventive care[2] For recommended preventive care services, including an annual wellness visit	• 100%	• Nothing	• Nothing
Medical services & supplies Doctors' services Inpatient and outpatient medical and surgical services/supplies Physical and speech therapy Diagnostic tests Durable medical equipment and other supplies	• 80% of Medicare-approved amounts for covered services	• Not a covered benefit	• 100% of the Part B deductible[3] • Remaining 20% of Medicare-approved amounts for covered services
Outpatient mental health services	• 80% of Medicare-approved amounts for covered services	• Not a covered benefit	• 100% Part B deductible[3] • Remaining 20% of Medicare-approved amounts for covered services
Clinical laboratory service Tests for diagnostic services	• 100% of Medicare-approved amounts for covered services	• Not a covered benefit	• Costs above Medicare-approved amounts or services not covered by Medicare
Part B excess charges Up to 15% above Medicare-approved amounts	• Nothing	• Not a covered benefit	• 100% of Part B charges

[1] You are responsible for 100% of any charges not covered by Medicare Part B or that are above the Medicare Part B approved amount.

[2] For those enrolled in Medicare Part B. Medicare pays 100% of costs for recommended preventive care services (including an annual wellness visit), per *Your Guide to Medicare Preventive Services*. You may find a copy of this guide at *www.medicare.gov.*

[3] You pay the $198 Part B deductible once a year.

Part A and B services	Medicare pays	Senior Plan pays	You pay[1]
Home Health Care • Medicare-approved services • Durable medical equipment	• 100% of medically necessary skilled care services and medical supplies • 80% of Medicare-approved amounts	• Nothing for home health care services • Not a covered benefit for Part B services	• Nothing for home health care services • 100% of the Part B deductible[2] • Remaining 20% of Medicare-approved amounts for durable medical equipment
Benefits not covered by Medicare	**Medicare pays**	**Senior Plan pays**	**You pay**
Foreign travel emergency Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA	• Nothing	• Not covered benefit	• 100%

[1] You are responsible for 100% of any charges not covered by Medicare or that are above the Medicare-approved amount.
[2] You pay the $198 Part B deductible once a year.

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 healthcare expenses.

3. Who is eligible

A. Retiree Coverage

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

You are an Eligible Retiree if all of the following apply:

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

Covered Classes are groups of retirees to whom your Employer offers Plan coverage. Your Employer may put retirees into groups based on such things as years of service, and other factors. Your Employer decides which groups of retirees are Covered Classes under the Plan.

Your Employer may offer Plan coverage to some, but not to all groups of retirees.

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

B. Dependent Coverage

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

To get Dependent Coverage, You must have Retiree Coverage under this Plan.

Your Eligible Dependent under this Plan is:

- Your Spouse who is eligible for Medicare and not actively working for an eligible Employer.
- Your Child who is disabled and is eligible for Medicare and not actively working for an eligible Employer.
- Not on active duty in the armed forces of any country.

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 or Your Spouse must provide healthcare by court order or order of a state agency authorized to issue National Medical Support Notices under federal law.
- A Child for whom You or Your Spouse 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 this Plan as a dependent of two Covered Persons. You must decide which of You will carry the Child as a dependent. You also have to tell your Employer what You decide.

4. When coverage begins

A. Enrolling yourself

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

- Be eligible for coverage.
- Give your Employer a signed enrollment form no later than the 20th of the month prior to the date You first become eligible.
- Pay any required costs of coverage.

If You meet the above requirements, You will be covered on the date You are eligible.

B. Enrolling your dependents

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

- Enroll yourself for Retiree Coverage.
- Give your Employer a signed enrollment form for your Eligible Dependents no later than the 20th of the month prior to the date You first become eligible.
- Pay any required costs of coverage.

If You meet the above requirements, your Dependent Coverage will begin when your Retiree Coverage begins. Any Eligible Dependents You do not enroll when You enroll yourself for Retiree Coverage may be enrolled later upon first Medicare eligibility or loss of eligibility for other coverage.

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

C. Dropping dependents from coverage

You can drop a dependent from your coverage at any time. You must tell your Employer promptly about the change and submit a Medicare termination form to your Employer.

5. When coverage ends

A. End of Retiree Coverage

Your Retiree Coverage will end when any of these things happen:

- GuideStone or your Employer stops offering the Plan.
- You are no longer eligible for Medicare.
- Required costs of coverage are not paid when due.
- You become enrolled in any other Medicare Part D plan.

B. End of Dependent Coverage

Your dependents will lose coverage if any of these things happen:

- 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 Dependent Coverage.
- Required costs of coverage are not paid when due.
- Your Spouse or Child becomes enrolled in any other Medicare Part D plan.

C. Important Notice Requirement

You must report changes to coverage eligibility for You and your Covered Dependent immediately. Failure to report could be interpreted as fraud or intentional misrepresentation. You may make unnecessary contribution payments that may not be refundable in accordance with GuideStone policies and procedures, and your coverage may be subject to retroactive termination.

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 of these things happen:

- Your dependent is no longer an Eligible Dependent.
- The Plan, or your Employer stops offering Dependent Coverage.
- GuideStone or your Employer stops offering this Plan.
- Required costs of coverage are not paid when due.
- Your Spouse or Child becomes enrolled in any other Medicare Part D plan.

6. Covered Services and Supplies

The term Covered Services and Supplies means the expenses Incurred by or on behalf of a person for the charges listed below if they are Incurred after You become covered for these benefits. Expenses Incurred for such charges are considered covered expenses to the extent that the Services or supplies provided are first determined by Medicare to be eligible.

Covered Services and Supplies:

- Charges made for Part A Medicare Eligible Expenses.
- Other Covered Services and Supplies as shown in the "Benefit summary".

7. Plan Exclusions

A. The Plan does not cover all medical expenses

This section tells You about many of the services and supplies that the Plan does not cover. If You have any questions about coverage, call or write to the Claims Administrator before You receive the Service or supplies.

B. Exclusions

The Plan does not cover charges for You or your Covered Dependents for any Services or supplies that are:

- Not a Medicare Eligible Expense.
- Beyond the limits imposed by Medicare for such expense.
- Excluded by name or specific description by Medicare.
- Charges made for Part B Medicare eligible expenses
- Any portion of a Covered Service or Supply to the extent paid by Medicare.
- Any benefits payable under one benefit of this Plan to the extent payable under another benefit of the Plan.
- Covered Services Incurred after coverage terminates.
- Other Services and Supplies as shown in the "Benefit summary" as not covered.

Typically, Medicare does not cover the following:

- Expenses for supplies, care, treatment or surgery that is not medically necessary.
- To the extent that You or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- To the extent that payment is unlawful where the person resides when the expenses are Incurred.
- Charges made by a Hospital owned or operated by or which provides care or performs service for the United States Government, if such charges are directly related to a military service connected Injury or Sickness.
- Charges for or in connection with an Injury or Sickness which is due to war, declared or undeclared.
- Charges which You are not obligated to pay or for which You are not billed or for which You would not have been billed except that they were covered under this Plan.
- Charges for or in connection with experimental, investigational or unproven Services that are
    - Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed.
    - Not approved by the U. S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use.
    - The subject of review or approval by the review board for the proposed use.
- Cosmetic surgery and therapies defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- Unless otherwise covered in this Plan, for reports, evaluations, physical examinations or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.

- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this Plan.
- Private Hospital rooms and/or private duty nursing.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, complimentary meals and other articles which are not for the specific treatment of an Injury or Sickness.
- Blood administration for the purpose of general improvement in physical condition.
- Charges for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Charges made by any covered provider who is a member of your family or your Dependent's family.

8. Outpatient Prescription Drug program

Outpatient Prescription Drugs are not covered under this Plan.

9. Claim and Appeal Procedure

See "Appendix 1" for complete information on Claim and Appeal Procedures. GuideStone reserves the right to change these claim and appeal procedures at any time as required or permitted by applicable law.

10. Coordination with Original Medicare

Plan coordinates with Original Medicare. Benefits provided under this Plan will not duplicate any benefits paid by Original Medicare. Determination of the amount payable under this Plan will be based upon the difference between the amount paid by Medicare and the Medicare Approved Amount for Part A.

11. When someone else is responsible for your Sickness or Injury

A. Subrogation

Subrogation means that if another person causes you or your Covered Dependent to have a Sickness or Injury and the Plan pays benefits relating to the Sickness or Injury, then the Plan has the right to recover the amount of benefits it has paid from that other person or, if the person (or the person's insurance company) has paid you or your Covered Dependent, from you or your Covered Dependent. The Plan's right to recover benefits it has paid in this situation is called its "right of subrogation."

For example, if you have an Injury due to an Accident that was caused by another person and the Plan pays benefits for treatment of the Injury, then the Plan has the right to sue the person who caused the Accident for the amount of benefits the Plan has paid for your care and treatment. Also, if the person who caused the Accident (or an insurance company for that person) pays you any amount for the damage caused in the Accident, the Plan has the right to require that you repay the Plan for the benefits it has paid for you. This includes the right to withhold future payment of benefits until you have reimbursed the Plan.

The Plan's right to seek repayment of benefits it has paid applies even if you have not received payment for all of the damages you suffered. In addition, the Plan's right of subrogation applies to any funds paid to you, your estate, any beneficiary or to any other person, entity or trust as payment for damages you suffered, including damages for pain and suffering, without deducting the amount of any legal fees owed to any lawyer you have retained or other litigation expenses.

The Plan's subrogation rights do not apply to any money you receive under an individual insurance policy that you have purchased separately for yourself or your dependents and do not apply if and to the extent specifically prohibited by law

B. Transfer of rights

In those instances where this section applies, the rights of You or your Covered Dependent to claim or receive compensation, damages, or other payment from the other party or parties are automatically transferred to the Plan, but only to the extent of benefit payments made under this Plan.

Obligations of You and your Covered Dependent

To secure the rights of the Plan under this section, You or your Covered Dependent must:

- Complete any applications or other instruments and provide any documents the Plan might require, and cooperate with the Claims Administrator or its agents in order to protect the subrogation rights of this Plan.
- If payment from the other party or parties has been received, or deposited into any account, fund or trust, reimburse the Plan for benefit payments (but not more than the amount paid by the other party or parties before legal fees and other litigation expenses are deducted).
- You or your Covered Dependent will not take any action that prejudices the rights of this Plan. If You or your Covered Dependent enter into litigation or settlement negotiations regarding obligations of other parties, You or your Covered Dependent must not prejudice, in any way, the subrogation rights of the Plan.

The costs of legal representation retained by the Plan in matters related to subrogation will be borne solely by the Plan. The costs of legal representation retained by You or your Covered Dependent will be borne solely by You or your Covered Dependent.

12. 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 that has not made a 410(d) election under ERISA, it is not subject to the requirements of ERISA. For example, this Plan does not have to follow the COBRA Continuation Coverage requirements.

C. Group health plan

This Plan is intended to be a group health plan as defined in the Employee Retirement Income Security Act (ERISA).

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 healthcare Providers, including Hospitals, are independent contractors to GuidStone. No healthcare Provider works for GuideStone either as an employee or agent. No GuideStone employee works for any healthcare Provider, either as an employee or agent. That means that each healthcare 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 healthcare provider.

13. Your confidential medical information

A. Collecting information

We rely on information from You and your Covered Dependent 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 in this section the "Covered Entity") 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(s) 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 16(B), or as otherwise required by HIPAA.
(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 Covered Entity 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, 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, disenrollment, employee costs of coverage, 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 at Your employer handling your employee benefits program; provided that nothing in this section 16(B)(2) shall permit or require the disclosure of PHI to Your employer to the extent such disclosure is prohibited by HIPAA.
(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 website communications, marketing, fundraising, research, and on-site medical staff needs;
(h) by persons handling information systems, mailroom/fax delivery, research and product development, legal services, finance, accounting, and audit for the Plan.
(i) as otherwise permitted by, and in compliance with, HIPAA; provided that nothing in this section 16(B)(2) shall permit or require the disclosure of PHI to the Covered Entity to the extent such disclosure is prohibited by HIPAA.

(3) Requirements of Covered Entity. The Covered Entity shall:

(a) 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 business associates (including subcontractors) to whom it provides such Electronic PHI agree to implement reasonable and appropriate security measures to protect such information.
(b) report to the Plan any Security Incident of which it becomes aware.
(c) 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.
(d) ensure that any business associate (including a subcontractor) to whom the Covered Entity 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 Covered Entity under this section 16(B)(3).
(e) 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 Covered Entity other than the Plan or a health benefit provided under the Plan.
(f) 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 16(B)(3) and of which the Covered Entity becomes aware.
(g) make the PHI of a Plan participant, Spouse or Covered Dependent(s) available to that Individual, upon the Individual's written request, in accordance with the requirements of the Privacy Rule.
(h) incorporate amendments of PHI of a Plan participant, Spouse or Covered Dependent(s) as and to the extent required by the Privacy Rule.
(i) make available to a Plan participant, Spouse or Covered Dependent(s) 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.
(j) make the Covered Entity'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.
(k) if feasible, return or destroy all PHI received from the Plan or any Health Insurance Issuer providing benefits under the Plan that the Covered Entity 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.
(l) 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 Covered Entity 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 16(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 Covered Entity.
(c) Non-compliance. If the Covered Entity becomes aware of any issues relating to non-compliance with the requirements of this section 16, the Covered Entity 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 Covered Entity to be responsible for such non-compliance, shall be subject to disciplinary action, as determined by the Covered Entity, 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.
- Reprima
- 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 Covered Entity. The Plan or any Health Insurance Issuer providing benefits thereunder shall disclose PHI to the Covered Entity and to the individuals described in section 16(B)(2) above only if the Covered Entity has certified that the Plan has been amended to incorporate the provisions of this section 16(B)(5) and that it agrees with the restrictions and other rules set forth in section 16(B)(3).

(6) Authorized representative. The Plan shall recognize an individual who is the authorized representative of a Plan participant, Spouse or Covered Dependent(s) as if the individual were the Plan participant, Spouse or Covered Dependent(s) himself or herself provided that the Individual has designated the authorized representative in accordance with the procedures established by the Covered Entity.

(7) Action by the Covered Entity. The Covered Entity may act as prescribed in this section 16 or may delegate, in writing and in its sole discretion, any and all of its functions under this section 16 to the Privacy Officer or other officer or employee or to a group of officers or employees of the Covered Entity. The Covered Entity or such delegate shall have the authority to establish rules and prescribe forms and procedures for performing its functions.

(8) Action by member. For additional information or to contact the Covered Entity, You may call the GuideStone toll free number at 1-844-INS-GUIDE 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.guidestone.org/hipaa.*

14. 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.
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.

Alcohol/Drug Abuse. Any use of alcohol/drug which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.

Alcohol/Drug Abuse Treatment Facility. A Facility Other Provider licensed by the state and approved by the Joint Commission on Accreditation of Healthcare Organizations which, for compensation from its patients, is primarily engaged in providing detoxification or rehabilitation treatment for Alcohol/Drug Abuse. This facility must also meet the minimum standards set by the appropriate governmental agency.

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.
- 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 Anesthesia for covered Surgery when ordered by the attending Professional Provider and rendered by a Professional Provider other than the surgeon or the assistant at surgery.

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 under this Plan is a calendar year except when referring to Medicare Part A hospitalizations.

Birthing Facility. A Facility Other Provider licensed by the state which, for compensation from its patients, is primarily organized and staffed to provide maternity care and is under the supervision of a Nurse-Midwife.

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 healthcare facility, as defined in the Health Care Facilities Act, or by an anesthesiology group.

Child. Your Child, including:

- 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 or Your Spouse must provide healthcare by court order or order of a state agency authorized to issue National Medical Support Notices under federal law.
- A Child for whom You or Your Spouse are a 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. Claim includes:

- **Post-service Claim** – A request for payment or reimbursement of the charges or costs associated with a Covered Service and Supply that You have received.
- **Pre-service Claim** – A request for prior approval of a Service or supply which may need to be approved before You receive the Covered Service and Supply.
- **Urgent Care Claim** – A Pre-service Claim which, if decided within the time periods established for making non-urgent care Pre-service Claim decisions, could seriously jeopardize your life, health, ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, would subject You to severe pain that cannot be adequately managed without the Service.

Claims Administrator. For eligibility claims, GuideStone. For medical benefits, Highmark Blue Cross Blue Shield. See "Appendix 1" for Claim and Appeal Procedure.

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

Co-insurance. The percentage of eligible expenses You and the Plan share. The exact Co-insurance depends on the Plan provisions. Your Co-insurance will be the amount of Covered Services or Supplies which must be paid by You.

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.

Continuation Coverage. Plan coverage available to You and your Covered Dependent(s) when coverage under the Plan would otherwise end. See "When coverage ends."

Co-payment (Co-pay). The fixed, up-front dollar amount You pay for certain Network Eligible Expenses. Co-payment amounts do not apply toward your Deductible or Co-insurance, but they do accumulate toward the Maximum Out-of-Pocket limit.

Covered Class. A class of retirees who are eligible for Plan coverage as determined by the Employer.

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

Covered Entity. GuideStone.

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 "Medical Benefits."

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

Covered Services and Supplies. A Service or supply specified in Covered Services and Supplies 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/rehabilitation Services in the aggregate do not constitute skilled nursing Services/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/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.

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

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.

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 Retirees.

Facility Other Provider. An entity other than a Hospital which is licensed, where required, to render Covered Services. Facility Other Provider includes but is not limited to, licensed Skilled Nursing/Rehabilitation Facilities and sub-acute facilities.

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

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.
- Is in general use in the medical or dental community.
- 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.

Habilitative Services. Services that help a person learn or improve skills and functioning for daily living.

Home Health Care Agency. A Facility Other Provider or Hospital program for home healthcare, 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.
- 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.
- Provides 24-hour nursing Services by or under the supervision of Registered Nurses.

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 organization accredited by URAC or a similar nationally-recognized accrediting organization that will conduct external reviews in accordance with the Claim and Appeal Procedures described in "Appendix 1".

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 Inpatient Stay Charges are 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 Inpatient that is appropriate to both the Inpatient 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 Out-of-Pocket limit. The maximum amount a Covered Person or Family must pay for Network Eligible Expenses in a Benefit Period, after which the Plan pays 100%.

Maximum Reimbursable Charge. 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.

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.

Medically Necessary and Appropriate (Medical Necessity and Appropriateness). Services, supplies or covered medications that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (i) in accordance with generally accepted standards of medical practice, (ii) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease, (iii) not primarily for the convenience of the patient, physician or other healthcare provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Claims Administrator reserves the right, utilizing the criteria set forth in this definition, to render the final determination as to whether a service, supply or covered medication is Medically Necessary and **Appropriate**. No benefits will be provided unless Claims Administrator determines that the service, supply or covered medication is Medically Necessary and Appropriate.

Medicare. The programs of healthcare for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended, also known as Original Medicare.

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 does not have a pharmacy service agreement with Express Scripts.

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.

Original Medicare. The Original Medicare plan has two parts: Part A (hospital insurance) and Part B (medical insurance). It is a fee-for-service health plan. You must pay the Deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (Co-insurance and Deductibles).

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

Outpatient Treatment Facilities. A Facility Other Provider which, for compensation from its patients, is primarily engaged in providing Services on an Outpatient basis. This facility must also meet the minimum standards set by the appropriate governmental agency. Examples of Outpatient Treatment Facilities include, but are not limited to, Alcohol/Drug Abuse Treatment Facilities, physical rehabilitation facilities and outpatient psychiatric facilities.

Participating Pharmacy. A licensed and registered pharmacy, which has a pharmacy service agreement with Express Scripts, subscribed to by this Plan.

Pharmacy Identification Card (Pharmacy ID Card). The currently effective card issued to You by Express Scripts

Physical Handicap. A substantial physical or mental impairment which:

- Results from Injury, accident, congenital defect or Sickness.
- 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 consultation between a Physician or Physician's staff and a patient for the purpose of Medical Care or Services.

Plan. This document constitutes your 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 certain 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 include but are not limited to:

- Audiologist
- Certified Behavioral Analyst/Specialist
- Certified Dependency Counselor
- Certified Registered Nurse
- Chemical Dependency Counselor
- Chiropractor
- Clinical Molecular Geneticist
- Dentist
- Licensed Family Therapist
- 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 healthcare Services provided to You, or payment for healthcare Services provided to You.

Provider. A Facility Provider, Professional Provider or 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.

Rescission. An impermissible cancellation or discontinuation of coverage that has a retroactive effect. Cancellation or discontinuation of coverage if attributable to non-payment of monthly rates, fraud or intentional misrepresentation is not rescission and is permissible.

Retail Clinic. Walk-in centers that are limited to treating minor illnesses and preventive services. Retail Clinics are generally located in supermarkets or pharmacies.

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 /Rehabilitation Facility. A licensed institution (other than a Hospital, as defined) which specializes in:

- Physical rehabilitation on an inpatient basis; or
- Skilled nursing and medical care on an inpatient basis. But only if that institution:
    - maintains on the premises all facilities necessary for medical treatment,
    - provides such treatment for compensation, under the supervision of Physicians, and
    - provides nursing Services.

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, and 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.
- 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.

- **Cardiac Rehabilitation** - the physiological and psychological rehabilitation of patients with cardiac conditions through regulated exercise programs.
- **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.
- **Infusion Therapy** - treatment by means of Infusion Therapy when performed by, furnished by and billed by a Facility Provider or Facility Other Provider.
- **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.
- **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, provide or restore maximum function, and prevent disability following disease, Injury or the loss of a body part or parts
- **Radiation Therapy** - the treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.
- **Respiration Therapy** - the introduction of dry or moist gases into the lungs for treatment purposes.
- **Speech Therapy** - the treatment for the correction of a speech impairment resulting from Autism Spectrum Disorder, disease, Surgery, Injury, or previous therapeutic processes.

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

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 not to exceed one Visit per day per Provider.

Wellness Benefit. Includes a schedule for Preventive Services, without cost sharing, recommended by the U.S. Preventive Services Task Force, the Advisory Commission on Immunization Practices of the Centers for Disease Control, and the Health Resources and Services Administration. See "Covered Services and Supplies."

You. An Eligible Retiree. Sometimes "You" means both the Covered Person and his or her Covered Dependent(s). The booklet will tell You when this is the case.

Appendix 1: Claim and Appeal Procedures

A. Internal Claims and Appeals

1. Eligibility

Eligibility and participation in the Plan is discussed in Sections 3, "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 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, Insurance Services
Insurance Operations Department GuideStone
5005 LBJ Freeway, Ste. 2200
Dallas, Texas 75244-6152

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

a. How to File a Claim

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
Your medical provider will file claims with Medicare. After Medicare has determined benefits, Medicare will forward the claims to Your Claims Administrator to process remaining amounts that are eligible under Your Plan benefits. 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 website. Make sure all information is completed properly, and then sign and date the form. Attach all itemized bills, including Medicare's Explanation of Benefits, to the claim form and mail everything to the address on the form. Multiple Services You can be filed with one claim form. 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;
- Medicare's Explanation of Benefits.

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.

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. The Claims Administrator must notify You of the decision no more than 72 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 period You are given to provide the additional information.

Pre-Service Claim: If our 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 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
- Information sufficient to identify the Claim involved, including the date of service, the healthcare provider, the Claim amount (if applicable), the diagnosis code, the treatment code, and the corresponding meanings of these codes;
- 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 monthly rates for coverage. A rescission is permitted if You (or an individual seeking coverage on your behalf) perform 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 permits two levels of internal appeal. 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 healthcare 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
- 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 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;
- Information sufficient to identify the Claim involved, including the date of service, the healthcare provider, the claim amount (if applicable), the diagnosis code, the treatment code, and the corresponding meanings of these codes.
- 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

External reviews are available exclusively for claim denials based on medical necessity after exhausting two levels of internal appeals, 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 healthcare 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 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 healthcare 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 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 healthcare professional's recommendation;
- Reports from appropriate healthcare 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 healthcare 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 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, Insurance Services
Insurance Operations Department
GuideStone
5005 LBJ Freeway, Ste. 2200
Dallas, Texas 75244-6152
844-467-4843

Medical Benefits Appeals

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

F. Facility of Payment

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

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.