



**SIM USA**

  
**GuideStone<sup>®</sup>**  
Insurance Plans

*Do well. Do right.<sup>®</sup>*

# Employee Benefits for

SIM USA

Dear Participant:

GuideStone is pleased to help SIM USA provide insurance benefits to meet your needs. Your effective date for the following plans is **January 1, 2012** :

✂ Health Choice 2000 Plus

In this packet you'll find the resources you need to enroll and get the most from your benefit plan:

- ✂ *Benefit Summaries* for your insurance plan.
- ✂ Important resources available to you.

At GuideStone, our mission is to serve those who serve the Lord. We look forward to serving you. If you have any questions about your plans, please speak with your ministry's authorized Benefits Administrator.

Sincerely,

GuideStone Insurance



# Health Choice 2000 Plus

Effective January 1, 2012

Your plan offers two levels of benefits. You will receive the highest level of benefits when you receive services from any overseas provider or from a stateside provider in the Blue Cross Blue Shield PPO network. You will receive a lower level of benefits if you use a stateside provider who is not in the PPO network. In either case, you coordinate your care. There is no requirement to select a Primary Care Physician (PCP) to coordinate your care.

BENEFITS	CARE RECEIVED FROM ANY OVERSEAS* PROVIDER OR FROM IN-NETWORK PROVIDERS STATESIDE	CARE RECEIVED OUT-OF-NETWORK STATESIDE
Deductible for an individual	\$2,000	\$4,000
Deductible for a family	\$4,000	\$8,000
Plan pays/individual pays (coinsurance after deductible)	80% / 20%	50% / 50%
Annual coinsurance maximum for an individual / family	\$4,000	\$10,000
Primary care physician copay / Specialist copay	\$25 / \$35	50% after deductible
Wellness and preventive care copay (primary care / specialist)	100% (no deductible)	Not covered
Hospital inpatient including maternity	80% after deductible	50% after deductible
Outpatient services (CT scans; MRI; diagnostic)	80% after deductible	50% after deductible
Outpatient surgery	80% after deductible	50% after deductible
Emergency room (per visit)	80% after \$100 copay	50% after deductible <sup>1</sup>
Chiropractic services (20 visits annually)	\$35	50% after deductible
Mental health and substance abuse: inpatient / intensive outpatient services	80% after deductible	50% after deductible
Mental health and substance abuse: office and professional services	\$25	50% after deductible
Eye exam (once every 12 months)	\$25	50% after deductible
Travel Immunizations	100%	100%

<sup>1</sup> If services are provided by an out-of-network emergency facility for a true emergency, as determined by the claims administrator, benefits will be paid at the network level.

\*Note that for overseas outpatient care, you'll need to pay the provider and then submit a claim for reimbursement.

PRESCRIPTION DRUG PROGRAM		
Retail (30-day supply)	Generic	20% with a per-prescription maximum of \$250 <sup>1</sup>
	Preferred	
	Non-preferred	
Mail order (90-day supply)	Generic	20% with a per-prescription maximum of \$750 <sup>2</sup>
	Preferred	
	Non-preferred	
Specialty (30-day supply)	Specialty	20% with a per-prescription maximum of \$250 <sup>1</sup>

<sup>1</sup> \$250 maximum is per 30-day prescription.

<sup>2</sup> \$750 maximum is per 90-day prescription.

## Glossary of terms

**Coinsurance maximum** — The most you will have to pay in a year in coinsurance for covered benefits after you meet your deductible. Once you reach your coinsurance maximum, you will still pay office visit and prescription copays.

**Emergency Care** — Medical services from the emergency department of a hospital to evaluate a medical condition that in the absence of immediate medical attention would place the health of the individual in serious jeopardy; cause serious impairment to bodily functions; or cause serious and permanent dysfunction to any bodily organ or part.

**Family deductible** — When family members meet the plan amount determined to be the family deductible, the plan will consider all family members to have met their deductibles. One individual cannot contribute to the family deductible more than the amount determined to be the individual deductible (this is an embedded deductible).

**Individual Deductible** — When an individual meets the plan amount determined to be the individual deductible, the plan will begin paying claims for that individual at the coinsurance level.

**Non-preferred drugs** — A list of prescribed medications that are not on the plan's formulary. **Preferred drugs** — Also known as formulary drugs; this is a list of commonly prescribed, brand-name medications that are selected based on their clinical effectiveness and opportunities to help control your plan's costs.

**Primary care physician copay** — The amount you pay for an office visit to a network primary care physician such as a pediatrician, general practitioner, family practitioner, internist or gynecologist.

**Specialist** — Any physician not considered a primary care physician. **Wellness and preventive care** — Covered services are based on Highmark's preventive health schedule for GuideStone.

This information only highlights the depth of coverage and benefits you can receive when you protect yourself with GuideStone. There are limitations and exclusions that apply. This is a general summary of plans that are offered. The official plan documents and insurance contracts set forth the eligibility rules, limitations, exclusions and benefits. These alone govern and control the actual operation of the plan.

# Preventive Care Schedule

**Effective January 1, 2012**

The plan pays for only preventive care only when given by a network provider. For in-network preventive care, use your Highmark Blue Cross Blue Shield ID card.

Well-child visits (birth-age 18)		Preventive Schedule
✳	Wellness exam	✳ Standard incremental infant check-ups for the first 12 months; every 12 months ages 1-18
✳	Visual screening	✳ Every 12 months ages 3-5; then at ages 6, 8, 10, 12 and 15
✳	Hearing screening	✳ Every 12 months ages 4-6; then at ages 8, 10, 12 and 15
<b>Immunizations:</b> Includes standard childhood immunizations.		At scheduled ages for each childhood immunization.
Adult (age 19+)		Preventive schedule
<b>Physical examination</b>		Every 12 months
<b>Pelvic and breast examination</b>		Every 12 months
<b>Pap test</b>		Every 12 months
<b>Mammogram</b>		Every 12 months after age 39
<b>Prostate cancer screening</b>		Every 12 months
<b>Urinalysis, venipuncture and CBC</b>		Every 12 months
<b>Lipid panel</b>		Every 12 months
<b>Glucose testing</b> (for high-risk patients)		Every 3 years after age 45
<b>Bone mineral density screening</b>		Every 2 years if high risk for osteoporosis
<b>Colorectal cancer screening</b>		As directed by a physician
<ul style="list-style-type: none"> <li>• Fecal occult blood test</li> <li>• Screening with flexible sigmoidoscopy or double contrast barium enema</li> <li>• Colonoscopy</li> </ul>		<ul style="list-style-type: none"> <li>• Every 12 months after age 50</li> <li>• Every 5 years after age 50</li> <li>• Every 10 years after age 50 (or as recommended by your doctor if high risk)</li> </ul>
<b>Immunizations:</b> Includes expanded age ranges for some immunizations.		Expanded adult immunizations for at-risk patients

Continued on next page.

## Maternity

### You should expect to receive the following screenings and procedures:

- Hematocrit and/or Hemoglobin (Anemia)
- Urine Culture & Sensitivity (C & S)
- Rh typing during your first visit
- Rh antibody testing for Rh-negative women
- Hepatitis B

In addition, your doctor may discuss breast feeding during weeks 28 through 36 and/or post delivery, tobacco use and behavioral counseling to reduce alcohol use.

**Note:** This schedule, based on recommendations from the Centers for Disease Control and Prevention, the American College of Obstetricians and Gynecologists, the American Cancer Society January 2008 Colorectal Cancer Screening guidelines and items/services required under the Patient Protection and Affordable Care Act of 2010 (PPACA), is a reference tool for planning your family’s preventive care. Your specific needs may vary according to your personal risk factors. Your doctor is always your best resource for determining if you’re at an increased risk for a condition. If you have questions about your coverage, please call the toll-free Member Service Number on your identification card.

### » Prevention of Obesity

Obesity places individuals at risk for a number of chronic and debilitating diseases. Highmark is working with physicians, policymakers, The Children’s Health Fund and representatives from the private sector to address the childhood obesity crisis and to create solutions to obesity-related problems. As part of Highmark’s “Prevention of Obesity” initiative, the following benefits are part of our Preventive Schedule. **For in-network services for the prevention of obesity, use your Highmark BCBS ID card.**

Schedule for children	Preventive schedule
<p><b>Children with a body mass index (BMI) in the 95<sup>th</sup> percentile are eligible for:</b></p>	<ul style="list-style-type: none"> <li>• Two additional annual preventive office visits specifically for obesity</li> <li>• Two annual nutritional counseling visits specifically for obesity</li> <li>• One set of recommended laboratory studies</li> </ul>
<p><b>Children with a BMI in the 85<sup>th</sup> percentile are eligible for:</b></p>	<ul style="list-style-type: none"> <li>• One additional annual preventive office visit specifically for obesity and blood pressure measurement</li> </ul>

Continued on next page.

Schedule for adults (age 19+)	Preventive schedule
<p><b>Adults with a BMI over 30 are eligible for:</b></p>	<ul style="list-style-type: none"> <li>• Two additional annual preventive office visits specifically for obesity and blood pressure measurement</li> <li>• Two annual nutritional counseling visits specifically for obesity</li> <li>• One set of recommended laboratory studies</li> </ul>

This general summary is not a complete list of the preventive health schedule provided under your plan. To determine if a specific procedure is covered under the wellness benefit, call Highmark Blue Cross Blue Shield® at 1-866-472-0924.

**» Preventive Medications**

The plan pays for preventive care only when given by a network provider. To determine if a specific medication is covered under the wellness benefit, call Medco at 1-800-555-3432. For over-the-counter medications purchased with a prescription from an in-network pharmacy, use your Medco ID card.

Medication	Coverage
<b>Aspirin</b>	Coverage to persons ages 45 years through 79 years
<b>Fluoride</b>	Coverage to persons through the age of five years old
<b>Folic acid</b>	Coverage to persons less than one year of age
<b>Iron</b>	Coverage to persons less than one year of age
<b>Smoking cessation</b>	Coverage to persons age 18 years and older

**Note:** This is not a complete schedule. For detailed immunization benefits, view the *Preventive Care Schedule* on our website at [www.GuideStoneInsurance.org/FormsandFAQ/GroupForms](http://www.GuideStoneInsurance.org/FormsandFAQ/GroupForms).

# Traditional PPO Plans (Highmark BCBS)

## Frequently Asked Questions

---

---

### General information

#### » How much are my copays/coinsurance?

You can find your medical plan copay and/or coinsurance amounts – office visit (OV), Specialist (SP), emergency room (ER) and preventive – listed on your medical ID card. To find out how the drugs you take are classified and how much they'll cost, visit [www.medco.com](http://www.medco.com) and click on "Price a medication" on the menu at the top left of the page or call the Medco customer service number at **1-800-555-3432**.

#### » How do my deductibles work?

Since your plan has a medical deductible, you must meet that deductible before your coinsurance benefits start. Some services – such as office visits – have a copay that is not subject to the deductible and do not count toward meeting the deductible.

**Note on family deductibles:** No one family member is responsible for more than the individual deductible on your plan. Once a family member meets the individual deductible, GuideStone starts paying according to plan benefits. That means you start paying your coinsurance percentage for eligible healthcare services and copays for prescription drugs. Other family members must continue to pay toward the remaining family deductible until it is met. Once the deductible is met by two or more family members' claims, benefits begin to be paid by GuideStone for all family members.

#### » How many ID cards will I get?

You'll receive two ID cards: one for your medical benefits (from Highmark BCBS), and the other for your prescription drug benefits (from Medco). Be sure to provide these new cards to your providers and pharmacy.

#### » Am I subject to any pre-existing condition limitations?

If you have been on your employer's health plan for fewer than 12 months, you will receive a letter from GuideStone requesting that you submit a certificate of creditable coverage. A *Certificate of Creditable Coverage* is a document to you from your prior carrier that provides evidence that you had previous medical coverage. If we do not receive the requested copy of the certificate, you or your dependents age 19 or older may be subject to a 12-month pre-existing condition limitation if pre-existing conditions exist.

#### » I need to add my newborn or adopted child to my health plan. When do I need to do this?

As soon as possible. To make sure your claims are properly processed and the child added to your health plan, you need to add the dependent child **within 60 days** of the child's birth, adoption or placement for adoption.

## Medical coverage

### » How can I find doctors and healthcare facilities participating in the PPO network?

**For medical providers:** You can call 1-866-472-0924 or visit [www.highmarkbcbs.com](http://www.highmarkbcbs.com) to use Highmark’s “Find Providers” tool. Be sure to select “BCBS PPO” as your health plan.

**To find vision providers:** Visit [www.highmarkbcbs.com](http://www.highmarkbcbs.com) and search for an ophthalmologist or optometrist through the “Find a doctor, hospital or other network provider” tool. Do **not** use the “find a network vision provider” tool — this will yield incorrect results under this benefit.

**Did you know?** Using network providers saves you money two ways:

- ✳ Provider discounts of up to 50% reduce the amount you—and the plan—have to pay;
- ✳ You have a higher level of benefits using network providers.

### » What kind of wellness benefits are covered on my health plan?

Wellness benefits, such as preventive care screenings, annual physicals and immunizations, are included in your GuideStone medical plan. These benefits are based on Highmark’s preventive care schedule. Eligible in-network wellness services are covered at 100%, do not require a copay and are not subject to the deductible. There is no annual maximum benefit. Wellness services received from providers outside the PPO network are not covered. See the *Preventive Care Schedule* for an overview.

**GuideStone is committed to wellness.** To control healthcare costs, start by living a healthy life now. Through our wellness website ([www.GuideStone.org/Wellness](http://www.GuideStone.org/Wellness)), you have free access to a variety of wellness tools and information to help support a healthy lifestyle.

### » I need to be admitted to the hospital. Does that have to be pre-authorized?

Yes. Highmark Healthcare Management Services (HMS) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency inpatient admission. Some facility providers will contact HMS and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting HMS for precertification. If not, you are responsible for contacting HMS. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the patient will be responsible for payment of any costs not covered.

### » How do I know how my claims were paid?

Explanations of Benefits (EOBs) are mailed to you after you receive treatment and file a claim. They explain how benefits were paid under your health plan. You may also view EOBs electronically and opt to go paperless at [www.highmarkbcbs.com](http://www.highmarkbcbs.com).

### » I need to use laboratory services or get x-rays. How do those benefits work?

This depends on where and how you receive services.

- **If you go to your in-network, primary care physician for a wellness visit:** If you receive laboratory services covered under the *Preventive Care Schedule* associated with a wellness visit, the visit and the services will be covered at 100%, not subject to copay, coinsurance, or deductible. To qualify, the services (gathering of blood and urine samples, etc.) must be performed by the doctor’s staff in the office at the time of the visit.

Note that your doctor must file the services as a part of a qualified wellness visit, and these services must be covered under the *Preventive Care Schedule*.

- **If you go to an in-network primary care physician for a diagnostic (non-wellness related) visit:** If your doctor gathers the samples (blood, urine, etc.) and/or takes the x-ray in-office and then sends them to a facility for processing, you will only be charged the appropriate office visit copay. The services must be performed by the doctor's staff at the time of the office visit.
- **If you go to a freestanding x-ray or laboratory facility:** The plan will pay the applicable coinsurance (80% after deductible for in-network providers and 60% after deductible for out-of-network providers). If you have not yet met your deductible, you will pay the full cost until the deductible is met. The office visit copay will not apply.

**Exception:** Services covered by the *Preventive Care Schedule* and performed at a freestanding, in-network x-ray or laboratory facility will be covered at 100% not subject to copay, coinsurance or deductible.

**Note:** "Freestanding" x-ray or lab facilities are sometimes adjacent to or near your doctor's office. If you receive laboratory or x-ray services outside your immediate doctor's office, or on a date other than your regularly scheduled office visit, applicable coinsurance (after deductible) may apply.

## » What if I need medical attention while I'm traveling?

You're covered by a nationwide network – which means that within the U.S., you search for providers just like you would at home. If you need to be hospitalized, call the number on the back of your medical ID card (1-866-472-0924) for pre-certification or preauthorization (in the U.S. or overseas).

Did you know that your plan also includes international coverage? Outside of the U.S., you have in-network access to doctors and hospitals in more than 170 countries and territories around the world through the BlueCard Worldwide® Program. If an overseas doctor or hospital does not participate in the BlueCard Worldwide Program, your claims will be paid as out-of-network. Always call or visit [www.bcbs.com/bluecardworldwide](http://www.bcbs.com/bluecardworldwide) for claims instructions or to search for participating providers.

## » I've filed a claim, and now I've been contacted by a company called Healthcare Recoveries, asking for details about the claim. Should I respond?

Yes. Healthcare Recoveries is a legitimate, third-party organization that is contacting you on behalf of Highmark Blue Cross Blue Shield. Its job is to help determine whether your medical insurance or another party—worker's compensation, automobile insurance, a different insurance plan, etc.—should cover the claims resulting from an accident or injury. The goal is to ensure that claims are paid by the appropriate party—helping to keep things moving along and costs contained.

## Prescription drug coverage

### » What is Prior Authorization? Will this affect my prescriptions?

In general, Prior Authorization affects a only small percentage of drugs. It is a process intended to make sure each patient receives the appropriate medication at the right time. If your doctor prescribes a drug that requires Prior Authorization, a Medco pharmacist will discuss the prescription with your physician and determine coverage. To cover the medication, the plan may require evidence from your doctor that other medications in this class were tried and found ineffective or could not be used.

If special circumstances exist that require the use of this medication, your doctor may request a coverage review by calling Medco at 1-800-753-2851.

If you are *currently taking medication* for which you've already received Prior Authorization, you may call Medco at 1-800-555-3432 to discuss how changing plans may impact your Prior Authorization.

# Glossary of Terms

---

**Coinsurance** - The percentage of eligible claims you pay after you meet your deductible.

**Coinsurance Maximum** – The most you will have to pay in a year in coinsurance for covered benefits after you meet your deductible. Once you reach your coinsurance maximum, you will still pay office visit and prescription copays.

**Copay** - The fixed, up-front dollar amount you pay for certain covered expenses. Office visit copay amounts do not apply toward your deductible or coinsurance maximum.

**Deductible** – The up-front out-of-pocket expense. Participants must meet their deductible with eligible charges before claims will be paid.

**Family deductible** – When family members meet the plan amount determined to be the family deductible, the plan will consider all family members to have met their deductibles. One individual cannot contribute to the family deductible more than the amount determined to be the individual deductible (this is an embedded deductible).

**Generic** – A term used for prescription drugs identified by their chemical name. A bioequivalent to the brand-name drug made available to the public after the patent has expired on the brand-name drug. The generic version usually results in a less expensive drug.

**Individual deductible** – When an individual meets the plan amount determined to be the individual deductible, the plan will begin paying claims for that individual at the coinsurance level.

**In-network** – Health care services received from a provider in a network.

**Mail order** – When you need a prescription drug on an ongoing basis, you can mail your prescription to the Medco by Mail™ service to receive prescriptions for up to a 90-day supply of medication.

**Network provider** – A doctor, hospital or other health care facility that has entered into a contract to provide medical services or supplies at agreed upon rates to you or your covered dependents under the plan.

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

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

**Primary care physician copay** – The amount you pay for an office visit to a network primary care physician such as a pediatrician, general practitioner, family practitioner, internist or gynecologist.

**Retail pharmacy benefits** –When you need a prescription on a short-term basis, you can fill your prescription at a local participating network pharmacy to receive prescriptions for up to a 30-day supply.

**Specialist** – Any physician not considered a primary care physician.

**Wellness and preventive care** – Covered services are based on a preventive health schedule which includes preventive services for children and adults based on recommendations from the U.S. Preventive Service Task Force, the Centers for Disease Control and Prevention, the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics.

# Resources to help you use your plan overseas

---

Take GuideStone with you wherever you go. In this section, you'll find the information you need to use your health plan if you travel overseas. We've got you covered around the world.

## >> Important contact information

Getting healthcare overseas is as easy as making one phone call: **1-800-810-BLUE** (2583).

### **BlueCard® Worldwide Program – Medical benefits**

- Toll-free: 1-800-810-BLUE with AT&T access code
- Collect call: 1-804-673-1177

### **Medco Health Solutions – Prescription drugs**

- Toll-free: 1-800-555-3432
- International claims:
  - Toll-free: 1-800-497-4641 with AT&T access code
  - Collect call: 614-421-8292

## >> Important medical plan information

BlueCard® Worldwide helps you get medical assistance anywhere in the world. This program enables medical plan participants traveling or living abroad to obtain medical assistance and inpatient, outpatient and professional services.

### **Benefits to members:**

- Single point of contact for medical assistance services 24/7/365.
- Worldwide network of pre-screened healthcare providers – 900 hospitals and 6,800 physicians in over 200 countries.
- Cashless access to inpatient participating providers.
- Coverage continues while home on furlough or emergency leave for up to 45 days.
- Immunizations needed for travel are covered at 100%.

### **Worldwide medical assistance:**

- Provide referral to doctor or hospital.
- Facilitate verbal translations between provider and member.
- Perform medical monitoring of inpatient cases.
- Review the care and treatment rendered – includes BlueCard® Worldwide staff speaking with member, the treating medical officer and the member's family and/or member's primary physician.
- Medical Evacuation Coordination, Medical Repatriation Coordination and Repatriation of Remains included.

### **Evacuation:**

- In the event the current facility does not have the resources to provide the appropriate level of care:
  - Member (or family member/agent authorized to request medical care) must contact BlueCard Worldwide prior to or within 48 hours of hospitalization to get a BlueCard Worldwide medical assistance partner is assigned to coordinate your evacuation if necessary.
  - Member will be moved to a facility that can provide the level of care necessary.
  - Transportation will be arranged to the recommended facility.

### **Repatriation for medical coordination or remains:**

- Repatriated if treatment is extensive and it is appropriate and cost-effective for the member to be close to family and friends.
- Transportation will be arranged and the local hospital will be alerted.
- Repatriation of remains will be arranged when a member passes away while overseas.

### **Member responsibilities:**

- Call **1-800-810-BLUE** (2583) if you need information on available local hospitals or physicians.
- Notify BlueCard® Worldwide and your benefits administrator returning to the U.S. for 45 days or more.
- If you are admitted to a hospital, require treatment beyond routine preventive care or minor illness visit, need advanced diagnostics or the like, notify BlueCard Worldwide to obtain pre-certification.
- If you may need medical evacuation, you must contact BlueCard Worldwide prior to or within 48 hours of admission to get a BlueCard Worldwide medical assistance partner assigned to your case.
- For inpatient care at an in-network hospital, you are responsible for deductible or coinsurance expenses. There's no need to pay in advance the cost of services covered by your plan.
- For inpatient care at an out-of-network hospital, call BlueCard® Worldwide to arrange direct payment with the hospital. If payment arrangements can't be made, you will need to pay for the services and file a claim.
- For outpatient care or physician services, pay for the services and file a claim.

### **Prescription drugs:**

- Call **1-800-555-3432** if you need prescription drug coverage information.
- An advance 12-month supply may be filled through Medco Health Solutions prior to departure or shipped at any time to a stateside address (please allow two weeks for processing and shipping).
- Prescriptions filled abroad are reimbursed per plan benefits for non-participating pharmacies.

To file an international claim with Medco, call toll-free at 1-800-497-4641 with AT&T access code or call collect at 614-421-8292.

 <p><b>International Benefits</b></p> <p>For medical services overseas, call BlueCard Worldwide Program:</p> <p><b>[ 1-800-810-BLUE (2583) ]</b></p> <p>You can use this toll-free number overseas by using an AT&amp;T Direct® Access Number or call collect 1-804-673-1177.</p> <p><b>GuideStone®</b> Insurance Plans <i>Do well. Do right.®</i></p>	<p>Have your medical and/or prescription drug ID card handy when you call.</p> <p>For prescription drugs overseas, call Medco Health Solutions:</p> <p><b>[ 1-800-497-4641 ]</b></p> <p>You can use this toll-free number overseas by using an AT&amp;T Direct® Access Number or call collect 1-614-421-8292.</p> <p><b>GuideStone®</b> Insurance Plans <i>Do well. Do right.®</i></p>
---	--

(Cut out card)

# Notice of Special Enrollment Rights

---

## Group Plans

You are eligible to participate in the Group Plans health plans. To participate, you must enroll and pay the costs if required by your employer. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes provisions for workers and dependents that allow you to have special enrollment rights, should you decline enrollment when you are initially eligible.

HIPAA allows you special enrollment rights in our health care plans according to the following guidelines.

### » **Rule 1: Delayed enrollment**

If you initially decline enrollment for yourself or your dependent(s) (including your spouse) due to other health care coverage, in the future you may be able to enroll in this plan, provided that you enroll within 60 days after you lose other coverage.

### » **Rule 2: Life-changing events**

If you add a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and you dependent(s) in this plan, provided that you enroll within 60 days after the event.

If you would like more information about the plan's special enrollment provisions, contact your employer's authorized benefits representative.

# Privacy Practices of Health Plans

---

**This Notice describes how medical information about you may be used and disclosed by the Plans and how you can get access to this information. Please review it carefully.**

## » Summary of Privacy Notice

GuideStone Financial Resources of the Southern Baptist Convention is the plan sponsor of the self-funded Group and Personal health plans (Plans) that are subject to the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA).

This notice does not apply to Protected Health Information maintained in your employment records by your employer for employment or other non-health plan purposes.

## » How the Plans will use your information

The plans may use and disclose your Protected Health Information without authorization from you to pay medical benefits or operate the Plans. The Plans may also use, share or disclose your Protected Health Information in connection with treatment by a health care provider covered by HIPAA. In addition, the Plans may use or disclose your information in other special circumstances described in this notice. The Plans will require your written authorization for the use or disclosure of your Protected Health Information for any other purpose.

## » Your individual rights

You have the right to access certain Protected Health Information, inspect and copy this information, amend the information, request restrictions on the use and disclosure of the information, request the communications be made to you through alternate means or an alternative location, and obtain an accounting of the information that the Plans have disclosed for reasons other than treatment, payment, health care operations or in certain other circumstances.

## » Questions and complaints

You may contact the following person for more information about the Plans' privacy practices, to exercise your rights or to complain about how the Plans are handling your Protected Health Information:

HIPAA Privacy Contact

GuideStone Financial Resources

2401 Cedar Springs Road

Dallas, TX 75201-1498

*[hipaaprivacycontact@GuideStone.org](mailto:hipaaprivacycontact@GuideStone.org)*

**1-888-98-GUIDE** (1-888-984-8433)

The attached notice describes all of the Plans' privacy practices in more detail.

## » Notice of privacy practices of health plans

**This Notice describes how medical information about you may be used and disclosed by the Plans named below and how you can get access to your information. Please review it carefully.**

GuideStone Financial Resources is the plan sponsor of the Group and Personal self-funded health plans (Plans) that are subject to the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA).

The privacy of your Protected Health Information that is created, used, or disclosed by the Plans is protected by HIPAA. The plans are required by law to:

- maintain the privacy of your Protected Health Information;
- provide you with this notice of the Plans' legal duties and privacy practices with respect to your Protected Health Information; and
- abide by the terms of this notice.

### *Plan uses and disclosures for treatment, payment or health care operations*

Under HIPAA, the Plans and the individuals who administer them may use and disclose your Protected Health Information for treatment, payment or health care operations without obtaining a written authorization from you. This broad range of activities includes:

- **Treatment.** The Plans may disclose Protected Health Information to your providers for treatment, including the provision of care (diagnosis, cure, etc.) or the coordination or management of that care.
- **Payment.** The Plans may use and disclose your Protected Health Information for enrollment, to receive payment for coverage and to pay benefits. Payment activities include receiving claims or bills from your health care providers, processing payments, sending explanations of benefits (EOBs) to the Plan member, reviewing the medical necessity of the services rendered, conducting claims appeals and coordinating the payment of benefits between multiple medical plans.
- **Health care operations.** The Plans may use and disclose your Protected Health Information for activities compatible with and directly related to treatment and payment. For example, the Plans may use or disclose your Protected Health Information for the Plans' administration activities such as quality assessments, case management, disease-management programs and other Plan-related activities, including audits of claims.

Our Plans contract with other businesses for certain Plan administration services. Our third-party administrator provides underwriting for Group and Personal plans. The third-party administrator provides claims processing services for the Plans. The Plans may release your health information to one or more of these "business associates" for these purposes if the business associate agrees in writing to protect the privacy of your information.

Unless you authorize the Plans otherwise (or the individual identifying data is deleted from the information), your Protected Health Information will be available only to the individuals who need the information to conduct Plans' administration activities and the release will be limited to the minimum disclosure required unless otherwise permitted or required by law.

### *Other uses and disclosures permitted and required by the Plans*

In the following circumstances the Plans may be required or permitted to use or disclose your Protected Health Information without obtaining an authorization from you. These events are generally subject to certain conditions. More specific information is available from the Privacy Contact upon request.

- **Required by law.** The Plans may be required by law to release your Protected Health Information to a government or public health representative. The disclosure must comply with the relevant requirements of that law and be limited to the information that is required.
- **Public health.** The Plans are permitted to disclose your Protected Health Information for certain required public health activities to:
  - a public health authority that is authorized to collect or receive that information for the purpose of preventing or controlling disease, injury or disability;
  - a public health authority or other governmental authority authorized to receive reports of child abuse or neglect;
  - a person subject to the jurisdiction of the Food and Drug Administration (FDA) for activities related to the quality, safety or effectiveness of FDA-regulated products or activities; and
  - a person who may have been exposed to a communicable disease or is otherwise at risk for contracting or spreading a disease or condition, where authorized by law as necessary in the conduct of a public health intervention or investigation.
- **Victims of abuse, neglect or domestic violence.** The Plans may use and disclose your Protected Health Information to a government authority if the Plans reasonably believe you are a victim of abuse, neglect or domestic violence and such disclosure is required by law, or if the Plans, in the exercise of its professional judgment, believes the disclosure is necessary to prevent serious harm to you or other potential victims.
- **Health oversight activities.** The Plans may use and disclose your Protected Health Information to a health oversight agency for oversight activities authorized by law, including audits, civil, administrative or criminal investigations, actions or proceedings, and certain other oversight activities.
- **Judicial and administrative proceedings.** The Plans may use and disclose your Protected Health Information in the course of any judicial or administrative proceeding in response to a court or administrative tribunal's order, subpoena, discovery request or other lawful process. The Plans will only disclose information in response to a lawful process other than a court or administrative tribunal order if satisfactory assurances are received from the party seeking the information that notice of the request has been provided to you and that you have not filed an objection within the time provided for you to do so or that appropriate processes have been followed.
- **Law enforcement purposes.** The Plans may use and disclose certain Protected Health Information for a law enforcement purpose to a law enforcement official if certain legal conditions are met. For example, in certain situations, information may be disclosed to a public official where you are suspected to be a victim of a crime.
- **Decedents.** The Plans may use and disclose your Protected Health Information to a coroner or medical examiner or to a funeral director for the purpose of carrying out his or her duties as authorized by law.
- **Organ/eye/tissue donation.** If you are an organ donor, the Plans are permitted to use and disclose your Protected Health Information to an appropriate entity for cadaveric organ, eye or tissue donation and transplantation purposes.
- **Certain limited research activities.** If the Plans obtain documentation from the individual, or from a researcher that the applicable authorization requirement has been waived by an appropriate Institutional Review Board or privacy board, the Plans may use and disclose your Protected Health Information for research purposes.
- **Health and safety.** The Plans may use and disclose your Protected Health Information to avert a serious threat to the health or safety of you or any other person, consistent with applicable law and standards of ethical conduct.
- **Government functions.** The Plans may use and disclose your Protected Health Information for specialized government functions, for example, if you are in the Armed Forces or a veteran for purposes of certain national security, Presidential protection and intelligence activities.
- **Workers' Compensation.** The Plans may use and disclose your Protected Health Information as authorized by and to the extent necessary to comply with laws and regulations related to workers' compensation or similar programs.

## » Specific uses and disclosures

The Plans may also use and disclose your Protected Health Information for the following specific purposes:

- **Communications related to your health.** The Plans may use and disclose your Protected Health Information to provide information to you about disease management programs, treatment alternatives or other health-related benefits and services that may be of interest to you.
- **Plan sponsor.** The Plans may disclose your Protected Health Information to GuideStone for reasons consistent with the Privacy Rules of HIPAA and as described in the Plans' documents.

## » Limitations on use and disclosure

If a use or disclosure of your Protected Health Information identified in this notice is subject to a law more stringent than HIPAA, the more stringent law will apply. If you have a question about your rights under any particular federal or state law, please write to the HIPAA Privacy Contact at the provided address.

## » Authorizations required for all other uses and disclosures

Any other use or disclosure of your Protected Health Information not identified within this notice will be made only with your written authorization. You have the right to limit the type of information and the persons to whom it should be disclosed. You may revoke your written authorization at any time, and the revocation will be followed to the extent action on the authorization has not yet been taken. An authorization form is available by calling **1-888-98-GUIDE** (1-888-984-8433) or from GuideStone's website, [www.GuideStoneInsurance.org](http://www.GuideStoneInsurance.org).

## » Your rights

You have the right to:

- Request a restriction on certain uses and disclosures of your Protected Health Information by the Plans. The Plans are not required to agree to a requested restriction for payment or health care operations where the health care provider has not been paid out of pocket in full. To request a restriction, please write to the HIPAA Privacy Contact and provide specific information as to the disclosures that you wish to restrict and the reasons for your request. The Plans will respond in writing.
- Request that the Plans' confidential communications of your Protected Health Information be sent to alternative locations or by alternative communicative means. For example, you may ask that we send all explanation of benefits statements (EOBs) to your office rather than your home address. The Plans are not required to accommodate your request unless the request is reasonable and you state that the Plans' ordinary communication process could endanger you.
- Inspect and obtain a copy of the Protected Health Information by making a written request that may be used by the Plans to make decisions about your benefits. Access to psychotherapy notes, information compiled in a reasonable anticipation of or for use in legal proceedings may be denied. A reasonable, cost-based fee may be imposed for copying and mailing the requested information.
- Request that the Plans amend your Protected Health Information or record if you believe the information is incorrect or incomplete;
- Receive an accounting of certain disclosures made of your Protected Health Information for purposes other than treatment, payment or Plans operations in the six years prior to the date of the request.
- Request and obtain a paper copy of this notice at any time, even if you have agreed to receive it electronically.
- Receive notification in the event the Plans discover a breach of your unsecured Protected Health Information and determine notification is required under HIPAA.

To exercise these rights, please write to the HIPAA Privacy Contact at the provided address. There are circumstances where the Plans are allowed to deny or limit your requests. In such event, you may have the right to object and obtain a review of the

Plans' decision. The Plans will provide you with further information about those rights at that time. If you would like more specific information about these matters, contact the HIPAA Privacy Contact.

### » **Changes to this notice**

Each Plan reserves the right to change the terms of this notice and its information practices and to make the new provisions effective for all Protected Health Information it maintains. Any amended notice will be made available to you.

### » **Complaints and privacy contact**

You may file a complaint with the Plans' HIPAA Privacy Contact and with the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by any Plan. Their addresses are available under contact information. All complaints must be filed in writing. **You will not be retaliated against for filing a complaint.**

### » **Privacy contact information**

If you have any questions about this notice, please contact the HIPAA Privacy Contact:

HIPAA Privacy Contact

GuideStone Financial Resources

2401 Cedar Springs Road

Dallas, TX 75201-1498

*hipaaprivacycontact@GuideStone.org*

**1-888-98-GUIDE** (1-888-984-8433)

To contact the Secretary of Health and Human Services, write to:

U.S. Department of Health and Human Services

200 Independence Avenue, S.W.

Washington, D.C. 20201

(202) 619-0257

Toll free: 1-877-696-6775

*<http://www.hhs.gov/contacts>*