Group Health Choice 3500N

Intended for GuideStone Member Use Only



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Produced by GuideStone Financial Resources of the Southern Baptist Convention

Effective 01/01/2026

GuideStone®

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.

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1. Your booklet

A. Introduction

Thank You for choosing this Plan from GuideStone Financial Resources of the Southern Baptist Convention ("GuideStone"). This document constitutes your Health Choice 3500N Group Plan (“Plan”). The GuideStone Plan is made available to eligible employers for their employees and retirees.

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

Other organizations that 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. Highmark also provides patient advocacy services for members enrolled.
- **Express Scripts Holding Company(Express Scripts)** and its affiliates, the Claims Administrator for Outpatient retail pharmacy and mail order Prescription Drugs, administers payment of Claims, but has no liability for the funding of the Plan.

This booklet tells You about Plan benefits beginning 01/01/2026. Claims for medical Services You received before this 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 Covered Service 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	**1-866-472-0924**
Blue Cross Blue Shield Provider Network:	**1-800-810-BLUE** (1-800-810-2583)
Blue Cross Blue Shield Global Core (International Claims):	**1-800-810-2583** with AT&T USADirect access code or 804-673-1177 (call collect outside the U.S.) or Email: *customerservice@bcbsglobalcore.com*
Highmark Maternity Education and Support Program **(Baby BluePrints®):**	**1-866-918-5267**
Express Scripts:	**1-800-555-3432**
Express Scripts (International Claims):	**1-800-497-4641** with AT&T USADirect access code or collect (614) 421-8292
Teladoc:	**1-800-Teladoc** (1-800-835-2362)
Vitals SmartShopper:	**1-866-285-7475**

C. Important websites

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www.GuideStone.org

www.MyHighmark.com

www.bcbs.com

www.bcbsglobalcore.com

www.Express-Scripts.com

www.Member.Teladoc.com

D. Your guide to good care

For decades, Highmark has helped make healthcare affordable for all kinds of people, from all walks of life. Highmark works with Blue Cross Blue Shield Plans throughout the country to ensure coverage includes Preferred Provider Organizations (PPO) in many areas.

1. **Your Blue Cross Blue Shield PPO Network gives You freedom of choice.** The PPO Network program does not require that You select a Primary Care Physician to receive a Covered Service. Instead, the program gives You access to a vast network of Physicians, Hospitals and Professional Providers throughout the country. Your Network is your key to receiving the higher level of benefits. The Network includes: Primary Care Physicians, a wide range of Specialist Physicians, Hospitals and other Provider organizations.

Remember, if You want to enjoy the highest level of coverage, it is your responsibility to ensure that You receive In-Network Services. You may want to double-check any Provider to make sure the Physician or facility is in the PPO Network. You may contact Highmark Premier Member Service at 1-866-472-0924 or visit their website at *www.MyHighmark.com.*

2. **Your PPO Network covers care throughout the country.** If You are traveling and a Sickness or Injury occurs, You can call **1-866-472-0924** or go to *www.MyHighmark.com* to obtain the name of a PPO Network Provider in the area. If the Sickness or Injury is an emergency, You should seek treatment from the nearest Hospital emergency room. If the treatment results in an admission, You have certain responsibilities under Medical Management & Policy (MM&P). See "Medical Management & Policy" for additional information.

If the Sickness or Injury is not an emergency and You receive care from an Out-of-Network Provider, benefits for Eligible Expenses will be provided at the lower Out-of-Network level.

3. **The Blue Cross Blue Shield Global Core program** assists with medical problems You may incur while living or traveling outside the United States. Services include:

- Making referrals and appointments for You with nearby Physicians and Hospitals.
- Verbal translation from a multilingual service representative.
- Providing assistance if special help is needed.
- Making arrangements for medical evacuation Services.
- Processing Inpatient Hospital Claims.

For Outpatient or professional Services received abroad, You should pay the Provider, then complete an *International Claim Form* and send it to the Blue Cross Blue Shield Global Core Service Center at the address on the form. Claim forms can be obtained by calling **1-800-810-BLUE** (1-800-810-2583) or the member service telephone number on your Highmark ID card. Claim forms can also be downloaded from *www.bcbsglobalcore.com.*

4. **Your BlueCard Program** provides specific provisions through the Blue Cross Blue Shield Association. When a Member obtains Covered Services through BlueCard outside the geographic area serviced by Highmark Blue Cross Blue Shield, the amount You pay for Covered Services is calculated on the lesser of:

- The billed charges for a patient's Covered Service, or
- The negotiated prices that the local Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to the claims

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administrator. Then, the amount You pay is still based on Plan provisions.

Refer to “Appendix 2” in the back of the booklet for more information on the Blue Card Program.

2. General information

A. Right to amend or terminate the Plan

The provisions of the Plan may be modified by GuideStone, in whole or in part, at any time and for any reason, without prior notice to You. If material modifications are made, appropriate notices will be sent. Any change may cause your benefits to be different than those described in this booklet.

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

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). This Plan meets the minimum essential coverage requirements of the Affordable Care Act of 2010 (ACA), as amended.

D. Plan is not an employment contract

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

E. Choice of law

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

F. Relation among parties affected by the Plan

All healthcare Providers, including Hospitals, are independent contractors to GuideStone. 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 it provides to You. GuideStone is not responsible for providing You with any Services, nor for any services you may receive from a healthcare Provider.

3. Schedule of Benefits

Your Plan offers two levels of benefits. If You receive Services from a Provider who is in the PPO Network, You will receive the highest level of benefits. If You receive Services from a Provider who is not in the PPO Network, You will receive the lower level of benefits. You should confirm that your provider is in the PPO Network to receive the highest level of

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benefits.

A. Medical

Benefit	In-Network Care	Out-of-Network Care
Deductible Individual	$3,500	$8,000
Family	$7,000	$16,000
Payment level/Co-insurance	20% until Maximum Out-of-Pocket is met; then 100%	50% until Co-insurance and Deductible Out-of-Pocket limit is met; then 100%(based on Provider's Allowable Charge)
Maximum Out- of-Pocket limit Medical and Prescription Individual	$6,350	N/A
Family	$12,700	N/A
Co-insurance and Deductible Out-of-Pocket limit Individual	N/A	$21,000
Family	N/A	$29,000
Lifetime Maximum	Unlimited	Unlimited
Physician office Visit (Primary Care) Includes lab and X-ray Services	$25	50% after Deductible
Specialist office Visit Includes lab and X-ray Services	$45	50% after Deductible
Retail Clinic office Visit Includes lab and X-ray Services	$25	50% after Deductible
Teladoc	$0	N/A
Urgent Care	$50	50% after Deductible
Ambulance	20% after Deductible	50% after Deductible
Autism Spectrum Disorders Applied Behavior Analysis Speech Therapy Occupational Therapy Physical Therapy	20% after Deductible	50% after Deductible

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Benefit	In-Network Care	Out-of-Network Care
Chiropractic treatment Maximum 12 Visits/Benefit Period	$45	50% after Deductible
Diagnostic Services Lab, x-ray and other tests	20% after Deductible	50% after Deductible
Durable Medical Equipment	20% after Deductible	50% after Deductible
Emergency Room Services Emergency Care (Out-of-Network Emergency Room Services are covered at the in-network benefit level)	$250 copay, then 20%	
Home Healthcare Maximum 120 Visits/Benefit Period	20% after Deductible	50% after Deductible
Hospice	20% after Deductible	50% after Deductible
Hospital expenses Inpatient	20% after Deductible	$500 copay, then 50% after Deductible
Outpatient	20% after Deductible	50% after Deductible
Infertility counseling and testing	20% after Deductible	50% after Deductible
Maternity	20% after Deductible	50% after Deductible
Medical/Surgical expenses	20% after Deductible	50% after Deductible
Mental health and Alcohol/Drug Abuse Inpatient	20% after Deductible	$500 copay, then 50% after Deductible
Office Visit	$25	50% after Deductible
Organ transplants Blue Distinction Centers Other transplant services	0% 20% after Deductible	50% after Deductible
Physical Therapy	$45	50% after Deductible

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Benefit	In-Network Care	Out-of-Network Care
Pre- authorization requirements	Network facility providers will obtain Preauthorization of your Network Inpatient admission on your behalf	Performed by member Failure to Pre-authorize an Out-of-Network Inpatient admission will result in a 20% benefit reduction
Skilled Nursing Facility care Maximum 30 days, concurrent with Medicare if applicable	20% after Deductible	50% after Deductible
Speech & Occupational Therapy	$45	50% after Deductible
Vision Care One eye exam/Benefit Period	$25	50% after Deductible
Wellness Benefit	100% no Deductible	Not covered

This plan does not constitute “creditable coverage” for Massachusetts residents.
Co-pays for certain specialty medications will be set to the maximum available manufacturer Co-pay assistance. These Co-pays will be paid by the manufacturer after the participant applies for Co-pay assistance and will not apply toward Maximum Out-Of-Pocket (MOOP). Choosing not to enroll in Co-pay assistance will result in a 30% Co-insurance on applicable specialty medications after applicable deductibles have been met.
Medical claims Incurred outside the United States where no network exists will be considered In-Network.
Accumulators are met by both medical and prescription expenses. Co-pays do not accumulate towards your deductible.

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B. Prescription

Outpatient Prescription Drug	Plan Pays	You Pay
Retail (up to 30 day supply)		
Generic	80%	20% with a per prescription maximum of $250
Preferred	80%	20% with a per prescription maximum of $250
Non-preferred	80%	20% with a per prescription maximum of $250
Mail order (up to 90 day supply)		
Generic	80%	20% with a per prescription maximum of $750
Preferred	80%	20% with a per prescription maximum of $750
Non-preferred	80%	20% with a per prescription maximum of $750
Diabetic Supplies	80%	20% with a per prescription maximum of $750
Participating Insulin	Cost over Co-payment	$75
Specialty drug (up to 30 day supply)		
Generic	80%	20% with a per prescription maximum of $250
Preferred	80%	20% with a per prescription maximum of $250
Non-preferred	80%	20% with a per prescription maximum of $250

If a non-generic drug is purchased when a generic drug is available, the participant must pay a penalty of the difference in drug cost of the non-generic drug over its generic equivalent. This penalty does not accumulate toward the deductible or the maximum out-of-pocket limit.
A 90-day supply of maintenance drugs can be filled either by member selected retail pharmacy (Walgreens or CVS) or by mail order. Prices may vary.
Co-pays for certain specialty medications will be set to the maximum available manufacturer Co-pay assistance. This Co-pay adjustment will only apply after deductible satisfaction if this is a qualified high deductible plan. These Co-pays will be paid by the manufacturer after the participant applies for Co-pay assistance and will not apply toward MOOP.
Insulin Co-pay applies to select insulin products whose manufacturers have chosen to participate in the Patient Assurance Program.

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Preventive Immunization Comparison

The chart below shows the vaccines covered by Highmark and Express Scripts. Age limits may apply.

Highmark covers the vaccines if administered by a network provider at your doctor's office. Present your Highmark ID card to your provider in order to be covered by your plan.

Express Scripts covers the vaccines if administered by a participating pharmacy. Not all contracted pharmacies will be able to give all covered vaccines at all times. Contact your participating pharmacy regarding vaccine availability and times for administration by a pharmacist. Present your Highmark ID card at the pharmacy in order to be covered

by your plan.

Vaccines covered at a network doctor's office or participating pharmacy
Chicken Pox (Varicella)
Diphtheria/Tetanus/Pertussis (DTaP/Td/Tdap)
H. Influenzae Type B (Hib)
Hepatitis A and B
Influenza
Measles/Mumps/Rubella (MMR)
Meningococcal
Pneumococcal
Polio (IPV)
Rotavirus
Shingles (Zoster)

The following vaccines are only covered by Express Scripts. Present your Highmark ID card at the pharmacy in order to be covered by your plan.

Vaccines available only at a participating pharmacy
Japanese Encephalitis
Rabies
Typhoid
Yellow Fever

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 Express Scripts at 1-800-555-3432. For over-the-counter medications purchased with a prescription from an in-network pharmacy, use your Highmark ID card.

Medication	Coverage
Aspirin	Coverage to persons age 45 years old for men (55 years for women) through age 79 years old
Colonoscopy Preparation	Coverage to persons age 50 years old and older every 10 years, or earlier or more frequent for persons determined to be at a high risk for colon cancer
Fluoride	Coverage to persons through the age of 5 years old
Folic acid	Coverage to females through the age of 50 years old
Iron	Coverage to persons less than 1 year of age
Smoking cessation	Coverage to persons age 18 years old and older
Statins	Coverage of low to moderate dose statins for persons age 40 to 75 years old
Raloxifene Tamoxifen	Coverage for women without a cancer diagnosis who are determined to be at risk for breast cancer by their physician and meet certain criteria
Vitamin D supplement	Coverage to persons age 65 years old and older at risk for falls

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4. Who is eligible

A. Employee Coverage - coverage for employees and retirees

You are eligible for Employee Coverage under the Plan if You are not covered under any other group medical benefit plan offered by your Employer and You are either:

- An Eligible Employee
- An Eligible Retiree

You are an Eligible Employee if all of these things are true:

- You are an active, full-time employee (as defined by your Employer) earning wages from an Employer that offers Plan coverage to one or more Covered Classes of employees.
- You work at least the number of hours that your Employer requires to be considered a full-time employee, but not less than 20 hours a week.
- You have completed your Employer's waiting period (if any).
- You are in a Covered Class of employees to whom your Employer offers Plan coverage.
- You are a U.S. citizen, or You are a non-U.S. citizen with a valid work permit as verified by your Employer.

You are an Eligible Retiree if all of these things are true:

- 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.
- Your past Employer now offers Plan coverage to one or more Covered Classes of retirees.
- You are in a Covered Class of retirees to whom your past Employer offers Plan coverage.
- You meet the requirements of this section E.

Your Employer decides:

- If You are or were an active, full-time employee.
- If You are in a Covered Class of employees or retirees.

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

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

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

B. Dependent Coverage

Many Employers offer Dependent Coverage. If You have Employee Coverage under the Plan, your dependent(s) may be eligible for Dependent Coverage. Ask your Employer if Dependent Coverage is available.
To get Dependent Coverage, one of these must be true:

- You have Employee Coverage under this Plan.

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- You had Employee Coverage under this Plan but are now covered under one of GuideStone's plans for Medicare-eligible employees, retirees, and dependents.

Your Eligible Dependent(s) are:

- Your Spouse.
- Your Child through the end of the month in which they reach age 26.
- Your Child age 26 or over and is incapacitated. All of these rules must be met:
    - Your Child must have a Developmental Disability or have a Physical Handicap and be incapable of earning a living.
    - Your Child must have been incapacitated when his or her Plan coverage would have ended because of age, or in the case of a new employee or as a result of a Special Enrollment Event, with proof of prior continuous coverage.
    - You must send GuideStone proof of incapacitation at least 31 days before your Child's Plan coverage is scheduled to end.
    - You must send additional proof whenever asked to show that your Child is still incapacitated under this provision.

"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 the legal guardian or managing conservator.

C. If two covered employees want to cover the same dependent Child

Your Child can't be covered under the Plan as a dependent of two Covered Persons working for the same Employer. You and your Spouse may both work for the same Employer and both have Employee Coverage under the Plan, but You must decide which of You will carry the Child as a dependent. You also have to tell your Employer what You decide.

D. Exceptions - dependent not eligible

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

- Is on active duty in the armed forces of any country.
- Already has Employee Coverage under this Plan through this employer. (No one can have both Employee Coverage and Dependent Coverage under the Plan through the same Employer.)
- Is eligible for Medicare and Medicare pays benefits before this Plan. See "What happens if You are covered under Medicare or another government plan."

E. Special rule if You are eligible for Medicare

You can't be covered under this Plan if both of these things are true:

- You are eligible for Medicare.

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- Medicare pays benefits first. "What happens if You are covered under Medicare or another government plan" tells You when Medicare pays benefits before this Plan.

This special rule applies separately to You and your Eligible Dependents. So, even if You are not covered under this Plan because of this special Medicare rule, your Eligible Dependents can still be covered under this Plan. The reverse is also true. If this special rule applies, You or your Medicare Eligible Dependent can switch to a GuideStone Medicare coordinating health plan. Check with your Employer or call GuideStone at 1-844-INS-GUIDE (1-844-467-4843) for more information at least 31 days before You become eligible for Medicare benefits. Do not wait. If this rule applies, your coverage will end the first day of the month in which You first become eligible for Medicare.

5. When coverage begins

A. Enrolling yourself

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

- Be eligible for coverage.
- Give your Employer a signed *Enrollment Form* within 31 days after You first become eligible.
- Pay any required costs of coverage.

If You meet the above requirements, You will be covered on your date of hire or after any waiting period your Employer requires. If You enroll after the 31-day period, You will be a late enrollee. This means that your coverage will be delayed.

B. Enrolling your dependents

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

- Enroll yourself for Employee Coverage.
- Give your Employer a signed *Enrollment Form* that lists your Eligible Dependents, within 31 days after You first become eligible.
- Pay any required costs of coverage.

If You meet the above requirements, your Dependent Coverage will begin when your Employee Coverage begins. Any Eligible Dependents You do not enroll when You enroll yourself for Employee Coverage may be late enrollees. This means that their coverage will be delayed.

C. Late enrollees

These late enrollee rules apply in the same way to You and your Eligible Dependents. You will be a late enrollee if You or your dependents:

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

For late enrollees:

- Coverage will not begin until January 1 following the date You enroll.

D. Mid-year election changes under Internal Revenue Code Section 125

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You are permitted to enroll yourself and eligible dependents as allowed under the terms of your employer's Section 125 plan provided that the election change does not conflict with the eligibility rules or participation guidelines as outlined in this Plan booklet. The election change must be as a result of and correspond with the event that triggers the permitted change.

E. Special enrollment requirements

If your family status changes, You can enroll yourself, your Spouse and any other Eligible Dependents in the Plan as special enrollees if any one of these special enrollment events happens:

- Marriage.
- Birth of a newborn.
- Adoption or placement of a Child in your home.
- Death.
- Divorce.
- Loss of other coverage.

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

- Enroll them within 60 days after the event.
- Pay any required costs of coverage.

If You meet the above requirements, the Plan will cover You and the Eligible Dependents You enroll from the date of the marriage, birth, adoption or placement in the home, death, or divorce. If You do not do these things at the right time, You or your dependents may be late enrollees.

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

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

But You can enroll only if:

- Your prior group healthcare coverage was not terminated for cause (such as making a fraudulent claim or an intentional misrepresentation) or for late payment.
- You give your Employer a completed Enrollment Form no later than 60 days after the other health coverage ended.

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

F. Dropping dependents from coverage

You can drop a dependent from your coverage at any time. You must tell your Employer promptly about the change.

G. Making enrollment changes

Report all enrollment changes promptly so You and your Eligible Dependents become covered as soon as possible. Also, a change in coverage could make your costs of coverage to the Plan higher or lower. If You do not report a change promptly, You may pay higher costs of coverage than necessary. The Plan may not refund these excess payments. Your Employer has the forms You need to complete to enroll or to make any changes in coverage.

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H. Transfer between GuideStone plans

You or your Eligible Dependents may transfer between any eligible GuideStone medical plans offered by your Employer, only during an annual enrollment period or if a special enrollment event occurs.

6. When coverage ends

A. End of Employee Coverage

Your Employee Coverage will end if any of these things happen:

- You no longer work as an active, full-time employee for an Employer that offers Plan coverage.
- You retire prior to age 65 and your Employer does not offer Plan coverage to its early retirees.
- GuideStone or your Employer stops offering the Plan.
- Required costs of coverage are not paid when due. Your Employee Coverage will not end just because You do not pay costs of coverage for Dependent Coverage.
- You are eligible for Medicare and Medicare pays first before this Plan pays. See "What happens if You are covered under Medicare or another government plan."
- You supplied information for enrollment or claims for benefits that is determined to be fraudulent or an intentional misrepresentation.

If You are no longer an active full-time employee, check with your Employer at once to find out if You can continue your Plan coverage.

B. End of Dependent Coverage

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

- You lose your Employee Coverage for any reason except that You became eligible for Medicare coverage.
- Your Spouse or Child is no longer an Eligible Dependent.
- GuideStone stops offering the Plan.
- Your Employer stops offering Dependent Coverage.
- Required costs of coverage are not paid when due.
- Your Spouse or Child becomes eligible for Medicare and Medicare pays first. See "What happens if You are covered under Medicare or another government plan."
- You supplied information for enrollment or claims for benefits that is determined to be fraudulent or an intentional misrepresentation.

If your dependents lose coverage for any reason, call your Employer at once to find out if they can continue coverage.

C. Mid-year election changes under IRS Code Section 125

You are permitted to terminate coverage for yourself or dependents as allowed under the terms of your employer's Section 125 plan, provided that the election change does not conflict with the eligibility rules or participation guidelines as outlined in this Plan booklet. The election change must be as a result of and correspond with the event that triggers the permitted change.

D. Important Notice Requirement

You must report changes to coverage eligibility for You and Your Covered Dependents immediately. Failure to report

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could be interpreted as fraud or intentional misrepresentation as provided by the federal healthcare reform law known as the Affordable Care Act (ACA). GuideStone has adopted policies and procedures incorporating ACA guidance. You may make unnecessary contribution payments that may not be refundable in accordance with those policies and procedures, and your coverage may be subject to termination.

E. 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.
- Your dependent becomes eligible for benefits under any other group medical plan.
- The Plan stops offering Dependent Coverage.
- GuideStone or your Employer stops offering group medical plans.
- Required costs of coverage are not paid when due.
- Your Spouse or Child becomes covered under Medicare and Medicare pays first. See "What happens if You are covered under Medicare or another government plan".

F. Continuation Coverage for You and your Covered Dependents

Some Employers allow You and your Covered Dependents to continue Plan coverage after it would otherwise end. This applies only if the following are true:

- Your Employer elects to offer Continuation Coverage.
- Your Employer continues to offer Plan coverage to its employees.
- You were not fired for gross misconduct, as determined by your Employer.

The maximum length of Continuation Coverage is:

- 18 months for You and your Covered Dependents if the loss of Plan coverage is because You either lost your job or You work fewer than the hours required for active, full-time employment.
- 36 months for your Spouse or Covered Dependent Child if the loss of Plan coverage is due to You and your Spouse's divorce or legal separation, or your Covered Dependent Child is no longer an Eligible Dependent.

Enrollment for Continuation Coverage. If You want Continuation Coverage, You or your Covered Dependents must:

- Get an application and other information about this coverage from your Employer.
- Apply for Continuation Coverage within 60 days after the date Plan coverage would otherwise end.

Adding Eligible Dependents to your Continuation Coverage. You may add a newborn or an adopted Child to your Continuation Coverage within 60 days after birth, adoption or placement in your home. Also, if You get married, You may add your new Spouse and any new Eligible Dependents to your Continuation Coverage within 60 days after your marriage.
You must act promptly. If You do not, You and your dependents will not be eligible for this Continuation Coverage.

Charges for Continuation Coverage. The monthly charge for Continuation Coverage will be up to 102% of the full cost of each Covered Person's Plan coverage. Your Employer is responsible for collecting monthly charges and sending them to GuideStone. **You must pay these costs of coverage when due, or your Continuation Coverage will end.**

Early termination of Continuation Coverage. Continuation Coverage under this plan will end sooner than the 18 or 36 months if:

- Costs of coverage are not paid when due.
- The Covered Person becomes covered under other group medical coverage, either as an employee or dependent.

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- The Covered Person becomes eligible for Medicare.(You may be eligible to continue your remaining coverage under a Medicare-coordinating plan).
- GuideStone stops offering the Plan.
- Your Employer stops offering the Plan.

G. Family and medical leave

If your Employer has 50 or more employees, You may be covered under a special federal law called the Family and Medical Leave Act of 1993 (FMLA) or similar state laws. FMLA may let You take unpaid leave:

- For childbirth or adoption.
- To take care of a seriously ill family member.
- For your own serious illness.

If the FMLA applies to your Employer, your Plan coverage can continue if You take leave for one of these reasons. If You need to take family or medical leave, ask your Employer for more information about the FMLA and what You need to do to continue your coverage. Your Employer is responsible for complying with FMLA and similar state laws.

H. Military leave

If You have to leave your employment because You are serving in the military, You have special rights under the federal Uniformed Services Employment and Reemployment Rights Act (USERRA).

Under this law:

- You are entitled to continue coverage under the Plan (for both You and your Covered Dependents) for up to 24 months after your military leave begins.
- If your leave lasts more than 31 days, You may have to pay up to 102% of the total amount of both employee and Employer portions of the costs of coverage.
- If your leave is 31 days or less, You will only have to pay the same amount as You would have paid for your regular Plan coverage if You were not on military leave.
- If You were covered under the Plan when your military leave began, You may get immediate Plan coverage when You return to your prior Employer. Ask your Employer, the Department of Labor or the Department of Defense if You have any questions about your rights under USERRA.

7. Member Financial Responsibility

A. Deductibles

A Deductible is the amount that You must pay out of your pocket for Eligible Expenses before the Plan pays most benefits. After You pay the Deductible, the Plan pays a percentage of the rest of your Eligible Expenses. The Plan excludes Outpatient Prescription Drug program penalties from your Deductibles.

Individual Deductible: An Individual Deductible is the amount a Covered Person with single coverage must pay for Eligible Expenses each Benefit Period before the Plan pays most benefits for the Covered Person for the rest of the Benefit Period. After You pay the Individual Deductible, the Plan pays a percentage of the rest of your Eligible Expenses. Only payments for Eligible Expenses count toward the Individual Deductible.

Family Deductible: A Family Deductible is the amount You and each Covered Person in your family must pay for Eligible Expenses each Benefit Period before the Plan pays most benefits for each Covered Person in your family for the rest of the Benefit Period. After You pay the Family Deductible, the Plan pays a percentage of the rest of the Eligible Expenses for each Covered Person in the family. Only payments for Eligible Expenses count toward the Family Deductible.

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B. Co-insurance

In most cases, this Plan does not pay for all of your Eligible Expenses. It usually pays only a percentage of Eligible Expenses after You pay your Deductibles. This percentage is the Co-insurance.

Exceptions to normal payment rules: The benefit rules described above do not apply when:

- Emergency room Physician charges, anesthesiology, radiology and pathology Services provided by an Out-of-Network Provider will be payable at the Network level.
- A treatment or Service is performed by a Specialist Physician for a listed Eligible Expense and a Network Provider is not available in the Network area. Benefits for such treatment will be paid at the Network level if approved by the claims Administrator prior to obtaining such treatment or Service.
- Emergency Care is performed due to an Emergency Medical Condition (see "Emergency Medical Conditions" in the Definitions section of the booklet). Benefits for such treatment will be paid at the Network level (see the *Schedule of Benefits* for additional information).
- GuideStone contributes toward the cost of your coverage when participating in the Mayo Clinic Complex Care Program as a part of the GuideStone Plan. In some cases, GuideStone pays the full cost of eligible covered services under the GuideStone Plan as allowed by applicable law. In other cases, you share the cost of your coverage when participating in the Mayo Clinic Complex Care program available under the GuideStone Health Plan, or pay the full cost.

Who Pays the Cost	**Benefit**
Plan pays the full cost	Co-payment Deductible Co-insurance Travel expenses (up to allowable limit) Lodging expenses (up to allowable limit)
Member	Travel/lodging expenses beyond allowable limits Incidentals including food, toiletries, clothing

C. Maximum Out-of-Pocket limit

Individual Maximum Out-of-Pocket limit: This is the amount that a Covered Person must pay for Network Eligible Expenses in a Benefit Period (including Deductibles), before the Plan pays 100% of the Covered Person's Network Eligible Expenses for the rest of the Benefit Period.

The Plan limits your medical and prescription Maximum Out-of-Pocket limit for each Benefit Period. This means that after You have paid the stated amount, the Plan covers 100% of your remaining Eligible Expenses from Network Providers for the rest of that Benefit Period. The Plan counts the amounts You pay for Eligible Expenses from Network Providers toward your Maximum Out-of-Pocket limit. Out-of-Network expenses and Outpatient Prescription Drug program penalties do not count toward the Maximum Out-of-Pocket limit. Eligible Expenses for Outpatient Prescription Drugs do count toward the Maximum Out-of-Pocket limit.

There is a Benefit Period Maximum Out-of-Pocket limit for each Covered Person and a Benefit Period Maximum Out-of-Pocket limit for You together with all of your Covered Dependents.

Family Maximum Out-of-Pocket limit: This is the amount that You and the Covered Dependents in your family must pay for Network Eligible Expenses in a Benefit Period (including Deductibles) before the Plan pays 100% of a Covered Person's Eligible Expenses for the rest of the Benefit Period.

D. Co-insurance and Deductible Out-of-Pocket limit

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Individual Co-insurance and Deductible Out-of-Pocket limit: This is the amount that a Covered Person must pay in a Benefit Period, before the Plan pays 100% of the Covered Person's Out-of-Network Eligible Expenses for the rest of the Benefit Period.

For Out-of-Network expenses, once You pay all applicable deductibles, the Plan limits the amount You pay in Co-insurance for each Benefit Period. This means that after You have paid the stated amount, the Plan covers 100% of your remaining Eligible Expenses for the rest of that Benefit Period. The Plan counts the amounts You pay for Eligible Expenses from Out-of-Network Providers toward your Co-insurance and Deductible Out-of-Pocket limit. Outpatient Prescription Drugs and penalties for not obtaining Preauthorization review do not count toward the Co-insurance and Deductible Out-of-Pocket limit.

Family Co-insurance and Deductible Out-of-Pocket limit: This is the amount that You and your Covered Dependents in your family must pay in a Benefit Period (after Deductibles) before the Plan pays 100% of a Covered Person's Out-of-Network Eligible Expenses for the rest of the Benefit Period

E. Co-payments

A Co-payment is the amount that You must pay out of your pocket for certain Eligible Expenses before the Plan pays any benefits. After You pay the Co-payment, the Plan pays a percentage of the rest of your Eligible Expenses. Services subject to the Network Co-payments are not subject to the Individual or Family Deductible.

Office Visit Co-payment: There is a Co-payment called the office Visit Co-payment, as shown in your Plan's Schedule of Benefits. You may have to pay this when You visit a Network Provider. With respect to the office Visit Co-payment, patient X-ray and laboratory charges will follow these rules:

- If You or an Eligible Dependent goes to a Network freestanding X-ray or laboratory facility, the office Visit Co-payment will not apply, and the normal Network level of benefits will apply. If the X-ray or laboratory facility is not a Network Provider, the level of benefits for Out-of-Network Providers will apply.
- If You or an Eligible Dependent goes to a Network Physician and the Physician sends the X-ray or laboratory work to a Network facility for processing, the office Visit Co-payment will apply.
- If You or an Eligible Dependent goes to a Network Physician and the Physician sends the X-ray or laboratory work to an Out-of-Network facility for processing, the office Visit Co-payment will apply.
- Under Wellness Benefit, if You or an Eligible Dependent goes to a Network Out-Patient Hospital or a Network freestanding facility for routine lab or X-ray charges, these routine Services will be considered at 100% subject to the Preventive Health Schedule. See "Covered Services".

These rules apply to the office Visit Co-payment: Some Eligible Expenses for Covered Services are not covered under the office Visit Co-payment even if they are both provided and billed by the Network Physician. These include Services such as:

- Office Surgery (excludes venipuncture).
- MRIs, CT Scans, and PET Scans even if administered in a Physician's office.
- Applied Behavior Analysis.
- Occupational Therapy, Physical Therapy or Speech Therapy.

Eligible Expenses that are not included in the Co-payments are subject to the Deductibles.
Your Outpatient Prescription Drug coverage has different Co-payments. See the Schedule of Benefits for Prescription Drug Coverage

8. Covered Services

A. Overview

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The Plan generally pays Eligible Expenses after member cost sharing for Covered Services.

The Plan does not cover any Service not considered Medically Necessary and Appropriate. The fact that a Physician recommends or approves a Service does not mean that it is Medically Necessary and Appropriate under the Plan's guidelines, or third party administrators medical policy.

You must get Preauthorization from Medical Management & Policy (MM&P) to receive the maximum benefits under the Plan. See "Medical Management & Policy" for more details.

Covered Services will also include MM&P by the Claims Administrator to utilize a more cost effective Generally Accepted form of Medically Necessary and Appropriate care when compared to use of covered expenses contained in this Plan.

B. Medical examinations

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

C. Covered Services

Here is a list of some Covered Services. "You" in the following description of Services means You and your Covered Dependents.

Allergy Treatment. Allergy treatment when prescribed by a Physician.

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 Services. Treatment or Service provided at an Ambulatory Surgical Facility.

Anesthesia. Anesthetics and their administration.

Artificial Limbs and Body Parts. Purchase and replacement of artificial limbs, larynx and eyes.

Autism Spectrum Disorder Therapy:

- Applied behavior analysis.
- Speech Therapy for dependent child under age six.
- Occupational Therapy for dependent child through age 16.
- Physical Therapy for dependent child through age 16.

Birthing Facility. Treatment or Service provided at a Birthing Facility.

Blood. Blood and blood plasma and storage and administration of the blood.

Blue Cross Blue Shield Global Core Program. Assists with medical claims Incurred while living or traveling outside the United States. Services include:

- Making referrals and appointments for You with nearby Physicians and Hospitals.
- Verbal translation from a multilingual service representative.
- Providing assistance if special help is needed.
- Making arrangements for medical evacuation Services.
- Processing Inpatient Hospital Claims.

For Outpatient or professional Services received abroad, You should pay the Provider, then complete an *International Claim Form* and send it to the Blue Cross Blue Shield Global Core Service Center. Claim forms can be obtained by calling **1-800- 810-BLUE** (1- 800-810-2583) or the member service telephone number on your Highmark ID card. Claim forms can also be downloaded from *www.bcbsglobalcore.com.*

Cardiac Rehabilitation. Cardiac rehabilitation Services only if provided both:

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- Under a Physician's supervision.
- In connection with a myocardial infarction, coronary occlusion or coronary bypass surgery.

Chemotherapy. The treatment of malignant disease by chemical or biological antineoplastic agents, including materials and technician Services.

Chiropractic Treatment. Charges related to the adjustment and manipulation of the spinal column and associated nervous system, X-ray lab and modalities, whether provided by a licensed Chiropractor or other Physician.

Cochlear Implants - Cochlear implants are covered, one per ear every 3 years.

Contraceptives. See "Outpatient Prescription Drug program" for coverage of certain oral contraceptives**.** Non-oral contraceptives that are non-abortive in nature are covered under the medical portion of the Plan. The Plan covers the insertion of an intrauterine device (IUD) only for non-contraceptive purposes.

Cosmetic Procedures and Services. Cosmetic procedures and Services, but only to:
- Correct the result of an accidental Injury.
- Treat congenital birth defects.
- Treat any condition that impairs bodily functions.
- Reconstruct a breast for the treatment of a Sickness.

Dental Services. Services for any of these:
- Excision of third molars that are not completely erupted.
- Surgical extraction of erupted or non-erupted third molars.
- Excision of a tooth root without removing the entire tooth but not including root canal therapy.
- Other incision or excision procedures on the gums and tissues of the mouth when not performed in connection with tooth repair or removal. This does not include cleaning, root scaling, planing or other scraping procedures.
- Treatment or removal of a malignant tumor.
- Outpatient facility charges and Anesthesia, provided the dental Service is covered under the Plan and is Medically Necessary and Appropriate.
- Accidental Injury to your jaws, sound natural teeth, mouth or face. The Plan covers only those expenses Incurred within 12 months of the Accident. It is not considered an accidental Injury if You chew or bite an object or substance that You place in your own mouth. It does not matter whether You knew at the time that the object or substance could cause an Injury if chewed or bitten.

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

Dialysis Treatments. The treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials for the body through hemodialysis or peritoneal dialysis. Dialysis treatment includes home dialysis.

Drug Abuse. See Mental Illness and Alcohol/Drug.

Durable Medical Equipment. The rental or, at the option of the Claims Administrator, the purchase, adjustment, repairs and replacement of Durable Medical Equipment for therapeutic use when prescribed by a Professional Provider. Rental costs cannot exceed the total cost of purchase.

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

Emergency Care. With respect to an Emergency Medical Condition:

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

Emergency transportation and related emergency Services provided by a licensed Ambulance Service shall

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constitute Emergency Care. Emergency Care shall not include treatment for an occupational Injury for which benefits are provided under any Workers' Compensation Law or any similar Occupational Disease Law.

In the event that you receive emergency care services from an out-of-network provider and require an inpatient admission or observation immediately resulting from your injury or emergency medical condition, and upon stabilization:

- you are unable to travel using nonmedical transportation or nonemergency medical transportation; or
- you do not consent to be transferred.

Covered services directly related to such injury or emergency medical condition and received during the inpatient admission or observation will be covered at the network services level of benefits as set forth in the Hospital Services benefit in the Schedule of Benefits section of this booklet. You will not be subject to any balance billing amounts.

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

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

Emergency Medical Evacuation Coordination. This Service is provided to You and Your Covered Dependents when outside of the United States. When a member is already receiving care, the Blue Cross Blue Shield Global Core medical assistance partner will determine whether the current facility has the resources to provide the appropriate level of care. This benefit may be utilized when in the professional opinion of the medical assistance partner, a clear and significant risk of death or imminent serious injury or harm to You or Your Eligible Dependents exists. In instances where the medical assistance partner determines that medical evacuation is appropriate, the medical assistance partner will contact the member's Blue Cross and Blue Shield Plan and recommend that the member be moved to the nearest facility (identified by the medical assistance partner) that can provide the level of care necessary. The medical assistance partner will arrange for transportation to the recommended facility. Travel expenses will only be covered if determined medically necessary and coordinated by the medical assistance partner. See also "Repatriation for medical coordination" in this section.

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

Enteral Formulae. The Plan will cover Enteral Formulae, as described in Covered Services, for home use that is prescribed by a Physician for Medically Necessary and Appropriate care, as determined by the Claims Administrator. The Enteral Formulae must be proven effective as a disease specific treatment regimen for individuals who are or will become malnourished or suffer from disorders, which if left untreated would cause chronic physical disability, mental retardation or death. Specific diseases shall include, but are not limited to, inherited diseases or amino acid or organic acid metabolism, Crohn's Disease, gastroesophageal reflux with failure to thrive disorders or gastrointestinal motility, and multiple severe food allergies.

Habilitative Services. Services that help a person gain, keep, or improve skills for daily living. Some examples include Physical and Occupational therapy, Speech therapy, and other needed Services.

Hearing Aids. Available for dependents through age 18. Hearing aids are covered, one per ear every 3 years. Including, but not limited to, semi-implantable hearing devices, audient bone conductors and Bone Anchored Hearing Aids.

Hearing Exams. Treatment from an Audiologist if You suffer from a hearing loss or impairment. This includes examinations to decide if You need a hearing aid or a hearing aid adjustment. The Plan does not cover:

- Replacement hearing aid batteries or tests to evaluate hearing aids.
- Hearing examinations required as a condition of employment.
- Any Services that a school system legally must provide.
- Special education needed because of hearing loss or impairment. This includes sign language lessons.

Home Healthcare Services. Covered Services will include charges by a Home Health Care Agency for:

- Part-time or intermittent home nursing care by or under the supervision of a licensed Registered Nurse

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(R.N.).
- Part-time or intermittent home care by a home health aide.
- Physical, Occupational, Speech or Respiratory Therapy.
- Intermittent Services of a registered dietician or social worker.
- Part-time or intermittent home care by any other individual of the home healthcare team.
- Drugs and medicines which require a Physician's prescription, as well as other supplies prescribed by the attending Physician.
- Laboratory Services but only to the extent that such Services are provided under the terms of a home healthcare plan. These Covered Services are subject to all provisions of the Plan that would apply to any other medical treatment or Service.

Home healthcare Services must be rendered in accordance with a prescribed home healthcare plan. The home healthcare plan must be:
- Established prior to the initiation of the home healthcare Services and,
- Required as a result of a Sickness or Injury.

The general Plan exclusions and maximums listed in this booklet will apply to home healthcare. In addition, Covered Services will **not** include charges for:
- Services not included in the home healthcare plan.
- More than 120 Visits in a Benefit Period. For a home health aide, up to four hours of continuous Service will be counted as one Visit. A Visit by any other covered Provider equals one Visit regardless of the length of the Visit.
- The Services of any person who normally lives in your or your dependent's home.
- Custodial Care.
- Transportation Services.

Hospice Care. Covered Services will include charges for Hospice Care Services provided by a Hospice, Hospice Care team, Hospital, Home Health Care Agency or Skilled Nursing Facility for:
- Any Sickness or Injury that, in the opinion of the attending Physician, the individual has no reasonable prospect of cure and is expected to live no longer than six months.
- The family (You and your dependents) of any such individual but only to the extent that such Hospice Care Services are provided under the terms of a Hospice Care program and are billed through the Hospice that manages that program.

Hospice Care consists of:
- Inpatient and Outpatient care, home care, nursing care, counseling and other supportive Services provided to meet the physical, psychological, spiritual and social needs of the individual.
- Drugs and medicines (requiring a Physician's prescription) and other supplies prescribed for the individual by any Physician who is a part of the Hospice Care team.
- Instructions for care of the patient, counseling and other supportive Services for the family of the individual.

The general Plan exclusions listed in this booklet will apply to Hospice Care. In addition, Covered Services will **not** include Hospice Care charges that:
- Are for Hospice Care Services not approved by the attending Physician.
- Are for transportation Services.
- Are for Custodial Care.
- Are for Hospice Care Services provided at a time other than during an episode of Hospice Care.

Hospital Expenses. Room and board in a semi-private Hospital room and all other supplies and non-professional Services a Hospital provides for medical care (but not more than the Hospital Room Maximum for each day of confinement in a private room). You must get Preauthorization before You have a Hospital Inpatient Stay. See "Care Coordination Process**"** for more details.

Infusion Therapy. Treatment performed by a Facility Provider.

Laboratory Tests. Laboratory tests ordered by a Physician.

Maternity Care. The Plan covers maternity care and treatment as it would any other Sickness. If the mother is a

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Covered Person under the Plan, the Plan covers the Hospital Inpatient Stays for childbirth:

- **Normal vaginal delivery**. The Plan covers a Hospital Inpatient Stay of at least 48 hours following childbirth for both the mother and the newborn.
- **Caesarean section**. The Plan covers a Hospital Inpatient Stay of at least 96 hours following childbirth for both the mother and the newborn.

For either type of delivery, the mother and her attending Physician can both agree to a shorter stay. You do not need to ask for a Hospital Admission Review if your stay is within these limits. But You must obtain Preauthorization for any stay past these limits. See "Medical Management & Policy" for more details.

Highmark provides a voluntary Maternity Education and Support Program, **Baby BluePrints®,** available at no cost to You during your pregnancy. For additional information about the program contact Highmark at **1-866-918-5267** or by accessing their website at *www.MyHighmark.com*.

Medical Supplies. Certain medical supplies ordered by a Physician. Some examples are: surgical dressings, heart pacemakers, casts, splints, trusses, braces, crutches, insulin pumps and oxygen.

Mental Illness and Alcohol/Drug Abuse Treatment. Outpatient and Inpatient treatment for Mental Illness and Alcohol/Drug Abuse. Before receiving Inpatient treatment, You must obtain Preauthorization. See "Care Coordination Process**"** for more details.

Newborn Baby Care. The Plan covers the care for a newborn who is an Eligible Dependent even if the newborn is not a Covered Dependent during the first 31 days of life. See special enrollment requirements in "When coverage begins."

Nursing Services. The Plan covers the Services of a Licensed Practical Nurse or a graduate Registered Nurse, but only when such Services are provided during confinement in a Hospital or Skilled Nursing Facility, or when such Services are provided as a part of home healthcare or Hospice Care.

Occupational Therapy. Treatment by a Professional Occupational Therapist that is ordered by a Physician.

Physical Therapy. Treatment by a Professional Physical Therapist that is ordered by a Physician.

Physician Service. A Physician's Service for diagnosis, Medical Care, Surgery, and Physician Visits.

Physician Visit. A consultation between a Physician or Physician's staff and a patient for the purpose of Medical Care or Service.

Prescription Drugs. Drugs and medicines prescribed by a Physician if they are dispensed and administered in a Physician's office, a Hospital or another medical care facility. Drugs and medicines prescribed for You under other circumstances may be covered under the "Outpatient Prescription Drug program."

Radiation Therapy. The treatment with X-ray, gamma ray accelerated particles, mesons, neutrons, radium, or radioactive isotopes. The materials and Services of technicians are included. High dose levels of radiation requiring stem cell rescue **are not** covered, except for some transplants.

Repatriation for Medical Coordination. This Service is provided to You and your Covered Dependents when outside of the United States. The Blue Cross Blue Shield Global Core medical assistance partner may determine that the needed treatment will be extensive, and it is appropriate and cost-effective to have the member near family and friends. In these cases, the medical assistance partner will contact the member's Blue Cross and Blue Shield Plan and recommend that the member be repatriated. The partner will arrange for the transportation and alert the local hospital of the impending patient move and the level of care needed.

Repatriation of Remains. This Service is provided to You and your Covered Dependents when outside of the United States. The Blue Cross Blue Shield Global Core arranges for repatriation of remains when a member passes away while out of the U.S. Arrangements include moving the body from the foreign country back to the selected funeral home in the United States. The laws and customs of the country will be taken into consideration.

Respiration Therapy. The introduction of dry or moist gases into the lungs for treatment purposes.

Skilled Nursing/Rehabilitation Facility. Covered Services will include charges by a Skilled Nursing/Rehabilitation Facility for room, board and other Services required for treatment, provided the confinement:

- Is certified by a Physician as necessary for recovery from a Sickness or Injury.

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- Requires Skilled Nursing/Rehabilitation Services. Covered Services will not include:
    - Charges for more than 30 days for all Skilled Nursing/Rehabilitation Facility confinements that result from the same or a related Sickness or Injury.
    - Charges Incurred for a Skilled Nursing/Rehabilitation Facility confinement after the date the attending Physician stops treatment or withdraws certification.

Before receiving Inpatient treatment, You must obtain Preauthorization. See "Medical Management & Policy**"** for more details.

Speech Therapy. Treatment by a qualified Speech-Language Pathologist that is ordered by a Physician.

Sterilization Procedures. Coverage of surgical procedures for any reproductive sterilization procedure but will not cover expenses Incurred for the reversal or attempted reversal of these procedures.

Surgical Procedures. Physician Service for surgical procedures such as:

- 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.

Benefits will be payable for the Services of an assistant to a surgeon if such Services are determined by the Claims Administrator to be Medically Necessary and Appropriate. An assistant to a surgeon is considered to be Medically Necessary and Appropriate if the skill level of an M.D. or D.O. would be required to assist the primary surgeon. For more information, You or your Physician should contact the Claims Administrator.

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

TMJ. Diagnostic Services and Surgery relating to the treatment of temporomandibular joint disorders. The Plan does not cover splinting or orthodontia treatment for TMJ.

Transplant Services. Benefits will be provided for covered services furnished by a hospital which are directly and specifically related to the Medically Necessary and Appropriate transplantation of organs, bones, tissue or blood stem cells.

If a human organ, bone, tissue or blood stem cell transplant is provided from a living donor to a human transplant recipient:

- when both the recipient and the donor are members, each is entitled to the benefits of their program;
- when only the recipient is a member, both the donor and the recipient are entitled to the benefits of this program subject to the following additional limitations: 1) the donor benefits are limited to only those not provided or available to the donor from any other source, including, but not limited to, other insurance coverage, other Blue Cross or Blue Shield coverage or any government program; and 2) benefits provided to the donor will be charged against the recipient's coverage under this program to the extent that benefits remain and are available under this program after benefits for the recipient's own expenses have been paid;
- when only the donor is a member, the donor is entitled to the benefits of this program, subject to the following additional limitations: 1) the benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this program; and 2) no benefits will be provided to the non-member transplant recipient; and
- if any organ, tissue or blood stem cell is sold rather than donated to the member recipient, no benefits will be payable for the purchase price of such organ, tissue or blood stem cell; however, other costs related to evaluation and procurement are covered up to the member recipient's program limit.

Travel and Lodging. For BDC services and Other Centers of Excellence (OCE) approved by the Plan.

Travel and lodging reimbursement up to a maximum lifetime benefit of $10,000 for each approved transplant is also available for covered services when provided by Blue Distinction Centers and Other Centers of Excellence Approved by the plan. Specifically, travel and lodging reimbursement is available for the transplant recipient and one other adult or, if the recipient is under 18 years of age, for the recipient and two parents. If the facility provider is less than 100 miles from the recipient's home, standard automobile mileage and parking fees are reimbursable. No reimbursement is available for automobile maintenance or repair.

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Air travel on a commercial airline is reimbursable if the facility provider is further than one hundred miles from the recipient's home. Reimbursement for air travel will be based on the cost of two round trip coach tickets for the recipient and one other adult or, if the recipient is under 18 years of age, for the recipient and two parents.

Urgent Care. Benefits will be determined according to the *Schedule of Benefits* for the level of Service provided.

Vision Benefit. Includes one annual eye exam per Benefit Period, including eye health examination, dilation, and refraction for contact or glasses performed by an optometrist or ophthalmologist.

Wellness Benefit. A *Preventive Schedule* which includes Services, without cost sharing, for children and adults based on recommendations 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.

The general *Preventive Schedule* summary located at *https://www.guidestone.org/preventiveschedule* is not a complete list of the *Preventive Schedule* provided under your Plan. To determine if a specific procedure is covered under the Wellness Benefit, call Highmark at 1-866-472-0924. The Wellness Benefit applies only to charges Incurred when You have Services provided through an In-Network provider.

D. 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 provided in the form of Service.

9. Medical Management & Policy

For your benefits to be paid under this Plan, at either the Network or Out-of-Network level, Services and supplies must be considered "Medically Necessary and Appropriate."

Medical Management & Policy (MM&P), a division of Highmark, is responsible for ensuring that quality care is delivered to You within the appropriate setting.

A. Hospital Admission Review

Network facility providers will obtain Pre-authorization of your Network Inpatient admission on your behalf.

You are responsible for notifying MM&P of your Out-of-Network admission. However, some Out-of-Network facility providers will contact MM&P and obtain Pre-authorization of the inpatient admission on your behalf. Be sure to verify with MM&P that your provider is contacting MM&P for Pre-authorization. You should call 7 to 10 days prior to your planned admission. For emergency admissions, call MM&P within 48 hours of the admission, or as soon as reasonably possible. You can contact MM&P via the toll-free Member Service telephone number located on the back of your ID card.

An MM&P nurse will review your request for an inpatient admission to ensure it is appropriate for the treatment of your condition, illness, disease or injury, in accordance with standards of good medical practice, and the most appropriate supply of level of service that can safely be provided to You. When applied to hospitalization, this further means that You require acute care as an inpatient due to the nature of the services rendered for your condition and You cannot receive safe or adequate care as an outpatient.

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If You do not notify MM&P of your admission to an Out-of-Network facility provider, MM&P may review your care after services are received to determine if it was medically necessary and appropriate. **If your admission is determined not to be Medically Necessary and Appropriate, You will be solely responsible for all costs not covered by your program.**

See "Appendix 1" for Claim and Appeal Procedure.

B. Care Utilization Review Process

In order to assess whether care is provided in the appropriate setting, MM&P administers a care utilization review program comprised of prospective, concurrent and/or retrospective reviews. In addition, MM&P assists hospitals with discharge planning. These activities are conducted by an MM&P nurse working with a physician advisor.

C. Prospective Review

Prospective review, also known as Pre-authorization or pre-service review, begins upon receipt of treatment information. After receiving the request for care, MM&P:

- Verifies your eligibility for coverage and availability of benefits;
- Reviews diagnosis and plan of treatment;
- Assesses whether care is medically necessary and appropriate;
- Authorizes care and assigns an appropriate length of stay for inpatient admissions

D. Concurrent Review

Concurrent review may occur during the course of ongoing treatment and is used to assess the medical necessity and appropriateness of the length of stay and level of care.

- Reviews the progress and ongoing treatment plan with the facility staff.
- Decides, when necessary, to either: extend the care, discuss an alternative level of care or refer to the Physician advisor for a decision.

E. Retrospective Review

Retrospective review may occur when a service or procedure has been rendered without the required Pre-authorization.

F. Discharge planning

Discharge planning is a process that begins prior to your scheduled hospital admission. Working with You, your family, your attending physician(s) and hospital staff, MM&P will help plan for and coordinate your discharge to assure that You receive safe and uninterrupted care when needed at the time of discharge.

In planning for discharge, MM&P assesses the patient's:

- Level of function pre- and post-admission.
- Ability to perform self-care.
- Primary caregiver and support system.
- Living arrangements pre- and post-admission.
- Obstacles to care.
- Need for referral to case management or condition management.
- Availability of benefits or need for benefit adjustments.
- Psychological needs.

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G. Case management Services

Case management is a voluntary program in which a case manager, with input from You and your health care providers, assists when You are facing and/or recovering from a hospital admission, dealing with multiple medical problems or facing catastrophic needs. Highmark case managers can provide educational support, assist in coordinating needed health care services, put You in touch with community resources, assist in addressing obstacles to your recovery such as benefit and caregiver issues and answer your questions.

Highmark case managers are a free resource to all Highmark members. If You have an inpatient hospital admission, You may be contacted as part of our Outreach program. If your claims history indicates that your needs appear to be more complex, You may be contacted by a case manager from our Complex program. In either case, You are always free to call and request case management if You feel You need it by contacting Member Services at the telephone number listed on the back of your Highmark ID card.

Should You or an Eligible Dependent experience a serious Injury or Sickness, the case management program may be able to provide assistance.

If accepted into the program, and with your permission, the program will:

- Work collaboratively with You, family members and Providers to coordinate and implement a plan of care which meets the patient's needs.
- Identify community-based support and educational Services to assist with ongoing healthcare needs.
- Assist in the coordination of benefits and alternative resources.

H. Authorized representatives

You have the right to designate an authorized representative to file or pursue a request for Pre-authorization or other Pre-service Claim on your behalf. Procedures adopted by Highmark will, in the case of an Urgent Care Claim review, permit a Physician or other professional healthcare Provider with knowledge of your medical condition to act as your authorized representative.

10. Plan exclusions

A. The Plan does not cover all medical expenses

This section tells You about some of the Services that the Plan does not cover. **Remember, just because a Physician recommends or approves a Service does not mean that the Plan covers it.** If You have any questions about coverage, call or write to Clarity's Patient Advocacy Team **before** You receive the Services.

B. Exclusions

The Plan does not cover charges for You or your Covered Dependents for any of these Services:

Abortion. Elective termination of pregnancy by any method.

Acupuncture and Acupressure Treatment. Acupuncture or acupressure treatment.

Barrier-free Home Modifications. Barrier-free home modifications such as, but not limited to, elevators, lifts and ramps, whether or not recommended by a Physician.

Breast Implants. The insertion, removal or revision of breast implants for cosmetic purposes, unless provided post-

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mastectomy.

Comfort and Convenience Services. Personal comfort and convenience Services. This includes: Those Services provided during a hospital stay, such as

- Radio
- Television
- Telephone
- Guest meals

Those Services You receive at home, such as

- Air conditioners and air purification units
- Humidifiers
- Swimming pools and hot tubs
- Orthopedic mattresses
- Allergy-free pillows, blankets and mattress covers
- Stair lifts

Contraceptives. Oral contraceptives are not covered under the medical portion of the Plan. See "Outpatient Prescription Drug program" for coverage of certain oral contraceptives**.** Oral and non-oral contraceptives which are abortive in nature are not covered under either the medical or Outpatient Prescription Drug program. Insertion of an intrauterine device (IUD) for contraceptive purposes is not covered.

Cosmetic Procedures and Services. Procedures and Services mainly to change your appearance, unless the Surgery is expressly covered in "Covered Services."

Custodial Care. Services provided for Custodial Care.

Dental Services. Dental and oral Surgery, Services or X-ray exams involving one or more of these:

- One or more teeth.
- The tissue or structure around one or more teeth.
- The alveolar process.
- The gums.

This exclusion applies even if You have any of these Services because of a condition involving a part of the body other than the mouth.

This exclusion does not apply to dental Services listed specifically in "Covered Services."

Educational Problems, Training Problems or Learning Disorders. Services that are provided in connection with educational or training problems or learning disorders except for covered expenses related to Autism Spectrum Disorder as defined in the *Schedule of Benefits*.

Excess Charges. Charges in excess of the Allowable Charge.

Experimental or Investigational Services. Services that are considered by the Claims Administrator to be Experimental or Investigational. The denial of any Claim on the basis of the exclusion of coverage for Experimental or Investigational treatment or Service may be appealed through the procedure described in the notice of that Claim decision.

Felony Convictions. For any illness or injury you suffer during your commission of a felony, as long as such illness or injuries are not the result of an act of domestic violence.

Foot Care. Treatment or Service for foot care with respect to: corns, calluses, flat feet, fallen arches, trimming of toe nails, chronic foot strain or symptomatic complaints of the feet.

Government Coverage. Services, supplies or benefits provided by any government, unless the law requires the Plan to pay the charges.

Hair Loss. Services related to treatment for hair loss, hair transplants, any drug that promises hair or wigs (except for one wig per lifetime for covered individuals undergoing cancer treatment).

Hearing Aids. Including, but not limited to, semi-implantable hearing devices, audient bone conductors and Bone

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Anchored Hearing Aids. A hearing aid is any device that amplifies sound. Hearing Aids for covered Dependents through age 18 are covered as listed in Covered Services.

Infertility. Services related to the restoration of fertility or the promotion of conception (including reversal of voluntary sterilization).

Long term Care. Services that include medical and non-medical care provided to people who are unable to perform basic activities of daily living such as dressing or bathing.

Maintenance Care. The Services for maintenance or supportive level of care or when maximum therapeutic benefit (no further objective improvement) has been attained.

Marital or Social Counseling. Marital counseling or social counseling (except as described under "Hospice Care" in "Covered Services").

Medical Care Outside the United States. Treatment or Service provided outside the United States, unless You or your dependent are outside the United States for one of the following reasons:

- Travel.
- A business assignment.
- You are employed outside the United States.

Medical Services Provided by Non-approved Providers. Medical Services provided by someone other than a Physician, Professional Other Provider, Professional Provider or other Providers listed in "Definitions."

Miscellaneous Services. Treatment for gambling addiction, stress management, non-implantable communicator-assist devices, work- hardening Services or vocational rehabilitation programs.

Missed appointments. Charges for not showing up for a scheduled appointment or for a late cancellation.

No Obligation to Pay. Services for which the Covered Person is not legally required to pay.

Nursing Services. Any nursing Services (except as described in "Covered Services").

Prescription and Non-prescription Drugs. Drugs or medicines except for those covered under Covered Services and the Outpatient Prescription Drug program**.**

Replacement, repair or maintenance of Durable Medical Equipment. Charges for loss of or damage to Durable Medical Equipment due to negligence, abuse or improper use.

Services before or after coverage. Services for which a charge was Incurred before a person was covered under this Plan or after coverage under this Plan ended.

Services not filed in a timely manner. Services which are not filed within one year from the end of the year following the date of Service.

Services not listed as covered. Services that are not shown on the list of Covered Services**.**

Services not Medically Necessary and Appropriate. Any Service the Claims Administrator determines is not Medically Necessary and Appropriate. The fact that a Physician recommends or approves a Service does not mean that it is Medically Necessary and Appropriate under the Plan's rules. See "Definitions" for more details.

Services provided by immediate family. Services provided by a Spouse, natural or adoptive parent, Child or sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, or Spouse of grandparent or grandchild.

Sex changes or sexual disorder therapy. Charges for or related to gender dysphoria treatments, including but not limited to sex change surgery, sex hormones related to the surgery, and related preparation and follow-up treatment.

Sterilization reversal. Services to reverse any reproductive sterilization procedure.

Vision care. Any of these eye care Services:

- Routine vision screening.
- Eyeglasses or contact lenses except for the initial pair of glasses/contact lenses prescribed following

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cataract surgery in place of surgically implanted lenses or sclera shells intended for the use in the treatment of disease or injury.
- Radial keratotomy, laser or other eye Surgery to correct nearsightedness, farsightedness or blurring (astigmatism).

Vitamins, minerals, nutritional supplements, or special diets. Vitamins, minerals, nutritional supplements, or special diets (whether they require a Physician's prescription or not).

War. Services to treat any Sickness or Injury due to war or any act of war.

Weight Loss Programs.

Wellness Benefit. Any preventive healthcare Service not covered by the *Preventive Schedule.* See "Covered Services".

Work-connected Injury or Sickness. Services to treat an Injury or Sickness that either:
- Arises from or in the course of any employment for wage or profit.
- Is covered under a workers' compensation law, occupational disease law or similar law.

11. Outpatient Prescription Drug program

A. Overview

Express Scripts Holding Company administers the Plan's Outpatient Prescription Drug program. Under this program, You may purchase Outpatient Prescription Drugs:
- At a retail pharmacy.
- By mail order.

You and your Covered Dependents have the same benefits under this program.

B. Retail pharmacy benefits

You can go to any retail pharmacy to get your prescriptions filled, but your costs usually will be less at a Participating Pharmacy. You can get up to a 30-day supply of each prescription filled or refilled when You go to a retail pharmacy.

When You go to a Participating Pharmacy, You:
- Use your Highmark ID card.
- Do not file a Claim.

When You go to a Non-Participating Pharmacy, You:
- Pay the full price for the drug.
- File a Claim with Express Scripts for reimbursement within 12 months of the purchase. You can call Express Scripts or GuideStone for forms or visit the GuideStone website *www.GuideStone.org* to print a form.
- Receive reimbursement based on the Plan's cost as if You had gone to a Participating Pharmacy. Here is how You will be reimbursed:
    - If You buy a brand name drug when a generic is available, your reimbursement will be the amount of the Plan's cost for the generic substitution at a Participating Pharmacy.
    - In all other cases, your reimbursement will be the amount of the Plan's cost for the same drug at a Participating Pharmacy.

Call Express Scripts or GuideStone to find a Participating Pharmacy near You, or go to the Express Scripts website at *www.Express-Scripts.com.*

See "Appendix 1" for Claim and Appeal Procedure.

C. Mail order pharmacy benefits

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If You take maintenance medications (for example, for blood pressure, asthma or diabetes), You may want to use the mail order pharmacy to avoid penalties and save money. Each mail order prescription can be for up to a 90-day supply of the same medication. You cannot combine refills to equal one 90-day supply.

For International service You may order up to a one-year supply; however, your prescriptions will be delivered to your United States contact address. For International Claim questions, You may contact Express Scripts **at 1-800-497-4641** with AT&T access code or collect at **614-421-8292.**

Call Express Scripts or GuideStone for the *Mail Order Prescription Form*. You can also get a copy of this form from the Express Scripts website at *www.Express-Scripts.com* or from the GuideStone website at *www.GuideStone.org.*

D. Drug categories

Generic drugs. These are identified by their chemical name. They are therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient(s) and approved by the FDA.

Preferred drugs. Your Prescription Drug plan includes a formulary, which is a list of drugs that are preferred by your Plan. The Plan encourages the use of the preferred drugs to help control rising drug costs. Express Scripts may remind your Physician when a preferred drug is available as a possible alternative for a drug that is not preferred. This may result in a change in your prescription. However, your Physician will always make the final decision on your medication, which could affect your final cost. For more information about your covered drugs, visit "Price a Medication" at the Express Scripts website at www.Express-Scripts.com.

Non-preferred drugs. A non-preferred drug is a drug that is not included on the formulary.

Specialty drugs. Specific prescriptions used to treat complex, chronic or special health conditions, which include certain therapeutic agents that You or your Physician can administer.

Not all drugs are covered under the drug program and some drugs require Preauthorization. Call Express Scripts or GuideStone to obtain more information about the program.

E. Benefit Plan Protection Program

Manufacturer Assistance Program. The Plan uses a program to ensure that members and the Plan are paying appropriate amounts for specialty medications with manufacturers offering Co-pay assistance. This program assists members with manufacturer program enrollment where assistance is available. Co-pays for certain specialty medications will be set to the maximum available manufacturer Co-pay assistance. These Co-pays will be paid by the manufacturer. Enrollment in this program will provide members with $0 cost share even after manufacturer assistance is exhausted. Enrollment in this program is not mandatory. However, currently, choosing not to enroll in Co-pay assistance via our designated vendor will result in a 30% Co-insurance on applicable specialty medications, which will not accumulate towards your Deductible or Maximum Out-of-Pocket. Because of this, the coinsurance will continue even after you've met your plan's Maximum Out-of-Pocket. Any amounts paid by the manufacturer co-pay assistance program will not apply to your deductible or Maximum Out-of-Pocket.

Out of Pocket Protection Program. In cases where the Member has enrolled in Co-pay assistance directly through the manufacturer, amounts paid by the manufacturer will not be applied to Deductible or Maximum Out-of-Pocket. This program works in conjunction with the Manufacturer Assistance Program to ensure that amounts applied to Deductible and Maximum Out-of-Pocket are paid by the member.

F. Penalties

You may be penalized if you do not purchase a generic drug, when available, or if you do not purchase maintenance drugs through mail order after two retail fills. These penalties do not accumulate toward the

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Deductible or the Maximum Out-of- Pocket limit. See the *Schedule of Benefits* for information on these penalties.

G. Specialty drug medical channel management program

Specialty medications are drugs that are used to treat complex conditions and illnesses, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. These drugs usually require special handling, special administration, or intensive patient monitoring. Medications used to treat diabetes are not considered specialty medications. Whether they are administered by a healthcare professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service.

Specialty pharmaceuticals are covered under your prescription drug benefit program.

Your prescription drug program requires that certain specialty medications be accessed through Accredo Health Group, Inc., an Express Scripts specialty pharmacy. The list of medications subject to the program is available by calling the number on your ID card. If you are currently using specialty medications affected by the program and you do not obtain them through Accredo, you will be required to transfer those prescriptions to Accredo. If you continue to purchase your medications from your doctor or another pharmacy, you will be responsible for their full cost. When you order a covered specialty medication through Accredo, your out-of-pocket cost will be limited to the applicable mail-order co-payment.

The list of medications subject to this specialty drug program may change. You should check the list before you fill a prescription for a specialty medication.

To confirm whether a medication you take is part of the specialty program, you may call the number on your ID card.

H. Limitations and exclusions

This Prescription Drug program covers drugs and medicines that can be legally obtained only by a prescription written by a Physician. **Not all drugs are covered, and some drugs require Preauthorization.** Call Express Scripts at **1-800-555-3432** for more information, or go to their website at *www.Express-Scripts.com.* In addition to drugs that are excluded from Express Scripts' national formulary, *www.GuideStone.org/formulary,* GuideStone excludes oral and non-oral contraceptives which are abortive in nature and are not covered under either the medical or Outpatient Prescription Drug program.

12. Claim and Appeal Procedure

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

See "Appendix 1**"** for the complete section on Claim and Appeal Procedure.

13. If You are covered by more than one plan - coordination of benefits

The following coordination of benefits rules shall govern entitlement to benefits notwithstanding any contrary provisions in the Plan.

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A. Overview

Most healthcare plans, including this Plan, contain a coordination of benefits (COB) provision. This provision is used when You or your Eligible Dependent(s) are eligible for payment under more than one healthcare plan. The objective of the COB Rules is to provide a claim-payment procedure to assure You that your Eligible Expenses will be paid, while preventing duplication of benefit payments. If you receive more than you should have when your benefits are coordinated, You will be expected to repay any overpayment.

Generally, when this Plan is the primary plan with respect to a Member or Eligible Dependent, it pays full Plan benefits for the claim. When this Plan is the secondary plan with respect to a Member or Eligible Dependent, the benefits from the other plans will be taken into account if you have a claim.

If You are covered by more than one group health plan and your situation is not described below, call GuideStone for more detailed information.

This section applies if You are covered under any of these plans:

- Group insurance or other group coverage, whether insured or self-insured. This includes repayment, group practice or individual practice coverage.
- Governmental plans or programs, including Medicare. This Plan does not coordinate benefits with any of these plans.
- School accident-type coverage for students of any age.
- Medicaid or any plan that by law must pay benefits after those of any private insurance program or other non- governmental program.

B. Plan payment order

When You have a Claim, You need to tell the Plan about all the medical plans that cover You and your Eligible Dependents. The Plan needs this information to decide if it is primary or secondary. In other words, the Plan needs to decide which plan pays first and which pays second. The primary plan always pays first.

The determination of which plan pays benefits first is made as follows:

- The plan without a COB provision determines its benefits before the plan that has such a provision.
- The plan that covers a person other than as a dependent determines its benefits before the plan that covers the person as a dependent.
- The plan that covers a person as an actively working person determines its benefits before the plan that covers the person as a laid off or retired person or as a dependent of such person.
- The plan that does not cover a person under a right of continuation under federal or state laws determines its benefits before the plan that covers the person under a right of continuation.
- If the person is eligible for Medicare and is not actively working, the Medicare Secondary Payer rules will apply. Under the Medicare Secondary Payer rules, the order of benefits will be determined as follows.
- The plan that covers the person as a dependent of a working Spouse will pay first;
    - Medicare will pay second; and
    - The plan that covers the person as a retired employee will pay third.
- Child of Parents Not Separated or Divorced.
    - The benefits of the plan of the parent whose birthday falls earlier in a Calendar Year (month and day) are determined before those of the plan of the parent whose birthday falls later in the year; but
    - If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the other plan which covered the other parent for a shorter period of time.
- Child of Separated or Divorced Parents.
    - If a court decree states the parents will share joint custody of a dependent child, without stating that one of the parents is responsible for the healthcare expenses of the child, the parent birthday rule, described above, applies.
    - If a court decree gives financial responsibility for the child's healthcare expenses to one of the

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parents, the plan covering the child as that parent's dependent determines its benefits before any other plan that covers the child as a dependent.

- If there is no such court decree, the order of benefits will be determined as follows:
  - The plan of the natural parent with whom the child resides,
  - The plan of the stepparent with whom the child resides,
  - The plan of the natural parent with whom the child does not reside, or
  - The plan of the stepparent with whom the child does not reside.
- Dependent Coverage as both a Spouse and a Child.
  - The plan that has covered the spouse/child for the longest continuous period of time will be primary.

C. How benefits are paid

When this Plan is the primary plan, it pays as if there were no other plans involved.

When this Plan is secondary, it does not pay until after the primary plan has paid benefits. This Plan will then pay part or all of the Allowable Charges left unpaid.

D. Eligible Expense

An Eligible Expense is a healthcare Service covered by the plan. An Eligible Expense under this Plan is:

- An Allowable Charge.
- For a Service that is Medically Necessary and Appropriate.
- Covered, at least in part, under the Plan.

These are not eligible expenses:

- Co-payments.
- The difference between the charge for Hospital stay in a private room and what this Plan would cover for a Hospital stay, unless the private room charge is a Covered Service under one of the plans.
- Any amount over the Allowable Charge.
- An amount that a plan does not cover because You didn't follow the plan's cost containment provisions. Examples of cost containment provisions are:
  - Preauthorization rules.
  - Preferred Professional Provider arrangements.

E. Lower benefits

When these rules reduce more than one benefit that the Plan pays, each benefit is reduced in proportion. Any Plan benefit limit will state only the amount that the Plan pays for your benefits. It will not include any amount You receive from another plan.

F. Facility of payment

Sometimes another plan may pay for something that should have been paid by this Plan. If this happens, the Claims Administrator may repay the plan that made that payment. You may have received benefits in the form of Services. This can happen, for example, if You are covered by an HMO. In that case, the Plan may pay the reasonable cash value of the benefits provided.

Any amount that the Claims Administrator pays another plan under this provision is treated as though it were a benefit under this Plan. The Claims Administrator will not pay that amount again.

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14. What happens if You are covered under Medicare or another government plan

A. Medicare

Medicare has special payment rules if someone is covered under both Medicare and an employer plan. These rules are often called Medicare Secondary Payer rules. The Plan has to follow these rules. If these special rules apply, this Plan pays benefits before Medicare pays. If these rules do not apply, Medicare pays first and the person covered under Medicare can no longer be covered under this Plan.

Medicare Secondary Payer rules depend on these:

- The reason for Medicare coverage.
- The number of employees working for your Employer.

These are the rules for deciding when this Plan pays first.
This Plan pays benefits before Medicare in these cases:

- Medicare entitlement based on age if either You or your Covered Dependent(s) is entitled to Medicare due to reaching age 65 and both of these apply:
    - You remain an active employee.
    - Your Employer has 20 or more employees in the current or preceding Benefit Period.
- Medicare entitlement, prior to age 65, based on disability if You or your Covered Dependent(s) is entitled to Medicare because of disability and You have current employment status with your Employer as defined by federal law.
- Medicare entitlement based on end stage renal disease (ESRD). If You or a Covered Dependent(s) is entitled to Medicare because of ESRD, this Plan pays first during the first 30 months. After that, Medicare pays first.

Medicare pays benefits first if none of the above rules apply. If Medicare pays first under these special rules, You will not be covered by this Plan any longer but You may be able to enroll in one of the other medical benefit plans GuideStone offers to coordinate with your Medicare benefits. Call GuideStone for more information about these plans.

Because Medicare coverage that pays first ends your coverage under this Plan, You must enroll in Medicare as soon as You are eligible for Medicare benefits. If You do not, your medical expenses may not be covered by Medicare. These same rules apply to your Covered Dependent(s), if any of them becomes eligible for Medicare. If You do not enroll in Medicare when You are first eligible, You must enroll during the special enrollment period which applies to You when You stop being eligible under this Plan.

B. Other government plans

You may be covered under a government plan other than Medicare. If so, this Plan does not cover any Services covered under that government plan, unless the law requires it. These same rules apply to your Covered Dependents.

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

A. Subrogation

Subrogation means that if another person causes you or your Covered Dependent(s) to have a Sickness or Injury and

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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(s), from you or your Covered Dependent. The Plan's right to recover for 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(s) 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(s)

To secure the rights of the Plan under this section, You or your Covered Dependent(s) 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(s) will not take any action that prejudices the rights of this Plan. If You or your Covered Dependent(s) enter into litigation or settlement negotiations regarding obligations of other parties, You or your Covered Dependent(s) 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(s) will be borne solely by You or your Covered Dependent(s).

16. Your confidential medical information

A. Collecting information

We rely on information from You and your Covered Dependent(s) to operate the Plan. Generally, You give this information when You enroll and when You file Claims.

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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 Member, 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 Member, 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

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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.

(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 Member, 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 Member, Spouse or Covered Dependent(s) as and to the extent required by the Privacy Rule.

(i) make available to a Plan Member, 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.

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(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:

(d) Required additional training and education with respect to the use or disclosure of or access to PHI.

(e) Reprimand.

- Suspension of access to PHI or other diminution of duties or privileges.
- Removal from position or termination.
- In addition, an individual has a right to receive notice of a breach involving the individual's PHI, to the extent required by law.

(5) Certification of 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 Member, Spouse or Covered Dependent(s) as if the individual were the Plan Member, 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 **1-844-467-4843** 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.*

17. 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

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look at the definition of Injury, You will see its special meaning.

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

Admission Review. A review by the Utilization Management Administrator of a Provider's report of the need for Hospital Inpatient Stay (scheduled or emergency) to determine if the confinement is Medically Necessary and Appropriate.

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 accredited, 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.

Allowable Charge. The amount used to determine payment by your program for covered services provided to you and to determine your liability. The Allowable Charge is based on the type of provider who renders such services or as required by law.

In-Network Benefits. When covered medical services are received from a network provider, then the Allowable Charge is determined in accordance with the provider's contract with Highmark or on prices received from local licensees of the Blue Cross Blue Shield Association in accordance with your health care program's participation in the BlueCard program described in the How Your Health Care Program Works section of this booklet.

Out-of-Network Benefits When covered medical services are received from an out-of-network provider as described below, the Allowable Charge is determined as follows:

Non-Emergency Services Received at Certain In-Network Facilities from Out-of-Network Physicians
For non-emergency covered medical services received at certain in-network facilities from out-of-network physicians when such services are either ancillary, or non-ancillary that have not satisfied the notice and consent criteria required by federal law, the Allowable Charge may be based on the (i) the reference price (as defined below) if out of area; (iii) the recognized amount (as defined below); (iii) the amount agreed to by the out-of-network provider and Highmark; or (iv) the amount determined by Independent Dispute Resolution (IDR).

For the purpose of this preceding, "certain In-network facilities" are limited to a hospital, a hospital outpatient department, a critical access hospital, an ambulatory surgical center, and any other facility specified under federal law and regulation.

Emergency Services Provided by an Out-of-Network Provider
For emergency services provided by an out-of-network provider, the Allowable Charge is based on one of the following in the order listed below as applicable: (i) the reference price (as defined below) if out-of-area; (ii) recognized amount (as defined below) if out of area; (iii) the amount agreed to by the out-of-network provider and Highmark; or (iv) the amount determined by Independent Dispute Resolution (IDR).

Air Ambulance Transportation Provided by an Out-of-Network Provider
For Air Ambulance transportation provided by an out-of-network provider, the Allowable Charge is based on one of the following in the order listed below as applicable: (i) the recognized amount (as defined below); (ii) the amount subsequently agreed to by the out-of-network provider and Highmark; or (iii) the amount determined by Independent Dispute Resolution (IDR).

Your cost-sharing for each of the above out-of-network providers will be based on the recognized amount.

In All Other Cases

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If you receive covered medical services from an out-of-network provider, the Allowable Charge for an out-of-network provider located in the Highmark service area is based on an adjusted contractual allowance for like services rendered by a network provider in the same geographic region. You will be responsible for any difference between the provider's billed charges and your program's payment.
The Allowable Charge for an out-of-area network state-owned psychiatric hospital is what is required by law. When covered medical services are received from an out-of-network provider outside of the Highmark service area, the Allowable Charge may be determined on the basis of the reference price (as defined below) or on prices received from local licensees of the Blue Cross Blue Shield Association in accordance with your health care program's participation in the BlueCard program described in the How Your Health Care Program Works section of this booklet.

Recognized Amount – Except as otherwise provided, the Allowable Charge and the amount which coinsurance and applicable deductible is based on for covered medical services when provided by: (i) out-of-network emergency service providers; and (ii) non-emergency service received at certain in-network facilities by non-network providers, when such services are either ancillary or non-ancillary provider services that have not satisfied the notice and consent criteria under federal law and regulation. For the purpose of this definition, "certain facilities" are limited to a hospital (a hospital outpatient department, a critical access hospital, an ambulatory surgical center), as defined in federal law and regulation. The Recognized Amount is based on: (i) an all-payer model agreement, if adopted; (ii) state law; or (iii) the lesser of the qualifying payment amount as determined by Highmark (or the local licensee of the Blue Cross Blue Shield Association when the claim is incurred outside of the Highmark service area) under applicable law and regulation, or the amount billed by the provider or facility.

The recognized amount for air ambulance services provided by an out-of-network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law and regulation or the amount billed by the air ambulance service provider.

Reference Price – means a percentage of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market. When a rate is not published by CMS for the service, Highmark uses the price determined by a nationally recognized database or if no such price available, then 50% off billed charges.

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.

Autism Spectrum Disorder. Neurological disorders, usually appearing in the first three years of life, which affect normal brain functions and are typically manifested by impairments in communication and social interaction, as well as restrictive, repetitive and stereotyped behaviors.

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

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

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.

Blue Distinction Centers(BDC). Providers recognized by Blue Cross Blue Shield as those that meet quality standards and/or cost-efficiency standards. These include services for the following:

- Bariatric Surgery
- Cardiac Surgery
- Cancer Treatment
- Hip and Knee Surgery
- Spinal Surgery

BlueCard Program. A national program comprised of Blue Cross and Blue Shield plans which allows a Covered Person to receive Covered Services from participating Providers. The local Blue Cross and/or Blue Shield plan that Services the geographic area where the Covered Services are provided is referred to as the "on-site" Blue Cross and/or Blue Shield plan.

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 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 or a request for Preauthorization or prior approval of a Covered Service. Claim includes:

- **Post-service Claim** – A request for payment or reimbursement of the charges or costs associated with a Covered Service that You have received.
- **Pre-service Claim** – A request for Preauthorization or prior approval of a Service which may need to be approved before You receive the Covered Service.
- **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. For prescription drug benefits, Express Scripts Holding Company. See "Appendix 1" for Claim and Appeal Procedure.

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

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 which must be paid by You. See "Medical benefits".

Co-insurance and Deductible Out-of-Pocket limit. A specified dollar amount of Out-of-Network Eligible Expenses

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Incurred by a Covered Person for Covered Services in a Benefit Period, after which the level of benefits is increased as specified in the "Schedule of Benefits." Such expense does not include the amount of charges in excess of the Provider's Reasonable Charge and penalty amounts Incurred by the Covered Person under this Plan.

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.

Concurrent Review. A Medical Management & Policy review conducted during a patient's Hospital stay or course of treatment.

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

Contracting Supplier. A supplier who has an agreement with the PPO pertaining to payment for the sale or lease of Durable Medical Equipment, supplies and prosthetics to a Covered Person.

Contracting Supplier Allowance. The maximum payment amount determined by the Plan for a Contracting Supplier.

Co-payment. (Co-pay) The fixed, up-front dollar amount You pay for certain Eligible Expenses. Co-payment amounts do not apply toward your Deductible.

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

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

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

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

Covered Services. A Service means the care, treatment, services, and supplies described in the Plan Booklet that are eligible for payment or reimbursement under the Plan.

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.

Customary Charge. For Out-of-Network Providers, it is the amount commonly charged for Services rendered by a Provider which is the prevailing charge within the Out-of-Network Provider's geographical area.

Day/Night Psychiatric Facility. A Facility Other Provider licensed by the state which, for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic Services for the treatment of Mental Illness only during the day or only during the night.

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

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

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

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

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

Eligible Expense. An expense that meets all of these rules:

- It must be a charge that You have to pay for a Covered Service. These are listed in "Covered Services."
- It must not be more than the Allowable Charge for that Covered Service.
- It must not be excluded from coverage. These are listed in "Plan Exclusions."
- It must not be more than any Plan limit in Covered Service.

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

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

Enteral Formulae. A liquid source of nutrition administered under the direction of a Physician which may contain some or all of the nutrients necessary to meet the minimum daily nutritional requirements and is administered into the gastrointestinal tract either orally or through a tube.

Experimental/Investigational. The use of any intervention (treatment, Service, procedure, facility, equipment, drug, or device), which is not determined by the Plan to be medically effective for the condition being treated. Exceptions can be made to services agreed upon by a COE and the plan.

The Plan will consider an intervention to be Experimental/Investigational if:

- The intervention does not have FDA approval to be marketed for the specific relevant indication(s).
- Available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes.
- The intervention is not proven to be as safe or as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies.
- The intervention does not improve health outcomes.
- The intervention is not proven to be applicable outside the research setting.

If an intervention, as defined above, is determined to be Experimental/Investigational at the time of Service, it will not receive retroactive coverage even if, at a later date, it ceases to be classified as Experimental/Investigational in accordance with the above criteria.

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.

Family Coverage. Coverage for the Covered Person and Covered Dependents.

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

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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 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.

Hospital Room Maximum. Covered Services by a Hospital for room and board while confined in a private room up to:

- The Hospital's most frequent semiprivate room rate, if the Hospital has semiprivate rooms.
- The Hospital's most frequent private room rate, if the Hospital has no semiprivate rooms.

Incurred. A charge is considered Incurred on the date You receive the Service 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".

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

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

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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.

Marriage. Marriage is the uniting of one man and one woman in covenant commitment for a lifetime. GuideStone does not recognize common law marriage. Notwithstanding any definitions or understandings to the contrary that are or could be provided in connection with products or services made available to individuals by or through GuideStone Financial Resources of the Southern Baptist Convention, these definitions are controlling in all matters related to the coverages and benefits (including all ancillary benefits and coverages) provided for GuideStone members.

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. 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. 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 Highmark.

Medical Management & Policy (MM&P). A program which integrates all activity related to managing a patient's Medical Care from the time that an admission, surgical or diagnostic procedure, or certain Services become necessary. The program consists of any applicable pre-admission certification, admission certification of emergency/delivery-related maternity admissions, continued stay review, discharge planning, maternity risk assessment and management, pre-procedure certification/pre-service certification, surgical Pre-authorization, diagnostic services Pre-authorization, Therapy Services Pre-authorization, psychiatric/alcohol and drug abuse services Pre-authorization, Durable Medical Equipment Pre-authorization, Home Health Care Pre-authorization, and Skilled Nursing Facility Pre-authorization.

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.

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

Network. All Providers that have entered into a contractual agreement either directly or indirectly with the Plan to provide healthcare Services to Covered Persons under this Plan.

Network Facility Provider. A Facility Provider, licensed where required and performing within the scope of its license,

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that has an agreement either directly or indirectly with the Plan pertaining to payment as a Network Provider for Covered Services rendered to a Covered Person.

Network Provider. Preferred Professional Providers and Network Facility Providers licensed where required and performing within the scope of their license, that has an agreement either directly or indirectly with the Plan pertaining to payment as a Network Provider for Covered Services rendered to a Covered Person.

Network Service. A Service or treatment that is provided by a Network Provider or Contracting Supplier.

Network Service Area. The geographic area within the Plan's Service area served by the Preferred Professional Providers and Participating Facility Providers or Contracting Suppliers.

Non-Contracting Supplier. A Supplier who does not have an agreement with the Plan pertaining to payment for the sale or lease of Durable Medical Equipment, supplies and prosthetics to a Covered Person.

Non-Participating Facility Provider. A Facility Provider, licensed where required and performing within the scope of its license, that does not have an agreement with the Plan pertaining to payment for Covered Services rendered to a Covered Person.

Non-Participating Pharmacy. A licensed and registered pharmacy, which does not have a pharmacy service agreement with Express Scripts.

Non-Preferred Professional Provider. A Professional Provider or Professional Other Provider, licensed where required and performing within the scope of its license, who does not have an agreement with the Plan pertaining to payment as a Network Provider for Covered Services rendered to a Covered Person.

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.

Other Centers of Excellence(OCE). The Mayo Clinic, Dana Farber, Cleveland Clinic, and other COE programs as approved by the plan.

Out-of-Network Provider and Contracting Supplier. A Provider and Contracting Supplier who does not have an agreement with the Plan to provide Covered Services, and equipment to a Covered Person.

Out-of-Network Service. A Service or treatment that is provided by an Out-of-Network Provider and Contracting Supplier.

Outpatient. A patient who receives Services 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 Highmark.

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.

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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 and the *Preventive Schedule* constitute the Plan.

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

Preauthorization. The process whereby You, the Preferred Professional Provider or the Non-Preferred Professional Provider must contact the Plan to determine the eligibility of coverage for or the Medical Necessity and Appropriateness of certain Covered Services as specified in this Plan. Such Preauthorization must be obtained prior to providing Covered Services for a Covered Person as provided in MM&P in this section and in section 8.

Preferred Professional Provider. A Professional Provider or Professional Other Provider, licensed where required and performing within the scope of their license, that has an agreement with the Plan pertaining to payment as a Network Member for Covered Services rendered to a Covered Person.

Preferred Provider Organization (PPO). A group of Hospitals, Physicians and other Providers who are contracted to furnish Medical Care to a Covered Person at negotiated costs.

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.

Primary Care Physician. A pediatrician, general practitioner, family practitioner, internist or gynecologist.

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

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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 is permissible if attributable to non-payment of monthly rates, fraud or intentional misrepresentation.

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

Retrospective Review. A MM&P review conducted after the patient is discharged from a Hospital or other healthcare facility or has completed a course of treatment.

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

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

Skilled Nursing /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.

Specialist Physician. Any Physician not considered a Primary Care Physician.

Spouse. A person of the opposite biological 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. GuideStone does not recognize common law marriage. Notwithstanding any definitions or understandings to the contrary that are or could be provided in connection with products or services made available to individuals by or through GuideStone Financial Resources of the Southern Baptist Convention, these definitions are controlling in all matters related to the coverages and benefits (including all ancillary benefits and coverages) provided for GuideStone members.

Supplier. An individual or entity that is in the business of leasing and selling Durable Medical Equipment. 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.

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

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

- **Cardiac Rehabilitation** - the physiological and psychological rehabilitation of patients with cardiac

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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 a 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.

Transplant Network Provider (Blue Distinction Centers for Transplants). Any Provider or facility determined to be an appropriate transplant Provider and that has contracted with Blue Cross Blue Shield to provide transplant Services subject to a negotiated fee schedule.

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

Urgent Review. A MM&P review that must be completed sooner than a prospective review in order to prevent serious jeopardy to a patient's life or health or the ability to regain maximum function, or in the opinion of a Provider with knowledge of a patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without treatment. Whether or not there is a need for an Urgent Review is based upon the MM&P administrator's determination using the judgment of a prudent layperson who possesses an average knowledge of health and medicine. See "Appendix 1" for Claim and Appeal Procedure.

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

You. An Eligible Employee or 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.

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Appendix 1: Claim and Appeal Procedures

A. Internal Claims and Appeals

1. Eligibility

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

Senior Manager, 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 or Prescription Drugs

    a. How You file a Claim

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

Medical Benefits Claims

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

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

Highmark
PO Box 3355
Pittsburgh, PA 15230-3355

Claim forms are available at: *www.GuideStone.org;* Select Resources, Forms, 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 to the claim form and mail everything to the address on the form. Multiple Services for the same family member can be filed with one claim form. However, a separate Claim form must be completed for each person. Itemized bills must include the following information:

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

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

Once your Claim is processed, You will receive an explanation of benefits (EOB) statement. The statement lists: the Provider's charge, Allowable Charge, Co-payment, Deductible and Co-insurance You are required to pay; total benefits payable; and total amount You owe. You are responsible for paying the Out-of-Network Provider the charges You Incurred, including any difference between what You were billed and what the Plan paid.

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Prescription Drug Claims

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

Express Scripts Holding Company
PO Box 14711
Lexington, KY 40512-4711

Claim forms are available at: *www.Express-Scripts.com*

b. Timing of Initial Claim Decision

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

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

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

Post-Service Claim: If your Claim is a Post-Service Claim, You are entitled to receive a written notice from the Claims Administrator, within 30 days of filing your Claim, telling You whether your Claim is to be allowed in whole or in part, or denied. If special circumstances require a period of more than 30 days to decide your Claim, this time limit may be extended by an additional 15 days, and You will be notified of the extension within 30 days after You have filed your Claim. You will also have at least 45 days to provide any additional information requested by the Claims Administrator.

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

c. Claim Denial

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

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

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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 reason(s) for the decision, which must include the denial code, the meaning of this code, the standard, if any, that was used in denying the Claim, and a discussion of the decision;
- The specific Plan provision(s) on which the denial is based;
- A statement that you are entitled to have access to, and copies of, all documents relevant to your Claim free of charge;
- A description of your right to initiate a second level of internal appeal (if applicable) and your right to bring an external review;
- If an internal rule, guideline, or protocol was relied upon to determine a Claim, either a copy of the actual

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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

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an expedited external review after the denial of the Claim after a denial on the final level of internal appeal.

4. External Review Procedure

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

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

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

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

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

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

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

- Your medical records;
- The attending 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

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5. The opinion of the IRO's clinical reviewer(s) after considering relevant information described above

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 Financial Resources

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5005 LBJ Freeway, Ste. 2200
Dallas, Texas 75244-6152
844-467-4843

Medical Benefits Appeals

Highmark
PO Box 3355
Pittsburgh, PA 15230-3355

Prescription Drug Appeals

Express Scripts
Attn: Clinical Appeals Department
PO Box 66588
St. Louis, MO 63166-6588
Fax 1-877-852-4070

F. Facility of Payment

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

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

G. Medical Examinations

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

H. Plan's Right to Recover Overpayments

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

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

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

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Appendix 2: Inter-Plan Programs & Network Termination

Out-of-Area Services

Highmark has a variety of relationships with other Blue Cross and/or Blue Shield licensees referred to generally as "Inter- Plan Programs." Whenever members access healthcare services outside the geographic area Highmark serves, the claim for those services may be processed through one of these Inter-Plan Programs and presented to Highmark for payment in accordance with the rules of the Inter-Plan Programs policies then in effect.

Typically, members, when accessing care outside the geographic area Highmark serves, should obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, members may obtain care from non-participating healthcare providers.

Highmark's payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when members access covered services within the geographic area served by a Host Blue, Highmark will remain responsible to the group for fulfilling Highmark's contractual obligations. However, in accordance with applicable Inter- Plan Programs policies then in effect, the Host Blue will be responsible for contracting with and handling substantially all interactions with its participating healthcare providers.

Whenever members access covered services outside the area Highmark serves and the claim is processed through the BlueCard Program, the amount members pay for covered services is calculated based on the **lower** of:

- The billed charges for covered services, or
- The negotiated price that the Host Blue makes available to Highmark.

Often, this "negotiated price" will be a simple discount which reflects the actual price that the Host Blue pays to the member's healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with the healthcare provider or provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modification noted above. However, such adjustments will not affect the price Highmark uses for the claim because these adjustments will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to the calculation. If any state laws mandate other liability calculation methods including a surcharge, Highmark would then calculate member liability for any covered services according to applicable law.

Negotiated National Account Arrangements

As an alternative to the BlueCard Program, a member's claims for covered services may be processed through a negotiated national account arrangement with a Host Blue.

If Highmark has arranged for a Host Blue to make available a custom healthcare provider network in connection with this contract, then the terms and conditions set forth in Highmark's negotiated national account arrangements with such Host Blue shall apply.

Member liability calculation will be based on the lower of either billed covered charges or negotiated price made available to Highmark by the Host Blue that allows members access to negotiated participation agreement networks of specified participating healthcare providers outside of the geographic area Highmark serves.

Non-Participating Health Care Providers Outside of the Geographic Area Highmark Serves

Member Liability Calculation

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When covered services are provided outside of the geographic area Highmark serves by non-participating healthcare providers, the amount a member pays for such services will generally be based on the Host Blue's non-participating healthcare provider local payment unless otherwise specified under the terms of this contract or as required by applicable state law. In these situations, the member may be responsible for the difference between the amount that the non-participating healthcare provider bills and the payment Highmark will make for the covered services as set forth in this paragraph.

Exceptions

In some exception cases, Highmark may pay claims from non-participating healthcare providers outside of the geographic area Highmark serves based on a case-specific negotiated rate in situations where, for example, a member did not have reasonable access to a participating provider, as determined by Highmark in Highmark's sole and absolute discretion or by applicable state law. In any of these exception situations, the member may be responsible for the difference between the amount that the non-participating healthcare provider bills and the payment Highmark will make for the covered services as set forth in this paragraph.

Benefits After Provider Termination from the Network

If at the time you are receiving medical care from a network provider, notice is received from Highmark that: Highmark intends to terminate or has terminated all or portions of the contract of that network provider for reasons other than cause; or the contract of that network provider will not be renewed, or the participation status of that network provider is changing; you may, at your option, continue an active course of treatment with that provider until the treatment is complete or for a period of up to ninety (90) days from the date the notification of the termination or pending termination is received, whichever is shorter. For purposes of this section, active course of treatment means: (i) an ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; (ii) an ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring specialized medical treatment to avoid the reasonable possibility of death or permanent harm or complex ongoing care which you are currently receiving, such as chemotherapy, radiation therapy or post-operative visits; (iii) confirmed pregnancy, through the postpartum period; (iv) scheduled nonelective surgery, through postoperative care; (v) an ongoing course of treatment for a health condition that is life-threatening, degenerative, potentially disabling, or congenital and that requires specialized medical care over a prolonged period of time or for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes; or (vi) treatment for a terminal illness. If, however, the network provider is terminated for cause and you continue to seek treatment from that provider, then your plan will not cover payment for health care services provided to you following the date of termination. Any Services authorized under this section will be covered in accordance with the same terms and conditions as applicable to a network provider. Nothing in this section shall require payment of benefits for health care services that are not otherwise provided under the terms and conditions of your plan.

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