Southern Baptist Theological Seminary

HRA PLAN

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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 is your booklet for the Southern Seminary HRA Plan (Plan). GuideStone sponsors the Plan and offers it to eligible Southern Seminary employees.

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 help the Plan serve You:

- **Highmark Blue Cross Blue Shield® (Highmark),** the Claims Administrator for the medical Plan, administers payment of Claims, but has no liability for the funding of the benefit Plan.
- **Medco Health Solutions, Inc. (Medco Health)** and its affiliates, is the Claims Administrator for Outpatient retail pharmacy and home delivery Prescription Drugs.

This booklet tells You about Plan benefits beginning January 1, 2007. Your effective date is determined by your Employer; therefore, contact your Employer for your effective coverage date. Claims for medical Services or supplies You received prior to this Plan's 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 and Supply is received by a Covered Person.

B. Important phone numbers

GuideStone Customer Relations: **1-800-262-0511**
Blues On Call[sm]: **1-888-BLUE428**
Blue Cross Blue Shield Provider Network: **1-800-810-BLUE (2583)**
Highmark Blue Cross Blue Shield (Highmark): **1-866-472-0924**
Medco Health Solutions, Inc. (Medco Health): **1-800-555-3432**

C. Important Web sites

wwwGuideStonec.org
www.bcbs.com
www.highmarkbcbs.com
www.medcohealth.com

D. Pre-existing condition exclusion limitation

This Plan contains an exclusion for certain pre-existing conditions. See **Plan exclusions** for more information about this exclusion and whether it applies to You.

E. Your guide to good care

For more than 60 years, Highmark has helped make health care 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 gives You freedom of choice. The PPO program does not require that You select a Primary Care Physician to receive a Covered Service and Supply. Instead, the program gives You access to a vast network of Physicians, Hospitals, and Professional Other Providers throughout the country. Your provider 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 Network Services. You may want to double-check any Provider to make sure the Physician or facility is in the PPO Network. You can call Highmark customer

service at **1-866-472-0924,** Blue Cross Provider Network at **1-800-810-BLUE (2583)** or go to the Blue Cross Blue Shield Web site at *www.bcbs.com.*

2. Your PPO also covers care away from home. If You are traveling and a Sickness or Injury occurs, You can call **1-800-810-BLUE (2583)** or go to *www.bcbs.com* to obtain the name of a PPO Provider in the area. If the Sickness or Injury is a true emergency, You should seek treatment from the nearest Hospital emergency room. If the treatment results in an admission, You have certain responsibilities under Healthcare Management Services (HMS). See **Healthcare Management Services** 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 BlueCard worldwide program assists with medical problems You may Incur while 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 BlueCard Worldwide Service Center. Claim forms can be obtained by calling **1-800-810-BLUE** or the member service telephone number on your Medical Identification Card (Medical ID Card). Claim forms can also be downloaded from *www.bcbs.com*.

4. Your BlueCard Program provides specific provisions through the Blue Cross Blue Shield Association. When a participant 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 lower of:

- The billed charges for a patient's Covered Service, or
- The negotiated prices that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to Highmark. However, the amount You pay is still based on Plan provisions.

2. Benefit summary

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. In either case, You coordinate your own care. There is no requirement to select a Primary Care Physician (PCP) to coordinate your care.

HRA allocations are $500 Single/$1,000 Family and are available for all * Services listed below.

Benefits	In-Network Care	Out-of-Network Care
Deductible (combined In- and Out-of-Network) Individual Family	 $1,000 $2,000	 $2,000 $4,000
Your Payment level/Coinsurance	20% after Deductible* until Out-of-Pocket Maximum is met; then 100%	40% after Deductible* until Out-of-Pocket Maximum is met; then 100%(based on Provider's Allowable Charge)
Out-of-Pocket Maximums Excludes Deductible	 $3,000 Individual $6,000 Family	 $6,000 Individual $12,000 Family
Lifetime Maximum	$5,000,000	$5,000,000
Physician office Visit	20% after Deductible*	40% after Deductible*
Preventive Care[1] Includes routine physical exams, well-child check-ups, routine immunizations and routine GYN exams	100% not subject to Deductible	Not Covered
Inpatient Hospital expenses[2] Facility & Ancillary Physician	20% after Deductible*	40% after Deductible*
Outpatient Hospital expenses Facility & Ancillary Physician	20% after Deductible*	40% after Deductible*
Emergency Room	20% after Deductible*	40% after Deductible*
Mental health/Substance abuse Inpatient[2] Outpatient	20% after Deductible*	40% after Deductible*
Urgent Care Centers	20% after Deductible*	40% after Deductible*
Chiropractic care Limited to 30 visits per year	20% after Deductible*	40% after Deductible*
Physical & Occupational Therapy Limited to 30 visits per year	20% after Deductible*	40% after Deductible*

Benefits	In-Network Care	Out-of-Network Care
Lab & X-rays (excluding Office Visit) Limited to 30 visits per year	20% after Deductible*	40% after Deductible*
Eye exam[3]	100%	Not covered
Pre-authorization requirements [2]	Performed by member Failure to Pre-authorize an Inpatient admission will result in a 20% benefit reduction	Performed by member Failure to Pre-authorize an Inpatient admission will result in a 20% benefit reduction

[1] See **Covered Services and Supplies** for Wellness Benefit as defined by the preventive health schedule.

[2] Member is required to contact Blue Cross Blue Shield Health Care Management Services prior to a planned Inpatient admission or within 48 hours of an emergency admission. If this does not occur and it is later determined that all or part of the Inpatient stay was not Medically Necessary and Appropriate, the patient will be responsible for payment of any costs not covered.

[3] One exam every 12 months for individuals under age 18; one exam every 24 months for individuals 18 and above.

Outpatient Prescription Drug	Plan pays	You pay	Individual[4] Deductible	Family[4] Deductible
Retail (up to 30-day supply)				
In-Network Limited to $150 per script	80% after Deductible	20% after Deductible	$100	$200
Out-of-Network	Not covered by Plan	Entire Cost		
Home delivery (up to 90-day supply)				
In-Network Limited to $450 per script	80% after Deductible*	20% after Deductible*		
Out-of-Network	Not covered by Plan	Entire Cost		

[4] The Individual deductible and Family deductible for Retail and Home delivery are combined.

3. Who is eligible

A. Employee Coverage - coverage for employees

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:

- An Eligible Employee.

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.

Your Employer decides:

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

Covered Classes are groups of employees 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, earnings or other factors. Your Employer decides which groups of employees are Covered Classes under the Plan.

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

When Coverage begins tells You how to enroll.

B. Dependents Coverage

If You have Employee Coverage under the Plan, your dependents may be eligible for Dependents Coverage. Ask your Employer if Dependents Coverage is available.

To get Dependents Coverage, one of these must be true:

- You have Employee Coverage under this Plan.

Your Eligible Dependents are:

- Your Spouse.
- Your unmarried Child under age 25.
    - Dependent on You for support and maintenance.
- Your unmarried Child who is covered under the Plan and is incapacitated. All of these rules must be met:
    - Your Child must be Developmentally Disabled or Physically Handicapped and incapable of earning a living.
    - Your Child must have been incapacitated when his or her Plan coverage would have ended because of age.
    - 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 natural (biological) Child.
- Your legally adopted Child or a Child placed in your home for adoption.
- A Child living with You and dependent on You for support and maintenance. This may be:
    - Your stepchild.
    - Your foster Child.
    - Your grandchild.

- A Child for whom You must provide health care by court order or order of a state agency authorized to issue National Medical Support Notices under federal law.
- A Child for whom You are legal guardian or managing conservator.

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

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

D. Exceptions - dependents not eligible

There are 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 your Employer. (No one can have both Employee Coverage and Dependents 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**.

When coverage begins tells You how to enroll your Eligible Dependents.

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.
- 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 can switch to a special health plan offered to employees and dependents who are eligible for Medicare. Check with your Employer or call GuideStone at **1-888-984-8433** 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.**

4. When coverage begins

A. Enrolling yourself

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

- Be eligible for coverage.
- Give your Employer a signed enrollment form within 31 days after You first become eligible.
- Pay any required contributions.

If You do all these things at the right time, You will be covered on 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. You may also have to meet other requirements before You can become covered under the Plan as a late enrollee.

B. Enrolling your dependents

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

- Enroll yourself for Employee Coverage.
- Give your Employer a signed enrollment form within 31 days after You first become eligible that lists your Eligible Dependents.
- Pay any required contributions.

If You do all these things at the right time, your Dependents Coverage will begin when your Employee Coverage begins. Any Eligible Dependents You do not enroll when You enroll yourself for Employee Coverage may be late enrollees. This means that their coverage will be delayed. They may also have to meet other requirements before they can become covered under the Plan as late enrollees.

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.
- The Plan may delay coverage for any Pre-existing Sickness or Injury.

D. 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 qualifying events happens:

- Marriage.
- Birth of a newborn.
- Adoption or placement of a Child in your home for adoption.

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

To do so, You must:

- Enroll them within 60 days after the event.
- Pay any required contributions.

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

If you lose coverage under another health plan, You can enroll after the initial 31-day period if You have been covered under either:

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

But You can enroll only if:

- Your prior group health care coverage was not terminated for cause (such as making a fraudulent claim or an intentional misrepresentation) or for late payment of contributions.
- You give your Employer a completed enrollment form no later than 31 days after the other health coverage ended.

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

Dropping dependents from coverage

You can drop a dependent from your coverage at any time. This can happen if there is a death or divorce or your Child stops being eligible because of age. You must tell your Employer promptly about the change.

E. Making enrollment changes

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

F. Transfer from another GuideStone plan

You may transfer from another GuideStone sponsored medical plan if any of the following apply:

- You choose among medical plan options during an annual enrollment period or a qualifying event occurs.

5. When coverage ends

A. End of Employee Coverage

Your Employee Coverage will end if any one of these things happens:

- You no longer work as an active full-time employee for an Employer that offers Plan coverage.
- You retire and your Employer does not offer Plan coverage to its retirees.
- GuideStone or your Employer stops offering the Plan.
- Required contributions are not paid when due. Your Employee Coverage will not end just because You do not pay contributions for Dependents 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**.

Your Employer may offer Continuation Coverage if You retire, stop working or if your hours are reduced. 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 Dependents Coverage

Your dependents will lose coverage if any one of these things happens:

- 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 Dependents Coverage.

- Required contributions 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**.

Some Employers may offer Continuation Coverage to your Covered Dependents after their coverage would otherwise end. If your dependents lose coverage for any reason, call your Employer at once to find out if they can continue coverage.

C. Continued coverage for Covered Dependents after your death

If You die while covered under the Plan, your Covered Dependents may continue their Plan coverage. This continued coverage will end when any one of these things happens:

- Your dependent is no longer an Eligible Dependent.
- Your dependent becomes eligible for benefits under any other group medical plan.
- The Plan stops offering Dependents Coverage.
- GuideStone or your Employer stops offering group medical plans.
- Required contributions 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**.

D. Additional 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 your Employer does both of these things:

- Elects to offer this Continuation Coverage.
- Continues to offer Plan coverage to its employees.

This is the Continuation Coverage your Employer may offer under the Plan:

For You. If you are a Covered Employee You may choose Continuation Coverage if You would otherwise lose coverage because any one of these things happens:

- You retire and your Employer does not offer the Plan to its retirees.
- You lose your job for any reason, unless You were fired for gross misconduct.
- Your work hours fall below your Employer's requirement for full-time employees.
- Your employment class stops being a Covered Class under the Plan, but only if your Employer still offers Plan coverage to other Covered Classes.

For your Covered Dependents. Your Covered Dependents may choose Continuation Coverage under the Plan if they would otherwise lose coverage because any one of these things happens:

- You retire and your Employer does not offer the Plan to its retirees.
- You lose your job for any reason, unless You were fired for gross misconduct.
- Your work hours fall below your Employer's requirement for full-time employees.
- You get a divorce or legal separation from your Spouse who is a Covered Dependent.
- Your Child is no longer an Eligible Dependent.

- Your employment class stops being a Covered Class under the Plan, but only if your Employer still offers Plan coverage to other Covered Classes.

Enrollment for Continuation Coverage. If You want this 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 31 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 for adoption. 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 contributions when due, or your Continuation Coverage will end.**

Length of Continuation Coverage. Continuation Coverage may continue:

- For up to 18 months for You and your Eligible Dependents if the loss of Plan coverage is because You either lost your job or You work fewer hours.
- For up to 36 months for your Eligible Dependents if the loss of Plan coverage is for any other reason.

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

- Contributions are not paid when due.
- The Covered Person becomes covered under other group medical coverage, either as an employee or dependent.
- The Covered Person becomes eligible for Medicare.
- GuideStone stops offering the Plan.
- Your Employer stops offering the Plan.

E. 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 (FLMA) 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.

F. 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 contributions.
- 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 (with no pre-existing condition exclusions or similar limitations) 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.

G. How to obtain a certificate of creditable coverage

Certificates of creditable coverage are written documents provided by this Plan to show the type of coverage a person had (e.g., employee only, employee plus Spouse, etc.) and how long the coverage lasted. Under federal law, most group health plans must provide these certificates automatically when a person's coverage terminates. However, if a plan does not give You a certificate, You have the right to request one. Certificates apply both to Plan members and to Eligible Dependents.

This Plan will automatically give You a certificate after You lose coverage under the Plan. One will also be provided for your dependents when we have reason to know that your dependents are no longer covered.

In addition, the Plan will provide a certificate for You (or your dependents) upon request if You make the request within two years (24 months) after your coverage terminates. Contact GuideStone Customer Relations at **1-888-984-8433** to request a certificate of creditable coverage.

6. Medical benefits

A. Eligible Expenses

This Plan helps pay many of your medical expenses. However, it does not cover all medical expenses and it limits how much it pays for some expenses. Expenses that the Plan may cover are called Eligible Expenses.

To be an Eligible Expense, an expense must meet all of these rules:

- It must be a charge You have to pay for a Covered Service and Supply. These are listed in **Covered Services and Supplies**.
- It must not be more than the Allowable Charge for that Covered Service and Supply. See **Definitions.**
- It must not be excluded. **Plan exclusions** lists and explains the exclusions.
- It must not be more than any Plan limit on that Covered Service and Supply.

B. Benefit limits

The Plan limits what it covers for some medical Services and supplies. For example, the Plan limits the dollar amounts it pays for some Covered Services and Supplies. It also limits the number of days or Visits it pays for some covered Services.

Read the description of Services and supplies with Plan limits in **Covered Services and Supplies** and the **Benefit summary** for more information on the specific benefit limits.

C. Greater benefits when You use Network Providers

GuideStone has arranged for You to have access to the Blue Cross Blue Shield PPOs . A PPO is a Preferred Provider Organization made up of Physicians, Hospitals and other health care Providers (not including pharmacies). PPOs and other provider organizations are called "Networks." They have agreed to accept a negotiated rate for their Services. The Plan calls the Providers in these negotiated arrangements "Network Providers." All other Providers are called "Out-of-Network Providers."

You will have access to the names of Network Providers in your area. Health care Providers participate in Networks by choice and they can choose to stop participating in a Network at any time. Network Service is care You receive from Providers in the PPO program's Network. This Network includes Primary Care Physicians and a range of Specialist Physicians, as well as Hospitals and a variety of other treatment facilities. Remember to call **1-800-810-BLUE (2583)** or go to *www.bcbs.com* to locate the Provider nearest You or to check that your current Provider is in the Network. When You receive Covered Services and Supplies from Network Providers, You usually spend less Out-of-Pocket due to Network discounts and Coinsurance provisions. You present your Medical Identification Card (Medical ID card) to the Provider who submits your Claim to the local Blue Cross Blue Shield plan.

D. Deductibles

A Deductible is the amount that You must pay out of your pocket for Eligible Expenses before the Plan pays any benefits. After You pay the Deductible, the Plan pays a percentage of the rest of your Eligible Expenses. As a general rule, the Plan counts the amounts You pay for Eligible Expenses from Network or Out-of-Network Providers toward your Deductibles.

Two separate Deductibles might apply:

- Individual Deductible.
- Family Deductible.

Individual Deductible: An individual Deductible is the amount a Covered Person must pay for Eligible Expenses each Benefit Period before the Plan pays any 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.

Your individual Deductible is:

- **$1,000** for In-Network Eligible Expenses
- **$2,000** for Out-of-Network Eligible Expenses

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 any 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. No more than a specific amount for each Covered Person in your family will count toward the Family Deductible.

Your Family Deductible is:

- **$2,000** for In-Network Eligible Expenses**,** no more than $1,000 for each Covered Person in your family will count toward the Family Deductible.
- **$4,000** for Out-of-Network Eligible Expenses, no more than $2,000 for each Covered Person in your family will count toward the Family Deductible.

E. Coinsurance

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 Coinsurance.

The Plan's Coinsurance usually is:

- 80% of the negotiated rate for Eligible Expenses when You go to Network Providers.
- 60% of Eligible Expenses when You go to Out-of-Network Providers.
- 100% of Eligible Expenses for Preventive care performed in an In-Network Physician's Office.
- 100% of Eligible Expenses for annual eye exam when You go to a Network Provider.

Your Coinsurance usually is:

- 20% of the negotiated rate for Eligible Expenses when You go to Network Providers.
- 40% of Eligible Expenses when You go to Out-of-Network Providers.
- 0% of Eligible Expenses for Preventive care performed in an In-Network Physician's Office.
- 0% of Eligible Expenses for annual eye exam when You go to a Network Provider.

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 when such Services are provided at a Network Hospital.
- 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.
- A treatment or Service performed due to a medical emergency (See **Emergency Medical Services** in the Definitions section of the booklet).

Your Outpatient Prescription Drug coverage has different Copayments. See the **Benefit summary** for Prescription Drug Coverage.

F. Out-of-Pocket Maximum

Once You pay all applicable Deductibles, the Plan limits your Coinsurance for each Benefit Period. This means that after You have paid a certain amount in Coinsurance, 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 toward your Out-of-Pocket Maximum.

Penalties for not obtaining Pre-authorization review do not count toward the Out-of-Pocket Maximum.

There is an Out-of-Pocket Maximum for each Covered Person and an Out-of-Pocket Maximum for You together with all of your Covered Dependents.

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

Your individual Out-of-Pocket Maximum is:

- **$3,000** if You go to a Network Provider.
- **$6,000** if You go to an Out-of-Network Provider.

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

Your family Out-of-Pocket Maximum is:

- **$6,000** if You go to a Network Provider.
- **$12,000** if You go to an Out-of-Network Provider.

Out-of-Pocket reminders: These Services and supplies do not count toward the Out-of-Pocket Maximum:

- Deductibles.
- Prescription Drugs

7. Covered Services and Supplies

A. Overview

The Plan generally pays Eligible Expenses for Covered Services and Supplies.

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

You must get Pre-authorization from Healthcare Management Services (HMS) to receive the maximum benefits under the Plan. See **Healthcare Management Services** for more details.

Covered Services and Supplies will also include HMS 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. Covered Services and Supplies

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

Allergy treatment. Allergy treatment when prescribed by a Physician.

Ambulance. A facility 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. Treatment or Service provided at an Ambulatory Surgical Facility.

Anesthetics. Anesthetics and their administration.

Artificial limbs and body parts. Purchase and replacement of artificial limbs, larynx and eyes.

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

Blood. Blood and blood plasma not replaced for You or by You.

Cardiac rehabilitation. Cardiac rehabilitation Services only if provided both:

- 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. The Plan covers 30 Visits in a Benefit Period.

Contact lenses. The first pair of contact lenses or glasses prescribed after cataract Surgery.

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 after a mastectomy performed for the treatment of a Sickness.

Dental Services. Services and supplies for any of these:

- Excision of teeth that are not completely erupted.
- Surgical extraction of erupted or non-erupted teeth.

- 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 or Drug Abuse treatment.

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.

Eye Exam. Annual eye exam performed by a Network Provider. Benefit is limited to one eye exam per year for under age 18 and one eye exam every 24 months for ages 18 and over.

Health Care Extender. Covered Services and Supplies will include charges by a Health Care Extender.

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:

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

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

Home health care Services must be rendered in accordance with a prescribed home health care plan. The home health care plan must be:

- Established prior to the initiation of the home health care 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 health care. In addition, Covered Services and Supplies will not include charges for:

- Services or supplies not included in the home health care plan; or
- More than 100 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; or
- The Services of any person who normally lives in your or your dependent's home; or
- Custodial Care; or
- Transportation Services.

Hospice Care. Covered Services and Supplies 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 dying individual has no reasonable prospect of cure and is expected to live no longer than six months; and
- 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 and supplies provided to meet the physical, psychological, spiritual, and social needs of the dying individual; and
- Drugs and medicines (requiring a Physician's prescription) and other supplies prescribed for the dying individual by any Physician who is a part of the Hospice Care team; and
- Instructions for care of the patient, counseling, and other supportive Services for the family of the dying individual.

The general Plan exclusions listed in this booklet will apply to Hospice Care. In addition, Covered Services and Supplies will not include Hospice Care charges that:

- Exceed $10,000 for any one episode of Hospice Care; or
- Are for Hospice Care Services not approved by the attending Physician; or
- Are for transportation Services; or
- Are for Custodial Care; or
- 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 Pre-authorization before You have a Hospital Inpatient Stay. See **Healthcare Management Services** for more details.

Infusion Therapy. Treatment performed by a Facility Provider.

Laboratory tests and X-Rays. Laboratory tests and X-Rays ordered by a Physician. Limited to 30 Visits per Benefit Period if performed outside a Physician's office.

Maternity care. The Plan covers maternity care and treatment as it would any other Sickness. If the mother is either a Covered Member or a Covered Dependent 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 Pre-authorization for any stay past these limits. See **Healthcare Management Services** for more details.

Medical supplies. Some 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 or Drug Abuse treatment. Outpatient and Inpatient treatment for Mental Illness and Alcohol or Drug Abuse. Before receiving Inpatient treatment You must obtain Pre-authorization. See **Healthcare Management Services** 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 health care or Hospice Care.

Occupational Therapy. Treatment by a Professional Occupational Therapist that is ordered by a Physician. Limited to 30 Visits per benefit period.

Physical Therapy. Treatment by a Professional Physical Therapist that is ordered by a Physician. Limited to 30 Visits per benefit period.

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

Physician Visit. A face-to-face meeting 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.

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

Skilled Nursing Facility. Covered Services and Supplies will include charges by a Skilled Nursing 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; and
- Requires Skilled Nursing Services.

Covered Services and Supplies will not include:

- Charges for more than 60 days for all Skilled Nursing Facility confinements that result from the same or a related Sickness or Injury; or
- Charges incurred for a Skilled Nursing Facility confinement after the date the attending Physician stops treatment or withdraws certification.

Speech Therapy. Treatment by a qualified Speech-Language Pathologist that is ordered by a Physician. Limited to 30 Visits per benefit period. This Plan does not cover Speech Therapy related to developmental delay, education problems, training problems, or learning disorders. See **Plan exclusions** for limits and details.

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.

Substance Abuse. See Mental Illness and Alcohol or Drug Abuse treatment.

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; and
- 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.

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. These are Covered Services and Supplies Incurred in connection with the covered transplants listed below that are Medically Necessary and Appropriate and not considered Experimental or Investigational in nature. The following benefits will be payable for treatment or Service for transplant Services. These benefits will be payable instead of any other benefits described in this booklet, unless otherwise indicated below.

You or your Eligible Dependent will be eligible to receive the following human-to-human organ or bone marrow transplant procedures (including charges for organ or tissue procurement) when it is Medically Necessary and Appropriate (which is Generally Accepted treatment and not considered Experimental or Investigative in nature at the time the required predetermination of benefits for the transplant is completed). The transplant procedures will be subject to the annual Deductible as well as all limitations and maximums described in this section.

- Heart
- Heart/lung (simultaneous)
- Lung
- Kidney/Pancreas (simultaneous)
- Liver
- Kidney
- Pancreas
- Bone marrow transplant or peripheral stem cell infusion when a positive response to standard medical treatment or chemotherapy has been documented.

Cornea and skin transplants are covered under the normal provisions listed in **Medical benefits**, and are not subject to any conditions set forth in this section.

Transplant Covered Services and Supplies will include all Services listed in **Covered Services and Supplies**, including, but not limited to, Services by a Home Health Care Agency, Skilled Nursing Facility, or Hospice. Covered Services and Supplies will include cryopreservation and storage of bone marrow or peripheral stem cells when the cryopreservation and storage is part of a protocol of high dose chemotherapy, which has been determined by the Claims Administrator to be Medically Necessary and Appropriate, not to exceed $10,000 per approved transplant. Covered Services and Supplies will also include charges Incurred by the organ donor for a covered transplant if the charges are not covered by any other medical expense coverage.

For transplant Services provided by Blue Quality Centers for Transplant (BQCT) Providers, benefits payable for treatment or Service received each Benefit Period will be 100% of Covered Services and Supplies after satisfaction of the annual Deductible. If transplant related Services are provided by a BQCT Provider, travel and lodging expenses for the patient and a travel companion will be covered if the treating facility is greater than 150 miles one way from the patient's home (excluding travel or lodging provided by a family member or friend). This would include Ambulance Services that would otherwise be excluded under the Ambulance benefit. Travel and lodging benefits will be payable at 100% after the Deductible, up to a maximum benefit of $10,000 for each approved transplant for Services Incurred prior to the transplant and within 12 months after transplant has been performed.

- The general Plan exclusions listed in this booklet will apply to transplant Services. In addition, benefits will not be payable for:
- Cryopreservation and storage, except as described above**;** or
- If the transplant is not a covered transplant under this Plan, all charges related to the transplant will be excluded from payment under this Plan, including, but not limited to, dose-intensive chemotherapy; or
- Animal-to-human organ transplants; or
- Implantation within the human body of artificial or mechanical devices designed to replace human organ(s).

Limitations specific to home health care, Skilled Nursing Facility confinement, and Hospice Care provisions will apply to transplant Services if those benefits are used in connection with a covered transplant.

For each transplant episode, Covered Services and Supplies will be limited to transplant evaluations from no more than two transplant Providers.

Wellness Benefit. A preventive health schedule which includes preventive Services for children and adults based on recommendations from the U. S. Preventive Services Task Force, the Centers for Disease Control and Prevention, the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics. A summary of the preventive health schedule is listed as following:

• Procedure	Frequency
• Well child Visits This includes, at appropriate ages, height and weight measurement, developmental and behavioral assessment, and other care as determined by the doctor	Contact Highmark member services
• Immunizations Includes routine child immunizations and expanded age ranges for some immunizations	Contact Highmark member services
• Physical Examination	Annually
• Pelvic and Breast Exam	Annually
• Pap Test	Every 1 – 3 years based on history
• Mammogram	Annually after age 39
• Prostate Cancer Screening	Annually
• Urinalysis, venipuncture & CBC	Annually
• Lipid Panel	Every 5 years after age 20
• Bone Density Screening	Every 2 years if You are high-risk for osteoporosis
• Colorectal Cancer Screening	Beginning at age 50 annual screening with fecal occult blood test, screening with flexible sigmoidoscopy or double contrast barium Enema every five years or colonoscopy every 10 years.

The general summary above is not a complete list of the preventive health schedule provided under your Plan. To determine if a specific procedure is covered under the Wellness Benefit, call Highmark at **1-866-472-0924.** The Wellness Benefit applies only to charges Incurred when You have Services provided through a Preferred Provider Organization.

8. Healthcare Management Services

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.**

Healthcare Management Services (HMS), a division of Highmark, is responsible for ensuring that quality care is delivered to You within the appropriate setting.

An HMS nurse will review your request for an Inpatient admission to ensure it is:

- Appropriate for the symptoms and diagnosis or treatment of your condition, Sickness, disease, or Injury;
- Provided for your diagnosis or the direct care and treatment of your condition, Sickness, disease, or Injury;
- Not primarily for the convenience of You, your Physician, Hospital, or other health care Provider;
- In accordance with standards of good medical practice;
- Being delivered in the appropriate setting; and
- The most appropriate Service that can safely be provided.

A. Hospital Admission Review

When You are admitted to any Hospital as an Inpatient, You are responsible for contacting HMS for Pre-authorization. Your call to HMS prior to your admission to a Hospital will help You know your financial responsibility. You should call seven to 10 days prior to your planned admission. For emergency admissions, call HMS within 48 hours of the admission. You can contact HMS through the toll-free member service number on the back of your Medical ID Card.

B. Healthcare management requirements

Eligible Expenses for Hospital Inpatient Stay Charges will be reduced by 20% unless a Hospital Admission Review is requested from the HMS administrator by You, a dependent, or a designated patient representative as soon as a Hospital Inpatient Stay is scheduled, but no later than the first day of a Hospital Inpatient Stay for other than a Medical Emergency, and for a Medical Emergency within 48 hours of a Hospital Inpatient Stay.

If a Hospital Admission Review is not requested in a timely manner as specified above, the 20% reduction will be applied to all Hospital Inpatient Stay charges, but only to the charges Incurred up to the date a Hospital Admission Review is obtained.

Benefits will be payable only for that part of the Hospital Inpatient Stay charges the HMS administrator determines to be Medically Necessary and Appropriate.

The 20% reduction is a penalty for failure to comply with any of the HMS requirements. The reduction will not count toward satisfaction of the **Out-of-Pocket Maximum** described in this Plan.

C. Prospective review (Pre-authorization)

Prospective review, also known as Pre-authorization, begins once a request for medical Services is received.

After receiving the request for Inpatient care, HMS:

- Gathers information needed to make a decision, including patient demographics, diagnosis, and plan of treatment;
- Confirms care is Medically Necessary and Appropriate;
- Reviews available information regarding the patient's eligibility for coverage and/or availability of benefits;
- Authorizes care or refers to a Physician advisor for determination; and
- Assigns an appropriate length of stay.

D. Concurrent Review

Concurrent Review may occur during the course of Inpatient hospitalization and is used to assess the Medical Necessity and Appropriateness of the length of stay and level of care.

HMS:

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

E. Discharge planning

Discharge planning is a review of the case to identify the patient's discharge needs. The process begins prior to a planned admission or, in the case of an unplanned admission, at the time of admission, and extends throughout the patient's stay in the facility. Discharge planning facilitates continuity of care and is coordinated with input from the Physician and facility staff.

In planning for discharge, HMS 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; and
- Psychological needs.

F. Retrospective Review

Retrospective Review occurs when a Service or procedure has been rendered without the required Pre-authorization.

G. Case management Services

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 health care needs; and
- 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 health care Provider with knowledge of your medical condition to act as your authorized representative.

I. Request for reconsideration

You will receive written notice of any decision on a request for Pre-authorization or other Pre-service Claim, whether the decision is adverse or not, within a reasonable period of time appropriate to the medical circumstances involved. That period of time will not exceed 15 days from the date Highmark receives the Claim. However, this 15 day period of time may be extended one time by Highmark for an additional 15 days provided that Highmark determines that the additional time is necessary due to matters outside its control, and notifies You of the extension prior to the expiration of the initial 15 day Pre-service Claim determination period. If an extension of time is necessary because You failed to submit information necessary for Highmark to make a decision on your Pre-service Claim, the notice of extension that is sent to You will specifically describe the information that You must submit. In this event, You will have at least 45 days in which to submit the information before a decision is made on your Pre-service Claim.

Any time your request for Pre-authorization or other Pre-service Claim is approved, You will be notified in writing that the request has been approved. If your request for Pre-authorization or approval of any other Pre-service Claim has been denied, You will receive written notification of that denial which will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file an appeal.

If the Pre-authorization or Pre-Service Claim is denied, You, the patient, attending Physician or other ordering Provider can request an appeal. The appeal is to be directed in writing to the Claims Administrator, not the Plan. No appeals to the Plan are permissible on a Pre-authorization or other Pre-service Claim. You, the patient, attending Physician or other ordering Provider may submit written comments, documents, records, and other information relating to the request for appeal. A determination will be made within 30 calendar days of request for the appeal. However, if the appeal cannot be processed due to incomplete information, a written explanation will be sent of the additional information that is required or an authorization for your or the patient's signature so information can be obtained from the attending Physician or other ordering Provider. This information must be sent to the Claims Administrator within 45 calendar days of the date of the written request for the information. Failure to comply with the request for additional information could result in declination of the appeal. A determination will be made and notification of the outcome will be provided within 30 days.

You, the patient, attending Physician or other ordering Provider can request an expedited appeal if your appeal involves an Urgent Care Claim (see Claim in **Definitions**), by contacting a Healthcare Management Services representative at **1-800-547-3627**. A decision on your request will be made as soon as possible taking into account the medical exigencies involved. You will receive notice of the decision that has been made on your Urgent Care Claim no later than 72 hours following receipt of the Claim. This time frame may be shortened in those

cases where your Urgent Care Claim request seeks to extend a previously approved course of treatment and that request is made at least 24 hours prior to the expiration of the previously approved course of treatment. In that situation, Highmark will notify You of its decision concerning your Urgent Care Claim to extend that course of treatment not later than 24 hours following receipt of your request. **You are not entitled to an expedited appeal if the Services have already been received.**

9. Member services

Good health care is more than just Physician Visits. It's also the Service that supports your care. Whether it's for help with a Claim or a question about your benefits, You can call the toll-free member service number on the back of your Medical ID Card or log onto the Highmark Web site, *www.highmarkbcbs.com* and connect to My Blu*e*Link. A Highmark member service representative will help You with any coverage inquiry. Representatives are trained to answer your questions quickly, politely and accurately.

A. Blues On Call*sm*

From My Blu*e*Link page at *www.highmarkbcbs.com,* click on "Blues On Call" or dial the 24-hour toll free number, **1-888-BLUE428** to speak with a specially trained Registered Nurse. Your call will be kept strictly confidential.

Blues On Call*sm* addresses your total health care needs rather than focusing on one specific disease, condition or Sickness through interaction with both the patient and the Physician. Blues On Call*sm* promotes the philosophy of shared decision-making by helping You work with your Physicians in the task of choosing treatment options that take into account your values and preferences. Blues on Call*sm* provides You with health care support Services, including assistance in the self-management of certain health conditions. You have 24-hour access, seven days a week, to health information and personalized support for health decisions.

Support Services may include:

- Assessment of your functional and health status, including co-morbidities, risk factors, motivation and confidence in managing your health, and receptivity for change;
- Assessment of your knowledge of your particular condition and your understanding and adherence to the recommendations and instructions of your health care Provider;
- Education and training on health-related topics that can be helpful in improving your overall health status, such as appropriate diet and nutrition, smoking cessation and exercise; and
- Ongoing monitoring (coaching) to optimize your health status, ensuring adherence to the Physician's treatment plan, identifying and addressing barriers that prevent or hinder adherence to the Physician's treatment plan, and assessing the need for case management services.

B. Highmark Web site

Visit the Highmark Web site at *www.highmarkbcbs.com* for a world of information, interactive tools and Services. As a Blue Cross Blue Shield PPO participant, You have access to health and wellness information, user-friendly Services related to your PPO health care coverage, and valuable tools for managing your own health and well-being on My Blu*e*Link, your personal Web page. Simply go to the Web site and log onto My Blu*e*Link.

Here You can:

- Customize the content of your pages, including health and wellness content and links to other sites.
- Access a variety of Services related to your Blue Cross Blue Shield PPO coverage, order a Medical ID Card or Claim form, investigate a Claim, or find a Physician.
- Access valuable health resources including Blues On Call[sm]. You can look up any medical topic in the Healthwise Knowledgebase®, a comprehensive health information resource containing more than 28,000 pages of current medically accurate health information. You can also complete the personal wellness profile, which helps You identify your personal health risks and set goals to improve your wellness.
- Access "Healthy Living" page for fitness tools, calculators, personal wellness profile and more.

Highmark also keeps You informed through a quarterly newsletter, *Looking Healthward.* This newsletter contains new product updates as well as a wide variety of health and preventive care articles and "stay healthy" tips.

10. Plan exclusions

A. The Plan does not cover all medical expenses

This section tells You about many of the Services and supplies that the Plan does not cover. **Remember, just because a Physician recommends or approves a Service or supply does not mean that the Plan covers it.** If You have any questions about coverage, call or write to the Claims Administrator **before** You receive the Services or supplies.

B. Exclusions

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

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.

Blood. Blood or blood plasma that is replaced by or for the patient.

Breast implants. The insertion, removal, or revision of breast implants, unless provided post-mastectomy. Also, the treatment or Service for any Sickness or condition for which the insertion of breast implants or the fact of having breast implants within the body was a contributing factor, unless the Sickness or condition occurs post-mastectomy.

Comfort and convenience supplies and Services. Personal comfort and convenience supplies and Services. This includes:

- Those supplies and Services provided during a Hospital stay, such as:
  - Radio.
  - Television.
  - Telephone.
  - Guest meals.
- Those supplies and 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 and non-oral contraceptives are not covered in the medical portion of the Plan, however, oral contraceptives are covered in the **Outpatient Prescription Drug program.**

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

Custodial Care. Services and supplies 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 and Supplies**.

Developmental delay. Education or training for developmental delay.

Educational problems, training problems, or learning disorders. Services that are provided in connection with educational or training problems or learning disorders.

Excess charges. Charges in excess of the Allowable Charge.

Experimental or Investigational. Services or supplies 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.

Eye care. Any of these eye care Services or supplies:

- Eye exams performed by an Out-of-Network Provider.
- Eyeglasses or contact lenses except for the initial pair of glasses/contact lenses prescribed following cataract extraction.
- Radial keratotomy, laser or other eye Surgery to correct nearsightedness, farsightedness or blurring (astigmatism).

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, casting for orthotics, or any appliance (including orthotics).

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

Hair loss. Services and supplies 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. Hearing aids or adjustments to hearing aids.

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

Maintenance care. The Services and supplies 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 and Supplies**.)

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, provided the travel is for a reason other than securing health care diagnosis or treatment; or
- A business assignment; or
- You are employed outside the United States; or
- Full-Time Student status, provided your dependent is either:
    - Enrolled and attending an accredited school in a foreign country; or
    - Is participating in an academic program in a foreign country, for which the institution of higher learning at which the student is enrolled in the U.S. grants academic credit.

Medical Services or supplies provided by non-approved Providers. Medical Services or supplies provided by someone other than a Physician, Professional Other Provider, Professional Provider or other Providers listed in **Definitions**.

Miscellaneous Services. Treatment for nicotine addiction, 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 and supplies for which the Covered Person is not legally required to pay.

Nursing Services. Any nursing Services (except as described in **Covered Services and Supplies**).

Pre-existing Sickness or Injury. Services and supplies for treatment of a Pre-existing Sickness or Injury during the exclusion period.

The exclusion period begins on the hire date and ends 12 months after that date. When evidence of good health is required, the enrollment date is the date the Evidence of Good Health Application is received by GuideStone.

The exclusion period may be shorter if You were covered under another health plan before You enrolled in this Plan. This is called Prior Creditable Coverage. The length of time that You had this prior coverage is subtracted from the exclusion period. But your prior coverage does not count if it ended 63 days or more before You enrolled in the Plan. An employment waiting period does not count as part of the 63 days.

The Pre-existing Sickness or Injury exclusion does not apply to any of these:

- Genetic information, unless a condition related to that information is diagnosed.
- Pregnancy.
- A newborn that became covered within 31 days of the date of birth.
- A Child who was adopted or placed for adoption and who became covered within 31 days of the adoption or placement for adoption.

Prescription and non-prescription drugs. Drugs or medicines except for those covered under **Covered Services and Supplies** 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 and supplies before or after coverage. Services or supplies for which a charge was Incurred before a person was covered under this Plan or after coverage under this Plan ended.

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

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

Services and supplies provided by Immediate Family. Services or supplies 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.

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

Sex changes or sexual disorder therapy. Medications, implants, hormone therapy, Surgery, medical or psychiatric treatment connected to a sex change or sexual disorder therapy.

Smoking cessation. Services and supplies related to smoking cessation programs, including smoking-deterrent patches.

Sterilization reversal. Services and supplies to reverse any reproductive sterilization procedure.

Vitamins, minerals, nutritional supplements, or special diets. Vitamins, minerals, nutritional supplements, or special diets (whether they require a Physician's prescription or not). **Exception:** The Plan will cover Enteral Formulae 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. Such coverage for Enteral Formulae shall not exceed a maximum benefit of $1,000 in a Benefit Period.

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

Wellness Benefit. Any preventive health care Service not covered by the preventive health schedule or performed by an Out-of-Network provider. See **Covered Services and Supplies.**

Work-connected Injury or Sickness. Supplies or 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

Medco Health Solutions, Inc. administers the Plan's Outpatient Prescription Drug program. Under this program, You may purchase Outpatient Prescription Drugs:

At a Participating Pharmacy.

By home delivery.

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

B. Retail pharmacy benefits

You can go to any Participating Pharmacy to get your prescriptions filled. You can get up to a 30-day supply of each prescription filled or refilled when You go to a Participating Pharmacy.

When You go to a Participating Pharmacy, You:

Use your Pharmacy ID Card.

Pay only the Copayment for each prescription fill or refill once your Benefit Period Deductible is met.

Do not file a Claim.

Call Medco Health or GuideStone to find a Participating Pharmacy near You, or go to the Medco Health Web site at *www.medcohealth.com.*

C. Home delivery pharmacy service benefits

If You take medication on an ongoing basis (for example, for blood pressure, asthma, or diabetes), You may want to use the home delivery pharmacy to save money. Each home delivery prescription can be for up to a 90-day supply of the same medication. You cannot combine refills to equal one 90-day supply. You pay the Copayment listed in the **Benefit summary** each time You fill or refill the same medication.

Call Medco Health or GuideStone for the Home Delivery Prescription form. You can also get a copy of this form from the Medco Health Web site at *www.medcohealth.com* or from the GuideStone Web site at *www.GuideStone.org*.

D. Types of drugs

Generic drugs. These are identified by their chemical name. They are equivalent to brand name drugs and usually cost less than brand name drugs.

Brand name drugs. Your Prescription Drug plan includes a formulary, which is a list of drugs that are preferred by your Plan. This list includes a wide selection of drugs and is preferred because it offers You a choice while helping keep the cost of your Prescription Drug benefits affordable. Each drug is approved by the Food and Drug Administration (FDA) and reviewed by an independent group of Physicians and pharmacists for safety and efficacy. The Plan encourages the use of the preferred drugs on this list to help control rising drug costs. Medco Health 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. For more information about your formulary, visit the Medco Health Web site at *www.medcohealth.com* or call **1-800-555-3432.**

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. You receive:

- Expedited delivery of up to a 30 day supply of prescribed medication and supplies sent directly to your home, office, or Physician's office.
- Confidential, expert pharmacist counseling 24 hours a day.

- Educational materials to help You live better with your condition and therapy.
- A medication adherence program to offer tips and counseling to help You manage your medications, side effects and dosage schedule.
- Strict quality, safety and package delivery controls for every prescription order.

Not all drugs are covered under the specialty drug program and some drugs require Pre-authorization. Call Medco Health or GuideStone to obtain more information about the program.

E. Your drug Copayments

You must pay a Copayment every time You fill or refill a prescription.

Copayments are applicable once the individual/Family Deductible is met for the Benefit Period.

See the **Benefit summary** for the Copayment amounts.

F. 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 Pre-authorization.** Non-Participating Pharmacies are not covered under this Plan. No appeals to the Plan are permissible under the **Outpatient Prescription Drug program.** Call Medco Health at **1-800-555-3432** for more information, or go to their Web site at *www.medcohealth.com*.

12. How to file a Claim

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 within one year from the end of the year following the date of Service.

A. Notice of Claim for Out-of-Network

Know your benefits. Review this information to see if the Services You received are eligible under your medical program.

Get an itemized bill. Itemized bills must include:

- 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.

B. Claim forms

Make sure all information is completed properly, and then sign and date the form. Claim forms are available from GuideStone, Highmark member services or the Highmark Web site. After You complete the above steps, 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.

C. Explanation of benefits statement

Once your Claim is processed, You will receive an explanation of benefits (EOB) statement. The statement lists: the Provider's charge, Allowable Charge, Deductible and Coinsurance You are required to pay; total benefits payable; and total amount You owe.

If a Claim cannot be processed due to incomplete information, the Claims Administrator will send a written explanation prior to the expiration of the 30 calendar days. You are then allowed up to 45 calendar days to provide all additional information requested. The Claims Administrator will render a decision within 15 calendar days of either receiving the necessary information or upon expiration of 45 calendar days if no additional information is received.

In actual practice, benefits under the Plan may be processed and paid within a few days after the Claims Administrator receives completed proof of the expense. If a Claim cannot be paid, the Claims Administrator will promptly explain why.

D. Appeal of payment, denial and review

You may request an appeal of a Claim denial by written request to the Claims Administrator within 180 calendar days of receipt of notice of the denial. The Claims Administrator will make a full and fair review of the Claim. The Claims Administrator may require additional information to make the review. The Claims Administrator will notify the claimant in writing of the appeal decision within 60 calendar days of receiving the appeal request.

After exhaustion of the first appeal process, a second appeal may be requested. The second appeal must be requested in writing within 45 days of the denial of the first appeal. Written comments, documents, records, and other information relating to the Claim for benefits may be supplied to the Claims Administrator. The Claims Administrator will make a determination within 60 calendar days of request for a second appeal. However, if the appeal cannot be processed due to incomplete information, the Claims Administrator will send a written explanation of the additional information that is required or an authorization for the claimant's signature so information can be obtained from the Provider. Failure to comply with the request for additional information could result in declination of the appeal. A determination will be made and notification of the outcome will be provided within 60 calendar days of the receipt of all necessary information to properly review the appeal request.

If the Claims Administrator does not pay your Claim after it has gone through all levels of its own appeal process, it will send You a final denial letter. This letter will tell You how to appeal your Claims denial to the Plan. You cannot file an appeal with the Plan until You receive the final denial letter from the Claims Administrator.

If You decide to appeal your Claim to the Plan, You must send a written appeal within 60 days of the Claims Administrator's final denial letter. Your appeal should include:

- All the reasons why your Claim should not be denied.
- Any information that You wish to have the Plan consider in reviewing the appeal. You may send in any new or additional information that You think might affect the Claim review.
- Send this appeal to:

  Claims
  Insurance Operations Department
  GuideStone Financial Resources of the Southern Baptist Convention
  2401 Cedar Springs Rd.
  Dallas, Texas 75201-1498

The claims department will review your appeal. If the information You send clearly shows that You should receive Plan benefits, the claims department will reverse the Claim denial and notify You of the decision.

If your appeal does not clearly show that You should receive Plan benefits, the claims department may ask for additional information, either from You or from others. The claims department will send your appeal and all the related information to the Plan's claims appeals committee

for review. The committee also may ask You or other sources for additional information. The committee will make a final decision based on all the information it receives.

The committee will decide your appeal within 60 days after You file your appeal with the Plan. This review can take up to 120 days if special circumstances make it impossible for the committee to complete the review within 60 days. If this happens, You will be notified of the delay within the first 60 days. Once the committee completes its review, it will send You a letter about its decision. This letter will tell You the specific reasons for the final decision. It will also tell You about the Plan provisions that the committee relied on to make its decision.

The committee has complete discretion when it decides any appeals. Its decision is final and binding.

For purposes of this section, “claimant” means You, your dependent, or legal representative.

E. Legal action

Legal action for a Claim may not be started before the appeal procedures have been exhausted. Further, no legal action may be started later than two years after proof is required to be filed.

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 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.

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

A. Overview

Most health care plans, including this Plan, contain a coordination of benefits provision. This provision is used when You or your Eligible Dependent(s) are eligible for payment under more than one health care plan. The object of coordination of benefits is to assure You that your Eligible Expenses will be paid, while preventing duplication of benefit payments.

If You are covered under 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 uninsured. This includes prepayment, group practice or individual practice coverage.
- Governmental plans or programs, including Medicare.
- First-party medical expense provisions of any automobile policy issued under a no-fault insurance statute including the self-insured equivalent of any minimum benefits required by law.

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 family members. 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.

These rules tell which plan is primary and which is secondary.

- When your other coverage does not mention "coordination of benefits," then that coverage pays first. Benefits paid or payable by the other coverage will be taken into account in determining if additional benefit payments can be made under your Plan.
- When the person who received care is covered as an employee under one Plan, and as a dependent under another, then the Employee Coverage pays first.
- When a dependent Child is covered under two plans, the plan covering the parent whose birthday falls earlier in the Benefit Period pays first. But, if both parents have the same birthday, the plan which covered the parent longer will be the primary program. If the dependent Child's parents are separated or divorced, the following applies:
  - If the parent with custody of the Child has not remarried, the coverage of the parent with custody pays first.
  - When a divorced parent with custody has remarried, the coverage of the parent with custody pays first but the stepparent's coverage pays before the coverage of the parent who does not have custody.
  - Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the Child's health care expenses, the coverage of that parent pays first.
- **Special Medicare rule.** There is a special rule that reverses the order of payments if the person is also covered by Medicare and employed by an Employer who is exempt from the Medicare secondary payer rules. Call GuideStone for more information on this special rule if Medicare covers You.

- When none of the above circumstances applies, the coverage you have had for the longest time pays first; provided that:
  - The benefits of a plan covering the person as an employee other than a laid-off or retired employee or as the dependent of such person shall be determined before the benefits of a plan covering the person as a laid-off or retired employee or as a dependent of such person; and
  - If the other plan does not have a provision regarding laid-off or retired employees and, as a result, the benefits of each plan are determined after the other, then the provisions listed above shall not apply.

If You receive more than You should have when your benefits are coordinated, You will be expected to repay any overpayment.

Coordination of benefits prevents duplication and works to the advantage of all participants of the Plan.

C. How benefits are paid

When this Plan is the primary plan, it pays as if there were no other plan 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 health care supply or Service covered by one of the plans. An Eligible Expense under this Plan is:

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

These are not Eligible Expenses:

- Copayments.
- 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:
  - Pre-authorization 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.

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 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 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 based on disability**. If You or your Covered Dependent 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 ESRD**. If You or a Covered Dependent is entitled to Medicare because of end stage renal disease (ESRD), this Plan pays first during the first 30 months. After that, Medicare pays first.

Medicare pays benefits first if none of these rules applies. 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 two other medical benefit plans GuideStone offers to supplement your Medicare benefits. These plans are the Senior Plan and Senior Plus Plan. Call GuideStone for more information about these two plans.

Because Medicare coverage can end 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 Dependents, 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 or supplies 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 You Incur health care expenses for Injuries due to an Accident caused by another person or organization, the person or organization causing the Accident may be responsible for paying these expenses.

For example, if You or one of your Eligible Dependents receive benefits from this Plan for Injuries caused by another person or organization, the Plan has the right, through subrogation, to seek repayment from the other person or their insurance company for benefits already paid.

The Plan will provide eligible benefits when needed, but You may be asked to show documents or take other necessary actions to support the Claims Administrator in their subrogation efforts.

Subrogation does not apply to an individual insurance policy You may have purchased for yourself or your dependents or where subrogation is specifically prohibited by law.

B. Transfer of rights

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

Obligations of You and your Covered Dependent

To secure the rights of the Plan under this section, You or one of your Covered Dependents 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, reimburse the Plan for benefit payments (but not more than the amount paid by the other party or parties).
- You or your Covered Dependents will not take any action that prejudices the rights of this Plan. If You or your Covered Dependents enter into litigation or settlement negotiations regarding obligations of other parties, You or your Covered Dependents 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 Dependents will be borne solely by You or your Covered Dependents.

16. General information

A. Right to amend or terminate the Plan

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

GuideStone also can change any or all of the provisions of the Plan at any time and for any reason. It does not have to notify You first. Any change may cause your benefits to be different than those described in this booklet.

B. Church plan

The Plan is intended to be a “church plan” as defined in the Employee Retirement Income Security Act of 1974, as amended (ERISA), and the Internal Revenue Code. Because it is a church plan, many legal requirements that apply to most other health care plans do not apply to this Plan. For example, this Plan does not have to follow the COBRA Continuation Coverage requirements.

C. Plan is not an employment contract

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

D. Choice of law

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

E. Relation among parties affected by the Plan

All health care Providers, including Hospitals, are independent contractors to GuideStone. No health care Provider works for GuideStone either as an employee or agent. No GuideStone employee works for any health care Provider, either as an employee or agent. That means that each health care Provider You go to is responsible to You for the Services and supplies it provides to You. GuideStone is not responsible for providing You with any Services and supplies. Nor is it responsible for any Services and supplies You receive from any health care Provider.

F. Plan discretion

GuideStone has complete discretion to construe or interpret all provisions, to determine eligibility for benefits, and to determine the type and extent of benefits, if any, to be provided. GuideStone decisions in such matters shall be controlling, binding, and final. In any action to review any such decision by GuideStone, GuideStone shall be deemed to have exercised its discretion properly unless it is proved that GuideStone has acted arbitrarily and capriciously.

17. Your confidential medical information

A. Collecting information

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

The Claims Administrator may also collect information about You from other sources. The Claims Administrator needs this information to process Claims. For example, your coverage may have limits on it that depend on your salary or job class. The Claims Administrator would get that information from GuideStone.

B. 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 of Individually Identifiable Health Information set forth in 45 C.F.R. Subtitle A, Part 164, Subpart E, as it 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 Plan Sponsor) shall be required to use and disclose Protected Health Information (PHI) received from the Plan or any Health Insurance Issuer providing benefits under the Plan, as follows:

(a) for disclosure to the Secretary of Health and Human Services, when required by the Secretary for its investigation or determination of the compliance of the Plan with the Privacy Rule;

(b) for disclosure to a Plan Participant, Spouse or Covered Dependent of that Individual’s PHI upon the Individual’s written request or in appropriate response to an exercise by the Plan Participant, Spouse or Covered Dependent of any other of his or her individual rights with respect to PHI, all in accordance with the requirements of the Privacy Rule;

(c) for purposes of the Plan Administration functions set forth in paragraphs 3 and 4 of this section 17(B), or as otherwise required by HIPAA; and

(d) for use or disclosure to other persons, as required by applicable law other than HIPAA, provided that nothing in this paragraph (1)(d) shall permit or require the use by or disclosure of PHI to the Plan Sponsor to the extent such disclosure is prohibited by HIPAA.

(2) **Permitted uses and disclosures of PHI**. Except as otherwise set forth herein, the PHI received from the Plan or any Health Insurance Issuer providing benefits under the Plan shall be permitted to be used and/or disclosed as follows:

(a) by persons handling Plan operations and claims, members of the claims appeals committee, customer relations, legal services, executive management, actuarial and financial services, and marketing support for Treatment, Payment or Health Care Operations including but not limited to, eligibility, enrollment, provider verification of enrollment, internal verification of enrollment, qualified medical child support orders, disenrollment, employee contributions, participating employer contributions, payment of cost of coverage, payment of continuation of benefits, precertification, predetermination concurrent review, case management, centers for high risk procedures, claim adjudications, claim payments, claim status benefit determinations, medical necessity reviews, review of claim appeals, informal employee assistance, coordination of benefits, third party liability, stop loss claims, audit reports, claims audits, administration audits, information systems controls, legal/compliance audits, financial audits, establishment of the Plan, underwriting and actuarial valuations, amending the Plan, network development, terminating the Plan, selection of vendors, and any other activity that would constitute Treatment, Payment or Health Care Operations, provided that, to the extent required by administrative rules under the Plan or applicable law, such use or disclosure is made pursuant to and in accordance with a valid consent under the Privacy Rule;

(b) pursuant to and in accordance with a valid authorization under the Privacy Rule;

(c) by persons handling Plan operations and claims for wellness, prevention and disease management including but not limited to, voluntary medical examination, health profiles, screening, alternatives for financial incentive, disease management evaluation and disease management programs;

(d) by persons handling Plan operations and claims, auditing, customer relations, legal services, executive management, actuarial and financial services, and marketing support for other benefits and benefit plans including but not limited to short term or long term disability, workers' compensation, AD&D and life insurance;

(e) by persons handling human resources, Plan operations and claims for employment purposes including but not limited to, FMLA leave, return to work clearance or limitations, substance abuse policy, and required physical examinations;

(f) by persons handling Plan operations and claims, customer relations, legal services, and executive management for response to inquiries including but not limited to complaints and grievances, an Individual's own information, requests from the U.S. Department of Health and Human Services or U.S. Department of Labor, a public health agency or any other government agency, a subpoena or due diligence request and due diligence;

(g) by persons handling Plan operations and claims, and marketing support for other miscellaneous reasons including but not limited to Internet Web site communications, marketing, fundraising, research, and on-site medical staff needs;

(h) by persons handling human resources, corporate medical staff, information systems, mailroom/fax delivery, research and product development, legal services, finance, accounting, and audit for Plan and other purposes; and

(i) as otherwise permitted by, and in compliance with, HIPAA; provided that nothing in this section 17(B)(2) shall permit or require the disclosure of PHI to the Plan Sponsor to the extent such disclosure is prohibited by HIPAA.

(3) **Requirements of Plan Sponsor**. The Plan Sponsor shall:

(a) not use or disclose PHI received from the Plan or any Health Insurance Issuer providing benefits under the Plan, other than for Plan Administration, or as otherwise required by law;

(b) ensure that any agent (including a subcontractor) to whom the Plan Sponsor provides PHI received from the Plan or any Health Insurance Issuer providing benefits thereunder, agrees to the same restrictions and conditions with respect to PHI as apply to the Plan Sponsor under this section 17(B)(3);

(c) not use or disclose PHI received from the Plan or any Health Insurance Issuer providing benefits under the Plan, for employment-related actions and decisions or in connection with any employee benefit plan or benefit provided by the Plan Sponsor other than the Plan or a health benefit provided under the Plan;

(d) report to the Plan or Health Insurance Issuer providing benefits thereunder, as applicable, any use or disclosure of PHI received from the Plan or Health Insurance Issuer providing benefits under the Plan, that is inconsistent with the uses or disclosures required or permitted under this section 17(B)(3) and of which the Plan Sponsor becomes aware;

(e) make the PHI of a Plan Participant, Spouse or Covered Dependent available to that Individual, upon the Individual's written request, in accordance with the requirements of the Privacy Rule;

(f) incorporate amendments of PHI of a Plan Participant, Spouse or Covered Dependent as and to the extent required by the Privacy Rule;

(g) make available to a Plan Participant, Spouse or Covered Dependent upon the Individual's written request, the information necessary to provide an accounting of the disclosures of PHI as and to the extent required by the Privacy Rule;

(h) make the Plan Sponsor's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan or any Health Insurance Issuer providing benefits under the Plan, available to the Secretary of Health and Human Services for determinations as to the compliance of the Plan with HIPAA;

(i) if feasible, return or destroy all PHI received from the Plan or any Health Insurance Issuer providing benefits under the Plan, that the Plan Sponsor maintains and retains no copies thereof; or, if such return or destruction is not feasible, limit further uses and disclosures of PHI to the purposes that make the destruction or return infeasible; and

(j) ensure that the requirements set forth in paragraph (4)(b) and (c) below are satisfied with respect to PHI.

(4) **Access to Protected Health Information.**

(a) Minimum necessary. Except as to a use or disclosure of information related to the treatment of an Individual, when using or disclosing PHI or when requesting PHI from another entity, the Plan or any individual acting on behalf of the Plan, must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure or request. Adherence to policies established by the Plan Sponsor with respect to the use, disclosure, or request of PHI shall be deemed to constitute such an effort unless the circumstances otherwise require.

(b) Access. Access to and use of PHI shall be limited to individuals who perform functions relating to Plan Administration on behalf of or in connection with the Plan, as described in sections 17(B)(1) and (2) above, with respect to the performance of such functions. Other individuals or classes of individuals may be furnished with access to PHI with respect to functions that they are performing on behalf of or in connection with the Plan pursuant to a designation by the Plan Sponsor.

(c) Non-compliance. If the Plan Sponsor becomes aware of any issues relating to non-compliance with the requirements of this section 17, the Plan Sponsor shall undertake an investigation to determine the extent, if any, of such non-compliance; the individuals, policies, or practices responsible for the non-compliance; and appropriate means for curing or mitigating the effects of non-compliance and preventing such non-compliance in the future. Any individual who is determined by the Plan Sponsor to be responsible for such non-compliance, shall be subject to disciplinary action, as determined by the Plan Sponsor, in its sole discretion, including but not limited to, one or more of the following:

- Required additional training and education with respect to the use or disclosure of or access to PHI.
- Reprimand.
- Suspension of access to PHI or other diminution of duties or privileges.
- Removal from position or termination.

(5) **Certification of Plan Sponsor**. The Plan or any Health Insurance Issuer providing benefits thereunder shall disclose PHI to the Plan Sponsor and to the individuals described in section 17(B)(2) above only if the Plan Sponsor has certified that the Plan has been amended to incorporate the provisions of this section 17(B)(5) and that it agrees with the restrictions and other rules set forth in section 17(B)(3).

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

(7) **Action by the Plan Sponsor**. The Plan Sponsor may act as prescribed in this section 17 or may delegate, in writing and in its sole discretion, any and all of its functions under this section 17 to the Privacy Officer or other officer or employee, or to a group of officers or

employees of the Plan Sponsor. The Plan Sponsor or such delegate shall have the authority to establish rules and prescribe forms and procedures for performing its functions.

(8) **Action by member.** For additional information or to contact the Plan Sponsor, You may call the GuideStone toll free number at **1-888-984-8433** or contact them at *HIPAAPrivacyContact@GuideStone.org*.

18. Definitions

A. Words with special meanings

This section tells You the special meanings of many words and phrases used in this booklet. Sometimes there is a more detailed discussion of a particular word or phrase in another section in this booklet. If that happens, the definition should tell You what other section discusses that word or phrase.

Sometimes the definition of a word or phrase has another word or phrase in it that also has a special meaning. Look in **Definitions** for the special meanings. Here's an example: The definition of Accident has the word Injury in it. If You look at the definition of Injury, You will see its special meaning.

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

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

Allowable Charge (Also called Provider's Reasonable Charge).

- For medical care received from Network Providers, the dollar amount that your PPO has determined is reasonable for Covered Services and Supplies provided under your Plan.
- For medical care received from Out-of-Network Providers, the Allowable Charge, not the Provider's actual charge, as determined by the Claims Administrator.
- For drugs and medicines requiring a Provider prescription and considered a covered treatment or Service, if the Allowable Charge cannot be determined, Average Wholesale Price will be applied.
- For Medical Care received from a Transplant Network Provider, the amount will be based on the PPO negotiated fee.

Ambulance Service. A Facility Other Provider licensed by the state which, for compensation from its patients, provides local transportation by means of a specially designed and equipped vehicle used only for transporting the Sick and Injured.

Ambulatory Surgical Facility. A Facility Other Provider, with an organized staff of Physicians, which is licensed as required by the state, has the required certificate of need, and which, for compensation from its patients:

- Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
- Provides treatment by or under the supervision of Physicians and nursing Services whenever the patient is in the facility;
- Does not provide Inpatient accommodations; and
- Is not, other than incidentally, a facility used as an office or clinic for the private practice of a Professional Provider.

Anesthesia. The administration of a regional or rectal anesthetic or the administration of a drug or other anesthetic agent by injection or inhalation, the purpose and effect of which is to obtain muscular relaxation, loss of sensation or loss of consciousness.

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

Benefit Period. The specified period of time during which charges for Covered Services and Supplies must be Incurred in order to be eligible for payment by the Plan. A charge shall be considered Incurred on the date a Covered Person receives the Service or supply for which the charge is made. Benefit Period can be a calendar year or a Plan year as determined by your Employer.

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.

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

Blues On Call[sm] (Health Education And Support Program). A program administered by the Plan's designated agent through which a Covered Person receives health education and support Services, including assistance in the self-management of certain health conditions and, when appropriate, a referral to a Network specialist.

Certified Registered Nurse. A Certified Registered Nurse anesthetist, Certified Registered Nurse practitioner, certified enterostomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse, or certified clinical nurse specialist, certified by the State Board of Nursing or a national nursing organization recognized by the State Board of Nursing. This excludes any registered professional nurses employed by a health care facility, as defined in the Health Care Facilities Act, or by an anesthesiology group.

Child. Your unmarried Child, including:

- Your natural (biological) Child.
- Your legally adopted Child or a Child placed in your home for adoption.
- A Child living with You and dependent on You for support and maintenance. This may be:
  - Your stepchild.
  - Your foster Child.
  - Your grandchild.
- A Child for whom You must provide health care by court order.
- A Child for whom You are legal guardian or managing conservator.

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

Claim. A request for the payment or reimbursement of the charges or costs associated with a Covered Service and Supply **or** a request for Pre-authorization or prior approval of a Covered Service and Supply. Claim includes:

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

Claims Administrator. For medical coverage, Highmark Blue Cross Blue Shield.

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

Coinsurance. The percentage of eligible expenses You and the Plan share. The exact Coinsurance depends on the Plan provisions. Your Coinsurance will be the covered Services or supplies which must be paid by You. See **Medical benefits.**

Concurrent Review. A HMS review conducted during a patient's Hospital stay or course of treatment.

Continuation Coverage. Plan coverage available to You and your Covered Dependents 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.

Covered Class. A class of employees 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.

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

Covered Member. An Eligible Employee who becomes covered under the Plan. See **When You become covered**.

Covered Percent/Covered Percentage. The percentage of Eligible Expenses that the Plan pays. The Covered Percent is not the same for all Eligible Expenses. See **Medical Benefits.**

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

Covered Service and Supply. A Service or supply specified in **Covered Services and Supplies** for which benefits will be provided when rendered by a Provider or Supplier.

Custodial Care. Care provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting his or her activities of daily living and which is not primarily provided for its therapeutic value in the treatment of a Sickness, disease, bodily Injury, or condition. Multiple non-skilled nursing Services/non-skilled rehabilitation Services in the aggregate do not constitute Skilled Nursing Services Skilled Rehabilitation Services. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparing special diets and supervising the administration of medications not requiring Skilled Nursing Services/Skilled Rehabilitation Services provided by trained and licensed medical personnel.

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 and Supplies that must be Incurred by a Covered Person before the Plan will assume any liability for all or part of the remaining Covered Services and Supplies.

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

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

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

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

Drug Abuse. Any use of drugs 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.

Drug Abuse Treatment Facility. A Facility Other Provider which, for compensation from its patients, is primarily engaged in providing detoxification or rehabilitation treatment for Drug Abuse or Alcohol Abuse. This facility must also meet the minimum standards set by the appropriate governmental agency.

Durable Medical Equipment. Items which can withstand repeated use; are primarily and customarily used to serve a productive medical purpose; are generally not useful to a person in the absence of Sickness, Injury or disease; are appropriate for use in the home and do not serve as comfort or convenience items.

Eligible Dependent. Your Eligible Dependents are:

- Your Spouse.
- Your unmarried Child under age 25.
    - Dependent on You for support and maintenance.
- Your unmarried Child who was covered under the Plan and is incapacitated. All of these rules must be met:
    - Your Child must be mentally or physically incapable of earning a living.
    - Your Child must have been incapacitated when his or her Plan coverage would have ended because of age.
    - 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.

An Eligible Dependent does not include any of these:

- A Spouse or Child on active duty in the armed forces of any country.
- A Spouse or Child who already has Employee Coverage under this Plan through your Employer.
- A Spouse or Child eligible for Medicare if Medicare pays first before this Plan.

Eligible Employee. You are an Eligible Employee if You meet all of these rules:

- 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.

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

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

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

Emergency Care. The initial treatment of a sudden onset of a medical condition or Injury. This shall not include treatment for an occupational Injury for which benefits are provided under any Workers' Compensation Law or any similar Occupational Disease Law. The symptoms or Injury must be of sufficient severity to warrant immediate attention.

Emergency Medical Services. The initial treatment of a sudden onset of a medical condition with acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in:

- Permanently placing the patient's health in jeopardy; or
- Causing other serious medical consequences; or
- Causing serious impairment to bodily functions; or
- Causing serious and permanent dysfunction of any bodily organ or part.

Emergency transportation and related emergency Services provided by a licensed Ambulance Service shall constitute an Emergency Care Service.

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

Employee Coverage. Plan coverage for Eligible Employees 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.

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. There is a maximum benefit of $1,000 per Benefit Period.

Experimental/Investigative. The use of any treatment, Service, procedure, facility, equipment, drug, device or supply (intervention) which is not determined by the Plan to be medically effective for the condition being treated.

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

- The intervention does not have FDA approval to be marketed for the specific relevant indication(s); or
- Available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or
- 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; or
- The intervention does not improve health outcomes; or
- The intervention is not proven to be applicable outside the research setting.

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

Facility Other Provider. An entity other than a Hospital which is licensed, where required, to render Covered Services. Facility Other Providers include:

- Alcohol Abuse Treatment Facility.
- Ambulance Service.
- Ambulatory Surgical Facility.
- Birthing Facility.
- Day/Night Psychiatric Facility.
- Drug Abuse Treatment Facility.
- Freestanding Dialysis Facility.
- Freestanding Nuclear Magnetic Resonance Facility.
- Magnetic Resonance Imaging Facility.
- Home Health Care Agency.

- Home Infusion Therapy Provider.
- Hospice.
- Outpatient Alcohol Abuse Treatment Facility.
- Outpatient Drug Abuse Treatment Facility.
- Outpatient Physical Rehabilitation Facility.
- Outpatient Psychiatric Facility.
- Psychiatric Hospital.
- Rehabilitation Hospital.
- Skilled Nursing Facility.

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

Family Coverage. Coverage for the member and one or more of the member's dependents.

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

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.

Full-Time Student. Your dependent Child attending a school that has a regular teaching staff, curriculum and student body and who:

- Attends school on a full-time basis, as determined by the school's criteria; and
- Is dependent on You for principal support.

Generally Accepted. Treatment or Service that:

- Has been accepted as the standard of practice according to the prevailing opinion among experts as shown by (or in) articles published in authoritative, peer-reviewed medical and scientific literature; and
- Is in general use in the medical or dental community; and
- Is not under continued scientific testing or research as a therapy for the particular Injury or Sickness which is the subject of a Claim.

GuideStone. GuideStone Financial Resources of the Southern Baptist Convention.

Health Care Extender. An allied health practitioner who is delivering medical Services under the direction and supervision of a Physician. Direction and supervision means the Physician co-signs any progress notes written by the Health Care Extender or there is a legal agreement that places overall responsibility for the Health Care Extender's Services on the Physician.

Healthcare Management Services (HMS). 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, Case Management, 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.

Home Health Care Agency. A Facility Other Provider or Hospital program for home health care, licensed by the state and certified by Medicare which, for compensation from its patients:

- Provides skilled nursing and other Services on a visiting basis in the patient's home, and
- Is responsible for supervising the delivery of such Services under a plan prescribed by the attending Physician.

Home Infusion Therapy. The administration of Medically Necessary and Appropriate fluid or medication via a central or peripheral vein to patients at their place of residence.

Home Infusion Therapy Providers. A Facility Other Provider which has been accredited by the Joint Commission on Accreditation of Healthcare Organizations and Medicare, if appropriate, and is organized to provide infusion therapy in the home to patients at their place of residence.

Hospice. A Facility Other Provider, licensed by the state, which, for compensation from its patients, is primarily engaged in providing palliative care to terminally ill individuals.

Hospice Care. A program which provides an integrated set of Services and supplies designed to provide palliative and supportive care to terminally ill patients and their families. Hospice Services are centrally coordinated through an interdisciplinary team directed by a Physician.

Hospital. A duly licensed Provider that is a general or special Hospital which has been approved by Medicare, the Joint Commission on Accreditation of Healthcare Organizations, or the American Osteopathic Hospital Association which, for compensation from its patients:

- Is primarily engaged in providing Inpatient diagnostic and therapeutic Services for the diagnosis, treatment and care of Injured and Sick persons by or under the supervision of Physicians, and
- Provides 24-hour nursing Services by or under the supervision of Registered Nurses.

Hospital Room Maximum. Covered Services and supplies 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; or
- The Hospital's most frequent private room rate, if the Hospital has no semiprivate rooms.

Immediate Family. Your Spouse, Child, stepchild, parent, brother, sister, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, son-in-law, grandchild, grandparent, step-parent, step-brother or step-sister.

Incurred. A charge is considered Incurred on the date You receive the Service or supply for which the charge is made.

Individual Treatment Plan. A plan that has specific goals and objectives for the patient that is appropriate to both the patient and the program's treatment method.

Infusion Therapy. The administration of Medically Necessary and Appropriate fluid or medication via a central or peripheral vein.

Injury. A trauma to the body caused by an outside source.

Inpatient. A person who is a registered bed patient in a Facility Provider and for whom a room and board charge is made.

Inpatient Stay Charges. Covered Services by a Hospital for room, board, and general nursing Services.

Inpatient Treatment Plan. A plan that has specific goals and objectives for the patient that is appropriate to both the patient and the program's treatment method.

Licensed Practical Nurse (LPN). A nurse who has graduated from a formal practical nursing education program and who is licensed by the appropriate state authority.

Maximum. The greatest amount payable by the Plan for Covered Services and Supplies. This could be expressed in dollars, number of days, or number of Services for a specified period of time.

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

Medicaid. A federal program providing grants to states for medical assistance programs (Title XIX of the United States Social Security Act).

Medical Care. Professional Services rendered by a Professional Provider or Professional Other Provider for the treatment of a Sickness or Injury.

Medical Identification Card (Medical ID Card). The currently effective card issued to You by the Claims Administrator.

Medically Necessary and Appropriate (Medical Necessity and Appropriateness). Services or supplies provided by a Facility Provider, Professional Provider or Professional Other Provider that the Plan determines are:

- Appropriate for the symptoms and diagnosis or treatment of the patient's condition, illness, disease or Injury; and
- Provided for the diagnosis or the direct care and treatment of the patient's condition, illness, disease or Injury; and
- In accordance with current standards of good medical practice; and
- Not primarily for the convenience of the patient or Provider; and
- The most appropriate supply or level of Service that can be safely provided to the patient; and
- Delivered in an appropriate setting based on the patient's condition or the nature of the treatment required and which cannot be received safely or adequately in some other setting without adversely affecting the patient's condition or quality of Medical Care.

The Claims Administrator reserves the right to determine, in its sole judgment, whether a Service is Medically Necessary and Appropriate. No benefits hereunder will be provided unless the Claims Administrator determines that the Service or supply is Medically Necessary and Appropriate.

Medicare. The programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

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

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

Network Facility Provider and Contracting Supplier. A Facility Provider and Contracting Supplier, licensed where required and performing within the scope of its license, that has an agreement with the Plan pertaining to payment as a Network Provider for Covered Services rendered to a Covered Person.

Network Provider and Contracting Supplier. Preferred Professional Providers and Network Facility Providers and Contracting Suppliers licensed where required and performing within the scope of their license.

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

Network Service Area. The geographic area within the Plan's Service area served by the Preferred Professional Providers and Participating Facility Providers and 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 and Supplies rendered to a Covered Person.

Non-Participating Pharmacy. A licensed and registered pharmacy, which is not a Participating Pharmacy.

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 and Supplies 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.

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

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, equipment and supplies to a Covered Person.

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

Out-of-Pocket Maximum. A specified dollar amount of Eligible Expenses Incurred by a Covered Person for Covered Services and Supplies in a Benefit Period, after which the level of benefits is increased as specified in the **Benefit summary**. 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.

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

Outpatient Alcohol Abuse Treatment Facility. A Facility Other Provider which, for compensation from its patients, is primarily engaged in providing rehabilitative counseling Services for the treatment of Alcohol Abuse and diagnostic and therapeutic Services for the treatment of Alcohol Abuse on an Outpatient basis. This facility must also meet the minimum standards set by the appropriate governmental agency.

Outpatient Drug Abuse Treatment Facility. A Facility Other Provider which, for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic Services for the treatment of Drug Abuse on an Outpatient basis. This facility must also meet the minimum standards set by the appropriate governmental agency.

Outpatient Physical Rehabilitation Facility. A Facility Other Provider which, for compensation from its patients, is primarily engaged in providing Services for physical rehabilitative therapy on an Outpatient basis.

Outpatient Psychiatric Facility. A Facility Other Provider which, for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic Services for the treatment of Mental Illness on an Outpatient basis. This facility must also meet the minimum standards set by the appropriate governmental agency.

Participating Pharmacy. A licensed and registered pharmacy which has a pharmacy service agreement with Medco Health Solutions, Inc.

Physical Handicap. A dependent Child's substantial physical or mental impairment which:

- Results from Injury, accident, congenital defect, or Sickness; and
- Is diagnosed by a Physician as a permanent or long term dysfunction or malformation of the body.

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

Physician. A person who is a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.), licensed and legally entitled to practice medicine in all of its branches, perform Surgery and dispense drugs.

Physician Visit. A face-to-face meeting between a Physician or Physician's staff and a patient for the purpose of Medical Care or Services.

Plan. The Southern Seminary HRA Plan. This booklet describes the Plan.

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

Pre-authorization. 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 and Supplies as specified in this Plan. Such Pre-authorization must be obtained prior to providing Covered Services and Supplies for a Covered Person except as provided herein.

Pre-existing Sickness or Injury. A Sickness or Injury for which medical advice, diagnosis, care or treatment was recommended or received within the six months immediately before the person's hire date under this Plan.

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 participant for Covered Services and Supplies 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 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.

Prior Creditable Coverage. Coverage, which is any of these:

- A group health plan.
- Health insurance coverage.
- Medicare.
- Medicaid.
- Military-sponsored health care.
- A medical care program of the Indian Health Service or of a tribal organization.
- A state health benefits risk pool.
- The Federal Employees Health Benefit Plan.
- A public health plan.
- A health benefit plan described under Section 5(e) of the Peace Corps Act.

Prior Creditable Coverage does not include any of these:

- Accident or disability income insurance, or any combination of the two.
- Liability insurance and related supplemental insurance.
- Workers' compensation or similar insurance.
- Automobile medical payment insurance.
- Credit only insurance.
- Coverage for on-site medical clinics.
- Other similar insurance coverage (as specified in regulations) where benefits for medical care are secondary or incidental to other insurance benefits.

Professional Other Provider. A person or entity other than a Facility Provider or Professional Provider who is licensed, where required, to render Covered Services as prescribed by a Professional Provider within the scope of such licensure or under the supervision of a Professional Provider within the scope of such licensure. Professional Other Providers include:

- Occupational Therapist.
- Respiratory Therapist.

Professional Provider. A person or practitioner licensed where required and performing Services within the scope of such licensure. The Professional Providers are:

- Audiologist.
- Physical Therapist.
- Certified Registered Nurse.
- Physician.

- Chiropractor.
- Podiatrist.
- Clinical Laboratory,
- Psychologist, Licensed Social Worker or Master Level Therapist.
- Dentist.
- Speech-Language Pathologist.
- Nurse-Midwife.
- Optometrist.

Protected Health Information (PHI). PHI is any information about your health that reveals (or can be used as a reasonable basis to reveal) your identity. This information can relate to your past, present or future physical or mental health conditions; information about the health care Services provided to You; or payment for health care Services provided to You.

Provider. A Facility Provider, Professional Provider, Professional Other Provider licensed where required and performing within the scope of such licensure.

Psychiatric Hospital. A Facility Other Provider approved by the Joint Commission on Accreditation of Healthcare Organizations or by the American Osteopathic Hospital Association which, for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic Services for the Inpatient treatment of Mental Illness. Such Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing Services are provided under the supervision of a Registered Nurse.

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

Registered Nurse (RN). A nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program) and is licensed by the appropriate state authority.

Rehabilitation Hospital. A Facility Other Provider approved by the Joint Commission on Accreditation of Healthcare Organizations or by the Commission on Accreditation of Rehabilitation Facilities or certified by Medicare which, for compensation from its patients, is primarily engaged in providing Skilled Rehabilitation Services on an Inpatient basis. Skilled Rehabilitation Services consist of the combined use of medical, social, educational, and vocational Services to enable patients disabled by Sickness or Injury to achieve the highest possible level of functional ability. Skilled Rehabilitation Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing Services are provided under the supervision of a Registered Nurse.

Retrospective Review. A HMS review conducted after the patient is discharged from a Hospital or other health care 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 and Supply.

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

Skilled Nursing Facility. A Facility Other Provider approved by the state and certified by Medicare, which, for compensation from its patients, is primarily engaged in providing Skilled Nursing Services on an Inpatient basis to patients requiring 24-hour Skilled Nursing Services but not requiring confinement in an acute care general Hospital. Such care is rendered by or under the supervision of Physicians. A Skilled Nursing Facility is not, other than incidentally, a place that provides:

- minimal care, custodial care, ambulatory care, or part-time care Services, or
- care or treatment of Mental Illness, Alcohol Abuse, Drug Abuse or pulmonary tuberculosis.

Skilled Nursing Services/Skilled Rehabilitation Services. Services which have been ordered by and under the direction of a Physician and are provided either directly by or under the supervision of a medical professional, e.g., Registered Nurse, Physical Therapist, Licensed Practical Nurse, Occupational Therapist, Speech Pathologist or Audiologist with the treatment described and documented in the patient's

medical records. Unless otherwise determined in the sole discretion of the Plan, Skilled Nursing Services/Skilled Rehabilitation Services shall be subject to the following:

- The Skilled Nursing Services/Skilled Rehabilitation Services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge, and skills of a qualified licensed medical professional and must be such that the care could not be performed by a non-medical individual instructed to deliver such Services.
- The Skilled Rehabilitation Services must be provided with the expectation that the patient has restorative potential and the condition will improve materially in a reasonable and generally predictable period of time. Once a maintenance level has been established or no further progress is attained, the Services are no longer classified as skilled rehabilitation and will be considered to be Custodial Care.

The mere fact that a Physician has ordered or prescribed a therapeutic regimen does not, in itself, determine whether a Service is a Skilled Nursing Service or a Skilled Rehabilitation Service.

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

Spouse. A person of the opposite sex to whom You are married at the relevant time by a religious or civil ceremony effective under the laws of the state in which the marriage was contracted.

Substance Abuse. Any use of drugs or alcohol 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.

Supplier. An individual or entity that is in the business of leasing and selling Durable Medical Equipment and supplies. Suppliers include, but are not limited to, the following: Durable Medical Equipment Suppliers, vendors/fitters, prosthetic Suppliers, pharmacy/Durable Medical Equipment Suppliers.

Surgery.

- The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other procedures;
- The correction of fractures and dislocations; and
- Usual and related pre-operative and post-operative care.

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

- **Radiation Therapy -** the treatment of disease by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes.
- **Chemotherapy -** the treatment of malignant disease by chemical or biological antineoplastic agents.
- **Dialysis Treatments -** the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body through hemodialysis or peritoneal dialysis. Dialysis treatment includes home dialysis.
- **Physical Therapy -** the treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, Injury, or the loss of a body part or parts.
- **Respiration Therapy -** the introduction of dry or moist gases into the lungs for treatment purposes.
- **Occupational Therapy -** the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person’s ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person’s particular occupational role.
- **Speech Therapy -** the treatment for the correction of a speech impairment resulting from disease, Surgery, Injury, or previous therapeutic processes.
- **Infusion Therapy -** treatment by means of Infusion Therapy when performed by, furnished by and billed by a Facility Provider.

- **Cardiac Rehabilitation -** the physiological and psychological rehabilitation of patients with cardiac conditions through regulated exercise programs.

Transplant Network Provider (Blue Quality 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 on-set of symptoms that require prompt medical attention. Benefits will be determined according to the schedule of benefits for the level of Service provided.

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

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 of benefits for preventive Services recommended by the U. S. Preventive Services Task Force, the Centers for Disease Control and Prevention, the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics. See **Covered Services and Supplies.**

You. An Eligible Employee. Sometimes "You" means both the member and his or her Covered Dependents. The booklet will tell You when this is the case.

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