GuideStone®
Financial Resources
Do well. Do right.®

June 1, 2015

Dear Pastors and Friends,

The enclosed is information about a health benefits program to help your church avoid taxation penalties under the Affordable Care Act. This opportunity is provided through GuideStone. Please read the material carefully to determine if you, or your church, has any tax penalty exposure due to IRS actions related to tax years 2014 and 2015.

Sincerely,

Insurance Solutions and Services
GuideStone Financial Resources
1-888-98-GUIDE

Employer-Sponsored Coverage in Group Plans for 2-4 Employees

Thank you for your interest in GuideStone's group coverage for your employees. To qualify for participation in the Group Plans, an employer must meet the following eligibility requirements:

Medical

- Must have a minimum of two covered employees
- Must contribute 100% of the cost of medical coverage for employees
- Must have 100% of eligible employees enroll in the plan

Note: Employees enrolled in a Medicare-coordinating plan do not count toward the number of covered employees.

Dental

- Must have a minimum of two covered employees
- No minimum contribution of dental coverage is required

Your organization can offer our products if all of the following are met:

- Coverage is effective on the first of the month
- Contract for benefits and rates is based on calendar year
- Plan offering is limited to one classification of employees
- Plan offering is limited to one standard plan

Your employees are eligible to participate in the Group Plans if all of the following are met:

- Must be paid, full-time employees of an eligible church, agency or institution affiliated with, or that shares common religious bonds with, the Southern Baptist Convention
- Must work 20 or more hours per week
- Must receive a salary

Medical evidence: GuideStone will collect your employees' health information through individual health statements submitted by your employees. Our staff underwriters will evaluate your risk to develop your rates.

Two ways to get started:

By Email: Submit your contact information to our Insurance Plans Marketing Representatives at *InsuranceSolutions@GuideStone.org*

By Phone: Please call our Customer Relations Representatives at **1-888-98-GUIDE** (1-888-984-8433)

GuideStone® Insurance Plans

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FACT SHEET

Reimbursement Vehicles and the ACA: Impacts for Employers

The Internal Revenue Service ("IRS") has issued guidance on the application of certain provisions of the Affordable Care Act ("ACA") to employer health care reimbursement arrangements, including employer payment plans ("EPPs") and health reimbursement arrangements ("HRAs"). The following information was created to help employers of all sizes better understand the potential ACA impacts of health care reimbursement arrangements.

Consult with experts

- **Consult an expert regarding your specific situation.** The following is intended as general information only and is not intended as specific tax or legal advice. It's best to consult your ministry's attorney and/or accountant to discuss your organization's specific situation.

Determine whether you have "Individual" or "Group" coverage

- Many of the requirements discussed below depend upon whether a participant has an **individual** medical insurance policy or is covered under group medical coverage. If you are unsure as to what kind of coverage you have or are providing, consult your agent or provider.

  In general, an **individual** medical policy:

  Is not connected to a specific employer (i.e., they are exclusive between an individual and an insurance coverage provider).

  Is issued to a single named person/family.

  In general, an **group** health coverage:

  Is associated with an employer.

  Can provide coverage for multiple employees and their families through the employer's plan.

  Important notice: ALL of GuideStone's plans are "group health plans" — including both Group Plans and Personal Plans. In other words, GuideStone does not issue **individual** medical insurance policies; rather, it provides **group** health coverage through the plans it makes available. This is made possible because of GuideStone's unique structure as a church benefits board.

Become informed on ACA impacts on reimbursement vehicles

Employer Payment Plans ("EPPs")

- **General definition:**

  An arrangement under which an employer reimburses an employee for, or directly pays the cost of, individual insurance premiums or Medicare Part B or D premiums, regardless of whether the reimbursement or payment is made on a pre-tax or after-tax basis.

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- **ACA impacts:**

  In September of 2013, the IRS issued Notice 2013-54 (the "2013 Notice"), which provides that EPPs are considered group health plans and, therefore, are subject to ACA market reform provisions, specifically the prohibition on annual and lifetime limits and the preventive care requirements. This conclusion meant that an employer would incur significant excise tax penalties if it continued to operate an EPP after the effective date of the 2013 Notice (January 1, 2014 for most reimbursement arrangements).

  Many employers who utilized EPPs thought that the 2013 Notice created ACA penalty exposure only if the premiums reimbursed under the EPP were pre-tax. However, in November of 2014, several joint-agency FAQs were posted on the Department of Labor website, one of which said that taxing premium reimbursements did not, by itself, eliminate ACA penalty exposure. Accordingly, many employers found themselves facing potentially significant ACA penalties.

  In February of 2015, the IRS issued Notice 2015-17 (the "2015 Notice"), which provides additional guidance on EPPs and excise tax relief through June 30, 2015 for certain small employers operating EPPs. Under the 2015 Notice, excise taxes will not be imposed for a violation of the ACA market reform provisions by EPPs that pay or reimburse employees for individual health policy premiums or Medicare Part B or Part D premiums:

  - for 2014, for employers that are not applicable large employers ("ALEs") for 2014 under the ACA employer mandate; and
  - for January 1 through June 30, 2015, for employers that are not ALEs for 2015.

  The 2015 Notice includes transition relief which applies with respect to reporting excise taxes.

  An ALE is generally defined as an employer that employed an average of at least 50 full-time and full-time equivalent employees (as defined in the final employer mandate regulations) on business days during the preceding calendar year. Importantly, the excise tax relief does not extend to stand-alone HRAs or other arrangements to reimburse employees for medical expenses other than insurance premiums. GuideStone has created a dedicated landing page to provide additional guidance on the 2015 Notice.

  After June 30, 2015, employers are essentially prohibited from operating EPPs unless one of the following exceptions applies:

  - **Excepted Benefits:** The EPP is used to reimburse employees for, or directly pay the cost of, coverage that qualifies as an excepted benefit for purposes of the ACA market reforms. Examples of excepted benefits include limited-scope dental and vision coverage and certain Medicare supplemental health insurance (e.g., Medigap or MedSupp).
  - **One-Employee Health Plan:** The EPP covers less than two participants who are current employees. Please note that an employer with more than one employee that limits coverage under the reimbursement arrangement to only one employee may violate certain nondiscrimination requirements applicable to group health plans, so that premium reimbursements are taxable.
  - **Medicare Reimbursement Arrangements:** The EPP satisfies the following requirements:
    - The employer offers a group health plan to the employee in addition to the EPP that does not consist solely of excepted benefits and that provides minimum value;
    - The employee participating in the EPP is enrolled in Medicare Parts A and B;
    - The EPP is available only to employees who are enrolled in Medicare Part A and Part B or Part D; and
    - The EPP is limited to reimbursement of Medicare Part B or Part D premiums and excepted benefits, including Medigap premiums.

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Example: Maple Street Baptist Church is an employer with 5 employees. The Church had been reimbursing employees for their medical coverage, which was obtained either through a spouse's employer, an individual policy or a Medigap plan. The Church has learned that such reimbursement methods for individual coverage are not allowed for small employers after June 30, 2015.

Effective July 1, 2015, the Church will establish and adopt an EPP meeting the following ACA requirements:

- The employer offers GuideStone group health plan coverage to its employees through GuideStone's Personal Plans, including the GuideStone Medicare-coordinating plans;
- Any EPP participant must be enrolled in Medicare Parts A and B;
- The EPP is available only to employees who are enrolled in Medicare Part A and Part B or Part D; and
- The EPP may only reimburse Medicare Part B or Part D premiums.

Result: The EPP will not cause the employer to be subject to ACA excise tax penalties. In addition, the employer coverage of the group health plan and the employer's reimbursement of the Medicare premiums are not taxable to the employee.

Important to note: A section 125 plan (described below) is required if the employee will be contributing to the cost of the group health plan coverage on a pre-tax basis. Also note that other rules may apply, for example, Medicare Secondary Payer.

Health Reimbursement Arrangements (HRAs)

- **General definition:**

  An arrangement funded solely by an employer under which an employee is reimbursed for certain medical expenses. The maximum reimbursement amount is specified and reimbursements are not taxable to the employee. Learn more about HRAs.

  Note: It is very important that you work with a qualified resource when setting up your organization's HRA, as they can be complex. For example, certain fees under the ACA will depend on how an HRA and corresponding medical plan are structured. GuideStone does not provide HRAs, but can refer ministries to a resource for assistance.

- **ACA impacts:**

  An HRA is considered a group health plan. Therefore, it is subject to the requirements under the ACA that apply to other group health plans. However, on its own, an HRA typically would not comply with the ACA's provisions that prohibit annual limits on benefits or require preventive care at no cost. In order to meet these requirements, the 2013 Notice requires an HRA to be "integrated" with the employer's **group** health plan that complies with the ACA. Certain "non-integrated" (aka "stand-alone") HRAs are still permitted, but only in very limited circumstances. For example, a non-integrated HRA may be used for retiree-only plans and for certain accepted benefits, such as limited-scope vision or dental plans.

  In order for an HRA to be "integrated" with group health plan coverage, the HRA must be offered with the employer's group health that complies with the ACA. It must also satisfy one of two integration methods set forth in the 2013 Notice. One of the integration methods requires the group health plan with which the HRA is integrated to satisfy the minimum value requirements of the ACA. The second integration method does not require the group health plan with which the HRA is integrated to satisfy the minimum value requirements of the ACA but, instead, requires reimbursements from the HRA to be limited to certain expenses further described below. GuideStone Personal and Group Plans generally satisfy the minimum value requirements of the ACA. Please contact GuideStone for additional information about the Seminarian Plan.

Continued on next page »

1. **Integration with a group health plan that satisfies minimum value requirements**

   The HRA must satisfy all of the following requirements to be considered "integrated" with a group health plan that satisfies minimum value:

   - The employer offers a group health plan to employees that provides minimum value;
   - The employee receiving the HRA is actually enrolled in a group health plan that provides minimum value – regardless of whether the employer sponsors the non-HRA group coverage (e.g., the HRA may be offered only to employees who do not enroll in the employer's group health plan but are enrolled in other non-HRA group coverage, such as a plan maintained by the employer of the employee's spouse);
   - The HRA is available only to employees who are actually enrolled in non-HRA group coverage – regardless of whether the employer sponsors the non-HRA group coverage;
   - Under the terms of the HRA, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA at least annually; and
   - Upon termination of employment, the remaining amounts in the HRA are either forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA.

2. **Integration with a group health plan that DOES NOT satisfy minimum value requirements**

   An HRA must satisfy all of the following requirements to be "integrated" with a group health plan that does not satisfy minimum value:

   - The employer offers a group health plan (other than the HRA) to the employee that provides major medical coverage;
   - The employee receiving the HRA is actually enrolled in a group health plan that provides major medical coverage – regardless of whether the employer sponsors the group health plan;
   - The HRA is available only to employees who are enrolled in non-HRA group coverage – regardless of whether the employer sponsors the group health plan;
   - The HRA is limited to reimbursement of one of more of the following: co-payments, co-insurance, deductibles, and premiums under the non-HRA group coverage, and medical care under Internal Revenue Code section 213(d) that does not constitute essential health benefits;
   - An employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA at least annually; and
   - Upon termination of employment, the remaining amounts in the HRA are either forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA.

   Bottom line: HRAs cannot be used with individual insurance policy coverage. They must be integrated with group coverage or used for one of the limited circumstances discussed above under which stand-alone HRAs are permitted.

※ Helping employees pay for coverage: different approaches

GuideStone continues to discourage use of the "salary package" approach with respect to health care and other benefits. Under this approach, the employer provides a salary package from which the employee must pay for his or her own medical coverage and other benefits on an after-tax basis. This approach can create adverse tax consequences, resulting in less value to both the employer and the employee. In addition, under the ACA, any increase in an employee's salary to assist with payments of individual insurance policy premiums cannot be conditioned on the purchase of health coverage. For more detailed information about planning compensation, please see our Compensation Planning Guide workbook.

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Below are a few ways to approach helping employees pay for coverage.

Directly paying the cost of employee group health plan coverage as a part of employees' benefits packages

As a reminder, an employer is still permitted to pay all or a portion of the cost of **group** health plan coverage for its employees. Both GuideStone Group and Personal medical plans qualify as "group" coverage under the ACA.

The employer's payment of all or a portion of the cost of **group** health plan coverage for employees is not taxable to employees.

But keep in mind — if the employee is contributing to the cost of this **group** health plan coverage, a section 125 plan (described below) is required.

Using a Section 125 plan to allow employees to pay for a portion of premiums on a pre-tax basis

An employer may permit an employee to pay premiums for group health coverage on a pre-tax basis through a cafeteria plan that complies with section 125 of the Internal Revenue Code, for example, a flexible spending arrangement. A cafeteria plan may only be used for group health plan coverage, including coverage provided through GuideStone Personal and Group Plans. A cafeteria plan cannot be used to purchase coverage on a federal or state exchange, other than coverage provided through the Small Business Health Options Program (SHOP) Exchange.

There are a number of legal requirements applicable to section 125 cafeteria plans, including a written plan document requirement, certain nondiscrimination requirements, and other design and administration rules. Accordingly, it is important that a church or other ministry employer consult with an attorney, accountant or other professional in establishing a plan to ensure compliance.

"Integrated" Health Reimbursement Arrangements ("HRAs")

An HRA is an arrangement funded solely by an employer under which an employee is reimbursed for certain medical expenses. The maximum reimbursement amount is specified and reimbursements are not taxable to the employee. Under the ACA, HRAs are required to be "integrated" with group health plan coverage unless a limited exception applies. See "HRA" section for additional information about HRAs and the integration requirements.

Because HRA requirements are complex, employers should arrange for an HRA administrator. Contact GuideStone for resource information.

GuideStone Financial Resources of the Southern Baptist Convention welcomes the opportunity to share this general information. However, this information and the information in the calculator are not intended to be relied upon as legal advice. This information may be subject to interpretation or clarification over time, so we cannot guarantee its long-term accuracy or how it might be determined to apply in certain situations. However, we hope it will provide you a useful frame of reference as you endeavor to carry out your responsibilities and serve your employees.

GuideStone®
Insurance Plans

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2401 Cedar Springs Road, Dallas, TX 75201-1498

1-888-98-GUIDE • *GuideStoneInsurance.org*

 26105 05/15

Personal Health Questionnaire (Small Group)

Employee Name: _____ **Employer Name:** _____

Daytime Phone: ( ) - _____ **Date of Hire:** _____

Are you planning to enroll in your employer's health insurance plan? ☐ **Yes** ☐ **No**

***** If you selected "No", please select one of the following, then skip the remainder of the form and sign the bottom of page 2.**

☐ **Covered by Spouse's plan** ☐ **Not Eligible**
☐ **Do Not Want Coverage** ☐ **Other Reason (_____)**

· ***If you selected "yes," please complete the rest of this form.***
· *Answer the following questions for yourself and eligible enrolling family members.*
· *Include additional sheets for detailed explanations or additional dependents.*
· *All questions must be answered or the form may not be accepted.*

I. Demographic, Build and Tobacco Use

	Relation to Employee	Member Name	Gender (M / F)	Date of Birth (mm/dd/yyyy)	Height		Weight (lbs)	Home Zip Code	Tobacco use in last year? (Yes / No)
					ft.	in.			
1	Employee								
2	Spouse								
3	Child								
4	Child								
5	Child								
6	Child								

II. Medical Conditions & Treatments

In the past five years, has any person listed above seen a medical provider, had treatment recommended, received care (including prescriptions) or been hospitalized for any of the following?

***** Check "YES" or "NO" for each question. Please complete ADDITIONAL DETAIL TABLE on p. 2 for ALL "Yes" answers.**

1. Cancer (if yes, list location and type of cancer below) **Yes** ☐ **No** ☐
Location and type of cancer _____
Check one: ___Stage 1, ___Stage 2, ___Stage 3, ___higher
Date of remission (if applicable):

2. Cardiac or Heart Disease / Disorder **Yes** ☐ **No** ☐
If yes, check all that apply:
___ heart attack,
___ bypass surgery or angioplasty on **single** vessel, or
___ bypass surgery or angioplasty on **multiple** vessels;
___ **ANY other heart conditions (list here):** _____
(i.e. arrhythmia, aneurysm, heart failure, heart valve disorder)

3. Diabetes (if yes, list type 1 or 2) **Yes** ☐ **No** ☐
Type: _____
If yes, list 3 most recent HbA1c / fasting blood sugar levels:
1) 2) 3)

4. High Cholesterol **Yes** ☐ **No** ☐
If yes, list 3 most recent readings:
1) 2) 3)

5. High Blood Pressure **Yes** ☐ **No** ☐
If yes, list 3 most recent readings:
1) 2) 3)

	Yes	No
6. Arthritis (i.e. rheumatoid, osteo, psoriatic, gout)	☐	☐
7. Autoimmune Disease (i.e. lupus, MS, anemia)	☐	☐
8. Back Disorder (i.e. degenerative disk disease, herniated disk, spinal fusion, spondylitis, strain)	☐	☐
9. Benign Growth (i.e. tumor, cyst)	☐	☐
10. Bowel (i.e. irritable bowel IBS, Crohn's ileitis)	☐	☐
11. Circulatory System Disease (i.e. stroke, arterial / vascular diseases)	☐	☐
12. Immunodeficiency (i.e. AIDS, HIV+, hemophilia)	☐	☐
13. Kidney Disorder (i.e. nephritis, renal failure)	☐	☐
14. Liver Disease (i.e. cirrhosis, hepatitis A, B, C, E)	☐	☐
15. Mental Illness (i.e. mild or major depression, anxiety, bipolar disorder, or schizophrenia)	☐	☐
16. Counseling Current or prior counseling?	☐	☐
17. Muscular Disorder	☐	☐
18. Respiratory (i.e. asthma, allergies, pneumonia, COPD, emphysema, bronchitis)	☐	☐
19. Stomach (i.e. ulcer, acid reflux, GERD)	☐	☐
20. Substance dependency (i.e. alcohol, drug)	☐	☐
21. Transplants (if yes, list organ(s): _____)	☐	☐

II. Medical Conditions & Treatments (continued)

	Yes	No
22. Is anyone currently taking prescription medication(s).....	☐	☐
23. Has anyone had any of the following for a **serious illness** in the past 5 years?		
a) Treatment.....	☐	☐
b) Hospitalization.....	☐	☐
c) Surgery.....	☐	☐
24. Is anyone **currently**:		
a) Hospitalized or confined in a treatment facility?.....	☐	☐
b) Confined at home, incapacitated or incapable of self-support?.....	☐	☐
25. Is any of the following **pending**?		
a) Treatment (medical treatment or diagnostic testing).....	☐	☐
b) Hospitalization.....	☐	☐
c) Surgery.....	☐	☐
26. In the past 5 years, has anyone enrolling had **symptoms** of any serious medical condition not yet indicated on this form?.....	☐	☐

Reminder: Please complete ADDITIONAL DETAIL TABLE for **ALL** items answered "YES" on Pages 1 & 2

III. Pregnancy and Childbirth

	Yes	No
27. Is anyone **pregnant?** (If no, mark "No" and skip question 27.).....	☐	☐
a) The due date is:_____		
b) Is this a High Risk Pregnancy, any complications or bleeding?.....	☐	☐
c) Previous c-section or pre-term birth?.....	☐	☐
d) Are multiple births expected? If so, please check one: __**twins**__**triplets**__**more**		

ADDITIONAL DETAIL TABLE - Please Fill In Details Below For All Questions Answered "YES"

Question #	Name of Individual	Condition / Diagnosis	Date of Onset	Last Date Treated	Treatment / Drug	Still taking? (Y / N)	Degree of Recovery

*** If you marked "Yes" to any item on Page 1 or 2, please complete ADDITIONAL DETAIL TABLE above, or this form will not be accepted.**

I represent that all statements and answers I have given are complete and accurate to the best of my knowledge and belief. I understand that it is a crime to knowingly provide false, incomplete or misleading information to GuideStone Financial Resources for the purpose of defrauding the medical plan. Penalties may include fines or denial of medical benefits. I will promptly inform GuideStone in writing before my coverage takes effect if I become aware that anything has occurred and makes this health statement incomplete or incorrect. I understand that I or any other adult to be covered by this policy may be contacted for additional information or asked to sign an authorization for the release of medical records. Health care providers listed on this form will not be contacted unless you or your dependent signs a separate written medical authorization.

Employee SIGN HERE and Date:

➡_____ Date:_____

Compare Your Medical Plan Options

Effective January 1, 2015

Group Plans

Highmark Blue Cross Blue Shield

GuideStone® Insurance Plans

		Health Choice 5000[1]	Health Choice 3000[1]	Health Choice 2500[1]	Health Choice 2000	Health Choice 1500	Health Choice 1000	Health Choice 500	Health Today
IN-NETWORK	MEDICAL BENEFITS								
	Annual deductibles: individual/family	$5,000/$10,000	$3,000/$5,000	$2,500/$5,000	$2,000/$4,000	$1,500/$3,000	$1,000/$2,000	$500/$1,000	$0/$0
	Plan pays/individual pays [co-insurance] [after deductible]	70%/30% or 80%/20%	70%/30% or 80%/20%	80%/20%	80%/20%	80%/20%	80%/20%	80%/20%	80%/20%
	Medical and prescription maximum out-of-pocket: individual/family [in-network services only, including deductible, co-pays and co-insurance]	$6,350/$12,700	$6,350/$11,000	$6,350/$10,500	$6,350/$10,000	$6,350/$9,000	$6,350/$8,000	$5,000/$6,000	$5,000/$6,000
	Primary care or retail clinic visit/specialist visit co-pay	$25/$45	$25/$45	$25/$45	$25/$45	$25/$45	$25/$35	$25/$35	$20/$30
	Wellness visits [per *Preventive Care Schedule*]	100% no co-pay	100% no co-pay	100% no co-pay	100% no co-pay	100% no co-pay	100% no co-pay	100% no co-pay	100% no co-pay
	Hospital inpatient [including maternity] and outpatient surgery facility [after deductible]	70% or 80%	70% or 80%	80%	80%	80%	80%	80%	80% after $100 co-pay
	Emergency room services [deductible does not apply]	70% or 80% after $100 co-pay	70% or 80% after $100 co-pay	80% after $100 co-pay	80% after $100 co-pay	80% after $100 co-pay	80% after $100 co-pay	80% after $100 co-pay	80% after $100 co-pay
	Urgent care	$50	$50	$50	$50	$50	$50	$50	$50
	Outpatient services [CT scans, MRI, diagnostic] [after deductible]	70% or 80%	70% or 80%	80%	80%	80%	80%	80%	80%
	Chiropractic services co-pay [20 visits annually]	$45	$45	$45	$45	$45	$35	$35	$30
	Mental health/substance abuse: • Inpatient [after deductible]	70% or 80%	70% or 80%	80%	80%	80%	80%	80%	80% after $100 co-pay
	• Office and professional services co-pay	$25	$25	$25	$25	$25	$25	$25	$20
	Lifetime maximum benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
	Vision [one exam every 12 months]	$25	$25	$25	$25	$25	$25	$25	$20
RETAIL	PRESCRIPTION DRUG BENEFITS								
30-DAY SUPPLY	Generic drug co-pay	$15	$15	$15	$15	$15	$15	$15	$15
	Preferred drug co-pay[2]	$35	$35	$35	$35	$35	$35	$35	$35
	Non-preferred drug co-pay[2]	$50	$50	$50	$50	$50	$50	$50	$50
MAIL ORDER									
90-DAY SUPPLY	Generic drug co-pay	$35	$35	$35	$35	$35	$35	$35	$35
	Preferred drug co-pay[2]	$90	$90	$90	$90	$90	$90	$90	$90
	Non-preferred drug co-pay[2]	$125	$125	$125	$125	$125	$125	$125	$125
	Specialty drug co-pay [up to a 30-day supply]	$50	$50	$50	$50	$50	$50	$50	$50

[1] These plans do not constitute "creditable" coverage for Massachusetts residents.

[2] If a preferred or non-preferred drug is purchased when a generic is available, the cost difference will not apply toward the participant's deductible or maximum out-of-pocket expenses. After the deductible is met, the participant must pay the cost difference between the preferred/non-preferred drug and its generic equivalent, if available. If the cost of the prescription is less than the co-pay, the participant will pay the full cost of the prescription. The cost difference does not accumulate toward the maximum out-of-pocket limit.

OUT-OF-NETWORK

MEDICAL BENEFITS	Health Choice 5000[1]	Health Choice 3000[1]	Health Choice 2500[1]	Health Choice 2000	Health Choice 1500	Health Choice 1000	Health Choice 500	Health Today
Annual deductibles: individual/family	$10,000/$20,000	$5,000/$10,000	$4,500/$9,000	$4,000/$8,000	$3,000/$6,000	$2,000/$4,000	$1,000/$2,000	$500/$1,000
Plan pays/individual pays [co-insurance] [after deductible]	50%/50%	50%/50%	50%/50%	50%/50%	50%/50%	50%/50%	60%/40%	50%/50%
Annual co-insurance maximums: individual/family [after deductible]	$15,000/$15,000	$10,000/$10,000	$10,000/$10,000	$10,000/$10,000	$10,000/$10,000	$10,000/$10,000	$10,000/$10,000	$10,000/$10,000
Primary care or retail clinic visit/specialist visit co-pay	50%	50%	50%	50%	50%	50%	60%	50%
Wellness visits [you pay 100%]	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Hospital inpatient [including maternity] and outpatient surgery facility [after deductible]	50%	50%	50%	50%	50%	50%	60%	50%
Emergency room services [as determined by Highmark]:								
• For emergency care only	70% or 80% after $100 co-pay	70% or 80% after $100 co-pay	80% after $100 co-pay	80% after $100 co-pay	80% after $100 co-pay	80% after $100 co-pay	80% after $100 co-pay	80% after $100 co-pay
• Other than for emergency care [after deductible]	50%	50%	50%	50%	50%	50%	60%	50%
Outpatient services [CT scans, MRI, diagnostic] [after deductible]	50%	50%	50%	50%	50%	50%	60%	50%
Chiropractic services [20 visits annually] [after deductible]	50%	50%	50%	50%	50%	50%	60%	50%
Mental health/substance abuse [after deductible]:								
• Inpatient	50%	50%	50%	50%	50%	50%	60%	50%
• Office and professional services	50%	50%	50%	50%	50%	50%	60%	50%
Lifetime maximum benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

Note: A corresponding *Summary of Benefits and Coverage* was created to help consumers more easily understand their insurance benefits and compare plans. To view and download the *Summary of Benefits and Coverage* documents for all GuideStone medical plans available to you, visit *www.GuideStone.org/Summaries*. You may also request printed copies by calling **1-888-98-GUIDE** (1-888-984-8433) Monday through Friday, between 7 a.m. and 6 p.m. CST.

Health Saver Plans for Group Plans

Highmark Blue Cross Blue Shield

Effective January 1, 2015

This chart provides an overview of the benefits and prescription drug program for the Health Saver 2800, Health Saver 3000 and Health Saver 5000, federally-qualified High Deductible Health Plans (HDHPs) eligible for use with a Health Savings Account.

See the reverse side for a glossary of terms used.

*Note: These plans do not constitute "creditable coverage" for Massachusetts residents.

	PLAN FEATURES	HEALTH SAVER 2800	HEALTH SAVER 3000	HEALTH SAVER 5000[5]
In-network	Deductible for employee-only coverage	$2,800[1]	$3,000[1]	$5,000[1]
	Deductible for employee + dependent(s) coverage (aggregate)	$5,600[1]	$6,000[1]	$10,000[1]
	Plan pays/individual pays (co-insurance)	80%/20%[2]	100%[2]	100%[2]
	Medical and prescription maximum out-of-pocket: individual/family (in-network services only, including deductible and co-insurance)	$5,800/$11,600	$3,000/$6,000	$5,000/$10,000
	Primary care physician office visit/specialist office visit	80%[2]	100%[2]	100%[2]
	Wellness and preventive care (primary care/specialist)	100% no deductible	100% no deductible	100% no deductible
	Hospital inpatient (including maternity)	80%[2]	100%[2]	100%[2]
	Outpatient surgery	80%[2]	100%[2]	100%[2]
	Emergency room	80%[2]	100%[2]	100%[2]
	Urgent care	80%[2]	100%[2]	100%[2]
	Outpatient services (CT scans, MRI, diagnostic)	80%[2]	100%[2]	100%[2]
	Chiropractic services (20 visits annually)	80%[2]	100%[2]	100%[2]
	Mental health and substance abuse: inpatient services	80%[2]	100%[2]	100%[2]
	Mental health and substance abuse: office and professional services	80%[2]	100%[2]	100%[2]
	Vision (one exam every 12 months)	80%[2]	100%[2]	100%[2]
Out-of-network	Deductible for employee-only coverage	$5,600[1]	$6,000[1]	$10,000[1]
	Deductible for employee + dependent(s) coverage (aggregate)	$11,200[1]	$12,000[1]	$30,000[1]
	Plan pays/individual pays (co-insurance)	50%/50%[2]	60%/40%[2]	70%/30%[2]
	Annual co-insurance maximum for employee-only coverage	$10,000[4]	$8,000[4]	$15,000[4]
	Annual co-insurance maximum for employee + dependent(s) coverage	$12,000[4]	$15,000[4]	$15,000[4]
	Wellness and preventive care	Not covered	Not covered	Not covered
	Hospital inpatient (including maternity)	50%[2]	60%[2]	70%[2]
	Outpatient surgery	50%[2]	60%[2]	70%[2]
	Emergency room services: for emergency care only, as determined by Highmark	80%[2] after in-network deductible	100%[2] after in-network deductible	100%[2] after in-network deductible
	Emergency room services: other than for emergency care	50%[2]	60%[2]	70%[2]
	Mental health and substance abuse: all services	50%[2]	60%[2]	70%[2]
	Vision (one exam every 12 months)	50%[2]	60%[2]	70%[2]

PRESCRIPTION DRUG PROGRAM		HEALTH SAVER 2800	HEALTH SAVER 3000	HEALTH SAVER 5000
	Individual/family[1]	**$2,800/$5,600[2]**	**$3,000/$6,000[2]**	**$5,000/$10,000[2]**
Retail (30-day supply)	Generic	80% after deductible	100% after deductible	100% after deductible
	Preferred	80% after deductible[3]	100% after deductible[3]	100% after deductible[3]
	Non-preferred	80% after deductible[3]	100% after deductible[3]	100% after deductible[3]
Mail Order (90-day supply)	Generic	80% after deductible	100% after deductible	100% after deductible
	Preferred	80% after deductible[3]	100% after deductible[3]	100% after deductible[3]
	Non-preferred	80% after deductible[3]	100% after deductible[3]	100% after deductible[3]
	Specialty drug	80% after deductible	100% after deductible	100% after deductible

[1]Your deductible is met by both medical and prescription drug expenses.

[2]Plan deductible must be met before benefits are paid.

[3]If a preferred or non-preferred drug is purchased when a generic is available, the participant must pay the cost difference between the preferred/non-preferred drug and its generic equivalent.

[4]Your co-insurance maximum is met by both medical and prescription drug expenses.

[5]Plan effective 11/1/2014.

Glossary of terms

Co-insurance — The percentage of eligible claims you pay after you meet your deductible.

Co-insurance maximum, out-of-network — The most you will have to pay in a year in out-of-network co-insurance for covered benefits after you meet your out-of-network deductible.

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

Deductible for employee + dependent(s) coverage — This applies to an employee who has dependents included on their coverage. You and your dependents are responsible for paying for medical and prescription drug claim costs up to the plan's family deductible amount, before GuideStone begins paying claims for anyone in the family. The family deductible may be met by one individual or by multiple family members' combined claims. This is known as an aggregate or combined deductible**.**

Deductible for employee-only coverage — This applies only to an employee who has no dependents included on their coverage. You are responsible for paying for medical and prescription drug claim costs up to the plan's individual deductible amount, before GuideStone begins paying claims.

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

Generic — A bioequivalent to the brand-name drug made available to the public after the patent has expired on the brand-name drug. The generic version usually results in a less expensive drug.

Health Savings Account (HSA) — An account that can be used to pay current medical expenses as well as to provide for future qualified medical expenses on a tax-advantaged basis. Contributions, earnings and distributions are exempt from federal income and Social Security (FICA) taxes when used to pay for qualified medical expenses.

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

Mail order — Mail order is a service that allows you to refill recurring prescriptions (90-day supply) through an online pharmacy. You receive your prescriptions by mail.

Maximum out-of-pocket (medical and prescription) — The maximum out-of-pocket limit includes the deductible, co-pays and co-insurance for eligible, in-network services. After an individual has satisfied this amount, the health plan covers all eligible, in-network health care expenses, including co-pays, for the rest of the plan year.

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

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

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

Retail pharmacy benefits — This refers to filling your prescriptions at a participating network pharmacy. This approach is best for short-term prescriptions (up to 30-day). You could save money on co-pays by filling recurring prescriptions via mail order (see above).

Specialist — Any physician not considered a primary care physician.

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

Vision — Covers one annual eye exam per covered family member, which may include an eye health examination, dilation and/or refraction. Coverage does not include glasses or contact lenses (unless there has been a cataract extraction), eye surgery or retinal telescreening. See the *Preventive Care Schedule* for additional vision screening coverage for children when performed by a pediatrician or primary care physician as part of an annual well-child visit.

Wellness and preventive care — Refers to the services listed on the *Preventive Care Schedule*, which are covered at 100%, not subject to the deductible. The *Preventive Care Schedule* is based on services required under the Patient Protection and Affordable Care Act of 2010 (PPACA), as amended.

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

Note: A corresponding *Summary of Benefits and Coverage* was created to help consumers more easily understand their insurance benefits and compare plans. To view and download the *Summary of Benefits and Coverage* documents for all GuideStone medical plans available to you, visit *www.GuideStone.org/Summaries*. You may also request printed copies by calling **1-888-98-GUIDE** (1-888-984-8433) Monday through Friday, between 7 a.m. and 6 p.m. CST.

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