ELCA Health Benefits Plan
ELCA-Primary Coverage

Effective Jan. 1, 2013

SUMMARY PLAN DESCRIPTION

100-05 (2/2013)

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NOTE: This 2013 summary plan description replaces and supersedes all previous materials.

About Our Plans

The ELCA Pension and Other Benefits Program provides health, flexible spending, retirement, disability, and survivor benefits presented as one comprehensive program to members. Benefit plans are governed and administered individually through separate plan documents. Portico Benefit Services maintains the following plans: ELCA Retirement Plan, ELCA Disability Benefits Plan, ELCA Survivor Benefits Plan, ELCA Health Benefits Plan (which includes post-retirement medical benefits, an obligation of the ELCA), and ELCA Flexible Benefits Plan. We also maintain three group retirement plans for ELCA-affiliated social ministry organizations – the ELCA Master Institutional Retirement Plan, the ELCA Retirement Plan for The Evangelical Lutheran Good Samaritan Society and the ELCA 457(b) Deferred Compensation Plan. The assets of each plan are held in various trusts and therefore do not allow one plan to fund a shortfall of another plan. Portico Benefit Services' plans are not subject to the Employee Retirement Income Security Act (ERISA). The health, disability, and survivor plans are self-insured and are not protected through any type of insurance program. Our ability to pay claims is dependent on continued contributions and market performance. We reserve the right to change any of the terms of the plans at any time through the amendment or termination process described in each plan's summary plan description.

About This Plan

In the ELCA we are called to live well. We believe that when we strive to live well we're more able to enhance the lives of others. As a ministry of the Evangelical Lutheran Church in America (ELCA), Portico Benefit Services' mission is to provide retirement, health, and related benefits and services to enhance the well-being of those who serve through the ELCA and other faith-based organizations. That's why we design and manage benefit plans to help you steward your gifts of mind, body, and spirit.

To serve those who serve, Portico administers the ELCA Pension and Other Benefits Program, which includes a self-insured health plan — the ELCA Health Benefits Plan. We contract with companies that specialize in health and wellness benefits to administer the plan. These companies are not owned by Portico.

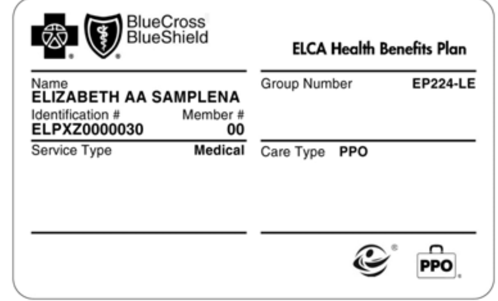
This summary plan description describes the ELCA Health Benefits Plan, effective Jan. 1, 2013. Use it as a reference when you have questions about these benefits. For the most current information, visit *PorticoBenefits.org* and sign in at myPortico.

Plan Document

The ELCA Health Benefits Plan is legally known as the ELCA Medical and Dental Benefits Plan. **Your rights under the plan are governed by the plan document (the full, legal description of the plan). If this summary is found to be inconsistent with the plan document, the plan document will be considered the controlling document.** Portico Benefit Services reserves the right to change any term of the plan or terminate the plan at any time through the amendment or termination process described later in this summary. A copy of the plan document is available from the Portico Service Center.

Benefit Identification Cards

The medical and mental health benefit is administered by Blue Cross and Blue Shield. Show this card to your medical or mental health care providers. Contact Blue Cross at 866.455.8216 if you need additional identification cards. See page 3 for details of this benefit.



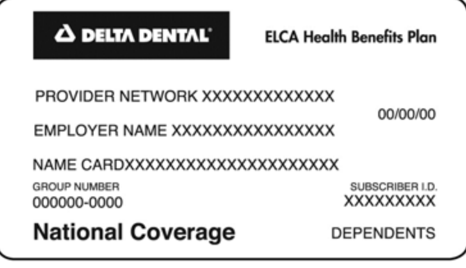
The prescription drug benefit is administered by Express Scripts, Inc. Show this card when you purchase prescriptions at your local pharmacy. Use the information on this card when you purchase prescription drugs through Express Scripts home delivery service. Contact Express Scripts at 800.575.8090 if you need additional identification cards. See information beginning on page 16 for details of this benefit.

ELCA Health Benefits Plan

Prescription ID Card

RxBIN 003858
RxPCN A4
RxGrp BNJA
Issuer (80840) 9151014609
ID 123456789
Name SUBSCRIBER S DOE

The dental benefit is administered by Delta Dental. Show this card to your dental care provider. Contact Delta Dental at 800.448.3815 if you need additional identification cards. See information beginning on page 22 for details of this benefit.



Medical and Mental Health Benefit

Your medical and mental health benefit is administered by Blue Cross and Blue Shield. Benefits are subject to providers' billing practices and Blue Cross' claims payment rules.

2013 Medical and Mental Health Benefit **Administered by Blue Cross and Blue Shield**		
Annual Deductible and Out-of-Pocket Limit	**In-Network**	**Out-of-Network**
Deductible (member's responsibility)	• $1,000 per person • $1,500 member and child(ren) • $2,000 member and spouse or same-gender partner • $2,000 member, spouse or same-gender partner, and child(ren)	• $1,000 per person • $1,500 member and child(ren) • $2,000 member and spouse or same-gender partner • $2,000 member, spouse or same-gender partner, and child(ren)
Out-of-pocket limit (member's responsibility; plan pays 100% after limit is reached; limit includes only deductible and coinsurance)	• $3,600 per person • $7,200 member and child(ren) • $7,200 member and spouse or same-gender partner • $7,200 member, spouse or same-gender partner, and child(ren)	• $3,600 per person • $7,200 member and child(ren) • $7,200 member and spouse or same-gender partner • $7,200 member, spouse or same-gender partner, and child(ren)
Medical and Mental Health Services **In-Network** — 85% **after** deductible | **Out-of-Network** — 65% **after** deductible		
Hospital, specialized facility, surgical, office visit, urgent care, emergency room, lab work, X-rays, imaging, individual and group counseling, medication management, etc.		
Preventive/Screening Services **In-Network** — 100%; **no** deductible | **Out-of-Network** — 65%; **no** deductible		
Preventive care visits, laboratory tests and screenings, routine prenatal care, vision and hearing examinations, cancer screenings, certain FDA-approved contraceptive methods, immunizations (pediatric and adult), certain counseling services, and other services. See the complete list of covered *Preventive and Screening Services* on pages 4 – 5.		

NOTE: Services are considered preventive/screening services when billed by a provider as preventive. All other services are considered medical services except that the first of the following services billed as preventive or non-preventive will be paid at the preventive/screening services benefit level: cholesterol/lipid profile; PSA test; Pap test; colonoscopy; mammogram; hemoglobin A1C test; vision exam; and urine microalbumin screening.

IMPORTANT

- Benefit is subject to change without notice.
- Out-of-network services are subject to the amount Blue Cross allows.
- All emergency room and urgent care services are considered in-network.
- Certain services require prior authorization.
- Only eligible expenses under the terms of the plan are eligible for coverage.
- Facility expenses for knee/hip replacements, spinal/bariatric surgeries and transplants will receive: 85% of facility charges covered after deductible if performed at a Blue Cross

"Blue Distinction Center;" 65% of facility charges covered after deductible for an in-network facility that is not a Blue Distinction Center; no plan benefit if the procedure is performed at an out-of-network facility.

Medical Necessity

Services you receive for treatment or diagnosis of an illness, injury, disease, or its symptoms must be medically necessary to be eligible for reimbursement under this plan, except for specific preventive/screening services listed on pages 4 – 5. See *Glossary* for definition of *Medically Necessary Treatment*.

Blue Cross and Blue Shield may review your treatment to ensure that it is medically necessary and not inappropriate, misused, or over used. In this situation, Blue Cross may contact your doctor or you for information on the planned course of treatment. Based on its review, Blue Cross may coordinate, limit, or deny services and supplies.

Deductibles and Coinsurance

This benefit reimburses your eligible medical and mental health expenses, subject to the deductible and coinsurance. The in-network deductible and out-of-pocket limit are separate from the out-of-network deductible and out-of-pocket limit. Deductibles, coinsurance, and out-of-pocket limits are subject to change.

Claim Filing Deadline

The claim filing deadline is 12 months from the date you incurred the expense. For example, if you incur expenses on Feb. 12, 2013, the filing deadline for that claim would be Feb. 12, 2014.

Preventive and Screening Services

Preventive health services are intended to promote wellness, prevention, and early detection.

- **In-network** — The plan pays 100% of eligible expenses, with no deductible.
- **Out-of-network** — The plan pays 65% of eligible expenses, with no deductible.

The following are eligible preventive services when billed by a provider as routine or preventive:

- Preventive care visits, including screenings for depression and hypertension, and, if age-appropriate: skin, testicular prostate-digital rectal, rectal-digital, and breast examinations
- Laboratory tests and screenings, including urine microalbumin, cholesterol/lipid profile, thyroid, and diabetes
- Well woman visits, including preconception counseling and routine prenatal care
- Vision examinations, including glaucoma, acuity, and refraction screenings
- Routine hearing examination: pure tone, air-only screening, and threshold audiometry
- Well child care including medical history, height, weight, and body mass index and developmental/autism, lead, and tuberculosis screenings
- Immunizations (pediatric and adult)
- Routine gynecological examination
- Routine physical examination
- Radiological osteoporosis screenings
- Cancer screenings:

- Colorectal: occult blood test, proctosigmoidoscopy, barium enema, sigmoidoscopy, and colonoscopy
  - Cervical: Pap test, HPV screening
  - Breast: mammogram
  - Ovarian: CA-125 test, trans-vaginal ultrasound
  - Prostate: prostate specific antigen (PSA)
- Counseling related to chemo-prevention of breast cancer, counseling about BRCA breast cancer gene screening
- Abdominal aortic aneurysm screening
- FDA-approved contraceptive methods (except those methods covered under this plan's prescription drug benefit), sterilization by certain intratubal occlusion device and delivery systems, intrauterine device (IUD), and contraceptive counseling for women
- Gestational diabetes screening for pregnant women
- Sexually transmitted infection counseling and screening, including HIV
- Iron deficiency anemia, bacteriuria, hepatitis B virus, and Rh incompatibility screening in pregnant women
- Breast-feeding support, counseling, and supplies, including costs for renting or purchasing specified manual breastfeeding equipment from a network provider or national durable medical equipment supplier
- Domestic violence screening and counseling
- HPV DNA testing for all women 30 years and older
- Screening and certain counseling services for alcohol or substance abuse, tobacco use, obesity, diet, and nutrition
- Newborn screening for hearing, thyroid disease, phenylketonuria, and sickle cell anemia plus standard metabolic screening panel for inherited enzyme deficiency diseases
- Other tests, screenings and services considered eligible preventive services by Blue Cross and Blue Shield

NOTE: Services noted above are covered as preventive services when billed by a provider as routine or preventive. All other services are considered medical services. EXCEPTION: The first of the following services billed as preventive or non-preventive will be paid at the preventive/ screening services benefit level: cholesterol/lipid profile, PSA test, Pap test, colonoscopy, mammogram, hemoglobin A1C test, vision exam, and urine microalbumin screening.

Provider Network

You may seek care from the provider of your choice. If you choose an in-network preferred provider organization (PPO) provider, your out-of-pocket costs may be lower than if you visit a provider not participating in the Blue Cross and Blue Shield PPO network. Before seeking care, find out if your provider (including providers of diagnostic services such as X-rays, CT scans, imaging, laboratory exams, and tests) participates in Blue Cross and Blue Shield's PPO network. See page 56 for Blue Cross contact information.

In-Network

When you receive medical and mental health care from an in-network provider, eligible services will be paid at the in-network benefit level (see chart on page 3). You are responsible for your deductible and coinsurance only. In-network PPO providers have contracted with Blue Cross to

accept contracted rates as payment in full for treatment or services (less deductible and coinsurance). In-network providers will not bill you for any amount that exceeds the contracted rate. Your provider will call Blue Cross to obtain prior authorization if needed and will submit claims for you. NOTE: See pages 10 – 11 for details about in-network benefits for knee or hip replacement surgery, bariatric or spine surgery, and transplants.

Out-of-Network

When you choose an out-of-network provider, eligible services will be paid at the out-of-network level (see chart on page 3). Out-of-network services are subject to Blue Cross and Blue Shield's allowed amount for the services. The allowed amount can be significantly less than an out-of-network provider's billed charges. Costs that exceed the allowed amount are not eligible plan expenses. This means you are responsible for the out-of-network deductible and coinsurance plus any amount that exceeds the Blue Cross allowed amount. The excess amount does not apply to the plan's deductible or out-of-pocket limit. You are reimbursed directly by Blue Cross for most out-of-network claims and it is your responsibility to pay the out-of-network provider. Some out-of-network providers will not file claims with Blue Cross on your behalf so you may need to file claims. NOTE: See pages 10 – 11 for details about out-of-network benefits for knee or hip replacement surgery, bariatric or spine surgery, and transplants.

You or your out-of-network providers are responsible for contacting Blue Cross for any services requiring prior authorization.

Eligible Medical Providers

An eligible medical provider must perform services within the scope of his or her license and be licensed by the state in which the services are performed. The following providers are eligible medical providers:

- Medical doctor
- Nurse practitioner
- Optometrist
- Osteopath
- Naturopath
- Dentist
- Chiropractor
- Podiatrist
- Acupuncturist

The plan also covers care from the following providers if they are licensed by their state and performing services within the scope of their license and acting under the orders and/or supervision of a provider listed above:

- Physical therapist
- Physician assistant
- Audiologist
- Respiratory care practitioner
- Occupational therapist
- Dietitian
- Registered nurse
- Licensed practical nurse
- Massage therapist
- Speech therapist

Eligible Mental Health Providers

An eligible mental health provider must perform services within the scope of his or her license and be licensed by the state in which the services are performed. An eligible provider is one of the following:

- Licensed psychiatrist who is either a medical doctor or a doctor of osteopathy

- Licensed doctoral-level psychologist with a Ph.D., Ed.D., or Psy.D. degree
- Masters-prepared therapist who possesses a master's degree from an accredited institution in a licensable mental health discipline
- Pastoral counselor who is a licensed doctoral-level psychologist who holds a Ph.D., Ed.D., or Psy.D. degree, or a masters-prepared therapist who possesses a master's degree from an accredited institution in a licensable mental health discipline
- Any other provider considered eligible by Blue Cross and Blue Shield

Eligible Medical and Mental Health Hospitals and Facilities

An eligible hospital or alternative specialized treatment facility is a hospital or facility that qualifies for reimbursement from and meets the standards and requirements of Blue Cross and Blue Shield. Call Blue Cross before receiving inpatient care and certain outpatient services that require prior approval.

Office Visit

The plan covers medically necessary office visits with an eligible provider that may include medical history, examination, decision-making, counseling, coordination of care, consultation about your presenting problem, and treatment.

Urgent Care

When you visit your urgent care center or urgent care clinic, you receive in-network benefits for all eligible treatment if billed by the provider as an urgent care visit.

Emergency Care

In a life-threatening emergency, call 911 or go immediately to the nearest hospital or source of medical or mental health care. You receive in-network benefits for outpatient emergency department care whether the facility is in-network or out-of-network.

After the emergency has been treated and you are released, you receive in-network benefits if the follow-up care is provided by an in-network PPO provider.

You or someone acting on your behalf must notify Blue Cross and Blue Shield within 48 hours following an emergency inpatient admission so the treatment plan can be reviewed with your doctor and a determination made regarding the medical necessity of the admission and any continued inpatient care.

Failure to notify Blue Cross of an emergency inpatient admission may result in a delay in processing your claim. Your claim will be reviewed retrospectively. If the treatment is determined not medically necessary, the treatment and all related expenses will not be eligible for reimbursement under the plan.

Ambulance Service

This benefit covers expenses for ambulance services only in these situations:

- An emergency
- Local transfers to your home when required by the attending doctor

- Transfers to the nearest hospital with adequate facilities, if the patient's condition requires treatment at a facility not available at the hospital at which he or she is hospitalized
- Medical transportation to the patient's home or a medical rehabilitation facility when prescribed by the attending physician following knee or hip replacement surgery, spinal surgery, or transplant performed at a Blue Cross Blue Distinction Center.

The cost of air ambulance service to the nearest hospital with adequate facilities is an eligible medical expense only:

- When the patient's condition requires treatment and adequate facilities are not available at the hospital at which he or she is hospitalized
- When the patient is transported to the nearest hospital on an emergency basis from a remote geographic area

Hospital and Facility-Based Medical Care

The health plan covers eligible hospital or alternative specialized treatment facility expenses, including:

- Semi-private room, meals, special diets, and general nursing care, including hospice care
- Private room when isolation or intensive care is medically necessary and prescribed by your doctor, or when you are in a hospital or facility that has only private room accommodations
- Operating rooms, emergency rooms, special-care units, hospital-based clinics, casts and surgical dressings, drugs, oxygen, X-rays, blood and plasma, anesthesia, and any other medically necessary hospital or facility services and supplies
- Skilled nursing, convalescent, or extended care in an alternative specialized treatment facility not to exceed 120 days per calendar year

Hospital and Facility-Based Mental Health and Substance Abuse Care

This benefit covers allowed amounts for medically necessary mental health and substance abuse treatment including:

- Room, meals, 24-hour general nursing care, psychotherapy, a structured milieu for the administration of necessary medical services, daily medical care, and supplies incurred while admitted as a patient in an accredited hospital or specialized care facility
- Treatment provided in a halfway house or residential treatment facility
- Partial hospitalization program and intensive outpatient program that provide coordinated, intense, comprehensive, multi-disciplinary outpatient treatment when there is no need for 24-hour intensive psychiatric or nursing care
- Electroshock therapy
- Emergency department, laboratory, and ambulance services

Chiropractic Care

You receive in-network benefits when you visit a chiropractor who participates in the Blue Cross and Blue Shield PPO network. You receive out-of-network benefits when you receive care from a non-participating provider. Blue Cross will review claims to ensure that your chiropractic care is medically necessary. NOTE: Treatments that are not medically necessary, such as nutritional supplements and adjustments primarily for the maintenance of health, are not covered.

Maternity Care

Routine prenatal care is a covered preventive service. The plan covers maternity expenses, including a hospital stay, as a medical service. Consistent with federal law, the plan does not require authorization for a maternity hospitalization of up to:

- 48 hours following a normal vaginal delivery
- 96 hours following a Caesarean section

After consultation with the mother, the mother's or newborn's attending provider may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable). Any hospitalization that extends beyond 48 hours (or 96 hours) must be authorized by Blue Cross and Blue Shield.

The plan also covers medical expenses for services provided in a qualified hospital or eligible facility by a midwife, if he or she is state-licensed or state-certified or acting under the supervision of a doctor.

Home Health Care

If prior authorization is given, the plan covers home health care, including private duty or visiting nurse care, or home health aide services as an alternative to confinement in a hospital or facility.

Hospice Care

This benefit covers the following medical expenses for care received from a home hospice care agency during the final six months of a terminal illness:

- Up to eight hours per day for part-time or intermittent care by a professional nurse or a licensed home health aide
- Medical social services, including assessment of the patient's social, emotional, and medical needs, and identification of available community resources
- Psychological and dietary counseling
- Consultation or case-management services by a doctor
- Physical and occupational therapy
- Medical supplies, drugs, and medicines prescribed by a doctor

Contact Blue Cross and Blue Shield for Certain Services

In order to receive benefits, some medical and mental health services require approval from Blue Cross to verify that they are medically necessary and that treatment is provided at the proper level of care. You or your provider should call Blue Cross at least 10 days prior to a non-emergency hospital stay or before receiving medical or mental health services requiring approval. Visit *PorticoBenefits.org* and sign in at myPortico for the list of these services.

If you or your provider does not contact Blue Cross, your claim will be reviewed retrospectively. If Blue Cross determines that the treatment is not medically necessary, the treatment and all related expenses will not be eligible for reimbursement under the plan.

Recuperative Nursing Home

You or your doctor must contact Blue Cross and Blue Shield for prior authorization before you enter a nursing home or other alternative specialized treatment care facility for recuperative

purposes. To be eligible, the nursing home or facility must meet Blue Cross' standards and requirements. If prior authorization is given, the plan covers up to 120 days per calendar year for skilled nursing, convalescent, or extended care that is provided in a treatment facility for recuperative purposes only.

Durable Medical Equipment

This benefit covers the purchase or rental of durable medical equipment if it meets all the criteria listed below.

- Prescribed by your doctor to treat an illness or injury
- Essentially medical in nature
- Usable only in the presence of illness or injury
- Usable only by the patient for whom it was prescribed
- Able to withstand repeated use

To be eligible for in-network benefits, durable medical equipment (rented or purchased) must be obtained from an in-network PPO provider. Prior authorization is required for some durable medical equipment. Visit *PorticoBenefits.org* and sign in at myPortico for the list of services requiring prior authorization.

Breast Reconstruction

In conformity with federal law, the plan provides breast reconstruction benefits to members and dependents who are receiving care in connection with a mastectomy. These benefits will be provided in a manner determined in consultation with the attending doctor and the patient. The plan provides coverage for:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment for physical complications, including lymphedema, in all stages of a mastectomy

Specific Surgeries and Organ Transplants

Knee or hip replacement surgery, spine surgery, or bariatric surgery — Call Blue Cross for approval before receiving these surgeries. Coverage will be provided for facility expenses only if such surgery is performed at an in-network Blue Distinction Center or an in-network facility. The plan covers 85% of facility charges after deductible for surgery done at a Blue Cross Blue Distinction Center. The plan covers 65% of facility charges after deductible for surgery done at an in-network facility not designated a Blue Cross Blue Distinction Center. The plan provides no coverage of facility expenses if surgery is performed at an out-of-network facility.

If approved in advance by Blue Cross, you will also be reimbursed up to $10,000 for travel and lodging expenses related to the organ transplant, bariatric, spinal, knee replacement, and hip replacement surgery for you and a companion. Due to IRS regulations, meals cannot be reimbursed. Contact Blue Cross for details and approval.

NOTE: For dependents under 18 years old, the in-network benefit applies to knee and hip replacement, spinal, and bariatric surgeries performed at an in-network facility. Out-of-network benefit applies at an out-of-network facility.

Organ transplant — Coverage will be provided for facility expenses only if such procedures are approved in advance by Blue Cross and Blue Shield and performed at an in-network Blue Distinction Center or an in-network facility — except in case of emergency or if you are too ill to travel. The plan covers:

- 85% of facility charges after deductible for surgery done at a Blue Cross Blue Distinction Center
- 65% of facility charges after in-network deductible for surgery done at an in-network facility not designated a Blue Cross Blue Distinction Center
- No coverage of facility expenses if surgery is performed at an out-of-network facility

The following transplants and any others approved by Blue Cross are covered under the plan:

- Bone marrow
- Cornea
- Heart
- Heart-lung
- Kidney
- Liver
- Lung (single or double)
- Pancreas

Traveling Within the United States

Medically necessary medical and mental health care is covered if you become ill or injured while traveling within the United States. In a medical or mental health emergency, seek care immediately. You receive in-network benefits for any emergency care, 24 hours a day, seven days a week. After the emergency has been treated and you are released, you receive in-network benefits only if your ongoing care is provided by a participating Blue Cross and Blue Shield PPO provider. In a non-emergency, benefits are determined by the provider's PPO network participation unless you are treated at an urgent care center or urgent care clinic. Treatment or services billed by the provider as an urgent care visit are considered in-network medical or mental health expenses.

Traveling Outside the United States

Medically necessary medical and mental health care (excluding preventive care) is covered if you become ill or injured while traveling outside the United States. In a medical or mental health emergency, seek care immediately. You always receive in-network benefits for an emergency room or urgent care visit and appropriate follow-up care as determined by Blue Cross and Blue Shield.

Non-emergency eligible expenses charged by an in-network PPO provider outside the United States will receive in-network benefits. Care you receive from an out-of-network provider will be considered an out-of-network expense. Send your claims to Blue Cross for evaluation and processing.

Eligible Expenses

Expenses for treatment or diagnosis of medical or mental health illness, injury, or condition are eligible expenses only if they are:

- Medically necessary (see *Glossary*)
- Qualified for reimbursement as determined by Blue Cross and Blue Shield
- Allowed amounts according to Blue Cross' guidelines

- Performed by an eligible medical or mental health provider and/or in an eligible hospital or alternative specialized treatment facility

Eligible Medical Services and Supplies

In addition to services and supplies already described in this document, this benefit covers the allowed amount for the following medically necessary services and supplies:

- Casts and surgical dressings
- X-rays, CT scans, magnetic resonance imaging, or other similar diagnostic imaging procedures
- Laboratory examinations and tests, including preadmission testing on an outpatient basis for an illness or injury requiring hospitalization
- Physical therapy performed by a licensed or registered physical therapist or occupational therapy performed by a licensed or registered occupational therapist, under the orders or supervision of an eligible medical provider
- Private duty nursing by a registered nurse or a licensed practical nurse who is not a member of the patient's immediate family, in a hospital that does not have an intensive care unit or when care in such a unit is not available or medically feasible, if prior authorization is given
- Emergency care and up to 12 months of follow-up care for treatment of accidental injury to the teeth or their supporting structures, including care provided by a dentist
- Up to $10,000 lifetime maximum for infertility treatment per member: includes doctor visits and services, tests, imaging procedures, doctor-administered medications, all methods of artificially assisted fertilization such as artificial insemination, in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), embryo transfer procedures, and infertility counseling for, or related to, artificially assisted fertilizations (does not include sperm banking, donor ova or sperm, services and prescription drugs for, or related to, gender selection service) when pre-certified by Blue Cross and Blue Shield
- Up to 12 visits per calendar year for acupuncture performed by an eligible medical provider for:
  - Treatment of chronic pain that has lasted six months or more or when other forms of therapy have failed or
  - Prevention and treatment of nausea associated with surgery, chemotherapy, or pregnancy
- Up to 12 massage therapy visits per calendar year. Massage therapy visits include:
  - Any service provided by a licensed massage therapist and
  - Massage therapy received from another eligible medical provider
- Smoking-cessation treatment provided by an eligible medical provider
- Over-the-counter nicotine replacement products if you are enrolled in and are participating in the Blue Cross telephonic *Stop Smoking* program
- Weight loss treatment and services provided by an eligible medical provider (medical doctor, dietitian) or in a hospital-based program
- Treatment for cleft lip and palate including oral surgery and orthodontia
- Treatment for temporomandibular joint disorder and craniomandibular disorder including orthodontia

- Hospital and anesthesiologist services rendered in connection with eligible dental services
- Speech therapy by a licensed or registered speech therapist for adults and children who originally had speech ability is covered in the event of vocal cord surgery, stroke, accidental injury, or speech-related illness (children's speech therapy for medically necessary speech development is also covered)
- Services or prescribed devices to prevent conception, other than those covered as preventive service under this medical and mental health benefit or those drugs or devices purchased at a pharmacy and covered under the plan's prescription drug benefit
- Initial diagnostic X-rays prior to initiation of chiropractic treatment
- Certain routine care for approved cancer clinical trials approved by Blue Cross in advance of treatment
- Other allowed amount medical expenses determined to be medically necessary by Blue Cross

Non-Eligible Medical Services and Supplies

This benefit does not cover these medical expenses:

- Medical care, supplies, or treatment received in facilities owned or operated by the government or received elsewhere for which you are not (in the absence of insurance) legally obligated to pay
- Services or supplies that are experimental or investigational, as determined by Blue Cross and Blue Shield
- Costs for out-of-network services that exceed Blue Cross' allowed amount for the service
- Treatments not provided or prescribed by eligible medical providers or that are outside the scope of the provider's license or not medically necessary as defined by this plan
- Services by unlicensed doctors, practitioners, or providers of service, or by providers of service not specified as eligible medical providers under this plan
- Treatment or diagnosis of any disease, illness, injury, or physical or mental condition that is covered under this plan's prescription drug or dental benefit
- All acupuncture treatment that does not meet the requirements of those listed in *Eligible Medical Services and Supplies* on beginning on page 12
- Additional costs for private rooms, unless isolation or intensive care is prescribed by the attending doctor
- Costs incurred for services in a hospital that do not meet the requirements established for a hospital or facility as determined by Blue Cross
- Prescription drugs covered under this plan's prescription drug benefit (except when administered to a hospitalized patient and included as a hospital expense)
- Personal comfort services (radio, television, beauty and barber services, guest services, and similar incidental services)
- Nursing home or convalescent facility care (except up to 120 days per calendar year if solely for recuperative purposes and determined to be medically necessary by Blue Cross)
- Cosmetic surgery (except when needed for prompt treatment and correction due to an accidental injury)

- Oral surgery or any other services by a dentist or dental care practitioner covered under this plan's dental benefit, except those listed as eligible medical services by this plan (treatment of oral cancer)
- Routine exams not considered preventive services under this plan
- Services for correction of refraction error
- Hearing aids, eyeglasses, or contact lenses (except for one pair of eyeglasses or contact lenses required after cataract surgery, or medically necessary prosthetic contact lenses)
- Private duty nursing and home health aide services for respite and all other care (except those with prior authorization)
- Medibus, cabulance, bus fare, taxi fare, or personal car expense, except as described on pages 7 – 8
- Weight loss treatments and programs, unless rendered by an eligible medical provider
- Treatments and programs for smoking cessation, unless rendered by an eligible medical provider
- Exercise programs and equipment
- All massage therapy that does not meet the requirements as listed in *Eligible Medical Services and Supplies* on pages 12 – 13
- Sperm banking, donor ova or sperm, services and prescription drugs for, or related to, gender selection services
- Facility expenses if knee replacement, hip replacement, spine, bariatric, or organ transplant surgery is performed at an out-of-network facility (unless under age 18)
- Induced abortions after 20 weeks of pregnancy (except when the life of the mother is threatened or the fetus has lethal abnormalities indicating death is imminent)
- Services or treatment related to sex reassignment surgery
- Other medical expenses determined ineligible by Blue Cross and Blue Shield

Eligible Mental Health and Substance Abuse Care Expenses

The plan covers allowed amounts for medically necessary mental health or substance abuse treatment when provided by an eligible mental health provider, including:

- Outpatient mental health therapy sessions
- Medication management
- Outpatient assessment to confirm the presence of a mental health disorder (DSM-IV or ICD-9)
- Detoxification and treatment of substance abuse or addiction
- Marital counseling

Blue Cross and Blue Shield may review treatment to determine if it is medically necessary, appropriate, and eligible for reimbursement.

Non-Eligible Mental Health Expenses

Except as covered under employee assistance program (EAP) benefit or as determined as medically necessary by Blue Cross and Blue Shield, this benefit does not cover costs for treatment that is:

- Court-ordered, including adjudication of marital and child support and child custody, unless assessed and certified to be medically necessary

- Experimental, investigational, primarily for research, or not in keeping with national standards of practice, including but not limited to:
  - Treatment of sexual addiction, codependency, and conditions that do not have a DSM-IV diagnosis
  - Regressive therapy
  - Megavitamin therapy
- Educational or vocational testing and services, including treatments for personal growth and development
- Incurred for the treatment of social or economic problems or physical health without a corresponding DSM-IV or ICD-9 diagnosis
- Residential mental health care services as a diversion from incarceration in the juvenile or adult justice system
- Required by law to be provided to a child by the school system
- Required to maintain employment or insurance, professional continuing education, or credentialing criteria
- Treatment incurred as part of a treatment plan for:
  - Smoking cessation
  - Weight reduction
- Alternative types of substance abuse treatment, including but not limited to:
  - Nutritionally-based therapies
  - Non-abstinence-based treatment
  - Aversion therapy
  - Individual therapy in the absence of a structured outpatient program, unless deemed necessary by Blue Cross
- Custodial in nature; includes (but is not limited to) treatment not expected to reduce the disability to the extent necessary to enable the patient to function outside a protected, monitored, or controlled environment
- Not medically necessary because the treatment is not reasonably expected to improve an individual's condition or level of functioning. This includes (but is not limited to) treatment for the following conditions, diagnoses, or treatment methods:
  - Stammering or stuttering
  - Mental retardation (except initial diagnosis)
  - Chronic organic brain syndrome
  - Delirium, dementia, amnesia, and other cognitive disorders
  - Mental disorders due to a general medical condition
  - Learning disabilities
  - Obesity
  - Transsexualism
  - Tobacco dependence
  - Chronic pain, except for pre-certified psychotherapy, biofeedback, or hypnotherapy incurred in connection with a DSM-IV disorder
  - Sleep/wake schedule disorders
  - Biofeedback
  - Therapeutic foster care
  - Group homes
  - Supervised apartments

  - Three-quarter houses
  - Wilderness programs
  - Residential/therapeutic schools
  - Camps
- Treatment or diagnosis of any disease, illness, injury or physical condition that is covered under this plan's prescription drug or dental benefit
- Early intensive behavioral intervention for pervasive development disorders and autism spectrum disorders
- Other mental health expenses determined ineligible by Blue Cross and Blue Shield

Prescription Drug Benefit

The prescription drug benefit is administered by Express Scripts. The plan covers certain FDA-approved prescription drugs purchased for the treatment or prevention of illness and conditions. You are responsible for the prescription drug copayment established by the plan. Copayments are subject to change annually.

Eligible Prescription Drugs

Eligible prescription drugs include medically necessary:

- FDA-approved drugs available by prescription only
- Injectable and oral drugs determined to be specialty drugs by Express Scripts when purchased through Accredo Specialty Pharmacy (formerly CuraScript)
- Disposable diabetes supplies

Drugs must be medically necessary for the condition, diagnosis, or symptoms based on:

- FDA-specific indications
- Outcome data from clinical trials
- National care and treatment standards
- Express Scripts' determination of appropriate use through such programs as prior authorization, drug quantity management, and step therapy

2013 Prescription Drug Benefit Administered by Express Scripts®		
Generic Drug	**Preferred Brand-Name Drug**	**Non-Formulary Drug**
Express Scripts Network Retail Pharmacy up to 31-day supply		
100% **after** $8 copayment 100% and **no copayment** for: • Certain generic contraceptives • Fluoride for children • Iron supplements for children ages 6 – 12 months • Folic acid for women ages 18 – 45	100% **after** $43 copayment	100% **after** $69 copayment
Express Scripts Home Delivery up to 90-day supply		
100% **after** $18 copayment 100% and **no copayment** for: • Certain generic contraceptives • Fluoride for children • Iron supplements for children ages 6 – 12 months • Folic acid for women ages 18 – 45	100% **after** $94 copayment	100% **after** $152 copayment
Accredo Specialty Pharmacy up to 31-day supply		
100% **after** $8 copayment	100% **after** $43 copayment	100% **after** $69 copayment
Non-Participating Pharmacy up to 31-day supply		
100% **after** $8 copayment **plus** cost difference	100% **after** $43 copayment **plus** cost difference	100% **after** $69 copayment **plus** cost difference

IMPORTANT:

- Specialty drugs are limited to a 31-day supply and must be purchased from the Express Scripts specialty pharmacy, Accredo (formerly CuraScript).
- If you use a non-participating pharmacy or do not present your Express Scripts card at the time of purchase, in addition to the copayment, you are responsible for the difference between the Express Scripts contracted rate and the purchase price of your prescription.
- Benefits subject to change without notice.

Preventive Medications

Under the Affordable Care Act of 2010, you pay nothing when you purchase certain prescription drugs from an in-network retail pharmacy or through Express Scripts home delivery, including:

- Certain generic oral contraceptives
- Fluoride for children

- Iron supplements for babies ages 6 – 12 months
- Folic acid for women ages 18 – 45
- Immunizations

Contact Express Scripts with questions.

Medications Not Covered

- Over-the-counter medications, except insulin
- Drugs for cosmetic treatment of hair loss or other cosmetic purposes
- Vitamins for preventive purposes
- Drugs taken in preparation for, or in conjunction with, artificial insemination
- Drugs taken to terminate a pregnancy
- Drugs considered not medically necessary, based on FDA-specific indications, clinical trial outcomes, and national care and treatment standards
- Drugs deemed investigational or experimental because FDA approval for marketing has not been granted
- Drugs and supplies covered as medical expenses under Medicare hospital insurance (Part B)
- Herbal, mineral, and nutritional supplements
- Drugs that are covered under any other plan, including those covered under a Medicare prescription drug plan
- Specialty drugs not purchased from Accredo Specialty Pharmacy

Formulary

A formulary is a list of preferred medications reviewed and approved by a group of doctors and pharmacists based on clinical effectiveness and cost. Formulary drugs include generic and preferred brand-name medications that provide an affordable alternative to non-formulary drugs. If a generic version of a drug becomes available midyear, the brand-name drug will be non-formulary from that time forward.

- **Generic drugs** have the lowest copayment. The FDA requires generics to have the same quality, strength, purity, and stability as their brand-name equivalents.
- **Preferred drugs** are brand-name drugs that have the midlevel copayment. Preferred drugs have been reviewed and approved for formulary inclusion by an independent committee of doctors and pharmacists.
- **Non-formulary drugs** are brand-name drugs that have the highest copayment. These brand-name drugs are not included on the formulary because they are new to the marketplace or therapeutically equivalent drugs are available for less money.

To view the current formulary, visit *PorticoBenefits.org* and sign in at myPortico. This list is subject to change without notice.

Short-Term Prescriptions

Prescriptions of up to 31 days may be purchased:

- **At a local in-network pharmacy** — You pay the prescription drug copayment. At the time of purchase, show your Express Scripts identification card, and the pharmacist will process your prescription claim. There are no claims for you to file.
- **At an out-of-network pharmacy** — You pay the full price at the time of purchase and submit your claim to Express Scripts for reimbursement. You are responsible for your copayment plus the difference between the purchase price and the Express Scripts contracted rate of your prescription.
- **At a pharmacy outside the United States** — You pay the full price at the time of purchase and submit your claim for reimbursement. You will be reimbursed for the difference between the health plan's formulary brand-name copayment and the purchase price of your prescription.

Maintenance Medication

For long-term prescriptions, order a 90-day supply through Express Scripts home delivery service. You'll pay nearly a third less than you would if you filled a 30-day supply three times at your local retail pharmacy.

Most maintenance medications ordered through Express Scripts home delivery are shipped by first-class mail to your home or another address you designate. For your convenience, you will receive an email or a phone call when your order is shipped. Perishable drugs (insulin, etc.) are shipped in temperature-controlled containers or cold packs via an overnight delivery service.

To request order forms for home delivery, contact Express Scripts or Portico's Health Care Advocacy Team.

Specialty Drugs

Specialty drugs are limited to a 30-day supply due to the high cost (average monthly cost is $1,500), special storage needs, limited shelf life, and frequent dosage changes.

You must purchase specialty drugs through Express Scripts' specialty pharmacy, Accredo Specialty Pharmacy, to receive coverage under the ELCA prescription drug benefit. Specialty drugs are not available through Express Scripts home delivery service or your local retail pharmacy.

Contact an Accredo patient care coordinator at 866.848.9870, who will explain the services offered, coordinate order delivery, and provide refill reminders. Accredo will send up to a 31-day supply of your specialty drug to your home or doctor's office. Syringes and needles for administering specialty drugs are provided to you at no additional cost. There is no shipping cost for specialty drugs. A list of specialty drugs is available by visiting *PorticoBenefits.org* and signing in at myPortico. This list is subject to change without notice.

Find a Network Pharmacy

Find a pharmacy that participates in the Express Scripts network. Use the *Pharmacy Locator* at *express-scripts.com* or call Express Scripts at 800.575.8090.

If you forget to show your identification card at a participating pharmacy, you may be charged the full retail price for your prescription drug rather than the Express Scripts allowed amount. Contact Portico's Health Care Advocacy Team at 800.352.2876 for assistance.

Prescription Drug Programs

Step therapy — This program provides an effective approach to reducing the cost of drugs. In step therapy, specific high-cost "step-two" drugs are covered by the plan only after you try clinically appropriate, proven, and more cost-effective "step-one" drugs. If step-one drugs do not provide the desired therapeutic benefit, the plan may cover a step-two drug. The step therapy list is subject to change without notice.

For more information about step therapy and a list of drugs and medical conditions included in this program, visit *PorticoBenefits.org* and sign in at myPortico. If you have one of these medical conditions, ask your doctor to prescribe a step-one drug. If you have a question about a specific drug, contact Express Scripts' customer service.

Drug quantity management — A per-prescription quantity limit for certain medications promotes patient safety and avoids waste. Quantity limits are based on FDA-approved prescription drug dosing guidelines that prove beneficial for the most medical conditions for the most patients. If your medication has a quantity limit, you make one copayment for each purchase of the maximum allowed quantity. Even if your prescription is written for more than the allowed quantity per prescription, Express Scripts will fill only the maximum allowed quantity unless you obtain a medical-necessity exception.

To obtain a medical-necessity exception to the quantity limit, your doctor must contact Express Scripts at 800.417.8164 and request authorization for an exception. Authorization is required before an exception can be made.

If you have questions about quantity limits for a specific drug, contact Express Scripts. Quantity limits are subject to change without notice.

Prior authorization — Certain prescription drugs require approval before being dispensed because they are costly or may be used inappropriately. To request prior authorization, your doctor must contact Express Scripts at 800.417.8164. Standard medical-necessity criteria will be used to review all coverage requests. A list of drugs requiring prior authorization is available by visiting *PorticoBenefits.org* and signing in at myPortico. This list is subject to change without notice.

During a Hospital Stay

Prescription drugs administered during an inpatient hospital stay are considered medical expenses. When you're discharged, to save money on drugs you will use at home, verify that the hospital pharmacy is in the Express Scripts network and show your Express Scripts identification card. If the hospital pharmacy is not in the Express Scripts network, you can save money by filling your prescription at your local in-network pharmacy.

Coordination of Benefits

The ELCA health plan does not coordinate benefits for prescription drug expenses with other insurance plans.

Automatic Reimbursement

Most prescription drug copayment expenses will be automatically submitted to SelectAccount for reimbursement from spending accounts. (For specifics, see *Crossover Feature*, page 27.) If you have a health care flexible spending account balance, you will be reimbursed first from it, then from your personal wellness account.

Submit an Out-of-Network Claim

If you use an out-of-network pharmacy, send the original receipt with a member reimbursement form to the Express Scripts claims address listed on the form within 12 months of the date of purchase. Contact Portico's Health Care Advocacy Team to request a reimbursement form.

Claim Filing Deadline

The claim filing deadline is 12 months from the date you incur the expense. For example, if you incur an expense on Feb. 12, 2013, the filing deadline for that claim is Feb. 12, 2014.

Medicare and Prescription Drug Coverage

If you have ELCA-Primary health coverage and become eligible for ELCA Medicare-Primary health coverage, you cannot simultaneously have ELCA prescription drug coverage administered by Express Scripts and be covered under a non-ELCA Medicare prescription drug plan. If you enroll in a non-ELCA Medicare prescription drug plan, your ELCA prescription drug benefits administered by Express Scripts will end.

Creditable Coverage

ELCA prescription drug coverage administered by Express Scripts is creditable coverage. "Creditable coverage" means that the ELCA prescription drug benefit is, on average, expected to pay as much or more than the Medicare standard prescription drug benefit. It also means that you can enroll in Medicare's prescription drug coverage (within 63 days of ending ELCA coverage) with no penalty.

Dental Benefit

The dental benefit is administered by Delta Dental and covers preventive, basic, major restorative, and orthodontic care. It covers allowed amounts for your eligible dental expenses, subject to the deductible, coinsurance, and annual benefit maximum.

Reimbursement percentages are the same for any dentist, but you may have lower out-of-pocket expenses if you use a dentist who participates in a Delta Dental network. Network providers have agreed to accept Delta Dental's allowed amount as complete reimbursement for services, along with any coinsurance or deductible for which you are responsible.

Deductibles and Benefit Limits

Basic dental and major restorative expenses are subject to the deductible. Expenses for eligible preventive services are covered at 100% with no deductible. Deductibles, the lifetime orthodontic benefit limit, and annual benefit maximum are subject to change annually.

2013 Dental Benefit Administered by Delta Dental®	
Deductible and Benefit Limits	**Amounts**
Annual deductible (member's responsibility)	$150 per person $300 per family
Annual benefit maximum (other than orthodontia) (maximum benefit paid per year by the plan for preventive, basic, and major restorative care)	$2,850 per person
Lifetime orthodontia benefit maximum (your maximum is based on the year services first received)	$2,850 per person
Type of Service	**Plan Pays**
Diagnostic/preventive care Teeth cleaning, oral examinations, periodontal maintenance, X-rays, and other services. See the *Preventive Care* section for a list of specific covered services.	100%; **no** deductible
Basic care (fillings, tooth extractions, root canal therapy, oral surgery)	80% **after** deductible
Major restorative care (crowns, bridges, dentures, implants)	50% **after** deductible
Orthodontia	50%; **no** deductible

IMPORTANT

- Out-of-network services are subject to the amount Delta Dental allows.
- Benefit is subject to change without notice.

Dental Expenses

This benefit covers eligible dental expenses for procedures, services, or supplies received from a qualified dentist or licensed dental care practitioner acting within the scope of his or her license or under the supervision of a qualified dentist or doctor. The expenses must be for procedures, services, and supplies that are:

- Typically used for treatment of the dental condition
- Rendered on the basis of generally accepted standards of dental practice
- Medically necessary (except for specified preventive dental care)

Preventive Care

This benefit pays 100% of eligible expenses for the following preventive dental care:

- Routine dental cleaning — two per calendar year
- Periodontal maintenance cleaning — two per calendar year
- Oral exam — two per calendar year
- Full-mouth X-ray or panorex — one every 60 months
- Supplementary bitewing X-rays — one every 24 months for adults and one every 12 months for dependents through age 18
- Topical application of fluoride — one per calendar year for dependents through age 18

- Sealants or preventive resin restorations for permanent molars — one per lifetime for dependents through age 18
- Space maintainers for extracted posterior primary teeth for dependents through age 18
- Oral hygiene instructions as prescribed by the dentist — one per lifetime per individual

Basic Dental Care

This benefit pays 80% of eligible diagnostic, therapeutic, and restorative expenses (after deductible) for the following basic dental care:

- Oral exams, including specialist exams and those done in the course of emergency treatment for the relief of pain
- Tests and laboratory exams, including bacteriologic cultures and pulp vitality tests
- Non-routine dental X-rays, including full-mouth or other dental X-rays required to diagnose and treat a specific condition
- Oral surgery:
  - Routine oral surgery for tooth removal (including alveolectomy, if indicated, and pre- and post-operative care)
  - All other oral surgeries, such as alveoloplasty, vestibuloplasty, removal of cysts, tumors, growths, neoplasms, and treatment of simple fractures that can be managed in the office of a qualified dentist or licensed dental care practitioner
- Treatment of periodontal and other diseases of the gums and tissues of the mouth, including gingivectomy, osseous surgery, and splinting. This includes periodontal scaling and root-planing, repeat non-surgical treatment every 24 months, and repeat surgical treatment every 36 months.
- Endodontic treatment, including root canal therapy and pulpotomies on primary and permanent teeth (does not cover retreatment of pulpotomies)
- The following services and supplies, if provided in the office of qualified dentists or licensed dental care practitioners:
  - Anesthetics (conscious sedation), when medically necessary and administered in connection with cutting procedures in the oral cavity
  - Injection of antibiotic drugs by an attending dentist
  - Application of desensitizing medications
- Restoration of lost tooth structure as a result of tooth decay or fracture, when restored with amalgams (silver alloys), resin (white-colored filling) restorations, or pre-formed crowns for primary teeth
- Removable appliances for the treatment of bruxism and other harmful habits

Major Restorative Care

This benefit pays 50% of eligible expenses (after deductible) for the following services and supplies related to major restorative dental care:

- Repair or recementing of crowns, inlays, onlays, and fixed or removable dentures (including one relining or rebasing of dentures every 36 consecutive months, if the relining or rebasing occurs more than six months after the installation of an initial or replacement denture)
- Crowns, onlays, or porcelain inlays when the amount of lost tooth structure cannot be restored with filling restorations as described under *Basic Dental Care*

- Bridges, standard partial dentures, and full dentures for the replacement of extracted permanent teeth. Eligible expenses are limited to the commonly performed method of tooth replacement.
- Repairs and adjustments to prosthetic appliances if they serve as the permanent prosthetic appliance
- Replacement of an existing prosthetic appliance, if five years have elapsed from when last benefited and only if the existing appliance is not and cannot be made satisfactory. Services that are necessary to make an appliance satisfactory will be eligible.

Orthodontic Care

This benefit covers orthodontic treatment for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. It pays 50% of eligible orthodontic expenses, up to a lifetime benefit limit, including initial orthodontic examinations, X-rays and models. The lifetime benefit limit for each individual is fixed in the first year orthodontic expenses are incurred.

Non-Eligible Expenses

This benefit does not cover:

- Charges that exceed allowed amounts
- Procedures, services, or supplies primarily for cosmetic reasons and beautification, including charges for personalization and characterization of dentures
- Procedures, services, or supplies that are not necessary according to accepted standards of dental practice. If a dentist or member elects an alternative or more expensive dental procedure, service, or supply, the plan will cover only the portion of the charge for the adequate treatment of the dental condition.
- Procedures, services, or supplies that do not meet accepted standards of dental practice, including those that are experimental
- Replacement of a lost, missing, or stolen orthodontic or prosthetic device or any dental appliance
- Precision attachments
- Emergency dental care and up to 12 months of follow-up care for an accidental injury to teeth or their supporting structures that is eligible for reimbursement under the medical portion of this plan
- Diagnosis or treatment of any disease, illness, injury, or physical condition that is covered under medical or prescription drug benefits
- Costs for dental veneers and related services and supplies
- Costs for procedures, services, or supplies, including retreatment, that exceed the frequency limits established by Delta Dental
- Costs for procedures, services, or supplies that are medical in nature, including but not limited to oral surgery services performed in a hospital
- Inpatient and outpatient hospital expenses
- Costs for prescription drug expenses

Using Out-of-Network Providers

To process claims from out-of-network providers, Delta Dental uses allowed amounts from the Health Insurance Association of America. They are specific to each dental procedure and grouped by geographic area.

You are responsible for paying any portion of the fee that exceeds this allowed amount. If your out-of-network dentist's fee for a service is higher than the fee charged by 80% of dentists in the same geographic area, the portion of the fee that exceeds the allowed amount is not covered by this benefit.

Pre-Treatment Estimate

Delta Dental recommends that you ask your provider for a pre-treatment estimate for all dental care expected to exceed $300. This step clarifies coverage before you receive treatment.

Claims Submission and Payment

In network — Ask your dentist to submit claims to the Delta Dental address on the back of your identification card. Reimbursement for eligible dental expenses will be paid directly to your in-network provider.

Out of network — Submit claims for care received in 2013 for out-of-network providers to the address on your Delta Dental identification card. Your claim must be filed within 12 months of the date the expense was incurred. For example, if you incurred expenses on Feb. 12, 2013, the filing deadline for that claim would be Feb. 12, 2014. Because your dentist does not participate in Delta Dental's networks, Delta Dental will reimburse you rather than your out-of- network dentist.

Most dental procedures are performed and completed on the same day. However, some dental services require multistage procedures and multiple appointment dates. Claims payment is made after the completion of all services.

Automatic Reimbursement

Most dental deductible and coinsurance expenses will be automatically submitted to SelectAccount for reimbursement from spending accounts. (For more information, see *Crossover Feature*, page 27.) If you have a balance in your health care flexible spending account, you will be reimbursed first from it, then from any balance in your personal wellness account.

Personal Wellness Account

ELCA-Primary health coverage offers members a personal wellness account (legally defined as a health reimbursement arrangement, or HRA, under Internal Revenue Service *Notice 2002-45*). Earned personal wellness account (PWA) credits may be used only to reimburse eligible medical expenses as defined by the IRS. Any balance remaining in your PWA at the end of the plan year will be carried over to the next year.

You earn personal wellness account credits by taking the Mayo Clinic Health Assessment offered to you on the Mayo Clinic EmbodyHealth web portal between January 1 and September 30 of each year. You earn additional wellness credits by completing specific follow-up activities between January 1 and November 30. Your spouse or eligible same-gender partner is also eligible to earn credits for your PWA if he or she has ELCA-Primary health coverage. For more information about earning wellness credits, visit *elcaforwellness.org*.

Eligibility for a Personal Wellness Account

You are eligible for a PWA if you are enrolled in ELCA-Primary health coverage and are:

- Sponsored, retired, disabled, or continuing coverage or
- A spouse or eligible family member designated as the ELCA-Primary health coverage "member" when the member no longer has ELCA-Primary health coverage

Maximum Credit Amount

The maximum PWA credit you can earn for the 2013 plan year is $500 ($1,000 total for you and your spouse or eligible same-gender partner):

- $150 for completing the health assessment on or before Sept. 30, 2013
- $350 for completing specific follow-up activities on or before Nov. 30, 2013

Personal wellness account credits may only be used to reimburse eligible expenses (see *Glossary*). NOTE: New members who enroll in ELCA-Primary health coverage after Sept. 30, 2013, will not be eligible to earn PWA credits in 2013.

Administrator

Your PWA is administered by SelectAccount℠ (affiliate of Blue Cross and Blue Shield). When you complete the Mayo Clinic Health Assessment or follow-up activities, Mayo Clinic reports your Blue Cross identification number, name, address, and date of birth to SelectAccount. SelectAccount then credits your personal wellness account.

Eligible Dependent

You can be reimbursed from your PWA for eligible health care expenses incurred by family members who are:

- Your tax dependents or
- Your adult children until they reach age 26 (even if not your tax dependent)

Eligible Expenses

Eligible PWA expenses are 2013 out-of-pocket health care expenses:

- Incurred by you or your eligible dependent(s)
- Not reimbursed from another source (the health plan, a flexible spending account, or another insurance plan)
- Considered eligible health expenses under a health reimbursement arrangement by the IRS

You cannot withdraw cash from your account or use the balance for non-eligible expenses.

Non-Eligible Expenses

The following expenses are not eligible to be reimbursed from PWA credits earned in 2013:

- An expense incurred prior to Jan. 1, 2013
- An expense incurred before you are enrolled in ELCA-Primary health coverage
- An expense previously reimbursed or eligible to be reimbursed through the health plan, a health care FSA, other insurance, or any other accident or health plan
- Health insurance premiums
- Health-related expenses not eligible under IRS guidelines
- An expense for an individual who is not your eligible spouse or dependent

Crossover Feature

To simplify reimbursement, a member's and family's out-of-pocket costs related to eligible medical and mental health, dental, and prescription drug claims will cross over automatically from the benefit administrator to SelectAccount for processing. This crossover feature is automatic, unless you suspend it by completing a crossover opt-out request at *bluecrossmn.com/elca*.

SelectAccount verifies when a claim crosses over that you have a health care flexible spending account (FSA). If you do not have an ELCA health care FSA or have used up your health care FSA election amount for the year, SelectAccount will automatically reimburse you from your PWA if funds are available (unless you opt-out of the crossover feature).

If you have a balance in both your PWA and your ELCA health care FSA, your eligible expense will be reimbursed first from your FSA money because FSA dollars are forfeited if not used within the plan year and grace period. After your health care FSA has been depleted, your expenses will be reimbursed from your PWA.

You are responsible for contacting SelectAccount to opt out of the crossover feature if any family member with ELCA-Primary coverage is not a tax dependent as defined in Code §105(b). NOTE: The automatic crossover feature is not available if you are age 65 or older.

Claims Reimbursement

For eligible expenses that do not cross over to SelectAccount (prescription eyeglasses, etc.), you must submit a claim for reimbursement no later than 12 months from the end of the plan year in which the expense was incurred. If the claim is denied for reimbursement from your personal wellness account, you have 180 days from the date of the initial denial letter to provide additional information to SelectAccount. Follow the appeals procedure for denied claims described on pages 44 – 45.

Ending Participation

You will no longer have a PWA upon the earlier of the:

- Termination of the personal wellness account portion of the plan or
- Date you are no longer covered under ELCA-Primary health coverage and have reduced your personal wellness account balance to zero

After terminating employment, you can continue to be reimbursed for eligible medical expenses incurred until your account balance is reduced to zero.

If you elect to continue ELCA-Primary health coverage after you terminate employment, you can continue to earn and use your PWA credits.

ELCA Medicare-Primary Coverage Eligibility

When you (or an eligible family member) become eligible for ELCA Medicare-Primary coverage, you cannot earn additional PWA credits. You can, however, continue to be reimbursed from your PWA for eligible expenses incurred after changing to ELCA Medicare-Primary coverage. Submit a claim form with expense documentation to SelectAccount.

If your spouse or eligible same-gender partner continues ELCA-Primary health coverage after you become eligible for ELCA Medicare-Primary coverage, he or she is eligible to earn credits toward his or her own PWA up to the maximum credit amount for 2013.

If you have an eligible same-gender partner, he or she is eligible to earn credits toward his or her own PWA only if he or she is a tax dependent as defined in Code §105(b).

Rehired After Termination

If you terminate employment (including retirement or resignation) without having earned the maximum wellness dollar amount and are rehired within the same plan year, when you enroll in ELCA-Primary health coverage, you can continue to earn additional credits up to the maximum allowed for the current plan year.

If You Die

If you die, your surviving eligible family members may continue to be reimbursed from your PWA for eligible expenses they incur after your death, until your PWA balance is reduced to zero.

No Additional Contributions

You and your employer cannot make contributions to your PWA. The PWA cannot be funded with salary-reduction contributions, employer contributions (flexible credits), or other contributions under a cafeteria plan.

Requirements Waived for Medical Reasons

If you have an injury, illness, or mental disorder that prevents you from taking the health assessment and engaging in follow-up activities, contact the ELCA Health Care Advocacy team at 800.352.2876 to request a *Personal Wellness Account Request for Waiver of Requirements* form. Your doctor must describe how your condition prevents you from participating in these activities. If a waiver is granted, up to $500 will be credited to your PWA.

Employee Assistance Program (EAP)

EAP counseling, support, and referral services are available to you and your covered family members. You can call to talk to an EAP professional about stress, relationships, family issues,

work issues, or any other personal concern — 24 hours a day, seven days a week, at 800.432.5155. An initial phone consultation for legal and financial issues is offered at no cost to you. The EAP is a confidential resource to:

- Help you with personal and work concerns
- Obtain referrals to professionals
- Find support and information resources in your community

ValueOptions, a partner of Blue Cross and Blue Shield, administers the employee assistance program (EAP) benefit.

Eligible EAP Services

Eligible EAP services include telephone consultation and assessment and in-person EAP counseling (when clinically appropriate) related to any concern or issue, including:

- Spouse relational problem
- Parent-child relational problem
- Child abuse or neglect
- Sibling relational problem
- Relational problem related to a mental disorder or general medical condition
- Occupational problem
- Academic problem
- Acculturation problem
- Religious or spiritual problem/phase of life problem
- Relational problem not otherwise specified
- Bereavement
- Adult anti-social behavior
- Childhood or adolescent anti-social behavior
- Overweight or obesity
- Tobacco dependence

In-person counseling — Call 800.432.5155 to access your EAP for help addressing personal concerns, work issues, stress, relationship problems, and family issues. When assessed by the EAP as clinically appropriate, the EAP will refer you to an in-person counselor for one to six in-person counseling sessions at no cost to you.

NOTE: An EAP counselor will authorize in-person counseling only if it is clinically appropriate. This means you will not have in-person counseling authorized if your issue is not expected to be resolved within one to six in-person EAP visits. In this situation, the EAP counselor will advise you to seek counseling using the Medical and Mental Health benefit.

If, after receiving one to six in-person EAP visits, your counselor determines that you require additional medically necessary care, you can then access the Medical and Mental Health benefit. To have mental health services paid at the in-network level, seek care from an in-network Blue Cross mental health provider.

Visit *bluecrossmn.com/elca* and use *Find a Doctor* (or call 866.455.8216) to find a mental health provider in the Blue Cross Network.

Life events — The EAP can assist with:

- Work/life concerns including child care, adoption, child development, adult/elder care, and balancing work and family. EAP can provide referrals to resources in your community and printed educational materials.
- Legal concerns including divorce, lawsuits, wills and estates, and real estate. EAP provides one 30-minute telephonic or in-person consultation with an attorney at no cost to you. You may also receive discounted services if you retain the services of a participating attorney after your initial consultation.
- Financial concerns including managing credit, budgeting, and consolidating debt. If you agree to any services that require fees, you will be responsible for the fees.

Health and Wellness Benefits

ELCA NurseLine[SM]

Health information from a registered nurse is just a phone call away with ELCA NurseLine. This service is provided by OptumHealth[SM] and is available to you 24 hours a day, seven days a week. Call ELCA NurseLine at 877.856.8145 if you need help:

- Deciding when self-care, a doctor visit, or the emergency room is appropriate
- Knowing how to handle a common health problem
- Understanding a medical condition, recent diagnosis, test results, or treatment options
- Planning for your doctor visit
- With questions about medications

Fitness Discount

Portico contracts with Blue Cross to offer a fitness discount that helps members pay for membership at an eligible gym. Work out eight days in a month, and you'll receive a $20 credit to your bank account or fitness center dues. The discount is available to up to two adults with ELCA-Primary health coverage in your household. Visit *PorticoBenefits.org* and sign into myPortico for specifics.

Health Care Advocacy Team

Portico provides plan members with a team of professionals who understand how the various parts of the health care system fit together. Portico health care advocates know the ins and outs of our health plan benefits including aspects like insurance billing and coding, Medicare payment rules and procedures, insurance industry policies, and procedures. They will work with you and our benefit administrators to answer your questions and assist in resolving your problem. Contact the Portico Health Care Advocacy Team at 800.352.2876 for assistance.

Hearing Discount Program

Delta Dental of Minnesota has partnered with HearPO to offer members a hearing discount program. With the hearing discount program, you and your eligible family members may save money with:

- Discounts on more than 1,000 models of digital hearing aids from leading manufacturers

- A 40% discount on hearing diagnostic testing, including advanced audiology tests
- A three-year warranty on most hearing aids, covering repairs, loss, and damage
- A 60-day free trial with no restocking fee
- Free batteries for two years with a new hearing aid purchase (maximum of 160 cells per hearing aid)
- One year of free aftercare services
- More than 2,700 locations nationwide

Access the hearing discount program by calling 855.531.4694 or visit *hearpo.com/deltadentalmn*.

Mayo Clinic Health Solutions

Portico contracts with Mayo Clinic Health Solutions to provide health and wellness information based on the experience, knowledge, and credibility of more than 2,000 Mayo Clinic doctors and scientists.

- **Web portal** — The EmbodyHealth portal, *elcaforwellness.org*, is a reliable protected website offering health and wellness information. It also is where you earn personal wellness account (PWA) credits by taking your annual health assessment and pursuing follow-up activities. This interactive web portal presents you with customized information, suggestions, and tools on a range of subjects based on your health assessment results and the selections you make in *My Health Topics*. The more information you provide, the more customized and interactive the portal becomes for you.
- **Health assessment** — This online tool helps you take stock of your health and lifestyle habits in less than 30 minutes. You enter personal health information (height, weight, cholesterol, blood sugar, etc.) and the tool identifies your health strengths and risks. It also recommends strategies to maintain or improve health, and delivers a personal action plan. Taking the assessment earns you $150 in your PWA. You can also earn an additional $350 to your PWA by doing certain follow-up activities.
- **Health coaching** — Plan members and spouses with certain health risks can receive Mayo Clinic health coaching. If your health assessment indicates certain risks, you will see an online form asking if you are willing to be contacted by a health coach. If you agree to be contacted, a trained health coach will call you. Health coaches provide support and encouragement to help you make lifestyle changes, reduce health risks, and improve your health. Working one-on-one with the coach, you will create an action plan and set health-improvement goals. This confidential service is paid for by your ELCA health plan. There is no cost to participants and participation is voluntary.
- **Monthly newsletter** — Plan members also receive the Mayo Clinic monthly newsletter, *EmbodyHealth.* This newsletter provides easy-to-read, practical information on a variety of important health topics written and reviewed by Mayo Clinic. It also features front- and back-page commentary on wellness from Portico.

Health Support Programs

Blue Cross and Blue Shield offers the following voluntary support programs, which provide a telephonic nurse and/or coach to support efforts to improve your health and/or better manage a health condition.

- *Health Support* reaches out by letter and/or phone to those whose overall health status (based on medical and pharmacy claims) suggests a meaningful opportunity for health improvement. If you're contacted and willing to participate, you'll be assigned a dedicated registered nurse who will assess your health needs, offer advice on how to integrate with other health plan services and help you take positive action.
- *Healthy Start* pregnancy program offers support from a dedicated nurse to women wanting guidance and support during pregnancy. Call Blue Cross at 866.455.8216 about this program.
- *Stop Smoking* program offers coaching guidance and support before, during, and after quitting smoking. Call 888.662.2583.

Vision Discount Program

EyeMed Vision Care is your vision discount program administrator. When you show your EyeMed vision discount program card to participating EyeMed providers, you can save on eye care products and services, including eyeglasses and contact lenses, non-prescription sunglasses, contact lens solutions, and accessories. EyeMed also offers a discount for Lasik (laser vision correction) surgery. If you have any questions about the EyeMed discount program, participating provider locations, identification cards, or services, please call EyeMed at 866.723.0391 or visit *eyemedvisioncare.com.*

NOTE: An annual preventive eye exam is covered under your Medical and Mental Health benefit. Show your Blue Cross and Blue Shield card when you receive a preventive eye exam.

Eligibility

You are eligible to enroll in the ELCA Pension and Other Benefits Program, which includes the health plan, when you are:

- Sponsored in the program and:
  - A pastor or rostered layperson serving under call, employed by an eligible employer, and scheduled to work at least 15 hours per week for six or more months per year, or
  - A lay employee employed by an eligible employer, scheduled to work at least 20 hours per week for six or more months per year, and have completed any probationary period specified by your employer (not to exceed 90 days)
- A self-sponsoring ELCA pastor and:
  - Called to a non-ELCA ministry and your employer chooses not to sponsor you in the ELCA benefits program, or
  - Called to a ministry in which you are considered self-employed in accordance with Internal Revenue Code §414(e)(5)(A)(i)

Eligible Family Members

When you are sponsored in the ELCA Pension and Other Benefits Program, the following family members are eligible to enroll in the ELCA health plan:

- Your spouse or eligible same-gender partner (see *Glossary*). NOTE: You are responsible for any taxes incurred as a result of coverage under this plan if your partner is not your tax dependent.

- A child under age 26 who falls within one of three categories:
  1. You or your spouse's natural child, legally adopted child, or a child placed in your home for adoption
  2. Your never-married grandchild or a child for whom you are a guardian if he or she is:
     - Living in your household and
     - Receiving primary support from you and
     - Claimed by you as a tax dependent for federal income tax purposes
  3. The natural or legally adopted child of your eligible same-gender partner. NOTE: You are responsible for any taxes incurred as a result of coverage under this plan if the child is not your tax dependent.
- Your adult child who has been continuously enrolled (or has waived coverage) in the plan since age 26 and is totally and permanently disabled as determined by the Social Security Administration

When you have a new spouse, eligible same-gender partner, or child

- Your new family members may be enrolled in the health plan following your marriage or filing of your *Affidavit of Partnership.*
- Your eligible children may be enrolled following birth, adoption, or placement for adoption without a six-month waiting period if enrolled within 60 days of becoming eligible.

If your new family member(s) enrolls within 60 days of the date of becoming eligible, coverage will take place as follows:

- No six-month waiting period for health coverage will apply
- Child's coverage will take effect the date of birth, adoption, or placement for adoption
- Spouse's (and stepchild's) coverage will take effect the date of your marriage
- Eligible same-gender partner's (or your partner's child's) coverage will take effect the date the Service Center receives your *Affidavit of Partnership*

Contact the Portico Service Center for a coverage election change form. Complete the form and return it to our Service Center within 60 days of becoming eligible.

Medicare Eligibility

You may be eligible for primary coverage under Medicare if you are:

- Age 65 or over and retired or
- Age 65 or over and employed by an organization with fewer than 20 employees or
- Under age 65 and entitled to Medicare due to disability or end-stage renal disease

If you (or any member of your family) have Medicare as your primary coverage, your ELCA health benefits are different than those described in this booklet. The *Summary Plan Description for ELCA Health Benefits Plan — ELCA Medicare-Primary Coverage* is available by visiting *PorticoBenefits.org* and signing into myPortico or by contacting the Portico Service Center at 800.352.2876 or *mail@PorticoBenefits.org*.

As you approach your 65th birthday, the Portico Service Center will contact you about the transition to ELCA Medicare-Primary coverage. If you become eligible for ELCA Medicare-

Primary coverage midyear, your progress toward meeting your ELCA-Primary health deductible and out-of-pocket limit will not transfer to your ELCA Medicare-Primary deductible and out-of-pocket limit.

Change from ELCA Global Mission

If you terminate employment midyear as a missionary with ELCA Global Mission and become sponsored in ELCA-Primary health coverage by another eligible ELCA employer, your health benefit administrator will change. You will be covered by the ELCA health benefit described in this document. Your eligible medical and mental health expenses incurred in the same calendar year while you were covered under Aetna International prior to your employment change will be applied as follows:

- In-network medical and mental health expenses incurred prior to the change will be applied to your in-network deductible and out-of-pocket limit under your medical and mental health benefits administered by Blue Cross and Blue Shield
- Out-of-network deductible and out-of-pocket limits will be applied to your out-of-network benefits

Enrollment

Timely Enrollment

Timely enrollment means you have completed your enrollment (or election change) within 60 days of meeting the ELCA benefits program's eligibility criteria and the first date of your coverage is within this 60-day period.

If you enroll in a timely manner:

- Your health coverage takes effect for you (and your family) on the date designated by your employer (or the date you were hired, if you are employed by a synod, seminary, or ministry of the ELCA churchwide organization)
- You avoid a six-month waiting period for health coverage

Late Enrollment

Late enrollment means you have not completed your enrollment within 60 days of eligibility or the first date of your coverage is not within this 60-day period.

You and your family will have to wait six months to enroll in health coverage unless you:

- Enroll during the annual open enrollment period (November 1 – 30, with health coverage effective the next January 1)
- Had other employer-provided group health coverage within 60 days prior to enrolling

The six-month waiting period begins the day your application is received by the Portico Service Center. No health plan contribution is due during this waiting period.

If you enroll late, health coverage takes effect for you (and your family) the first day of the month following the end of the six-month waiting period or January 1 of the following year, whichever is earlier.

Annual Open Enrollment

If you are eligible to enroll but do not enroll in a timely manner, you can enroll during the annual open enrollment period (November 1 – 30) without a six-month waiting period for health coverage. Health coverage is effective January 1 of the next year.

If you are an eligible member who previously waived coverage in the ELCA health plan and your other employer-provided group coverage has been terminated for more than 60 days, you may activate coverage in the ELCA plan during the annual open enrollment period.

Eligible spouses and eligible children may also enroll during this period.

Open enrollment is *not* available to individuals whose eligibility period to elect coverage continuation under the health plan has lapsed (former spouses, surviving spouses, or individuals who previously terminated coverage, except retirees).

Continuing Coverage

If your medical coverage is ending, you (or your eligible family members) may under certain circumstances continue your ELCA health coverage for a limited period of time by paying the contributions yourself. See *Continuing Coverage During Life Changes* beginning on page 37 for more information.

To activate ELCA health coverage, submit a *Coverage Election Change* form (available by visiting *PorticoBenefits.org* and signing in at myPortico or by calling the Portico Service Center) and include information about your current health insurance provider.

It is to your advantage to activate coverage while still enrolled in your other employer-provided group coverage, or within 60 days of losing your other coverage. Timely activation prevents a six-month waiting period for ELCA coverage.

If you activate ELCA-primary health coverage:

- **While enrolled in other employer-provided group health coverage** — Your ELCA-primary health coverage will take effect any date you choose but not more than 60 days prior to the date the Portico Service Center receives your *Coverage Election Change* form and information to confirm other group coverage from your current health insurance provider.
- **Within 60 days after ending other employer-provided group health coverage** — Coverage will take effect the date your other coverage ends or any date within 60 days of losing your other group coverage if the Portico Service Center receives the form and proof of other group coverage within 60 days of the date you lose your other coverage.
- **More than 60 days after ending your other employer-provided group health coverage:**
  - You and your dependents will have a six-month waiting period for ELCA health coverage. The waiting period begins the day your *Coverage Election Change* form is received by the Portico Service Center. There is no contribution for the health plan during this period.

- Your health coverage will take effect the first day of the month following the end of the waiting period or January 1 of the following year, whichever is earlier.

Waiving Coverage

You can decline, or waive, ELCA health coverage if you are covered by other employer-provided group health coverage, not an individual policy.

Other Employer-Provided Group Coverage

To waive ELCA health coverage, you must have group health coverage provided by one of the following:

- An employer other than your sponsoring employer, provided that employer is not an ELCA congregation, seminary, synod, or ministry of the ELCA churchwide organization
- An employer or former employer of your eligible spouse, as a result of your spouse's employment
- Your former employer, as a result of your previous employment
- Your (or your spouse's) employer or former employer if you are a retired member
- Your (or your spouse's) employer or former employer if you are on leave from call
- Your parent's employer or former employer (if you are a dependent)
- A government-sponsored program outside the United States
- Federal Medicaid and state-sponsored Medicaid-like medical assistance programs
- A post-secondary educational institution attended by a coverage continuation member, eligible spouse, or eligible child
- A Medicare health plan option under *Medicare Advantage*

Waiver Effective Date

If you have other employer-provided group coverage through an organization other than your sponsoring employer and you choose to waive ELCA health coverage, your waiver of coverage will take effect the first day of the month following the date your waiver form and information about other group coverage are received by Portico, or on any future date designated by you. Visit *PorticoBenefits.org* and sign in at myPortico for more information and forms.

If you waive ELCA-Primary health coverage, your spouse or eligible same-gender partner and children:

- Must also waive ELCA coverage if you are sponsored or receiving disability benefits
- May continue ELCA coverage at their own expense if you are an ELCA pastor or rostered layperson on leave from call
- May continue ELCA coverage at their own expense if you are retired

While you are waiving coverage, remember to notify the Portico Service Center of any change in family status — marriage, birth, divorce, loss of eligibility for a dependent, and death.

Certificate of Coverage

If you terminate or waive ELCA-Primary health coverage and enroll in other employer-provided group health coverage, contact the Portico Service Center for a certificate of group health

coverage (Health Insurance Portability and Accountability Act — HIPAA — creditable coverage notice). You may need this certificate to confirm prior coverage and prevent exclusion from coverage due to pre-existing conditions.

Activating Coverage After Waiving

You can activate ELCA coverage after waiving it if you meet the plan's eligibility criteria. Contact the Portico Service Center for more information about eligibility, proof of health coverage, timing, and enrollment.

Contributions

Contribution rates are set annually by Portico Benefit Services.

Who Pays for Coverage?

When sponsored by an eligible employer — Your employer is responsible for paying the contribution amount for your participation in the program, including the cost of health coverage for your covered family members.

When a couple is sponsored — If you and your spouse are both sponsored in the ELCA benefits program, the cost of health coverage for each member is calculated according to the percentage of the couple's total defined compensation provided by that employer. (See *Glossary* for definition of *Defined Compensation.*)

When you sponsor yourself — You are responsible for paying the contribution for your participation in the program, including the cost of health coverage for your eligible family members. You will receive a monthly billing statement for this coverage.

When Your Contributions Aren't Paid

Your health coverage will end when the contribution is not paid in full within 60 days after the due date. Your final date of coverage is the date through which the contribution has been paid. You (and your family) may reactivate coverage at a later date if you are eligible for coverage and if the unpaid amount is paid in full. You will be subject to the six-month waiting period for health coverage unless you reactivate coverage during the annual open enrollment period described on page 35 or had other employer-provided group coverage within 60 days prior to re-enrolling.

Continuing Coverage During Life Changes

After you enroll in the health plan, you (or your eligible family members) may continue coverage when you retire, become disabled, begin on leave from call status, terminate employment (other than for reasons of gross misconduct), experience a reduction in hours of employment that causes you to lose eligibility for coverage under the ELCA health plan, take a leave of absence without pay, or are called to military service. In some cases, coverage is available for a limited period of time.

“Continuing coverage” means you pay the costs to keep your health coverage. In some cases, coverage is available for a limited period of time. To continue coverage, you must complete a *Coverage Election* request within 60 days of your life change. You will receive a monthly billing statement for this coverage. Contact our Service Center at *mail@PorticoBenefits.org* or 800.352.2876 for more information.

When Sponsored Status Ends

Your participation in the program as a sponsored employee ends when:

- Your employment with an eligible employer terminates
- You no longer meet the ELCA benefits program’s eligibility requirements
- Your employer no longer meets the ELCA benefits program’s eligibility criteria
- Your employer has not paid the contribution in full within 60 days of the due date

Your participation ends the date through which the contribution has been paid. Your employer (except for ministries of the ELCA churchwide organization, synods, and seminaries) may discontinue sponsoring you in the program by notifying Portico. If your employer does not notify us and does not pay the required amount, your sponsored status will end 60 days after the contribution due date.

If your coverage ends following a termination of employment (other than for reasons of gross misconduct), you are eligible to continue ELCA health coverage for up to 18 months. Notify the Portico Service Center at *mail@PorticoBenefits.org* within 60 days of the change in your eligibility to continue coverage. You will receive a monthly billing statement for the cost of this coverage. If you choose not to continue coverage, you are responsible for paying any health claims incurred after your coverage terminated.

Health coverage ends — If the contribution is not paid in full within 60 days after the due date, your health coverage ends on the date through which the contribution has been paid. This coverage cannot be terminated retroactively.

When You Separate from Service

If you separate from service (other than for reasons of gross misconduct), you (and your family) may continue health coverage for up to 18 months at your own expense. A form electing to continue your coverage must be received by the Portico Service Center within 60 days of your change in status. You will receive a monthly billing statement for your next month’s benefits. After your health coverage continuation ends, health coverage can only be reinstated if you are sponsored again by an eligible employer.

Notification of a separation from service received after the effective date of coverage will be processed the date it is received by the Portico Service Center. Sponsoring employers are responsible for paying all contributions for coverage through the processing date, even if the employee has separated from service.

NOTE: An ELCA pastor or rostered layperson is not considered separated from service while on leave from call. (See *Glossary* for a definition of *Separation From Service.*)

When You Are On Leave from Call

If you are an ELCA pastor or rostered layperson on leave from call, you (and your family) may continue health coverage (or waive coverage based on plan provisions) throughout your leave, if you also continue the lump-sum survivor benefit coverage under the ELCA Survivor Benefits Plan. You will receive a monthly billing statement for the cost of this coverage.

If you continue these benefits throughout your leave, you will not have a new preexisting condition exclusion period under the disability or survivor plans when you are sponsored by an eligible employer following your leave.

When Your Child Reaches Age 26

Your child may continue coverage under the health plan at his or her own expense for an additional 36 months when he or she reaches age 26 if he or she has been covered under the plan up until age 26. He or she must enroll within 60 days of reaching age 26. Your child will receive a monthly billing statement for the cost of this coverage.

When You Become Medicare Eligible

When Medicare becomes your primary health coverage, you will be covered under ELCA Medicare-Primary coverage, unless you are waiving ELCA health coverage at that time. These benefits are described in a separate booklet. Contact the Portico's Health Care Advocacy Team for more information on ELCA Medicare-Primary coverage.

When You Retire

You may continue, waive, or terminate ELCA health coverage when you are eligible to retire (at age 60 or after completing 30 years of church service) and are sponsored in the ELCA benefits program up to the date of your retirement.

You'll have no health coverage interruption if you complete a coverage election request within 60 days of your retirement date. You pay for the cost of this coverage. Your payment can be deducted from your annuity payments or Portico can send you a monthly billing statement.

If at the time of your retirement you had waived ELCA health coverage because you have other employer-provided group health coverage, you may continue to waive ELCA health coverage in retirement. This will allow you to activate ELCA health coverage at any time within 60 days of terminating your other employer-provided group health coverage.

When You Are Disabled

If you are receiving partial or total disability benefits under the ELCA Disability Benefits Plan, you and your family may continue ELCA health coverage. If Medicare becomes your primary health coverage, you will be covered under ELCA Medicare-Primary coverage. This coverage is described in a separate booklet.

If you are sponsored — You and your eligible family members may continue health coverage if the required contribution is paid for the first two months following the date you became disabled. After two months, the disability trust will pay for your (and your family's) health coverage while you are disabled (as defined by the ELCA Disability Benefits Plan).

If both spouses are sponsored — If you are married and you and your spouse both were sponsored in the plan prior to one of you becoming disabled, only a portion of your family's health coverage is paid by the disability trust. Contact the Portico Service Center for details.

Health coverage ends — Your health coverage will end when you are no longer receiving benefits under the ELCA Disability Benefits Plan, unless you pay for the coverage or become sponsored in the ELCA health plan by an eligible employer.

When You Lose Eligibility Due to Reduced Hours

If your coverage ends following a reduction in hours that causes you to no longer be eligible for coverage under this plan, you are eligible to continue ELCA health coverage for up to 18 months. Notify the Portico Service Center at *mail@PorticoBenefits.org* within 60 days of the change in your eligibility to continue coverage. If you elect to continue coverage, you will receive a monthly billing statement for the cost of this coverage. If you choose not to continue coverage, you are responsible for paying any health claims incurred after your coverage terminated.

When You Are Called to Serve in the Military

You may continue ELCA health coverage for the first 24 months of military service to ensure continuous health coverage for your family during a military call-up. You will receive a monthly billing statement for the cost of this coverage at the same rate as those on leave from call.

When You Are Between Sponsoring Employers

If you separate from service with an eligible employer and are employed by another eligible employer who sponsors you in the program within 31 days, you (and your family) will continue to be covered under the ELCA health plan during this period of unemployment (not to exceed 31 days). This coverage is provided at no additional cost.

When You Become a Surviving, Separated, or Former Spouse

A surviving spouse or a legally separated or former spouse may continue coverage at his or her own expense:

- If enrolled in the health plan or waiving coverage at the time of the change in marital status and
- If continuation coverage is elected within 60 days of the change in marital status

ELCA health coverage may be continued by:

- A surviving spouse for his or her lifetime
- A former spouse who had coverage continuation as a former spouse on May 1, 2010, until remarriage. At the time of remarriage, the former spouse may continue coverage for an additional 36 months.
- A former spouse who began coverage continuation on or after May 2, 2010, for up to 36 months

If coverage continuation is not elected within 60 days of the change in marital status, a surviving spouse, legally separated spouse, or former spouse does not have the option to enroll at a later date, waive, or continue waiving health coverage.

Costs to Continue Coverage

Monthly Coverage Continuation Rates for 2013	
Adults who are: • Retired • On leave from call • Spouses, ESGPs[4], surviving spouses • Continuing coverage after loss of eligibility	Under age 60: $622 per person[1, 2] Age 60 – 64: $800 per person[1, 2]
Children (up to age 26) of members who are: • Retired • On leave from call • Divorced • Deceased • Continuing coverage after loss of eligibility	$436 per family[3]

[1]The ELCA may pay a portion for retired members and spouses who participated in a predecessor church plan. These rates do not reflect any subsidies.
[2]Less $48 for former retired LCA members who declined dental coverage in 1996.
[3]If at least one child is eligible for ELCA-Primary health coverage, this rate is for all children in a family.
[4]An eligible same-gender partner (ESGP) is an individual who satisfies Portico's same-gender partnership requirements as attested to on a completed *Affidavit of Partnership* filed with Portico.

Administrative and Miscellaneous Provisions

Confidentiality and Privacy Practices

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans to protect the confidentiality and privacy of individually identifiable health information. Portico Benefit Services is the plan administrator of the ELCA Health Benefits Plan and is committed to maintaining the privacy of your personal health information under the plan in accordance with HIPAA privacy standards, which took effect April 14, 2003. The plan and its benefit administrators will use and disclose health information only as allowed by federal law.

The plan has provided you with a *Notice of Privacy Practices*, describing how health information about you may be used or disclosed by the plan. If you would like to receive another copy of this notice, please contact the Portico Health Care Advocacy Team. (See *Glossary* for a brief list of your HIPAA rights and page 57 for *Privacy Contact* information.)

Protected health information (PHI) — PHI is the identifiable health information about you that is created, received, or maintained by the plan. The privacy of your health information that is used or disclosed by the plan is protected by HIPAA. The plan is required by law to:

- Maintain the privacy of your PHI
- Provide you with a notice of the plan's legal duties and privacy practices with respect to your PHI

The plan may use, share, or disclose PHI to pay your health care benefits, operate the plan, or for treatment by a health care provider. In addition, the plan may use or disclose your information in other special circumstances described in the privacy notice. For any other purpose, the plan requires your authorization for the use or disclosure of your PHI. An authorization form is available by visiting *PorticoBenefits.org* and signing in at myPortico or by calling the Health Care Advocacy Team at 800.352.2876.

Coordination of Benefits

The ELCA health plan is designed and funded to help protect you and your family from catastrophic financial loss due to medically necessary treatment of illness or injury. You share in the costs of your medical expenses (deductibles, copayments, and coinsurance) — even with duplicate coverage.

When you have more than one group health insurance policy for you and your family members, the ELCA health plan determines which plan pays first (primary), second (secondary), or third (tertiary). The health plan does not coordinate prescription drug coverage with other insurance plans. Generally, coverage under two group plans may be of value only if the benefits of the secondary plan are better than the benefits under the primary plan.

Determining primary coverage — When a plan member is covered under two or more group health plans, the primary responsibility for payment of benefits will be determined by the benefit administrator based on national coordination of benefits insurance guidelines. Generally:

- The plan that covers the member as an employee has primary responsibility for that individual's claims. For example, the ELCA plan will be primary for the sponsored ELCA member's claims and the employer plan of his or her spouse will be primary for the spouse's claims.
- When a child (whose parents are not divorced) is covered under the plan of both parents, the primary plan is the plan of the parent with the earlier birthday in a calendar year. For example, the plan of the parent born in March will be primary for the child; the plan of the parent born in October will be secondary.
- When a child is covered under the plan of both parents and his or her parents are divorced or their partnership is terminated:
  - The plan of the parent made responsible by legal decree is the primary plan for the child
  - If there is no legal decree that establishes responsibility for the child's medical expenses, the plan that covers the child as a dependent of the parent with custody shall have primary responsibility. However, if the parents have joint custody of the child, the plan that has covered the child for the longest time will have primary responsibility.
- If the above provisions do not establish responsibility, the primary plan is the plan that has covered the individual the longest.
- If you have Medicare coverage and ELCA-Primary health coverage, Medicare's payer order rules will apply.

Secondary payer — As the secondary payer, benefits under the ELCA health plan are calculated by first determining the "normal" benefits available, as if no other primary coverage existed. Then the amount already paid by the primary plan is subtracted from the "normal" benefits. If the primary plan paid the same or more than the "normal" benefits, the ELCA plan will pay zero. If the primary plan paid less than the "normal" benefits, the ELCA plan will pay the difference between the "normal" benefits and the amount paid by the primary plan. In either of these situations, the member will receive between the two plans, at least the amount he or she would have received if he or she had only ELCA plan benefits.

Third-Party Liability (Subrogation)

Subrogation is a legal process that allows Portico to substitute itself in your place regarding a claim or legal right to compensation from a third party (person or entity) who was responsible for your injury or illness.

Upon payment of benefits under the ELCA health plan, Portico will be subrogated to your rights of recovery against any third party, including recoveries from:

- People who commit wrongful acts, injuries, or damages for which a civil action can be brought (tort-feasor)
- Underinsured/uninsured motorist coverage
- Employers' and/or workers' compensation insurers
- Other substitute coverage or any other right of recovery, whether based on tort or contract

This applies to you and any person claiming benefits through you or on your behalf (trustee, personal representative, executor, next of kin, heirs, etc.).

Reimbursed first — Portico will be reimbursed from any recovery before payment of any other existing claims, including any claim by you for general damages. The entire amount of any damages recovered (not only the part specifically allocated to medical and dental expenses) is considered reimbursement for eligible expenses.

If you fail to remit to Portico any amount to which it is entitled, Portico may withhold the amount from future payments under this plan.

Mandated insurance — If you fail to obtain any type of state or federal mandated insurance coverage (Medicare, Medicaid, workers' compensation, or no-fault insurance), Portico will be allowed to fully assert our subrogation rights.

Lump-sum settlements — If you voluntarily accept a lump-sum (or other) settlement without the consent of Portico and the settlement results in a waiver or abolishment of our subrogation rights against the third party, we will be relieved of any obligation to pay past, present, or future claims or expenses relating to the illness or injury.

Appeals Procedure

The health plan's administrators are responsible for making decisions about claims or requests for benefits according to the terms of the ELCA Health Benefits Plan. The initial determination

of benefits is made by the benefit administrator. If you are dissatisfied with the administrator's initial decision, you may appeal as follows:

- To appeal a **medical and mental health benefit** adverse determination — Contact Blue Cross to request an external independent review with an organization contracted by Blue Cross to provide a binding, final determination.
- To appeal a **prescription drug benefit** adverse determination — Contact Express Scripts to request an external independent review with an organization contracted by Express Scripts to provide a binding, final determination.
- To appeal a **dental benefit** adverse determination — You may appeal in writing to the president of Portico within 180 days of your receipt of any adverse determination. Include the facts of your case, any new or additional information not considered in the initial decision, and the outcome you desire.

  President — The president will review your dental claim with the advice and counsel of the internal appeals committee, which will consist of at least three staff members who were not involved with the initial decision. The president will respond in writing within 30 days of receipt of your appeal and signed authorization for disclosure of protected health information (unless the president notifies you of the need for an additional 30 days).

  The president may approve an appeal only if it is determined that an error was made in the initial determination or the appeal involves matters relating to plan interpretation.

  In the case of changing technology or circumstances, the president may recommend an expansion of coverage requiring a plan amendment, which may or may not be retroactive. All plan amendments must be approved by the president, the Portico board of trustees, and/or the ELCA Church Council in accordance with the provisions described on pages 46 – 47.

  Appeals committee — A dental benefit appeal may be filed with the appeals committee of Portico's board of trustees within 60 days of your receipt of the president's written response if you are dissatisfied with the decision of the president.

  The appeals committee will consist of five to seven members of the board of trustees, at least one of whom must be a participant in the ELCA Pension and Other Benefits Program. Additionally, the committee may include independent consultants with expertise in the area of the appeal, to serve with voice but not vote.

  The appeals committee will schedule a meeting within 30 days of receiving your appeal and signed authorization. The final decision of the appeals committee will be forwarded to you within 60 days of receipt of the appeal. All decisions of the appeals committee are final.

  Court system — In the event you have exhausted the previously described appeals procedures and are dissatisfied with the final decision of the appeals committee of Portico, you may initiate legal action in the Minnesota Fourth Judicial District Court,

Hennepin County. Any removal of such action must be to the United States Court for the District of Minnesota.

Limitation of Liability

Portico is not liable for the failure of any employer to enroll its employee as a sponsored member in the plan or for the failure of any employer to make contributions to the plan on the employee's behalf. Also, Portico is not liable to any member or other person or entity for any of its acts carried out in good faith and based upon information available at the time.

Obligations of a Sponsored Member

As a sponsored member of the ELCA health plan, you agree to comply with all Portico requirements regarding enrollment and administration of the plan. This includes, but is not limited to, providing your:

- Date of birth
- Disability status
- Marital status
- Social Security number
- Family support obligations
- Medicare status

If you fraudulently or inappropriately use, misuse, or overuse these plan services and or supplies, Portico has the right to terminate your participation in the ELCA Pension and Other Benefits Program. In addition, you will not be eligible for coverage continuation under the ELCA health plan.

Obligation of a Sponsoring Employer

By sponsoring an eligible employee in the ELCA health plan, the sponsoring employer agrees to:

- Be bound by the terms of the ELCA health plan
- Provide the necessary information to Portico for the administration of the ELCA health plan
- Promptly notify Portico of any IRS audit or change in status that could cause the employer to cease to be eligible to participate in the plan

An employer may discontinue participating in the ELCA benefits program by notifying Portico and complying with any procedures established by Portico for discontinuing participation. Portico may discontinue the participation of an employer if Portico, in its sole discretion, determines the employer is no longer an eligible employer, as defined by the program, or if the employer has failed to comply with the provisions of the program.

Correction of Errors

It is recognized that in the operation and administration of the ELCA Health Benefits Plan, certain mathematical and accounting errors may be made or mistakes may arise for various reasons, including factual errors in information supplied to the benefit administrators, Portico, or its board of trustees. Portico has the power to make equitable adjustments to correct such errors as Portico, in its sole discretion, considers appropriate. Adjustments will be final and binding on all persons.

Plan Information

While every effort has been made to ensure that the information contained in this communication is correct, if there is any omission or misstatement, the applicable legal plan document will control. The eligibility for any benefit will be governed by the terms of the applicable plan, program, or policy. Portico (and its designee or the insurer or claims administrator, as applicable) shall have the power, including, without limitation, discretionary power to make all determinations that the plan requires for its administration, and to construe and interpret the plan for purposes of determining eligibility and benefits. The assets of each plan are held in various trusts and therefore do not allow one plan to fund a net shortfall of another plan.

The health plan is self-insured and is not provided through an insurance company. Portico's ability to pay claims is dependent on continued contributions, claims experience, and market performance. Portico reserves the right to amend, modify, or terminate any plan or benefit policies or programs in whole or in part at any time. Plan documents are available by contacting Portico. Our policies, programs, and plans are not subject to the Employee Retirement Income Security Act (ERISA).

Self-Insured Plan

The health plan is a self-insured plan. Although Portico has contracted with other companies to administer certain benefits of the plan, these companies do not insure any part of the plan. All benefits to which a person becomes entitled hereunder shall be provided only out of the ELCA Medical and Dental Benefits Trust and only to the extent that such trust is adequate therefore.

QMCSO Order Notice

Please call Portico for more information if you have a Qualified Medical Child Support Order (QMCSO) that needs to be processed.

Amendment to the Plan

The ELCA Churchwide Assembly, the ELCA Church Council, or Portico may propose amendments to the plan. All proposed amendments must be submitted to Portico for recommendation before final action is taken by the Church Council.

- The president of Portico will approve amendments involving no change in policy and little or no change in cost or benefits. Amendments approved by the president will be reported to the board of trustees of Portico.
- The ELCA Church Council will approve amendments involving a significant change in policy or a significant change in cost or benefits. The Church Council may, in its sole discretion, submit any proposed amendment to the Churchwide Assembly for final action.
- The board of trustees of Portico will approve all other amendments. Amendments approved by the board of trustees will be reported to the ELCA Church Council.

No amendment will reduce entitlement under the ELCA health plan for expenses incurred prior to the effective date of the amendment.

No Guarantee of Tax Consequences

Portico makes no commitment or guarantee that any amounts paid to or for the benefit of a member under this plan will be excludable from the member's gross income for federal, state, or local income tax purposes. It is the member's responsibility to determine whether each payment is excludable from his or her gross income for income tax purposes. It is also the member's responsibility to notify Portico if he or she has any reason to believe a payment is not excludable for income tax purposes.

Non-Assignability of Rights

The member's rights to receive any reimbursement under this plan are not transferable by the member through assignment or any other method and are not subject to claims by the member's creditors by any process whatsoever. Any attempt to do so will not be recognized by Portico, except as required by law.

Termination of the Plan

The plan is designed, and contribution rates are established, to maintain long-term plan viability. However, the ELCA Church Council may terminate the ELCA health plan by following the previously described amendment procedure. If the plan is terminated, the existing funds will be used to pay benefits for expenses incurred prior to the effective date of the termination. Any surplus funds will be distributed back to the ELCA. If the funds are distributed, no future benefit payments will be made from the plan.

Fiduciary Standards

Prudent investor rule — Managers and trustees administering or investing assets are bound by the "prudent investor" rule. This common-law concept has evolved through the years and is set forth in the American Law Institute's Restatement of the Law of Trusts, Third, section 227, which states in part that:

> *The trustee is under a duty to the beneficiaries to invest and manage the funds of the trust as a prudent investor would, in light of the purposes, terms, distribution requirements, and other circumstances of the trust.*
>
> *(a) This standard requires the exercise of reasonable care, skill, and caution, and is to be applied to investments not in isolation but in the context of the trust portfolio and as a part of an overall investment strategy, which should incorporate risk and return objectives reasonably suitable to the trust.*
>
> *(b) In making and implementing investment decisions, the trustee has a duty to diversify the investments of the trust unless, under the circumstances, it is prudent not to do so.*

Many states, including Minnesota, have incorporated the prudent investor rule in their statutes. Portico Benefit Services, a nonprofit corporation incorporated in Minnesota, is governed by Minnesota Statute §501B.151 which sets the statutory requirements governing trust investments.

Fiduciaries — Fiduciaries (those responsible for the plan's assets) invest the plan contributions expressly with members' interest in mind and in agreement with the following requirements:

- For the exclusive purpose of providing benefits to members, less reasonable expenses of administering the plan
- With the care, skill, prudence, and diligence under the current conditions that a prudent person with like character, similar aims, and knowledge of fiduciary matters would use
- By diversifying the investments of the plan to minimize the risk of large losses, unless, under the circumstances, it is clearly prudent not to do so
- In accordance with the provisions of the ELCA health plan

Glossary

Allowed Amount

The amount determined by a benefit administrator to be the maximum allowable charge — the lesser of billed charge or a percentage of the in-network contracted rate for the same or similar services — for the service provided by an out-of-network provider. Eligible expenses are limited to this amount. Amounts that exceed the allowed amount are the member's responsibility and do not apply to the deductible or out-of-pocket limit.

Blue Distinction Center

Blue Distinction® is a designation awarded by the Blue Cross and Blue Shield companies to medical facilities that have demonstrated expertise in delivering quality health care. The designation is based on rigorous, evidence-based, objective selection criteria established in collaboration with expert doctors' and medical organizations' recommendations. Its goal is to help consumers find quality specialty care on a consistent basis, while enabling and encouraging health care professionals to improve the overall quality and delivery of care nationwide.

Brand-Name Drug

A drug that has a trade name and is protected by a patent. It is known by this name rather than its chemical name. Brand-name drugs are usually sold for higher prices than their generic equivalents.

Coinsurance

The percentage amount you pay for covered expenses, up to the annual out-of-pocket limit.

Copayment

The specific dollar amount you pay for prescription drugs. For example, you'll have an $18 copayment for up to a 90-day supply of a generic drug purchased from Express Scripts home delivery service.

Deductible

The amount of covered expenses you incur each calendar year before the plan starts to pay a percentage of the expense. For example, if your medical and mental health benefit has a $1,000 deductible, you pay the first $1,000 of your covered medical and mental health benefit expenses each year. This is called "satisfying" or "meeting" the deductible.

Defined Compensation

Whether you are an ELCA pastor, rostered layperson, or lay employee, annual defined compensation includes your base salary, before any pretax benefit contributions* are deducted.

* Pretax benefit contributions include member pretax contributions to the ELCA Retirement Plan or another eligible retirement plan or to qualified reimbursement accounts for medical, child care, or transportation expenses.

If you are an ELCA pastor, your annual defined compensation also includes any Social Security tax allowance paid to you and one of the following:

- If housing is not provided, the cash housing allowance paid to you
- If housing is provided, an additional 30% of your base salary and any Social Security tax allowance, plus any household furnishings or utilities allowance paid to you

Annual defined compensation does not include:

- The cost of utilities paid to the utility company by your congregation or organization
- Employer contributions, including housing equity contributions made to the ELCA Retirement Plan or other eligible retirement plan
- Non-taxable reimbursements or expense allowances (auto and mileage, continuing education, book, or professional expenses)

Dental Benefit Administrator

The entity contracted with Portico to administer dental coverage. As the dental benefit administrator, Delta Dental:

- Credentials and contracts with dental providers to provide treatment and services to members who have dental coverage and to accept negotiated rates as payment in full
- Administers claims for eligible dental expenses
- Administers medical-necessity requirements and allowed amount limits for dental benefits coverage

Eligible Dependent

A person who is covered as a member of the ELCA Health Benefits Plan and meets the definition of an eligible spouse, eligible same-gender partner, or eligible child.

Eligible ELCA Employers

Congregations, ministries of the ELCA churchwide organization, and other organizations may sponsor their eligible employees in the ELCA Pension and Other Benefits Program.

- ELCA synods, seminaries, and other ministries of the ELCA churchwide organization (except for the ELCA publishing house, Augsburg Fortress) must sponsor all of their eligible employees. However, they are not required to sponsor temporary employees or pastors of other church bodies.
- ELCA congregations may sponsor any or all of their pastors, rostered laypersons, and other eligible employees.
- ELCA institutions not subject to the coverage requirements of the Tax Reform Act of 1986 may sponsor any or all of their eligible employees. Institutions that wish to provide only a retirement benefit may participate in the ELCA Master Institutional Retirement Plan, but then must sponsor all eligible employees (excluding those sponsored in the Pension and Other Benefits Program). These ELCA institutions generally include elementary and secondary schools, day care centers, camps, and conference centers.
- ELCA institutions subject to the coverage requirements of the Tax Reform Act of 1986 may sponsor any or all of their eligible ELCA pastors. They may also sponsor rostered laypersons and other employees, but then must enroll all those eligible. Institutions that elect to provide only a retirement benefit may participate in the ELCA Master

Institutional Retirement Plan, but then must sponsor all eligible employees (excluding those sponsored in the Pension and Other Benefits Program). These institutions generally include ELCA-affiliated social ministry organizations, colleges and universities, nursing homes, and hospitals.

Eligible Employers (Other)

Certain other employers may sponsor their eligible employees in the Pension and Other Benefits Program provided they meet one of the following criteria:

- Other tax-exempt organizations (referred to as 501(c)(3) organizations):
  - Former ELCA congregations (other than a congregation described below) that sponsored at least one eligible employee on or after Jan. 1, 2005, may sponsor any or all eligible employees.
  - A congregation or qualified church-controlled organization of a non-ELCA church body that has common religious bonds with the ELCA and has been approved by Portico to be the church body's sole benefits provider.
  - Ecumenical partner congregations may sponsor any or all ELCA pastors or rostered laypersons serving under call to a non-ELCA ministry.
  - Other tax-exempt organizations may sponsor any or all ELCA pastors serving under call to a non-ELCA ministry. They may also sponsor ELCA rostered laypersons serving under call but then must sponsor all those eligible. These organizations include social ministry organizations, ecumenical agencies, non-ecumenical congregations, and pastoral care organizations.
- Taxable organizations (referred to as non-501(c)(3) organizations) may sponsor any or all ELCA pastors serving under call to a non-ELCA ministry. These organizations include government agencies and for-profit organizations.

Eligible Expense

A service or supply that is considered for reimbursement under the plan, because it:

- Is incurred while you (or your family) are covered under the plan
- Is billed to you (or your dependent)
- Is ordered by an eligible plan provider
- Is medically necessary
- Is not specifically limited or excluded under the rules of this plan
- Meets the allowed amount guidelines used by one of the plan's benefit administrators

Eligible Family Member

A member's spouse, eligible same-gender partner, or eligible child who is enrolled in the ELCA Health Benefits Plan.

Eligible Same-Gender Partner

An individual who, together with a member of the ELCA benefits program, completes and signs an *Affidavit of Partnership* attesting that they are financially interdependent (share financial obligations), not married to or legally separated from anyone else, and live in a publicly accountable, lifelong, monogamous, same-gender relationship.

Experimental Drug, Device, Procedure, or Treatment

Charges related to a drug, device, procedure, or treatment that is deemed experimental or investigational by the benefit administrator are considered ineligible expenses under the ELCA Health Benefits Plan. The benefit administrator determines a drug, device, procedure, or treatment is experimental or investigational if:

- Controlled clinical trials have not substantiated its safety and effectiveness
- Approval has not been granted by the FDA for marketing, if required
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes only
- The protocol(s) used by the treating facility states that it is experimental, investigational, or for research purposes

If a member has a life-threatening illness or condition (which is likely to cause death within one year of the request for treatment), Blue Cross may determine that an experimental or investigative treatment meets the definition of a covered benefit for that illness or condition.

Family Deductible and Limits

The individual deductible and individual out-of-pocket limit apply to each covered family member, unless the deductible or out-of-pocket limit for the family coverage type (member and child, member and spouse or eligible same-gender partner, or member and spouse or partner and child) has been met. The family amount is met when the eligible expenses of two or more family members reach the family maximum amount during the year.#

Generic Drug

A drug known by its chemical name rather than by a brand name and not protected by patents. The FDA requires generics to have the same quality, strength, purity and stability as brand-name drugs. Generic drugs are usually sold for significantly lower prices than their name-brand equivalents.

Health Benefit Administrators

- Blue Cross and Blue Shield of Minnesota — administers the medical and mental health benefit
- Delta Dental — administers the dental benefit
- Express Scripts, Inc. — administers the prescription drug benefit
- EyeMed — administers the vision discount program
- HearPO — administers the hearing discount program
- Mayo Clinic Health Solutions — administers the EmbodyHealth web portal and health coaching
- OptumHealth℠ — administers the ELCA NurseLine℠ service
- ValueOptions — administers the employee assistance plan (EAP) benefit

HIPAA Rights

With respect to your protected health information (PHI), under the Health Insurance Portability and Accountability Act (HIPAA), you have the right to:

- Inspect and copy certain portions of your PHI maintained by the plan

- Request an amendment of your PHI
- Request restriction on the uses and disclosure of your PHI
- Request communication be made to you through an alternate means or location
- Obtain an accounting of disclosures the plan has made for reasons other than treatment, payment, or health care operations to you, or for required or authorized disclosures
- Request that your provider not share PHI with the plan if you paid for the entire service
- Request copies of your health records in electronic format, if available

Maintenance Medication

Medication taken on an ongoing basis for a chronic condition.

Medical and Mental Health Benefit Administrator

The entity contracted with Portico to administer the medical and mental health benefit. As the medical and mental health administrator, Blue Cross and Blue Shield:

- Credentials and contracts with in-network providers to provide treatment and services to members with ELCA-Primary health coverage and to accept contracted rates as payment in full
- May provide financial incentives to in-network providers to promote delivery of effective, cost-efficient care
- Administers claims for eligible in-network and eligible out-of-network medical and mental health expenses, subject to allowed amount limitations for expenses from out-of-network providers
- Administers the precertification and medical necessity requirements for ELCA-Primary health coverage
- Administers programs to help members improve health and manage chronic conditions

Medically Necessary Treatment

A service or supply furnished by an eligible provider that is determined by the benefit administrator to be appropriate for the diagnosis, care, or treatment of the disease or injury. The fact that a provider prescribes, orders, recommends, or approves health services does not in itself make the services medically necessary. To be appropriate, the health care service or supply must be one that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms. The service must be:

- In accordance with generally accepted standards of medical practice, standards that are based on creditable scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, specialty society recommendations, and the views of providers practicing in relevant clinical areas and any other relevant factors
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient’s illness, injury, or disease
- Not primarily for the convenience of the patient, physician, or other health care provider
- Not more costly than an alternative service or sequence of services
- At least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury, or disease

The following services or supplies are not considered to be medically necessary:

- Those that do not require the technical skills of a licensed provider of a service covered under this plan who is acting within the scope of his or her license
- Those furnished mainly for your personal comfort or convenience or that of your caregiver, family member, or health care provider or facility
- Those that are furnished solely because you are an inpatient, when the disease or injury could safely and adequately be diagnosed or treated while you are not hospitalized
- Those that could safely and adequately be provided in a less costly setting or manner
- Those that are inappropriately used, misused, or overused by a member

Member

A member is a sponsored or retired individual, or someone continuing coverage who is entitled to benefits from this plan. Also includes spouses, former or surviving spouses (or eligible same-gender partners), and children who are entitled to benefits from this plan.

Network Provider

A provider that has contracted with a plan benefit administrator to accept contracted rates as payment in full for treatment or services (less deductible and coinsurance) and to perform agreed upon tasks (obtain prior authorization, submit claims, etc.) on your behalf.

Non-Formulary Drugs

Brand-name drugs that are not included on the formulary because they are new to the marketplace or there are therapeutically equivalent drugs that cost less.

Out-of-Network Provider

An eligible plan provider or entity that has not contracted with the administrator but provides treatment or services that are eligible for reimbursement under this plan as eligible out-of-network medical expenses, subject to a benefit administrator's allowed amount guidelines. The allowed amount can be significantly less than the amount billed by the out-of-network provider.

Out-of-Pocket Limit

The maximum amount you pay in a calendar year for plan-eligible medical and mental health expenses. The plan pays 100% of eligible expenses after you reach the annual out-of-pocket limit.

Personal Wellness Account Administrator

The entity that has contracted with Portico to manage and administer the personal wellness account. As the personal wellness account administrator, SelectAccount (affiliate of Blue Cross and Blue Shield), processes and pays claims submitted to your personal wellness account.

Prescription Drug Benefit Administrator

The entity contracted with Portico to manage and administer the prescription drug benefit. The prescription drug administrator, Express Scripts, Inc.:

- Contracts with participating network pharmacies to provide prescription drugs to members who have prescription drug coverage and to accept negotiated rates as payment in full

- Operates the prescription drug home delivery service
- Establishes and administers medical-necessity criteria
- Administers claims for eligible prescription drug expenses
- Determines the list of eligible specialty drugs and operates the specialty drug pharmacy
- Administers Medicare prescription drug plans

Prior Authorization

A mandatory process (initiated by your doctor, you, or someone acting on your behalf) to request prior approval from a benefit administrator for all inpatient and certain types of outpatient medical, facility-based mental health services, and some drugs.#

Separation from Service

A member is considered separated from service when he or she is no longer serving in a participating congregation or organization due to resignation, discharge, retirement, death, or failure to return to active service at the end of an authorized leave of absence. NOTE: A pastor or rostered layperson on leave from call is not considered separated from service.

Spending Accounts

Spending accounts (flexible spending accounts, personal wellness account) are reimbursement arrangements that help you pay for health and day care expenses.

- You can contribute pretax dollars to health care or dependent care flexible spending accounts.
- You can earn personal wellness account credits, which are credited to your personal wellness account.

Use these savings to lower your out-of-pocket costs for health, health care, or day care expenses.

Contact Information

Portico Benefit Services

Health Care Advocacy Team

Contact the health care advocacy team if you need help understanding your health care benefits.

800.352.2876 or 612.333.7651 / F 612.752.4367
healthcare@PorticoBenefits.org

Portico Service Center

Contact or email with questions about your eligibility or contribution rates or if you have a change of family status, address, or coverage.

800.352.2876 or 612.333.7651 / F 612.334.5399
mail@PorticoBenefits.org

Hours
7:30 a.m. – 5 p.m. (Central), Monday – Friday

Mailing address
Portico Benefit Services
800 Marquette Ave., Ste. 1050
Minneapolis, MN 55402-2892

PorticoBenefits.org

Privacy Contact

Contact or email for information about the plan's privacy practice, to exercise your rights, or to complain about how the plan is handling your protected health information.

Portico Benefit Services
800 Marquette Ave., Ste. 1050
Minneapolis, MN 55402-2892
800.352.2876 or 612.333.7651, ext. 4420

privacycontact@PorticoBenefits.org

Blue Cross and Blue Shield

Contact Blue Cross with questions about medical and mental health benefit, personal wellness accounts, flexible spending accounts, and the fitness discount.

bluecrossmn.com/elca

Register or sign in to check medical and mental health claims history, view your personal wellness account and/ or FSA, download spending account claim and direct deposit forms, and find network providers.

Customer service
Call about medical and mental health claims, dedicated nurse support, fitness discount program, Healthy Start pregnancy program, Stop Smoking program, personal wellness account, flexible spending accounts (FSAs), and identification cards. Call to request prior authorization.

866.455.8216

Hours
7 a.m. – 8 p.m. (Central), Monday – Friday

Delta Dental — Dental Benefit

Use *Dentist Search* online to locate a participating provider: choose Delta Dental PPO or Delta Dental Premier providers.

deltadentalmn.org

Customer service
Call to ask about the benefit, claims, getting additional identification cards, or to find a participating dentist.

800.448.3815
7 a.m. – 7 p.m. (Central), Monday – Friday

Claims address
Delta Dental
P.O. Box 59238
Minneapolis, MN 55459-0238

Express Scripts, Inc. — Prescription Drug Benefit

Call or visit online to find participating pharmacies in your area (select *Pharmacy Locator*), order home delivery service prescriptions and refills, transfer a prescription to home delivery service, find information about drugs and health conditions.

express-scripts.com

Customer service
800.575.8090 / TTY 800.305.5376
Accessible 24 hours a day, seven days a week

Prior authorization — For doctors only
800.417.8164
Sometimes your doctor must request authorization for certain drugs from Express Scripts before the prescription can be filled (if the quantity exceeds the limit or if a drug is prescribed before the comparable, less expensive step-one drug has been tried).

Accredo Specialty Pharmacy

For assistance with specialty drugs, contact Accredo (formerly CuraScript), an Express Scripts subsidiary. Specialty drugs include injectable and oral drugs with specific storage and handling requirements.

Customer service
866.848.9870
7 a.m. – 8 p.m. (Central), Monday – Friday
8 a.m. – noon (Central), Saturday

EyeMed Vision Care#— Vision Discount Program

If you have any questions about the EyeMed discount program, participating provider locations, identification cards or services, call EyeMed at 866.723.0391. Reference Group Code 9238338.

eyemedvisioncare*.com*

For discount details, select Members, and then Login/Register. Bypass the registration option, and under Discount Plan Members, select "E" then ELCA Board of Pensions (9238338) from the list. To find participating discount program providers, select *Locate a Provider*, and then enter the security code displayed on the screen.

HearPO — Hearing Discount Program

(through a partnership with Delta Dental of Minnesota)

Members enrolled with ELCA coverage can call HearPO to get discounts on hearing aids and other hearing services.

Customer Service
855.531.4694
7 a.m. – 7 p.m. (Central), Monday – Friday

hearpo.com/deltadentalmn

Mayo Clinic Health Solutions — Health Assessment, EmbodyHealth Web Portal, and Newsletter

Register on the EmbodyHealth web portal using an email address and a password you choose. Enter the identification number from your Blue Cross identification card when requested.

elcaforwellness.org

OptumHealth℠ — ELCA NurseLine℠

Call with health questions or concerns 24 hours a day, seven days a week.

877.856.8145 / TTY 800.855.2880; ask to be connected to 877.856.8145

Outside the United States: 800.411.7998 and press “2” to speak to a nurse

ValueOptions — Employee Assistance Program

Call to talk to an EAP professional about stress, relationships, family issues, work issues, or any other personal concern. Eligible EAP services may include telephone consultation, assessment, and in-person counseling.

800.432.5155

Accessible 24 hours a day, seven days a week.

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