The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact myPortico.PorticoBenefits.org. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at myPortico.PorticoBenefits.org or call 800.352.2876 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network providers $1,700/person $2.550 /member + child(ren) $3,400 /member + spouse, family Out-of-network providers $1,700/person $2,550 /member + child(ren) $3,400 /member + spouse, family Separate in-network, out-of-network deductibles. Sponsored members may contribute pretax to a health flexible spending account (FSA) to help pay for eligible health care expenses.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services and prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. Even if you haven't met the deductible, the plan covers text-based primary care visits administered by 98point6 at $0 copayment.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network providers $4,300/person, $8,600/family Out-of-network providers $4,300/person, $8,600/family Separate in-network, out-of-network out-of-pocket limits.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit. Certain specialty drugs are considered non-essential health benefits; a portion of the drugs' cost is reimbursed by the drug manufacturer and will not apply to your out-of-pocket limit.

Will you pay less if you use a network provider?	Yes. See health.PorticoBenefits.org or call 877.851.5656 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your in-network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose for covered services without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	Limits for infertility treatment, acupuncture, and massage therapy visits. Preauthorization is required for autism services, dialysis and oncology services.
	Preventive care/screening/ immunization	No charge	40% coinsurance. Deductible does not apply.	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (X-ray, blood work)	20% coinsurance	40% coinsurance	Preauthorization is required for genetic testing.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization is required for MRI/MRA, and PET scans.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at myPortico.PorticoBenefits.org	Generic drugs	Per prescription— *Retail:* $12 copay *Mail order:* $24 copay	Per prescription (up to 31-day supply)— $12 copay plus any amount over the allowed amount	Up to a 31-day supply (retail); up to 90-day supply (mail order).
	Preferred brand-name drugs	Per prescription— *Retail:* 20% coinsurance, $55 min/$90 max *Mail order:* 20% coinsurance, $120 min/$210 max	Per prescription (up to 31-day supply)— 20% coinsurance, $55 min/$90max plus any amount over the allowed amount	Up to a 31-day supply (retail); up to 90-day supply (mail order). 30-day supply of preferred brand-name insulin: $25 copayment
	Non-preferred brand-name drugs	Per prescription— *Retail:* 35% coinsurance, $90 min/$180 max *Mail order:* 35% coinsurance, $210 min/$300 max	Per prescription (up to 31-day supply)— 35% coinsurance, $90 min/$180 max plus any amount over the allowed amount (up to 31-day supply)	Up to a 31-day supply (retail); up to 90-day supply (mail order).
	Specialty drugs	Per prescription— Generic: $12 copay *Preferred brand:* 20% coinsurance, $55 min/$90 max *Non-preferred brand:* 35% coinsurance, $90 min/$180 max	Not covered.	Limited to 31-day supply. Must be purchased from the Express Scripts specialty pharmacy, Accredo. See "Important Questions" regarding the plan's out-of-pocket limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Preauthorization is required.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Out-of-network emergency and urgent care services apply to the in-network deductible and out-of-pocket limit.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	20% coinsurance	

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Preauthorization is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Preauthorization is required for intensive outpatient and partial hospitalization services.
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	No charge	40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization is required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Preauthorization is required for autism services.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Preauthorization is required. Limit: 120 days/year
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization is required if > $1,500.
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	No charge	40% coinsurance. Deductible does not apply.	Limit: One preventive exam per year.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge	Amount exceeding Delta Dental allowed amount	Limit: 2 preventive dental check-ups/year, if enrolled in ELC Dental Benefit (administered by Delta Dental)

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Facility expenses for certain surgeries performed at an out-of-network facility
- Long Term Care
- Rehabilitative and habilitative services, unless medically necessary
- Routine foot care, unless medically necessary
- Services considered experimental, investigational

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture, up to 12 visits per year, for chronic pain lasting for more than 6 months, or for nausea associated with surgery, chemotherapy, and pregnancy
- Bariatric surgery, (preauthorization is required.)
- Chiropractic care, medically necessary
- Dental care (Adult) — covered under dental benefit for members enrolled in ELCA Dental Benefit
- Prescription hearing aids for adults, no more than $3,000 every 36 months
- Prescription hearing Aids for children, up to one aid per ear every 36 months, no more than $3000 per aid
- Infertility treatment, up to $20,000 maximum lifetime
- Non-emergency care when traveling outside the U.S. (eligible care with an in-network provider receives in-network benefits, out-of-network provider receives out-of-network benefits)
- Private duty nursing services for respite and other care (preauthorization is required)
- Routine eye care (Adult)
- Weight loss programs, if provided by eligible medical provider

Your Rights to Continue Coverage: There is an agency that can help if you want to continue your coverage after it ends. The contact information for the agency is: Portico Benefit Services, 800.352.2876. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 800.318.2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Quantum Health Care Coordinators, 877.851.5656.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 800.352.2876.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800.352.2876.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 800.352.2876.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800.352.2876.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments, and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$1,700**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$10
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,470**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$1,700**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$500
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,250**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$1,700**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(X-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$10
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,910**

Note: These numbers assume the patient does not participate in the plan's management program. If you participate in the plan's diabetes management program, you may be able to reduce your costs. For more information about the diabetes management program, please contact 877.851.5656.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.