

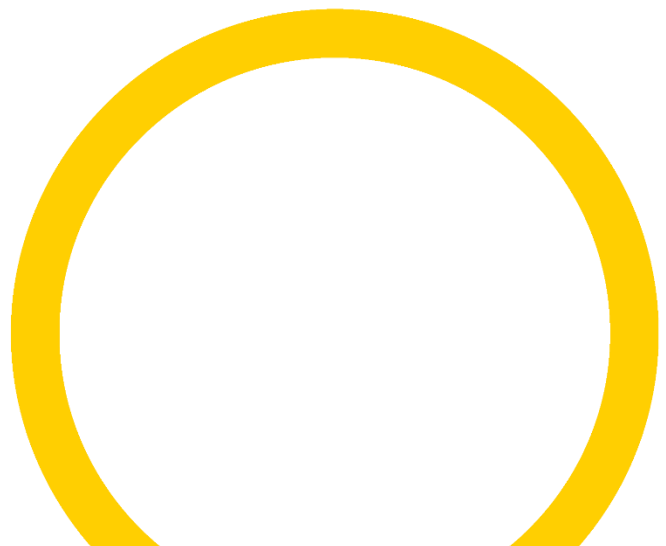
ELCA MEDICAL AND DENTAL BENEFITS PLAN

- **ELCA-Primary Health Benefits**
- **ELCA Medicare-Primary Health Benefits**

Traditional Benefits Program

Summary Plan Description

Effective January 1, 2022



Contents

Introduction	4
Section 1 Overview	5
ELCA-Primary Benefits	5
ELCA Medicare-Primary Benefits	5
Section 2 Eligible Employer, Eligible Employee, and Sponsorship Criteria	6
Section 3 Eligible Employee Enrollment	10
Enrollment	10
Waiving Coverage and Re-enrollment of a Sponsored Member	11
Starting or Resuming Coverage if Coverage Waived	11
Section 4 Spouse, Eligible Same Gender Partner, and Child Enrollment	12
Eligible Spouse and ESGP	12
Eligible Child	13
Enrollment of Spouse, ESGP, and Child	14
Waiving Coverage and Re-enrollment of a Sponsored Member's Spouse, ESGP, and Child	15
Section 5 Retired Member Enrollment	16
Enrollment as a Retired Member	16
Waiving Coverage and Re-enrollment of a Retired Member	17
Annual Enrollment for a Retired Member	18
Enrollment of Spouse, ESGP, or Child of a Retired Member	18
Waiving Coverage and Re-enrollment of a Retired Member's Spouse, ESGP, or Child	19
Section 6 Termination and Continuation of Coverage	20
Termination of a Sponsored Member's Enrolled Status	20
Termination of a Retired Member's Enrolled Status	20
Termination of a Spouse, ESGP, or Child's Enrolled Status	20
Termination for Cause	21
Coverage Continuation for Sponsored Members	21
Coverage Continuation for Dependents	22
Waiving Coverage and Re-enrollment for Certain Coverage Continuation Members	24
Section 7 Cost of Medical and Dental Coverage for Sponsored Members, Coverage Continuation Members, Retired Members and Dependents	25
Section 8 Predecessor ELCA Church Body Subsidies	27
Section 9 Mid-Year Changes, Coordination with Other Insurance, Subrogation/Claims	28
Mid-year Changes in Employment or Status	28
Coordination with Other Insurance	32
Portico's Right to Reimbursement (Subrogation)	34
Claim Filing Deadline	34
Section 10 ELCA-Primary Benefits Overview	35

	Deductible, Coinsurance and Maximum Out-of-Pocket for Eligible Medical and Mental Health Expenses.....	37
Section 11	ELCA Medicare-Primary Benefits	40
	Eligibility	40
	ELCA Medicare-Primary Options	41
	Group PPO Medicare Advantage Benefit.....	41
Section 12	ELCA-Primary Medical and Mental Health Expenses.....	43
	Basic Requirement for Medical Expenses	43
	Medical Providers	43
	Hospital and Facility Medical Expenses	44
	Surgical Expenses	44
	Organ Transplant, Bariatric Surgery, Knee or Hip Replacement, or Spine Surgery	44
	Preventive Services and Certain Other Services.....	46
	Other Eligible Medical Expenses.....	48
	Exclusions from Eligible Medical Expenses	52
	Basic Requirements for Mental Health Expenses.....	55
	Mental Health Providers	55
	Hospital and Facility Mental Health Expenses	55
	Exclusions from Eligible Mental Health Expenses	57
	Medical and Mental Health Precertification and Review Requirements	58
	Out-of-network Eligible Medical and Mental Health Expenses.....	60
Section 13	Dental Benefits and Expenses.....	61
	Deductibles and Coinsurance for Eligible Dental Expenses.....	61
	Exclusions from Dental Benefits	63
Section 14	Supporting Services.....	65
Section 15	Prescription Drug Benefit	66
	Exclusions from Eligible Prescription Drug Expenses.....	67
	Cost-Share for Prescription Drugs	68
Section 16	Claims Appeal Procedure	72
Section 17	Miscellaneous Provisions, Disclosures and Benefit Notices	74
Section 18	HIPAA Privacy Compliance.....	81
Section 19	Personal Wellness Account.....	83
Section 20	Glossary	86
Section 21	Vision Care Services	91
	Contact Information — Plan Administrator.....	94
	Contact Information — ELCA-Primary Benefits	95
	Contact Information — ELCA Medicare-Primary Benefits	98
	ID Cards — ELCA-Primary Benefits	100
	ID Cards — ELCA Medicare-Primary Benefits	101
	Appendix – ELCA Traditional Benefits Program	102

Introduction

About the ELCA Medical and Dental Benefits Plan

The legal name of the Plan is the Evangelical Lutheran Church in America Medical and Dental Benefits Plan. It is referred to in this document as the “ELCA Medical and Dental Benefits Plan,” “Medical and Dental Benefits Plan,” “Health Plan,” or “Plan.” The Plan has been amended and restated effective January 1, 2022. The restated Plan provisions apply to all Members obtaining benefits after that date.

About the Summary Plan Description

This Summary Plan Description includes the eligibility requirements, coverage details, and benefit requirements under the Medical and Dental Benefits Plan. The Plan document is the official legal document and your rights under the Plan are governed by it. If this Summary Plan Description is found to be inconsistent with the Plan document, the Plan document will control.

About the Traditional Benefits Program

The Traditional Benefits Program (also known as the ELCA Pension and Other Benefits Program) is a bundled-coverage program that provides one comprehensive set of wellness-oriented benefits to Members. With the Traditional Benefits Program, a Member is enrolled in all of the following four benefit plans:

- ELCA Medical and Dental Benefits Plan
- ELCA Retirement Plan
- ELCA Survivor Benefits Plan
- ELCA Disability Benefits Plan

Members may also be eligible to enroll in the ELCA Flexible Benefits Plan, which offers health savings account and flexible spending account options to Members.

About Portico Benefit Services

For more than 200 years, Portico Benefit Services and the predecessor ministries of the Evangelical Lutheran Church in America have supported the well-being of those who serve and have tailored its benefits to meet the unique needs of this community.

Doing business as Portico Benefit Services, the Board of Pensions of the Evangelical Lutheran Church in America offers health, dental, retirement, life insurance, disability coverage and other benefits designed to enhance the well-being of those serving ELCA-affiliated congregations and organizations.

In addition to the plans under the Traditional Benefits Program, Portico maintains the ELCA Retirement Savings Plan for Members in the Flexible Benefits Program, and the ELCA Master Institutional Retirement Plan and ELCA 457(b) Deferred Compensation Plan for ELCA-affiliated organizations. The assets of each plan maintained by Portico are held in separate trusts and do not allow one plan to fund another plan.

Section 1 Overview

Two benefit packages are available under the ELCA Medical and Dental Benefits Plan.

ELCA-Primary Benefits

An Eligible Employee will have the following ELCA-Primary Benefits if the Eligible Employee meets the Plan requirements, enrolls in the Plan, and is not eligible for primary coverage under Medicare:

- Medical and Mental Health Benefits see Section 12
- Dental Benefits..... see Section 13
- Supporting Services see Section 14
- Prescription Drug Benefits..... see Section 15

ELCA Medicare-Primary Benefits

An Eligible Employee will have the following ELCA Medicare-Primary Benefits if the Eligible Employee meets the Plan requirements, enrolls in the Plan, and is eligible for primary coverage under Medicare:

- Medicare Advantage Benefit see Section 11
- Dental Benefits see Section 13
- Supporting Services see Section 14
- Prescription Drug Benefits see Section 15

Section 2 Eligible Employer, Eligible Employee, and Sponsorship Criteria

Certain Eligible Employers are required to sponsor all Eligible Employees and certain Eligible Employers have partial or full discretion in determining the Eligible Employees to sponsor – provided the discretion is exercised without discrimination and without regard to a health status related factor within the meaning of applicable federal law.

The 7 subsections below describe Eligible Employers, their obligations for sponsoring their Eligible Employees and the criteria to be an Eligible Employee. An Eligible Employer will become a Participating Employer by enrolling an Eligible Employee in the Medical and Dental Benefits Plan.

Section I	Eligible Employers	<ul style="list-style-type: none"> • ELCA synods • ELCA seminaries • ELCA Churchwide Unit: <ul style="list-style-type: none"> ○ Churchwide Organization ○ Women of the ELCA ○ ELCA Mission Investment Fund ○ ELCA Foundation ○ Portico Benefit Services
	Sponsorship Requirement	<ul style="list-style-type: none"> • These Eligible Employers (except for ELCA seminaries) are required to sponsor all Eligible Employees except for temporary employees and non-ELCA ordained clergy. • ELCA seminaries have full discretion in deciding which Eligible Employees to sponsor.
	Eligible Employees	<ul style="list-style-type: none"> • ELCA Minister of Word and Sacrament serving under a letter of call and scheduled to work at least 15 hours a week for six or more months each year. • ELCA Minister of Word and Service serving under a letter of call and scheduled to work at least 15 hours a week for six or more months each year. • Non-ELCA ordained clergy serving under a letter of call or contract and scheduled to work at least 20 hours a week for six or more months each year. • Other employees scheduled to work at least 20 hours each week for six or more months each year, and who have completed any probationary period (not to exceed 90 days).

Section II	Eligible Employers	<ul style="list-style-type: none"> • ELCA congregations • Former ELCA congregations that sponsored an Eligible Employee in this Plan on January 1, 2005, and continuously thereafter • A congregation of a denomination that is in a full communion relationship with the ELCA • A congregation or qualified church-controlled organization of a non-ELCA church body that has common religious bonds with the ELCA and has petitioned to and been approved by Portico to be the church body's sole benefits provider
	Sponsorship Requirement	These Eligible Employers have full discretion in deciding which Eligible Employees to sponsor.
	Eligible Employees	<ul style="list-style-type: none"> • ELCA Minister of Word and Sacrament serving under a letter of call and scheduled to work at least 15 hours a week for six or more months each year. • ELCA Minister of Word and Service serving under a letter of call and scheduled to work at least 15 hours a week for six or more months each year. • Non-ELCA ordained clergy serving under a letter of call or contract and scheduled to work at least 20 hours a week for six or more months each year. • Any other employees scheduled to work at least 20 hours a week for six or more months each year and who have completed any probationary period (not to exceed 90 days).

Section III	Eligible Employers	<p>An ELCA "qualified church-controlled organization" as determined by the ELCA within the meaning of Internal Revenue Code § 3121(w).</p> <p>NOTE: An ELCA elementary or secondary school, day-care center, camp or conference center that is a separately incorporated legal entity will be treated as a separate "Eligible Employer" provided the employer otherwise meets the requirements of this <i>Section III</i>.</p>
	Sponsorship Requirement	These Eligible Employers have full discretion in deciding which Eligible Employees to sponsor.
	Eligible Employees	<ul style="list-style-type: none"> • ELCA Minister of Word and Sacrament serving under a letter of call and scheduled to work at least 15 hours a week for six or more months each year. • ELCA Minister of Word and Service serving under a letter of call and scheduled to work at least 15 hours a week for six or more months each year. • Non-ELCA ordained clergy serving under a letter of call or contract and regularly scheduled to work at least 20 hours a week for six or more months each year.

		<ul style="list-style-type: none"> Other employees scheduled to work at least 20 hours a week for six or more months each year, and who have completed any probationary period (not to exceed 90 days).
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Section IV	Eligible Employers	<p>An ELCA “church-controlled organization” but not a “qualified church-controlled organization” described in <i>Section III</i> above.</p> <p>NOTE: An ELCA elementary or secondary school, day-care center, camp or conference center that is a separately incorporated legal entity will be treated as a separate Eligible Employer provided the employer otherwise meets the requirements of this <i>Section IV</i>.</p>
	Sponsorship Requirement	These Eligible Employers may sponsor any ELCA Minister of Word and Sacrament and must sponsor either all or none of its other Eligible Employees.
	Eligible Employees	<ul style="list-style-type: none"> ELCA Minister of Word and Sacrament serving under a letter of call and scheduled to work at least 15 hours a week for six or more months each year. ELCA Minister of Word and Service serving under a letter of call and scheduled to work at least 15 hours a week for six or more months each year. A non-ELCA ordained clergy serving under a letter of call or contract and scheduled to work at least 20 hours a week for six or more months each year. Other employees scheduled to work at least 20 hours a week for six or more months each year, and who have completed any probationary period (not to exceed 90 days).

Section V	Eligible Employers	A 501(c)(3) organization (other than an organization described in <i>Sections I – IV</i> above) that employs an individual who is performing service as an ELCA Minister of Word and Sacrament or an ELCA Minister of Word and Service.
	Sponsorship Requirement	The Eligible Employers may sponsor any of its ELCA Ministers of Word and Sacrament and may sponsor all or none of its ELCA Ministers of Word and Service.
	Eligible Employees	<ul style="list-style-type: none"> ELCA Minister of Word and Sacrament serving under a letter of call and scheduled to work at least 15 hours a week for six or more months each year. ELCA Minister of Word and Service serving under a letter of call and scheduled to work at least 15 hours a week for six or more months each year.

Section VI	Eligible Employers	A non-501(c)(3) organization that employs an individual who is performing service as an ELCA Minister of Word and Sacrament.
	Sponsorship Requirement	The Eligible Employer may sponsor any of its ELCA Ministers of Word and Sacrament.
	Eligible Employees	ELCA Minister of Word and Sacrament serving under a letter of call and scheduled to work 15 or more hours a week for six or more months each year.

Section VII	Eligible Employers	<p>An individual will be treated as his or her own employer if he or she:</p> <ul style="list-style-type: none"> • is not sponsored by his or her Eligible Employer that is listed in <i>Sections III – VI</i> above, • is performing service in the exercise of his or her ministry as an ELCA Minister of Word and Sacrament, and • is scheduled to work 15 or more hours a week for six or more months each year.
	Sponsorship Requirement	
	Eligible Employees	

Section 3 Eligible Employee Enrollment

An Eligible Employee will become a Sponsored Member when he or she is sponsored by his or her Participating Employer in the Medical and Dental Benefits Plan.

Enrollment

Timely Enrollment

- For new Sponsored Members, the enrollment deadline is within 60 days of becoming a Sponsored Member. The effective date of coverage is the date designated by the Participating Employer, provided the date is within the 60-day application period.
- Newly ordained ELCA Ministers of Word and Sacrament who worked for a Participating Employer before ordination, but who were not sponsored in the ELCA Traditional Benefits Program, will have enrolled on a timely basis if enrollment is completed within 60 days of ordination.

Special Enrollment

- For Sponsored Members who had Other Valid Health Coverage, enrollment must be completed within 60 days after the Other Valid Health Coverage terminates. The effective date of coverage is the date designated by the Participating Employer, provided the date is within the 60-day enrollment period.

Other Enrollment

- For Sponsored Members who are required to be sponsored according to Section 2, subsection I, but who did not complete their Timely Enrollment, the effective date of coverage is the date that an acceptable application is received by Portico.
- For Sponsored Members whose coverage under this Plan was terminated and was not replaced with Other Valid Health Coverage, the effective date of coverage under this Plan, after Portico receives an acceptable application, will be the earliest of the following:
 - The first day after the end of a 90-day waiting period that begins on the day the acceptable application is received by Portico, or
 - January 1st following the annual enrollment period.

During the 90-day waiting period, the Eligible Employee will be considered a Sponsored Member for purposes of this Plan.

Annual Enrollment

- Sponsored Members will make annual benefit selections for the coming year during the annual enrollment period. The specific enrollment dates are determined by Portico. The effective date of coverage is the following January 1.
- Sponsored Members enrolling in this Plan during the annual enrollment period will not have a 90-day waiting period and coverage will be effective the following January 1.

If a Sponsored Member does not elect an option during the annual enrollment period, the Plan will assign a default option according to Portico's administrative provisions. The default option will be effective the following January 1.

Waiving Coverage and Re-enrollment of a Sponsored Member

A Sponsored Member may waive coverage any time he or she has Other Valid Health Coverage. A Sponsored Member who waives coverage will still be a Sponsored Member for purposes of this Plan, as long as he or she continues to be an Eligible Employee and has Other Valid Health Coverage.

A waiver of coverage will be effective on:

- The date Portico receives the acceptable request to waive coverage, or
- The date selected by the Sponsored Member if the date is not more than 45 days before the date Portico received the acceptable request to waive coverage.

Starting or Resuming Coverage if Coverage Waived

A Sponsored Member who has waived coverage may start coverage any time by contacting Portico. Enrollment must be completed within 60 days after the Other Valid Health Coverage terminates. The effective date that coverage will start or resume will be the date designated by the Participating Employer, provided the date is within the 60-day enrollment period.

Section 4 Spouse, Eligible Same Gender Partner, and Child Enrollment

A Participating Employer may enroll the Sponsored Member's Eligible Spouse, Eligible Same Gender Partner (ESGP), and/or Eligible Children. For purposes of being eligible to enroll, below is the criteria for an Eligible Spouse or ESGP, and Eligible Children.

Eligible Spouse and ESGP

A spouse or a separated spouse who is legally married to, or an **ESGP** who is the partner of, a:

- Sponsored Member,
- Retired Member, or
- Coverage Continuation Member who:
 - Is an ELCA Minister of Word and Sacrament or ELCA Minister of Word and Service who continues coverage while On Leave from Call,
 - Is a Disabled Member, or
 - Continued coverage at his/her own expenses following:
 - Termination of employment,
 - A reduction in hours of employment that caused the Sponsored Member to no longer be eligible for coverage,
 - Taking a leave of absence without pay,
 - Termination of sponsored status, or
 - Being called to active military duty.

A former spouse who is divorced from, or a **former ESGP** who is no longer a partner of, one of the following living or deceased Members, provided that the former spouse or former ESGP had been covered or had waived coverage at the time of the dissolution of marriage or partnership:

- Sponsored Member,
- Retired Member,
- Coverage Continuation Member who is:
 - An ELCA Minister of Word and Sacrament or ELCA Minister of Word and Service who continues coverage while On Leave from Call, or
 - A Disabled Member, or
- An individual who was covered under a Predecessor Church plan, if the Former Spouse was covered under that plan on December 31, 1987, and continuously on this Plan afterwards.

A Surviving Spouse who had been legally married to, or a **surviving ESGP** of, one of the following Members at the time of the Member's death and who had been covered or had waived coverage at the time of the Member's death:

- Sponsored Member,
- Retired Member, or
- Coverage Continuation Member who is:
 - An ELCA Minister of Word and Sacrament or ELCA Minister of Word and Service who continues coverage while On Leave from Call, or
 - A Disabled Member.

Eligible Child

An Eligible Child

- Has the following relationship with a Member listed below, and is a:
 - Natural or legally adopted child of the Member, spouse, or ESGP,
 - Child placed in the household as a step towards legal adoption by the Member,
 - Grandchild who has never been married, receives primary support from the Member, is eligible to be claimed as the Member's dependent for federal income tax purposes, and lives with the Member,
 - Child living in the Member's home and the Member has been appointed the legal guardian, or
 - Child of a Member who was covered under a Predecessor Church plan, if the Member was covered under that plan on December 31, 1987 and continuously on this Plan afterwards, and
- Is:
 - Under age 26 or within the calendar month in which he or she turns age 26, or
 - Totally disabled as determined by the Social Security Administration and continuously enrolled (or waived coverage) in the Plan since turning age 26

Members — For purposes of the Eligible Child defined above, the following are the “Members” that are included in the definition:

- Sponsored Member,
- Retired Member,
- Coverage Continuation Member who:
 - Is an ELCA Minister of Word and Sacrament or ELCA Minister of Word and Service who continues coverage while On Leave from Call,
 - Is a Disabled Member, or
 - Continued coverage at his or her own expense following:
 - Termination of employment,
 - A reduction in hours of employment that caused the Sponsored Member to no longer be eligible for coverage,
 - Taking a leave of absence without pay,
 - Termination of sponsored status, or
 - Being called to active military duty.
 - Continued coverage at his or her own expense as a Surviving Spouse, surviving ESGP, Former Spouse, or former ESGP of a Coverage Continuation Member who was an ELCA Minister of Word and Sacrament or ELCA Minister of Word and Service who continued coverage while On Leave from Call.

Enrollment of Spouse, ESGP, and Child

ELCA-Primary Option Coverage — An Eligible Spouse, ESGP, and/or Eligible Child of a Sponsored Member, Retired Member, or Coverage Continuation Member will have the same ELCA-Primary Option as selected by the Sponsored Member, Retired Member or Coverage Continuation Member, if eligible.

If the Eligible Spouse, ESGP, and/or Eligible Child are not eligible for the option provided above because Medicare is the primary coverage:

- An Eligible Spouse, ESGP, and/or Eligible Child of a Sponsored Member or On Leave from Call Member will have the ELCA Medicare-Primary Standard Option.
- An Eligible Spouse, ESGP, and/or Eligible Child of a Retired Member or Coverage Continuation Member (except an On Leave from Call Member) will have the ELCA Medicare-Primary Option chosen for the Eligible Spouse, ESGP, or Eligible Child by the Retired Member or Coverage Continuation Member.

ELCA Medicare-Primary Option Coverage — An Eligible Spouse, ESGP, and/or Eligible Child of:

- A Sponsored Member or On Leave from Call Member will have the ELCA Medicare-Primary Standard Option. However, if the Eligible Spouse, ESGP, and/or Eligible Child are not eligible for ELCA Medicare-Primary coverage, the Sponsored Member or On Leave from Call Member will select an ELCA-Primary option for the Eligible Spouse, ESGP, and/or Eligible Child.
- A Retired Member or Coverage Continuation Member (except an On Leave from Call Member) will have the ELCA Medicare-Primary Option chosen for the Eligible Spouse, ESGP, and/or Eligible Child by the Retired Member or Coverage Continuation Member, if eligible. However, if the Eligible Spouse, ESGP, and/or Eligible Child is not eligible for ELCA Medicare-Primary coverage, the Retired Member or Coverage Continuation Member will select an ELCA-Primary option for eligible family members.

Effective Date — An Eligible Spouse, ESGP, and/or Eligible Child who:

- Is enrolled within 60 days of the Member becoming a Sponsored Member, will begin coverage on the same date as the Sponsored Member or any later date within the 60-day enrollment period, as requested by the Sponsored Member.
- Is not enrolled within 60 days of the Sponsored Member becoming a Sponsored Member, will begin coverage on the first day after a 90-day waiting period that begins on the date an acceptable application is received by Portico, except for the following situations:
 - **Other Valid Health Coverage Termination:** Coverage for an Eligible Spouse, ESGP or Eligible Child who is enrolled within 60 days of the termination of his/her Other Valid Health Coverage will begin on the date designated by the Participating Employer, if the date is within 60 days of the Other Valid Health Coverage's termination date.
 - **Annual Enrollment:** A Sponsored Member may enroll an Eligible Spouse and/or Eligible Child during the annual enrollment period. The annual enrollment dates are determined by Portico. The effective date of coverage is the following January 1.
 - **Newly Eligible Spouse or Child:** An individual who becomes an Eligible Spouse or Eligible Child will begin coverage on the date designated by the Participating Employer, provided the date is within 60 days of the individual becoming an Eligible Spouse or Eligible Child.

Waiving Coverage and Re-enrollment of a Sponsored Member's Spouse, ESGP, and Child

Waiving Coverage and Re-enrollment — A Sponsored Member may waive coverage for his/her Eligible Spouse, ESGP, and/or Eligible Child any time the Eligible Spouse, ESGP, and/or Eligible Child has Other Valid Health Coverage.

A waiver of coverage will be effective on:

- The first day of the month after the acceptable request is received by Portico, or
- The date selected by the Sponsored Member, if the date is not more than 45 days before the date Portico received the acceptable request.

Starting or Resuming Coverage if Coverage Waived — Coverage that has been waived because of having Other Valid Health Coverage may start or resume at any time if:

- The individual is eligible for the coverage, and
- The request is made, and the coverage starts or resumes within 60 days after the Other Valid Health Coverage terminated.

Section 5 Retired Member Enrollment

Enrollment as a Retired Member

Sponsored Member enrolling as a Retired Member — An individual who is a Sponsored Member on the date of Separation from Service is eligible to enroll as a Retired Member if he or she has attained age 60 or completed a total of 30 years of service with an Eligible Employer. A Retired Member who is eligible for and enrolls in ELCA-Primary Benefits will begin coverage:

- On the date immediately following the Member's Separation from Service, if coverage is requested within 60 days after the date of the Separation from Service,
- On the first day after the end of a 90-day waiting period, if coverage is requested more than 60 days after the Separation from Service, or
- On the first day after the end of a 90-day waiting period, if coverage has terminated and the Retired Member re-enrolls.

A Retired Member who is eligible for and enrolls in ELCA Medicare-Primary Benefits will begin coverage:

- On the first day of the month following the Member's Separation from Service, if coverage is requested within 60 days after the date of the Separation from Service, or
- On the first day after the end of a 90-day waiting period, if coverage is requested more than 60 days after the Separation from Service or if the Retired Member's coverage under this Plan has terminated. However, if the first day of the month following the waiting period exceeds a 90-day wait, the Retired Member is entitled to enroll on the first day of the month immediately prior to the end of the 90-day waiting period.

The 90-day waiting period that is stated above begins on the day the acceptable application for enrollment is received by Portico.

A Retired Member who waives or terminates coverage on or after January 1, 2019 and is eligible for but not enrolled in ELCA Medicare-Primary Benefits will relinquish any and all ELCA subsidies (described in Section 8) on January 1, 2019 and thereafter.

Eligible Employee enrolling as a Retired Member — An individual, who is an Eligible Employee but not a Sponsored Member on the date of Separation from Service, is eligible to enroll as a Retired Member if he/she has attained age 60 or completed a total of 30 years of service with an Eligible Employer and immediately before the Separation from Service:

- The individual had Other Valid Health Coverage and continuously thereafter from the Separation from Service to a date that is within 60 days of when the Retired Member's coverage starts under this Plan,
- The individual was employed by an Eligible Employer described in Section 2, subsection III or IV and the Eligible Employer is a Participating Employer in the ELCA Master Institutional Retirement Plan, the ELCA Retirement Plan for The Evangelical Lutheran Good Samaritan Society, or the ELCA Retirement Plan, and
- The individual had an account in the ELCA Retirement Plan, ELCA Master Institutional Retirement Plan or ELCA Retirement Plan for the Evangelical Lutheran Good Samaritan Society.

1987 Plan Participant enrolling as a Retired Member — An individual not previously described who was a participant in The American Lutheran Church Major Medical-Dental and Disability Plan or the Ministerial Health Benefits Plan of the Lutheran Church in America on December 31, 1987, is eligible to become a Retired Member in this Plan, if:

- The former participating employer is eligible to be a Participating Employer in the ELCA Master Institutional Retirement Plan,
- The individual was employed continuously by the former participating employer from December 31, 1987 to his/her date of retirement, and
- The individual had Other Valid Health Coverage immediately before his/her retirement and continuously from the individual's date of retirement to a date that is within 60 days of when the Retired Member's coverage starts under this Plan.

ELCA Minister of Word and Sacrament or ELCA Minister of Word and Service enrolling as a Retired Member — An ELCA Minister of Word and Sacrament or ELCA Minister of Word and Service who is an Eligible Employee but not a Sponsored Member on the date of a Separation from Service is eligible to enroll as a Retired Member if he/she has attained age 60 or completed a total of 30 years of service with an Eligible Employer and if immediately before the Separation from Service:

- The individual had Other Valid Health Coverage and continuously from the Separation from Service to a date that is within 60 days of when the Retired Member's coverage starts under this Plan,
- The individual was employed by an Eligible Employer, and
- The individual had an account in the ELCA Retirement Plan, ELCA Master Institutional Retirement Plan, or ELCA Retirement Plan for The Evangelical Lutheran Good Samaritan Society.

Waiving Coverage and Re-enrollment of a Retired Member

A Retired Member may waive coverage any time the Retired Member has Other Valid Health Coverage. The waiver of coverage will be effective on:

- The first day of the month following the date Portico received the acceptable request to waive ELCA Medicare-Primary Benefits coverage, or
- The date selected by the Retired Member if the date is not more than 45 calendar days before Portico received the acceptable request to waive ELCA-Primary Benefits coverage.

A Retired Member who waives coverage on or after January 1, 2019 and is eligible for, but not enrolled in, ELCA Medicare-Primary Benefits will relinquish any and all ELCA subsidies (described in Section 8) on January 1, 2019 and thereafter.

Starting or Resuming Coverage if Waived — Coverage that has been waived may be started or resumed without a 90-day waiting period if the individual is eligible for coverage and coverage is requested and resumed within 60 days after the Other Valid Health Coverage terminated. A Retired Member will be considered to have waived coverage if the Retired Member is starting or resuming coverage and had Other Valid Health Coverage within 60 days of the effective date of coverage.

A Retired Member who has waived:

- ELCA-Primary Benefits may start or resume coverage at any time by contacting Portico within 60 days after the Other Valid Health Coverage is terminated to request that coverage start or be resumed.
- ELCA Medicare-Primary Benefits may start or resume coverage on the first day of the month following the acceptable request to Portico if coverage is initiated or resumed no later than 60 days after the Other Valid Health Coverage is terminated.

Annual Enrollment for a Retired Member

A Retired Member may enroll during the annual enrollment period. The specific annual enrollment dates are determined by Portico. A Retired Member enrolling during the annual enrollment period will not have a 90-day waiting period and the effective date of coverage will be the following January 1.

Enrollment of Spouse, ESGP, or Child of a Retired Member

An Eligible Spouse, ESGP, or an Eligible Child of a Retired Member who is eligible for and enrolls in ELCA-Primary Benefits will begin coverage:

- On the first day following the Retired Member's Separation from Service if coverage is requested within 60 days after the date of the Retired Member's Separation from Service,
- On the first day after the end of a 90-day waiting period, if coverage is requested more than 60 days after the Separation from Service, or
- On the first day after the end of a 90-day waiting period, if coverage has terminated and the re-enrollment is requested.

An Eligible Spouse, ESGP, or an Eligible Child of a Retired Member who is eligible for and enrolls in ELCA Medicare-Primary coverage will begin coverage:

- On the first day of the month following the Member's Separation from Service, if coverage is requested within 60 days after the date of the Separation from Service, or
- On the first day after the end of a 90-day waiting period, if coverage is requested more than 60 days after the Separation from Service or if the Retired Member's coverage under this Plan has terminated. However, if the first day of the month following the waiting period exceeds a 90-day wait, the Eligible Spouse, ESGP, or an Eligible Child of a Retired Member is entitled to enroll on the first day of the month immediately prior to the end of the 90-day period.

The 90-day waiting period that is stated above begins on the day the acceptable application for enrollment is received by Portico.

An Eligible Spouse, ESGP, or an Eligible Child of a Retired Member who is eligible for, but not enrolled in, ELCA Medicare-Primary Benefits on January 1, 2019 or within 60 days of the Member's retirement, will relinquish any and all ELCA subsidies (described in Section 8) on January 1, 2019 and thereafter.

Annual Enrollment — A Retired Member may enroll an Eligible Spouse or ESGP, and/or Eligible Child during the annual enrollment period. The specific enrollment dates are determined by Portico. The effective date of coverage is the following January 1. An Eligible Spouse, ESGP, and/or Eligible Child enrolling during this period will not have a 90-day waiting period.

Waiving Coverage and Re-enrollment of a Retired Member's Spouse, ESGP, or Child

A Retired Member may waive coverage for his or her Eligible Spouse, ESGP, and/or Eligible Child any time the Eligible Spouse, ESGP, and/or Eligible Child has Other Valid Health Coverage. Waiving coverage will be effective on:

- The first day of the month following the date Portico receives the acceptable request to waive ELCA Medicare-Primary Benefits, or
- The date selected by the Retired Member if the date is not more than 45 calendar days before Portico received the acceptable request to waive ELCA-Primary Benefits.

An Eligible Spouse, ESGP, and/or Eligible Child of a Retired Member who is waiving coverage on or after January 1, 2019 and is eligible for, but not enrolled in, ELCA Medicare-Primary Benefits will relinquish any and all ELCA subsidies (described in Section 8) on January 1, 2019 and thereafter.

Starting or Resuming Coverage if Waived — Coverage that has been waived may be started or resumed without a 90-day waiting period if the individual is eligible for coverage and coverage is requested and resumed within 60 days after the Other Valid Health Coverage terminated.

An Eligible Spouse, ESGP, and/or Eligible Child of a Retired Member who has waived:

- ELCA-Primary Benefits may start or resume coverage at any time by contacting Portico within 60 days after the Other Valid Health Coverage is terminated to request that coverage start or be resumed.
- ELCA Medicare-Primary Benefits may start or resume coverage on the first day of the month following the acceptable request to Portico.

Section 6 Termination and Continuation of Coverage

Termination of a Sponsored Member's Enrolled Status

Unless coverage is continued as provided in this Section 6, the enrolled status of a Sponsored Member is terminated, in accordance with Portico's administrative provisions, on the earliest of the following dates:

- The date designated by the Participating Employer in an advance notice that it will no longer sponsor the individual.
- The date determined by Portico that the Participating Employer stopped:
 - Making contributions for the Sponsored Member,
 - Providing accurate information needed for the Plan administration, or
 - Sponsoring all of its Eligible Employees (in the case of an Employer described in Section 2, subsection I).
- The date of the required contribution if full payment is not received within the timeframe specified in Portico's Past-Due Accounts Practice.

Termination of a Retired Member's Enrolled Status

The enrolled status of a Retired Member is terminated in accordance with Portico's administrative provisions on the date determined by Portico as the date that the Retired Member stopped making contributions.

A Retired Member whose ELCA Medicare-Primary coverage is terminated on or after January 1, 2019 will relinquish any and all ELCA subsidies described in Section 8 on January 1, 2019 and thereafter.

Termination of a Spouse, ESGP, or Child's Enrolled Status

Unless coverage is continued by an Eligible Spouse, ESGP, or Eligible Child, the enrolled status is terminated in accordance with Portico's administrative provisions on the earliest of the following dates:

- The date the individual is no longer an Eligible Spouse or ESGP.
- The last day of the month that the individual is no longer an Eligible Child.
- In the case of an Eligible Spouse or ESGP, the date the Eligible Spouse or ESGP is no longer sponsored for enrollment by the Participating Employer.
- In the case of an Eligible Spouse, ESGP, or Eligible Child of a Sponsored Member, certain Coverage Continuation Members or Retired Member:
 - the date the enrolled status of the Member ends,
 - the date the Member waives coverage, or
 - the date of the required contribution if full payment is not received within the time frame specified in Portico's Past-Due Accounts Practice.

An Eligible Spouse and/or Eligible Child of a Retired Member who is eligible for, but not enrolled in, ELCA Medicare-Primary Benefits on or after January 1, 2019 will relinquish any and all ELCA subsidies described in Section 8 on January 1, 2019 and thereafter.

Termination for Cause

Portico Benefit Services may terminate a Member's or Dependent's coverage under the Plan if the Member or Dependent:

- Provides false information or makes misrepresentations in a claim for benefits,
- Permits a non-participant to use a Plan identification card to wrongfully obtain benefits,
- Obtains or attempts to obtain benefits by false, fraudulent or misleading means,
- Fails to pay any amount due,
- Behaves in a disruptive, unruly, abusive, or uncooperative manner so that the Plan is unable to provide benefits to him or her, or
- Threatens the life or well-being of personnel or of providers administering the Plan.

Coverage Continuation for Sponsored Members

In certain situations, a Sponsored Member whose enrolled status is terminating may continue coverage and remain enrolled as a Coverage Continuation Member by submitting an acceptable election to continue coverage to Portico within 60 days of the date of the change in status, subject to the following conditions:

- **On Leave from Call Member** – A Sponsored Member who is an ELCA Minister of Word and Sacrament or Minister of Word and Service may continue coverage at his/her own expense during any period the Member is On Leave from Call. At the end of the On Leave from Call, the Member may continue coverage under this Plan for an additional 18 months.
- **Disabled Member** – A Sponsored Member, who becomes a Totally Disabled Member according to the ELCA Disability Benefits Plan, may continue coverage during the disability.

The Participating Employer shall pay the monthly contributions for this Plan's coverage for the Sponsored Member and his or her Dependents for the first 2 months of disability. If the Participating Employer does not make the contribution payments for the first 2 months, the Member may make the contribution on his or her own behalf and/or on behalf of his or her Dependents to prevent a lapse in coverage.

Beginning with the third month, a full or partial contribution will be paid to this Plan from the ELCA Disability Benefits Trust on behalf of the Member and Dependents, and contributions will continue until the Member is no longer eligible for benefits under the ELCA Disability Benefits Plan.

If the Member is no longer disabled and does not return to work as a Sponsored Member, the Member may continue coverage under this Plan at his or her own expense for an additional 18 months.

- **Terminated Member/No Longer Sponsored** – A Sponsored Member may continue coverage at his or her own expense for 18 months after a termination of employment (other than for reasons of gross misconduct), a reduction in hours of employment that causes the Sponsored Member to no longer be eligible for coverage, taking a leave of absence without pay, the Termination of Sponsored Member's Enrolled Status as described above in this Section 6 or being called to active military duty, provided, however, that a Sponsored Member who is performing qualified military service covered under the Uniformed Services Employment and Reemployment Rights Act may continue coverage at his or her own expense for 24 months.

The coverage will be terminated as of the due date of the required contribution if full payment is not received within the time frame specified in Portico's Past-Due Accounts Practice.

Coverage Continuation for Dependents

A Dependent whose enrolled status would terminate as provided above in this Section 6 under "Termination of a Spouse, ESGP, or Child's Enrolled Status" may remain enrolled at his or her own expense as a Coverage Continuation Member by sending an acceptable election to continue coverage to Portico within 60 days of the termination date and by making the required payments, subject to the following conditions:

- A **Surviving Spouse** or **surviving ESGP** of a Sponsored Member, Retired Member, or Coverage Continuation Member who is an ELCA Minister of Word and Sacrament or Minister of Word and Service who continued coverage while On Leave from Call or while a Disabled Member, may continue coverage at his/her own expense for his/her remaining lifetime.

NOTE: The Surviving Spouse who met the required status before January 1, 2004, may re-enroll and will not have a 90-day waiting period if Other Valid Health Coverage was in effect immediately prior to re-enrollment.

A Surviving Spouse who is eligible for and requests enrollment within 60 days of the termination of her/his Other Valid Health Coverage will be enrolled:

- in ELCA-Primary Benefits on the requested date if the date is within 60 days of the termination of the Other Valid Health Coverage,
- in ELCA Medicare-Primary Benefits on the first day of the month following the request. On January 1, 2019 and thereafter, a Surviving Spouse of a Retired Member who is eligible for, but not enrolled in, ELCA Medicare-Primary Benefits will thereafter relinquish any and all subsidies as described in Section 8.

- A **former spouse** or **former ESGP** of a living or deceased Sponsored Member, Retired Member, or Coverage Continuation Member who is an ELCA Minister of Word and Sacrament or Minister of Word and Service who continued coverage while On Leave from Call or while a Disabled Member, may continue coverage at his or her own expense for up to 36 months.

NOTE: If the former spouse began Coverage Continuation on or before May 1, 2010, the coverage may continue at the former spouse's expense until remarriage. After a remarriage, the former spouse may continue coverage for 36 months.

NOTE: The former spouse who met the required status before January 1, 2004, may re-enroll at any time and will not have a 90-day waiting period if Other Valid Health Coverage was in effect immediately prior to re-enrollment.

- An **Eligible Child** of a Surviving Spouse or surviving ESGP of a Sponsored Member, Retired Member, or Coverage Continuation Member who is an ELCA Minister of Word and Sacrament or ELCA Minister of Word and Service who continued coverage while On Leave from Call or while a Disabled Member, may continue coverage at his/her own expense during the time period the Surviving Spouse or surviving ESGP continues coverage. At the end of that time period, the Eligible Child may continue coverage at his/her own expense as long as he/she is an Eligible Child when he/she continues coverage.

NOTE: If an Eligible Child is no longer totally and permanently disabled as determined by the Social Security Administration or turns age 26, he or she may continue coverage at his or her own expense for 36 months beginning when he or she is no longer disabled or the first day of the month following the month the Eligible Child turns 26.

NOTE: An Eligible Child of a Surviving Spouse who met the required status before January 1, 2004, may re-enroll as long as he or she is an Eligible Child when re-enrolling. The Eligible Child will not have a 90-day waiting period if Other Valid Health Coverage was in effect immediately prior to re-enrollment or if he or she enrolls during the annual enrollment period.

An Eligible Child who is eligible for and requests enrollment within 60 days of the termination of his or her Other Valid Health Coverage will be enrolled:

- in ELCA-Primary Benefits on the requested date if the date is within 60 days of the termination of the Other Valid Health Coverage
 - in ELCA Medicare-Primary Benefits on the first day of the month following the request. On January 1, 2019, and thereafter, an Eligible Child of a Retired Member who is eligible for and not enrolled in ELCA Medicare-Primary Benefits will thereafter relinquish any and all subsidies as described in Section 8.
- An **Eligible Child** of a former spouse or former ESGP of a living or deceased Sponsored Member, Retired Member, or Coverage Continuation Member who is an ELCA Minister of Word and Sacrament or ELCA Minister of Word and Service who continued coverage while On Leave from Call or while a Disabled Member may continue coverage at his/her own expense until the earlier of:
 - the end of the time period the former spouse or former ESGP is allowed to continue coverage, as described in this Section 6, or
 - the end of the month in which the Eligible Child turns age 26.

NOTE: An Eligible Child, who is totally and permanently disabled as determined by the Social Security Administration and who has been continuously enrolled (or waived coverage) since turning age 26, is eligible to continue coverage at his or her own expense.

NOTE: If an Eligible Child is no longer totally and permanently disabled or turns age 26, he or she may continue coverage at his or her own expense for 36 months beginning the first day of the month following the month the Eligible Child turns 26.

- An **Eligible Child** of a deceased Sponsored Member, deceased Retired Member or deceased Coverage Continuation Member who was an ELCA Minister of Word and Sacrament, ELCA Minister of Word and Service or Disabled Member; or a deceased Sponsored Member who continued coverage after termination of employment (other than for reasons of gross misconduct), a reduction in hours of employment which caused the Sponsored Member to no longer be eligible for coverage, taking a leave of absence without pay, the termination of sponsored status as described above under "Termination of Sponsored Member's Enrolled Status", or being called to active military duty, may continue coverage at his/her own expense as long as he or she is an Eligible Child when coverage is continued.

NOTE: If an Eligible Child is no longer totally and permanently disabled or turns age 26, he or she may continue coverage at his/her own expense for 36 months beginning the first day of the month following the month the Eligible Child turns 26.

NOTE: An Eligible Child who met the required status before January 1, 2004, may re-enroll provided the Eligible Child is still an Eligible Child at re-enrollment. The Eligible Child will not have a 90-day waiting period if Other Valid Health Coverage was in effect immediately prior to re-enrollment.

An Eligible Child who is eligible for and requests enrollment within 60 days of the termination of his or her Other Valid Health Coverage will be enrolled:

- in ELCA-Primary Benefits on the requested date if the date is within 60 days of the termination of the Other Valid Health Coverage
 - in ELCA Medicare-Primary Benefits on the first day of the month following the request. On January 1, 2019, and thereafter, an Eligible Child of a Retired Member who is eligible for and not enrolled in ELCA Medicare-Primary Benefits will thereafter relinquish all subsidies as described in Section 8.
- If a **Sponsored Member** is not eligible to continue coverage, then the Sponsored Member's Eligible Spouse or ESGP, and Eligible Child are not eligible to continue coverage.
 - An **Eligible Spouse or Eligible Child** of an On Leave from Call or Disabled Coverage Continuation Member is eligible to continue coverage, generally up to eighteen (18) months in accordance with Portico's administrative practices.

Coverage will be terminated as of the due date of the required contribution if full payment is not received within the time frame specified in Portico's Past Due Accounts Practice.

Waiving Coverage and Re-enrollment for Certain Coverage Continuation Members

A Member who has continued coverage as either (i) an ELCA Minister of Word and Sacrament or ELCA Minister of Word and Service while On Leave from Call, or (ii) a Disabled Member, may waive coverage for the Member, Eligible Spouse, ESGP, and/or Eligible Child:

- If the Member has Other Valid Health Coverage.
- If the Eligible Spouse, ESGP, or Eligible Child has Other Valid Health Coverage.

A waiver of coverage will be effective on:

- The date Portico receives the acceptable request to waive coverage, or
- The date specified by the Member if the date is not more than 45 days before the date Portico received the acceptable request to waive coverage.

Starting or Resuming Coverage if Waived — Coverage that has been waived may be started or resumed without a 90-day waiting period if the Member, Eligible Spouse, ESGP or Eligible Child who waived coverage is eligible for coverage and coverage is requested and resumed within 60 days after the Other Valid Health Coverage terminated.

A Member, Eligible Spouse, ESGP, and/or Eligible Child who has waived:

- ELCA-Primary Benefits may start or resume coverage on any date following the acceptable request to Portico.
- ELCA Medicare-Primary Benefits may start or resume coverage on the first day of the month following the acceptable request to Portico.
- A Retired Member, an Eligible Spouse and/or Eligible Child of a Retired Member, or a Surviving Spouse of a Retired Member who is waiving ELCA Medicare-Primary Benefits on or after January 1, 2019, will thereafter relinquish any and all ELCA subsidies described in Section 8.

Section 7 Cost of Medical and Dental Coverage for Sponsored Members, Coverage Continuation Members, Retired Members and Dependents

A Participating Employer is responsible for paying contributions for its Sponsored Members for the ELCA-Primary Option it elects and the ELCA Medicare-Primary Standard Option. A Participating Employer is responsible for remitting to Portico:

- The Sponsored Member's portion of the contribution for an ELCA-Primary Option that has a higher contribution cost than the ELCA-Primary Option elected by the Participating Employer, and
- The coverage contributions for an Eligible Spouse, ESGP, and/or Eligible Child enrolled in this Plan.

Contribution Rates for Sponsored Members

- Contribution rates are determined annually by Portico, based on actuarial studies and established in such a way for the Plan to be self-sustaining.
- Contribution rates are a percentage of a Sponsored Member's Defined Compensation, subject to minimum and maximum compensation amounts. To achieve a fair sharing of total cost, contribution rates also take into account factors that affect the cost of coverage including, but not limited to, the Member's age, the extent that Dependents are enrolled, variations in the level of medical and dental costs by geographic area, expected claims experience, and the Member's eligibility for primary medical coverage under Medicare.

Contribution Rates for Sponsored Members who are Married to Each Other or are in an Eligible Same Gender Partnership and Employed by Participating Employers

- **Sharing Health Coverage:** When both Members are employed by Participating Employers and enroll in benefits under this Plan, Portico will designate one Member as the primary Member and one as the spouse or ESGP. The designations will be in effect until the end of the year unless the primary Member is no longer sponsored or becomes eligible for ELCA Medicare-Primary Benefits and then Portico will designate the spouse or ESGP as the primary Member.

The contribution amounts are calculated individually for each Sponsored Member. Then each Sponsored Member's Participating Employer is billed a share of the total cost of the family health coverage. If there are more than two Participating Employers, each Participating Employer will pay their respective share of contributions.

- **Not Sharing Health Coverage:** Each Sponsored Member may request to enroll separately from the other Sponsored Member. The separate designation will be in effect for the entire year unless one or both Members are no longer employed by Participating Employers. Each Participating Employer will be billed 100% of the contribution for its respective Sponsored Member and any Dependent.

Contribution Rates for a Member who is Employed by Two or More Participating Employers —

When a Sponsored Member is employed by two or more Participating Employers, the Participating Employers will be billed a share of the contributions provided, however, that any minimum and

maximum contributions will be based on the Member's combined Defined Compensation and shared according to Portico's administrative provisions.

Failure to Make Required Contributions by a Participating Employer — The enrolled status of a Sponsored Member and Dependents will be terminated if the Participating Employer has not paid the full contribution within 60 days after the due date, except that the Sponsored Member may make the contribution to continue coverage for the Sponsored Member and Dependents for up to 18 months as provided in Section 6. If, after 18 months of payment by the Sponsored Member, the Participating Employer does not resume contributions, the coverage will terminate.

Waiver of Contributions for Re-employment within 31 days — If a Sponsored Member terminates employment with a Participating Employer and becomes a Sponsored Member with another Participating Employer within 31 days, coverage for the Sponsored Member and Dependents during this period will be continued without the payment of any contributions. If the period between Participating Employers is greater than 31 days, the Member must purchase coverage continuation as provided in Section 6, in order to continue to have coverage between employers. However, contributions will not be waived for Sponsored Members who terminate employment and who were sharing health coverage with a spouse or ESGP who was also a Sponsored Member. In the event a terminated Sponsored Member was sharing health coverage, the contributions shall be paid as stated above in this Section 7.

Coverage Continuation Members, Retired Members and Family Members — The contribution rates for Coverage Continuation Members, Retired Members, and Retired Members' Spouses, ESGPs, and Eligible Children will be determined annually by Portico, based on actuarial studies and in such a manner that the Plan can be self-sustaining.

Waiver of Contribution for an Eligible Child of a Deceased Member — An Eligible Child who survived both parents prior to 2004, and who was covered under this Plan as an Eligible Child at the time of the death of the second parent, will continue to receive coverage at no cost as long as he or she is:

- Under age 26 or is within the calendar month in which he or she turns age 26, or,
- Totally and permanently disabled as determined by the Social Security Administration and continuously enrolled (or waived coverage) in the Plan since turning age 26.

Section 8 Predecessor ELCA Church Body Subsidies

The following retired individuals of the following churches may have a portion of the cost of their coverage paid by the ELCA in retirement if they previously participated in the health benefit plans of those churches:

- Former clergy of the Association of Evangelical Lutheran Churches (AELC)
- Former clergy and lay employees of the American Lutheran Church (ALC)
- Former clergy of the Lutheran Church in America (LCA)
- Certain churchwide agency lay employees

The contribution subsidies will be paid from the ELCA Benefit Contribution Trust or by the ELCA to the ELCA Medical and Dental Benefits Trust at the time the Member who is entitled to the subsidy pays a contribution.

The ELCA Church Council approved changes to the calculation of ELCA health coverage subsidies for eligible Retired Members, for all subsidies paid on or after January 1, 2019. The ELCA Church Council changes are intended to result in a more predictable and sustainable funding obligation. Annual subsidy amounts for eligible Retired Members and family members are calculated in accordance with the terms of this Plan. The subsidy and any annual modifications must be approved by the ELCA Church Council.

A Retired Member, Eligible Spouse and/or Eligible Child of a Retired Member, or a Surviving Spouse of a Retired Member, who is eligible for, but not enrolled in, ELCA Medicare-Primary Benefits on or after January 1, 2019, will thereafter relinquish any and all ELCA subsidies.

Section 9 Mid-Year Changes, Coordination with Other Insurance, Subrogation/Claims

Mid-year Changes in Employment or Status

Members may have mid-year changes in coverage due to changes in employment or status.

A. **Status Changes.** If a mid-year change in benefits occurs and the change occurs without a break in coverage due to the following status changes, the Eligible Medical and Mental Health Expenses that were incurred before the mid-year change will be applied during the same calendar year as provided below.

The Eligible Spouse or ESGP becomes designated as the primary Member and the original primary Member becomes designated as the Eligible Spouse or ESGP,

- An Eligible Child is no longer the primary Member's Eligible Child but becomes the Eligible Child of another Member, or
- An Eligible Child of the primary Member becomes a Sponsored Member

<u>Coverage</u>	<u>Changing from:</u>	<u>Changing to:</u>
	<ul style="list-style-type: none"> • ELCA-Primary Gold+ Option or • ELCA-Primary Platinum+ Option 	<ul style="list-style-type: none"> • ELCA-Primary Gold+ Option or • ELCA-Primary Platinum+ Option
Effect of Changes	<ul style="list-style-type: none"> • The Deductible Amount for In-network Eligible Medical and Mental Health Expenses will be applied toward the Deductible Amount for In-network Eligible Medical and Mental Health Expenses, and • The Deductible Amount and Coinsurance for In-network Eligible Medical and Mental Health Expenses and the Cost-Share for Eligible Prescription Drug Expenses will be applied toward the Maximum Out-of-Pocket Amount for In-network Eligible Medical and Mental Health Expenses and Eligible Prescription Drug Expenses. 	
<u>Coverage</u>	<u>Changing from:</u>	<u>Changing to:</u>
	<ul style="list-style-type: none"> • ELCA-Primary Gold+ Option or • ELCA-Primary Platinum+ Option 	<ul style="list-style-type: none"> • ELCA-Primary Bronze+ Option or • ELCA-Primary Silver+ Option
Effect of Changes	<ul style="list-style-type: none"> • The Deductible Amount for In-network Eligible Medical and Mental Health Expenses will be applied toward the Deductible Amount for In-network Eligible Medical, Mental Health and Eligible Prescription Drug Expenses, and • The Deductible Amount and Coinsurance for In-network Eligible Medical and Mental Health Expenses and the Cost-Share for Eligible Prescription Drug Expenses will be applied toward the Maximum Out-of-Pocket Amount for In-network Eligible Medical, Mental Health and Eligible Prescription Drug Expenses. 	

<u>Coverage</u>	<u>Changing from:</u>	<u>Changing to:</u>
	<ul style="list-style-type: none"> • ELCA-Primary Bronze+ Option or • ELCA-Primary Silver+ Option 	<ul style="list-style-type: none"> • ELCA-Primary Bronze+ Option or • ELCA-Primary Silver+ Option
<u>Effect of Changes</u>	<ul style="list-style-type: none"> • The Deductible Amount for In-network Eligible Medical and Mental Health Expenses and Eligible Prescription Drug Expenses will be applied toward the Deductible Amount for In-network Eligible Medical and Mental Health Expenses and Eligible Prescription Drug Expenses, and • The Deductible Amount and Coinsurance for In-network Eligible Medical and Mental Health Expenses and the Cost-Share for Eligible Prescription Drug Expenses will be applied toward the Maximum Out-of-Pocket Amount for In-network Eligible Medical and Mental Health Expenses and Eligible Prescription Drug Expenses. 	
<u>Coverage</u>	<u>Changing from:</u>	<u>Changing to:</u>
	<ul style="list-style-type: none"> • ELCA-Primary Bronze+ Option or • ELCA-Primary Silver+ Option 	<ul style="list-style-type: none"> • ELCA-Primary Gold+ Option or • ELCA-Primary Platinum+ Option
<u>Effect of Changes</u>	<ul style="list-style-type: none"> • The Deductible Amount for In-network Eligible Medical and Mental Health Expenses and Eligible Prescription Drug Expenses will be applied toward the Deductible Amount for In-network Eligible Medical and Mental Health Expenses, and • The Deductible Amount and Coinsurance for In-network Eligible Medical and Mental Health Expenses and the Cost-Share for Eligible Prescription Drug Expenses will be applied toward the Maximum Out-of-Pocket Amount for In-network Eligible Medical and Mental Health Expenses and Eligible Prescription Drug Expenses. 	
<u>Coverage</u>	<u>Changing from:</u>	<u>Changing to:</u>
	<ul style="list-style-type: none"> • ELCA-Primary Option 	<ul style="list-style-type: none"> • ELCA Medicare-Primary Option
<u>Effect of Changes</u>	The Deductible Amount, Coinsurance and Cost-Shares will not be applied to the new option.	
<u>Coverage</u>	<u>Changing from:</u>	<u>Changing to:</u>
	<ul style="list-style-type: none"> • ELCA Medicare-Primary Option 	<ul style="list-style-type: none"> • ELCA-Primary Option
<u>Effect of Changes</u>	The Deductible Amount, Coinsurance and Cost-Shares will not be applied to the new option.	

B. **Employment Changes.** If a mid-year change in benefits occurs, and the change occurs without a break in coverage due to employment as a foreign missionary terminating with ELCA Global Mission, the Eligible Medical and Mental Health Expenses that were incurred before the mid-year change will be applied during the same calendar year as provided below.

<u>Coverage</u>	<u>Changing from:</u>	<u>Changing to:</u>
	<ul style="list-style-type: none"> • ELCA Global Mission foreign missionaries benefits 	<ul style="list-style-type: none"> • ELCA-Primary Benefits
Effect of Changes	<ul style="list-style-type: none"> • The combined Deductible and Coinsurance for In-network Eligible Medical and Mental Health Expenses incurred under the insurance agreement for foreign missionaries will be applied toward the Deductible Amount and the Maximum Out-of-Pocket Amount for In-network Eligible Medical and Mental Health Expenses, and • The combined Deductible and Coinsurance for Out-of-network Eligible Medical and Mental Health Expenses incurred under the insurance agreement for foreign missionaries will be applied toward the Deductible Amount and the Maximum Out-of-Pocket Amount for Out-of-network Eligible Medical and Mental Health Expenses. 	

C. **Employment Changes.** If a mid-year change in benefits occurs, and the change occurs without a break in coverage due to moving from one Participating Employer to another Participating Employer, the Eligible Medical and Mental Health Expenses that were incurred before the mid-year change will be applied during the same calendar year as provided below.

<u>Coverage</u>	<u>Changing from:</u>	<u>Changing to:</u>
	<ul style="list-style-type: none"> • ELCA-Primary Benefits or • ELCA Medicare-Primary Benefits 	<ul style="list-style-type: none"> • ELCA-Primary Benefits or • ELCA Medicare-Primary Benefits
Effect of Changes	Sponsored Members will keep their ELCA-Primary Option or ELCA Medicare-Primary Standard Option in effect for the entire year if the Member is sponsored by the new Participating Employer and remains eligible for the option.	

D. **Employment Changes.** If a mid-year change in benefits occurs, and the change occurs without a break in coverage due to becoming a Member who is no longer sponsored, including becoming a Retired Member or an On Leave from Call Member, the Eligible Medical and Mental Health Expenses that were incurred before the mid-year change will be applied during the same calendar year as provided below.

<u>Coverage</u>	Changing from:	Changing to:
	<ul style="list-style-type: none"> • ELCA-Primary Benefits or • ELCA Medicare-Primary Benefits 	<ul style="list-style-type: none"> • ELCA-Primary Benefits or • ELCA Medicare-Primary Benefits
Effect of Changes	<ul style="list-style-type: none"> • A non-sponsored Member can elect a different ELCA-Primary Option than originally chosen. Deductible, Coinsurance, Cost-Share and Maximum Out-of-Pocket Amounts will apply to the new ELCA-Primary Option as provided above. Note, the Member will return to the ELCA-Primary Option initially chosen if the Member becomes a Sponsored Member again within the calendar year. • A Retired Member can elect a different ELCA Medicare-Primary Option than the ELCA Medicare-Primary Standard Option he/she was enrolled in for the remainder of the year. Deductible, Coinsurance, Cost-Share and Maximum Out-of-Pocket Amounts will apply to the new ELCA Medicare-Primary Option. • An On Leave from Call Member with ELCA Medicare-Primary Benefits will keep the ELCA Medicare-Primary Standard Option while On Leave from Call. 	

Coordination with Other Insurance

Other Group Coverage — If a Member has other group coverage that is primary, the Plan will pay the excess of the benefits that the Plan would have had to pay over the benefits provided by the other group coverage:

- Except as provided in the Medicare Coverage paragraph below, and
- Except the Plan will not pay for prescription drug expenses covered by group coverage other than the ELCA Part D Prescription Drug Benefit.

Medicare Coverage — If an ELCA Medicare-Primary Member has other group Medicare Advantage coverage, the Medicare Advantage Benefits Administrator will determine if ELCA Medicare-Primary Benefits or the other group coverage is primary. If the other group coverage is primary to this Plan, this Plan will pay the lesser of the following amounts:

- The reimbursement for Eligible Medical Expenses that the Plan would have paid in the absence of the other group coverage,
- The difference between the charge or the amount the provider must accept and the other group coverage payment, or
- The difference between the higher of the Medicare allowed amount or other group coverage allowed amount and the group coverage payment.

Other Insurance — If a Member makes a claim from the Plan for benefits that he or she received or could have received reimbursement from for a claim under Workers' Compensation, employers' liability, automobile no-fault insurance, or similar law or act, liability or similar insurance, or because of the act or omission of a third party, the Plan will pay secondary to that source.

If a Member makes a claim for benefits that, but for the Member's express exclusion of personal injury protection, are eligible to be reimbursed by automobile no-fault insurance or similar insurance then the Member will be deemed to have personal injury protection and the Plan shall pay secondary to such deemed source.

As a secondary payer, the Plan will pay only an amount equal to the excess, if any, of the benefits that the Plan would have paid in the absence of the other source, minus the reimbursement received or that could have been received from the insurance or other reimbursements.

Determining Responsibility — When a Member is covered under more than one group health plan, the primary responsibility for payment of benefits will be determined by the Medical and Mental Health Benefits Administrator or Dental Benefits Administrator, based on national coordination of benefits insurance guidelines. Generally,

- A plan will have primary responsibility if the plan:
 - Does not have a provision for coordination of benefits,
 - Covers the Member as an employee, or
 - Has covered the person for the longer time.
- In the case of an Eligible Child, primary responsibility is determined as follows (but not an Eligible Child whose parents are divorced or their partnership is dissolved):
 - The plan that covers the child as a dependent of the parent whose month and day of birth occurs earlier in a calendar year will have primary responsibility.

- If the month and day of birth of the parents are identical, the parent's plan with an earlier effective date will have primary responsibility.

If the plan of other group coverage does not have the above items to establish the order of benefits, then the rule set forth in the plan of other group coverage will determine the order.

- In the case of an Eligible Child whose parents are divorced or their partnership is dissolved:
 - The plan that covers the child as a dependent of the parent who has been made responsible by divorce decree or other court-approved custody document for the child's medical expenses will have primary responsibility,
 - If the divorce decree or other court-approved custody document does not establish responsibility for the child's medical expenses and there are two or more plans, the plan that covers the child as:
 - a dependent of the parent with custody will have primary responsibility
 - a dependent of the stepparent will have secondary responsibility
 - a dependent of the parent without custody will have tertiary responsibility
- If the parents have joint custody of the child, the parent's plan with an earlier effective date will have primary responsibility.

Portico's Right to Reimbursement (Subrogation)

Subrogation is a legal process that allows Portico to substitute itself in a Member's place (or person claiming benefits through member or on member's behalf) for a claim or legal right to compensation from a third party (person or entity) who was responsible for the injury or illness. Upon the payment of ELCA-Primary benefits under this Plan, Portico will be entitled to recovery against any third party, including recoveries from:

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

Member Assignment and Cooperation — Portico may require the Member to assign his/her right of recovery to Portico in the amount of the reasonable value of the benefits, services and payments provided to the Member plus the reasonable costs of collection. The Member must cooperate with Portico and its benefits administrators in assisting it to protect its legal rights under these subrogation provisions and will promptly notify Portico in writing of any situation that may allow Portico to raise its subrogation rights.

First Priority Claim — Portico will be paid before any other claims are paid, including any claim by the Member for general damages. The Plan's right to subrogation or reimbursement will not be affected or reduced by doctrines, regulatory diligence or any other equitable defenses. The Plan will not pay attorney's fees or costs associated with the claim or lawsuit without advance written authorization from Portico Benefit Services.

Government-mandated Insurance — If a Member fails to obtain any type of state or federal mandated insurance coverage, or expressly excluded such coverage, including, but not limited to, no-fault insurance, Portico will be allowed to fully assert its subrogation rights.

Settlements — If a Member settles a claim or action against a third party, the Member will be considered to have been made whole by the settlement and Portico will be entitled to immediately collect the present value of its first priority claim from the settlement proceeds. In addition, if a Member voluntarily accepts a lump-sum (or other) settlement without Portico's consent and the settlement results in a waiver or elimination of Portico's subrogation rights, Portico is released from any obligation to pay past, present, or future benefits or expenses involving the illness or injury.

The Member cannot prejudice Portico's rights under this provision, either before or after the time that the need for services or benefits under this Plan has elapsed. Portico may, at its option, immediately collect the present value of the amounts from the proceeds of any settlement or judgment that may be recovered by the Member or the Member's legal representative. Any proceeds of settlement or judgment will be held in trust by the Member for the benefit of Portico under these subrogation provisions, and Portico will be entitled to recover reasonable attorneys' fees from the Member when incurred in collecting proceeds held by the Member.

Claim Filing Deadline

No reimbursement or direct payment will be made for Eligible Expenses unless a claim for reimbursement is submitted within 12 months of the date the expenses were incurred; however, Portico, in its sole discretion, may waive the application of this provision due to circumstances beyond the control of the Member and/or the provider.

Section 10 ELCA-Primary Benefits Overview

A Member who meets the eligibility requirements of the Plan is an ELCA-Primary Member and will have ELCA-Primary Benefits, except as provided in Section 11 and the Special Provisions in Section 17.

ELCA-Primary Benefits includes the following benefits:

- Medical and Mental Health Benefits see Section 12
- Dental Benefits..... see Section 13
- Supporting Services see Section 14
- Prescription Drug Benefits..... see Section 15

ELCA-Primary Benefits provides the following coverage options to eligible Members:

- ELCA-Primary Platinum+
- ELCA-Primary Gold+
- ELCA-Primary Silver+ *
- ELCA-Primary Bronze+ *

* High-deductible health plan as defined by the IRS.

NOTE: An eligible Disabled Member will have the ELCA-Primary Gold Option only.

Benefit Payments — Except for any Deductibles, Coinsurance and Copays owed by the Member, the Plan will pay the provider directly or will reimburse the Member for the Eligible Medical and Mental Health Expenses provided in Section 12 that are incurred while the Member is enrolled with ELCA-Primary Benefits.

Preventive Services and Certain Other Services Payments — Eligible Medical Expenses for *Preventive Services and Certain Other Services* listed in Section 12 will be paid as follows:

- The Plan will pay 100% if provided by an In-network Eligible Medical Provider.
- The Plan will pay 60% if provided by an Out-of-network Provider; and the Member will pay 40% Coinsurance until the Maximum Out-of-Pocket Amount for Out-of-network Eligible Medical and Mental Health Expenses has been met.

Organ Transplant, Bariatric Surgery, Knee or Hip Replacement, or Spine Surgery Payments — In order to be an Eligible Medical Expense, a Member who is at least 18 and who requires an organ transplant according to Section 12, bariatric surgery, knee or hip replacement surgery, or spine surgery, must have the services:

- Approved in advance by the Care Coordinator, and
- Performed at a Center of Excellence (as defined by the Medical and Mental Health Benefits Administrator) or an In-network Hospital or Facility.

The Hospital and Facility Medical Expenses related to the approved transplant, bariatric surgery, knee or hip replacement surgery, or spine surgery will be reimbursed as follows:

- For a Center of Excellence, the Member will pay 20% Coinsurance of Eligible Hospital and Facility Medical Expenses in excess of the In-network Deductible Amount until the In-network Maximum Out-of-Pocket Amount has been reached.
- For a Center of Excellence, the Plan will reimburse up to \$10,000 for travel and lodging expenses, except meals, for the Member and his/her companion, if the expenses are approved in advance by the Care Coordinator.
- For a Hospital or Facility that is an In-network Provider but is not a Center of Excellence, the Member will pay 40% Coinsurance of Eligible Hospital and Facility Medical Expenses in excess of the In-network Deductible Amount until the In-network Maximum Out-of-Pocket Amount has been reached.
- For a Hospital or Facility that is an Out-of-network Provider, the Member will pay 100% of expenses.

Deductible, Coinsurance and Maximum Out-of-Pocket for Eligible Medical and Mental Health Expenses

ELCA-Primary Gold+ and Platinum+ Options: In-Network

- **Deductible**
 - A Member with individual coverage is responsible for the applicable individual Deductible Amount as shown in the Appendix.
 - For Members with family coverage, the sum of the In-network Eligible Medical and Mental Health Expense Deductible Amounts paid for the Member, Spouse, ESGP and Eligible Children must equal the In-network Deductible Amount for the family coverage elected by the Member before the Plan pays a percentage of Eligible Expenses, unless the amounts were incurred by a family member who already met the individual Deductible Amount.
- **Coinsurance**
 - The Member will pay 20% Coinsurance for Eligible Expenses that are more than the In-network Deductible Amount. The 20% Coinsurance will continue until the In-network Maximum Out-of-Pocket Amount has been reached for the year.
- **Maximum Out-of-Pocket Amount**
 - A Member with individual coverage will have the Maximum Out-of-Pocket Amount limit as shown in the Appendix.
 - For Members with family coverage, the sum of the In-network Eligible Medical and Mental Health Expense Out-of-Pocket Amounts and Eligible Prescription Drug Expense Cost-Share for the Member, Spouse, ESGP and Eligible Children must equal the Maximum Out-of-Pocket Amount for the family coverage elected by the Member before the Plan pays 100% of Eligible Expenses, unless the amounts were incurred by a family member who already met the individual Maximum Out-of-Pocket Amount.

ELCA-Primary Gold+ and Platinum+ Options: Out-of-Network

- **Deductible**
 - A Member with individual coverage is responsible for the applicable individual Deductible Amount as shown in the Appendix.
 - For Members with family coverage, the sum of the Out-of-network Eligible Medical and Mental Health Expense Deductible Amounts paid for the Member, Spouse, ESGP, and Eligible Children must equal the Out-of-network Deductible Amount for the family coverage elected by the Member before the Plan pays a percentage of Eligible Expenses, unless the amounts were incurred by a family member who already met the individual Deductible Amount.
- **Coinsurance**
 - The Member will pay 40% Coinsurance for Eligible Expenses that are more than the Out-of-network Deductible Amount. The 40% Coinsurance will continue until the Out-of-network Maximum Out-of-Pocket Amount has been reached for the year.

- **Maximum Out-of-Pocket Amount**

- A Member with individual coverage will have the Maximum Out-of-Pocket Amount limit as shown in the Appendix.
- For Members with family coverage, the sum of the Out-of-network Eligible Medical and Mental Health Expense Out-of-Pocket Amounts and Eligible Prescription Drug Expense Cost-Share for the Member, Spouse, ESGP, and Eligible Children must equal the Maximum Out-of-Pocket Amount for the family coverage elected by the Member before the Plan pays a percentage of Eligible Expenses, unless the amounts were incurred by a family member who already met the individual Maximum Out-of-Pocket Amount.

ELCA-Primary Bronze + and Silver+ Options: In-Network

- **Deductible**

- A Member with individual coverage is responsible for the applicable individual Deductible Amount as shown in the Appendix.
- For Members with family coverage, the sum of In-network Eligible Medical and Mental Health Expense and the Eligible Prescription Drug Expense Deductible Amounts paid for the Member, Spouse, ESGP, and Eligible Children must equal the family coverage In-network Deductible Amount before the Plan pays a percentage of Eligible Expenses. There is no individual Deductible Amount.

- **Coinsurance**

- The Member will pay 20% Coinsurance for Eligible Expenses that are more than the In-network Deductible Amount. The 20% Coinsurance will continue until the In-network Maximum Out-of-Pocket Amount has been reached for the year.

- **Maximum Out-of-Pocket Amount**

- A Member with individual coverage will have the Maximum Out-of-Pocket Amount limit as shown in the Appendix.
- For Members with family coverage, the sum of the In-network Eligible Medical and Mental Health Expense and Eligible Prescription Drug Expense Out-of-Pocket Amounts for the Member, Spouse, ESGP and Eligible Children must equal the In-network Maximum Out-of-Pocket Amount for the family coverage elected by the Member before the Plan pays a percentage of Eligible Expenses, except for an individual family member who already met the individual Maximum Out-of-Pocket Amount.

ELCA-Primary Bronze+ and Silver+ Options: Out-of-Network

- **Deductible**

- A Member with individual coverage is responsible for the applicable individual Deductible Amount as shown in the Appendix.
- For Members with family coverage, the sum of Out-of-network Eligible Medical and Mental Health Expense and the Eligible Prescription Drug Expense Deductible Amounts paid for the Member, Spouse, ESGP, and Eligible Children must equal the family coverage Out-of-network Deductible Amount before the Plan pays a percentage of Eligible Expenses. There is no individual Deductible Amount.

- **Coinsurance**

- The Member will pay 40% Coinsurance for Eligible Expenses that are more than the Out-of-network Deductible Amount. The 40% Coinsurance will continue until the Out-of-network Maximum Out-of-Pocket Amount has been reached for the year.

- **Maximum Out-of-Pocket Amount**

- A Member with individual coverage will have the Maximum Out-of-Pocket Amount limit as shown in the Appendix.
- For Members with family coverage, the sum of the Out-of-network Eligible Medical and Mental Health Expense and Eligible Prescription Drug Expense Out-of-Pocket Amounts for the Member, Spouse, ESGP and Eligible Children must equal the Out-of-network Maximum Out-of-Pocket Amount for the family coverage elected by the Member before the Plan pays a percentage of Eligible Expenses, except for a family member who already met the individual Maximum Out-of-Pocket Amount.

Section 11 ELCA Medicare-Primary Benefits

Eligibility

A Member is an ELCA Medicare-Primary Member if he/she is eligible for and enrolled in primary coverage under Medicare Part A and Part B.

Retired Members and family members who should be eligible for Medicare Part A and Part B as primary coverage due to age and Disabled Members receiving benefits under the ELCA Disability Benefits Plan and family members who should be eligible for Medicare as primary coverage due to age or satisfying the Social Security Disability Insurance qualifying period, but are not eligible for Medicare due to living outside the United States and Puerto Rico, untimely enrollment in Medicare, opting out of Social Security, or waiving participation in all or part of Medicare, are also not eligible for coverage under this Plan.

An ESGP is not eligible for benefits under this Plan if he/she does not qualify for Medicare benefits on and after the age of eligibility for Medicare benefits.

A Retired Member, Disabled Member and family members who are eligible for ELCA Medicare-Primary Benefits will not be eligible for coverage under this Plan if they:

- enroll in a Medicare Prescription Drug Program plan (Part D),
- enroll in a Medicare Supplement plan,
- enroll in an individual Medicare Advantage plan not provided by this Plan,
- opt out of the ELCA Part D Prescription Drug Benefit, or
- opt out of the ELCA Medicare Advantage Benefit.

An eligible ELCA Medicare-Primary Member may receive Group PPO Medicare Advantage Benefits for Eligible Hospital and Medical Expenses with ELCA Part D Prescription Drug Benefits, ELCA Dental Benefits and Supporting Services:

- Group PPO Medicare Advantage Benefits *Section 11*
- Dental Benefits..... *Section 13**
- Supporting Services *Section 14*
- Part D Prescription Drug Benefits..... *Section 15*

** A Retired Member of the ELCA Continuation of the LCA Ministerial Health Benefits Plan who elected not to add dental coverage under a one-time option in 1996 will not have Dental Benefits.*

Reimbursement of Medicare Premiums for Certain Members — The Plan will reimburse certain Members with ELCA Medicare-Primary Benefits for the premiums paid by the Members for Medicare Medical Insurance (Part B). However, the Plan will not reimburse the late enrollment penalty or other penalties imposed by Medicare.

Members eligible for reimbursement of Part B premiums are Sponsored Members and Disabled Members and their Eligible Dependents who are enrolled in ELCA Medicare-Primary Benefits. Members will be reimbursed until the Member is no longer a Sponsored Member or Disabled Member.

ELCA Medicare-Primary Options

ELCA Medicare-Primary Benefits offers three Options for eligible Members:

- ELCA Medicare-Primary Premium
- ELCA Medicare-Primary Standard
- ELCA Medicare-Primary Economy

Retired Member or Coverage Continuation Member — A Retired Member or Coverage Continuation Member may choose from the three ELCA Medicare-Primary Options as follows:

- During an annual enrollment period (coverage will be for the following calendar year and cannot be changed midyear).
- Midyear upon new eligibility for ELCA Medicare-Primary Benefits (coverage will be for the remainder of the calendar year).

Sponsored Member, Disabled Member, or a Member On Leave from Call — A Sponsored Member, Disabled Member or a Member who is On Leave from Call will have the ELCA Medicare-Primary Standard Option only.

Default Option — Members who do not choose an ELCA Medicare-Primary Option during the annual enrollment period or within 60 days of new midyear eligibility will be enrolled in the ELCA Medicare-Primary Standard Option.

Eligible Spouse, ESGP, and Eligible Children — A Sponsored Member, Retired Member or Coverage Continuation Member who is covered by ELCA Medicare-Primary Benefits will choose an option under ELCA-Primary Benefits for her or his Dependents who are eligible for ELCA-Primary Benefits.

Group PPO Medicare Advantage Benefit

Benefit Payments — Except for the Deductible Amount and Coinsurance owed by the Member, the Plan will pay the provider directly or will reimburse the Member for Eligible Hospital and Medical Expenses that are incurred while the Member is enrolled in ELCA Medicare-Primary Benefits.

Deductible and Coinsurance — Reimbursement of Eligible Medical Expenses under the Medicare Advantage Benefit will not be made until the Eligible Hospital and Medical Expenses incurred by the Member in a calendar year is more than the Deductible Amount, if applicable, shown in the Appendix.

After the Member has incurred Eligible Medical Expenses (subject to the provisions in subsection “Eligible Medical Expenses Under the Medicare Advantage Benefit” below) equal to the Deductible Amount, the Member will pay Coinsurance for the Eligible Hospital and Medical Expenses that are more than the Deductible Amount.

Maximum Out-of-Pocket Amount — The Maximum Out-of-Pocket Amount that a Member must pay for the Deductible and Coinsurance for Eligible Hospital and Medical Expenses incurred in a calendar year is shown in the Appendix.

Eligible Medical Expenses Under the Medicare Advantage Benefit — Medicare Advantage benefits are extended to eligible Members through an agreement between Portico and an insurance company. Eligible Medical Expenses include:

- **Hospital and Medical Services Covered under Medicare Part A and Part B** — Hospital and medical services determined to be Eligible Expenses by the Medicare Advantage Benefits Administrator.
- **Medically Necessary Hospital and Medical Expenses Worldwide Emergency and Urgent Care Outside the United States and Territories** — Medically Necessary emergency and urgent care hospital and medical expenses incurred for services that would have been eligible under Medicare Hospital Insurance (Part A) or Medicare Medical Insurance (Part B) had the services been provided within the territory covered by the Medicare program will be covered as shown in the Appendix.
- **Medically Necessary Inpatient Services** — Medically Necessary inpatient services provided to a Member in a qualified skilled nursing facility for up to 90 days of continuous care after Medicare became the primary health coverage for the Member, are eligible expenses if:
 - The care began and was authorized by the Care Coordinator while the Member was covered under ELCA-Primary Benefits, and
 - The care continued without interruption after the date Medicare became the Member's primary health coverage.

Section 12 ELCA-Primary Medical and Mental Health Expenses

Basic Requirement for Medical Expenses

Expenses for treatment or diagnosis of an illness, injury, or physical condition are Eligible Medical Expenses only if they are:

- Medically Necessary as determined by the Care Coordinator,
- Qualified for reimbursement as determined by the Medical and Mental Health Benefits Administrator or Care Coordinators designated by Portico Benefit Services,
- At a Reasonable and Customary cost, charge or expense,
- Considered Eligible Medical Health Expenses according to this Section 12, and
- Performed by an Eligible Medical Provider and/or in a Hospital or Facility in accordance with the Plan.

Medical Providers

An Eligible Medical Provider is a medical provider licensed by the state where the services are performed, and the services are within the scope of their license. Eligible Medical Providers are the following provider types:

- Acupuncturist
- Audiologist
- Chiropractor
- Dentist (only for services in Surgical Expenses and Other Eligible Medical Expenses)
- Dietician
- Osteopath
- Licensed practical nurse
- Massage therapist
- Naturopath
- Medical doctor
- Nurse practitioner
- Occupational therapist
- Optometrist
- Physical therapist
- Physician's assistant
- Podiatrist
- Registered nurse
- Respiratory care practitioner
- Speech therapist

Hospital and Facility Medical Expenses

A Hospital or alternative specialized treatment Facility is a hospital or facility that qualifies for reimbursement and meets the standards and requirements of the Medical and Mental Health Benefits Administrator or Care Coordinator.

The following costs for Medically Necessary treatment provided at a Hospital or Facility are Eligible Medical Expenses:

- Semi-private room and meals, special diets and general nursing care, including hospice care, except that private room charges will be reimbursed only when:
 - Isolation or intensive care is Medically Necessary and prescribed by the attending physician, or
 - Confinement is in a Hospital or Facility that only has private rooms.
- The use of 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 necessary services and supplies.
- Skilled nursing, convalescent, or extended care in an alternative specialized treatment Facility for up to 120 days each calendar year.

Surgical Expenses

Surgeon's fees for procedures performed by a physician legally authorized to practice surgery are Eligible Medical Expenses when determined to be Medically Necessary by the Care Coordinator and approved in advance by the Care Coordinator.

Organ Transplant, Bariatric Surgery, Knee or Hip Replacement, or Spine Surgery

Cornea, kidney, heart, heart-lung, bone marrow, liver, lung (single or double), and pancreas transplants and specialized transplant programs are Eligible Medical Expenses.

In addition, the Care Coordinator may approve transplant procedures that involve body organs other than those listed.

In order to be an Eligible Medical Expense, a Member who is at least 18 and who requires an organ transplant, bariatric surgery, knee or hip replacement surgery, or spine surgery, must have the services:

- Approved in advance by the Care Coordinator, and
- Performed at a Center of Excellence (as defined by the Medical and Mental Health Benefits Administrator) or an In-network Hospital or Facility.

The Hospital and Facility Medical Expenses related to the approved transplant, bariatric surgery, knee or hip replacement surgery, or spine surgery will be reimbursed as provided in Section 10.

If a human organ, bone, tissue or blood stem cell transplant is donated from a living donor to a Member and the organ, bone, tissue or blood stem cell transplant donor is also a Member, each Member is entitled to benefits under this Plan. When only the recipient, not the donor, is a Member in this Plan:

- Benefits for the donor are limited to only those not provided or available to the donor from any other source, including, but not limited to, other insurance coverage or any government program;
- Services provided to the donor that are considered Eligible Expenses under the Plan, will be considered Eligible Expenses under the Member receiving the donated organ, bone, tissue or blood stem cell, except that any expenses for the donor incurred for complications after the organ, bone, tissue or blood stem cell is removed from the donor are Ineligible Expenses; and
- No benefits will be payable for a sold rather than donated organ, tissue, or blood stem cell.

When only the donor is a Member, the donor is entitled to benefits of this Plan, subject to the following limitations:

- Benefits are limited only to those not provided or available to the donor from any other source; and
- No benefits will be provided to the non-member transplant recipient.

Preventive Services and Certain Other Services

The following services are Eligible Medical Expenses for Preventive Services when billed as routine and/or Preventive Services:

Services	Including
Preventive care visit	depression screening and hypertension screening; and skin, testicular, prostate-digital rectal, rectal-digital, and breast examination if age-appropriate
Laboratory testing	cholesterol/lipid profile, thyroid, and diabetes
Well woman visit	preconception counseling
Vision examination	glaucoma, acuity, and refraction screenings
Hearing examination and related screenings	
Well-child care	medical history, height, weight, and body mass index; developmental/autism, lead and tuberculosis screening
Immunizations	pediatric and adult
Radiological osteoporosis screening	
Colorectal cancer screening	occult blood test, proctosigmoidoscopy, barium enema sigmoidoscopy, and colonoscopy
Cervical cancer screening	pap smear, Human papillomavirus screening
Breast cancer screening	Mammogram (includes coverage for 3-D mammogram, if elected)
Counseling related to chemoprevention of breast cancer	
Counseling about BRCA breast cancer gene screening	testing for BRCA gene, when approved in advance by the Care Coordinator
Ovarian cancer screenings	CA-125 test, trans-vaginal ultrasound
Prostate cancer screening	prostate specific antigen (PSA)
Abdominal aortic aneurysm screening	
Urine microalbumin screening	
FDA approved contraceptive methods	sterilization by certain intratubal occlusion device and delivery systems; contraceptive counseling for women; and intrauterine devices (IUD); except those methods covered under Prescription Drug Benefits;
Routine, low-risk prenatal care	prenatal office visits, which include monitoring fetal heart tones, physical exams, weight and blood pressure

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	measurements, and routine urinalysis; gestational diabetes screening and related intensive behavioral counseling interventions, iron-deficiency anemia, bacteriuria, hepatitis B virus and Rh incompatibility screenings; screening and certain counseling services for alcohol or substance abuse, tobacco use, obesity, diet and nutrition
Sexually transmitted infection counseling and screening	human immunodeficiency virus (HIV) screening
Breast-feeding support, counseling and supplies	costs for renting or purchasing specified breast-feeding equipment from a network provider or national durable medical equipment supplier
Domestic violence screening and counseling	
Human papillomavirus 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	hearing, thyroid disease, phenylketonuria and sickle cell anemia, and standard metabolic screening panel for inherited enzyme deficiency diseases
Lung cancer screening	using low-dose computed tomography for ages 55-80 who currently smoke or have quit smoking within the last 15 years and have a history of smoking an average of 1 pack of cigarettes per day, subject to prior authorization requirements.
Other tests, screenings and services considered Eligible Preventive Services by the Medical and Mental Health Benefits Administrator	

If any of the following services is billed with a non-preventive diagnosis, it will be paid as if it was billed as a preventive service; however, the Plan will only pay for a service listed in below one time per year, in accordance with Preventive Services and Certain Other Services in Section 10. Subsequent occurrences during the calendar year for services billed as preventive or non-preventive services will be paid as Eligible Medical Expenses in accordance with Section 10.

• Lipid profile	• Mammogram	• Colonoscopy
• Prostate specific antigen (PSA) test	• Hemoglobin A1c test	
• PAP smear	• Vision examination	

Certain Other Services as determined by the Plan or required by federal law or mandate, shall be paid as Preventive and Certain Other Services in accordance with Section 10.

Other Eligible Medical Expenses

The following are Eligible Medical Expenses if Medically Necessary:

Other Services	Including
Casts and surgical dressings	
X-rays, CAT scans, magnetic resonance imaging, or other similar diagnostic imaging procedures	MRI/MRA and PET Scans, if approved in advance by Care Coordinator
Laboratory tests	including pre-admission testing on an outpatient basis for an illness or injury requiring hospital confinement
Physical therapy	performed by a licensed or registered physical therapist, or occupational therapy performed by a licensed or registered occupational therapist, under the orders and supervision of an Eligible Medical Provider
Medical equipment purchase or rental	provided the equipment is: <ul style="list-style-type: none"> • prescribed by a physician to treat an illness or injury; • essentially medical in nature; • usable only in the presence of an illness or injury; • usable only by the patient for whom it was prescribed; • able to withstand repeated use; and • if approved in advance by Care Coordinator
Private duty nursing	<ul style="list-style-type: none"> • 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 unit is not available or medically feasible; and • if determined to be Medically Necessary and approved in advance by Care Coordinator
Ambulance service:	limited to: <ul style="list-style-type: none"> • emergency ambulance service; • local transfers to the Member's home when requested by the attending physician; • transfers to the nearest hospital with adequate facilities, if the patient's condition requires treatment, and facilities are not available at the hospital where he/she is confined. the cost of air ambulance service: <ul style="list-style-type: none"> • to the nearest hospital with adequate facilities is to be considered an Eligible Medical Expense when the patient's condition requires treatment

	<p>and facilities are not available at the hospital where he/she is confined;</p> <ul style="list-style-type: none"> • to the nearest hospital on an emergency basis from a remote geographical area; or • medical transportation to the patient's home or a medical rehabilitation facility when prescribed by the attending physician following knee or hip replacement surgery, spine surgery or transplant performed at a Center of Excellence, in accordance with Section 10.
Treatment of accidental injury to teeth or their supporting structures	emergency care and up to 12 months of follow-up care, including care provided by a dentist, limited to re-implantation of original sound and healthy natural teeth, and/or restoration of crowns, fillings and bridges.
Midwifery	if licensed or certified by the state that the services are performed or if acting under the supervision of a medical doctor; and the services are provided in a qualified Hospital or Facility.
Hospice care provided to a Member during the final six months of terminal illness	<p>by a home hospice care agency if approved in advance by Care Coordinator:</p> <ul style="list-style-type: none"> • up to 8 hours a day of part-time or intermittent nursing care by a registered or licensed practical nurse; • medical social services, including assessment of the patient's social, emotional and medical needs, and identification of community resources available to the patient; • psychological and dietary counseling; • consultation or case management services by a physician; • physical and occupational therapy; • up to eight hours a day of part-time or intermittent care by a licensed home health aide; • medical supplies, drugs and medicines prescribed by a physician.
Home health care or home health aide services as an alternative to confinement in a Hospital or Facility	including private duty or visiting nurse care if approved in advance by Care Coordinator
Treatment for oral cancer, and tooth extractions and dental implants	required as a result of removal of a cyst, tumor, neoplasm or growth in the cheek or jaw and the surgery was covered as an Eligible Medical Expense
Hospital and anesthesiologist services	when necessary to provide dental care to a Member who is under age five (5), is severely disabled, or has a medical condition that requires hospitalization or general anesthesia if approved in advance by Care Coordinators.
Speech therapy performed by a licensed or registered speech therapist	limited to the following situations:

	<ul style="list-style-type: none"> • Adults. Speech therapy, in the event of (a) vocal cord surgery, (b) stroke, (c) accidental injury, or (d) speech-related illness. The adult must originally have had speech ability. • Children. In addition to the situations applicable for adults, speech therapy for Medically Necessary speech development, including treatment and services for autism spectrum disorder.
Chiropractic manipulation treatment	initial diagnostic x-rays
Smoking cessation treatment	provided by an Eligible Medical Provider
Over-the-counter nicotine replacement products	for Members who have enrolled in and are participating in the Care Coordinator's smoking cessation program
Weight loss treatment and services	provided by an Eligible Medical Provider
Infertility treatment	up to \$10,000 lifetime maximum per Member for all infertility treatment, including physician visits and services, tests, imaging procedures, physician 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, cryopreservation for iatrogenic infertility, and infertility counseling for, or related to, artificially assisted fertilizations
Cleft lip and palate treatment	including oral surgery and orthodontia; surgeries must be approved in advance by Care Coordinator.
Temporomandibular joint disorder and craniomandibular disorder treatment	including orthodontia
Acupuncture	up to 12 visits each calendar year performed by an Eligible Medical Provider for the: <ul style="list-style-type: none"> • treatment of chronic pain with a duration of six months or more when other therapies have failed; or • prevention and treatment of nausea associated with surgery, chemotherapy and pregnancy
Massage therapy	up to 12 visits each calendar year for massage therapy visits including any service provided by: <ul style="list-style-type: none"> • a licensed massage therapist; or • other eligible medical provider
Certain routine care for approved clinical trials	including items and services that would be covered for Members enrolled in an approved clinical trial
Gender reassignment surgery and all surgeries related to gender reassignment	if the surgery and related services are approved in advance by Care Coordinator, including, but not limited to, facial hair removal, blepharoplasty, face

	lift, facial bone reconstruction, rhinoplasty, liposuction and reduction thyroid chondroplasty
Foot care	Medically Necessary foot care including treatment for (i) bunions, when an open cutting operation is performed; (ii) treatment for mycotic toenails when at least part of the nail root is removed; (iii) surgical procedures; (iv) treatment for systemic metabolic or peripheral vascular disease; and (v) orthotics. Surgeries must be approved in advance by Care Coordinator.
Sexual dysfunction or impotence	service for testing and diagnosis, and such related treatment, if due to organic disease, a medical condition or an act of violence.
Reverse sterilization	Surgeries must be approved in advance by Care Coordinator.
Organic congenital disorders and development disorders	expenses for diagnosis and treatment of disorders for stabilization of an acute episode of such disorders or management of medication
Autism spectrum disorder	Medically Necessary treatment and services if approved in advance by Care Coordinator
Genetic testing	if approved in advance by Care Coordinator
Panniculectomy	if approved in advance by Care Coordinator
Telemedicine Provider Visits	If provided by an In-network provider
Hearing aids	limited to one aid per ear every 36 months and no more than \$3,000 per hearing aid, for Eligible Children under the age of 18 years with hearing loss due to illness, injury or congenital disorder; for Members age 18 and older, limited to no more than \$3,000 per Member every 36 months
Allergy extract and allergy injections	including testing and serum
Compression stockings	when prescribed by an Eligible Medical Provider, limited to 6 (six) pair each calendar year
Wig	following the diagnosis of alopecia areata and for hair loss due to chemotherapy treatment for cancer
Other medical expenses	as determined to be Medically Necessary by the Medical and Mental Health Administrator or Care Coordinator.

Exclusions from Eligible Medical Expenses

The following are not Eligible Medical Expenses:

Medical care, supplies or treatment received in facilities owned or operated by or furnished at the expense of the U.S. Government, state government, local government or any of their agencies	<ul style="list-style-type: none"> if the Member is not, in the absence of the Medical and Dental Benefits Plan, legally obligated to pay except the Plan will pay for benefits received at governmental medical facilities as required by law
Charges for services or supplies that are Experimental and/or Investigational	as determined by the Medical and Mental Health Benefits Administrator or the Care Coordinator
Treatment that: <ul style="list-style-type: none"> is not provided or prescribed by an Eligible Medical Provider, that is provided or prescribed outside of an Eligible Medical Provider's license, or is not Medically Necessary. 	
Services by unlicensed physicians, practitioners or providers of service, or by providers of service who are not Eligible Medical Providers	
Costs for treatment or diagnosis of any disease, illness, injury, or condition determined to be an Eligible Dental or Eligible Prescription Drug Expense	
Additional costs for private rooms, unless isolation or intensive care is prescribed by the attending physician	
Acupuncture treatment	if it does not meet the requirements under "Other Eligible Medical Expenses"
Costs for services in a Hospital or Facility that does not meet the requirements of a Hospital or Facility	as determined by the Medical and Mental Health Benefits Administrator or Care Coordinator
Personal comfort services	such as radio, television, beauty and barber services, guest services, and similar incidental services
Nursing home or convalescent Facility care	except up to 120 days each calendar year if solely for recuperative purposes and determined to be Medically Necessary by the Care Coordinator
Cosmetic surgery	except when necessary for treatment and correction because of accidental injury, congenital birth defect, or disease or injury resulting in functional impairment
Oral surgery or any other service provided by a dentist or dental care practitioner	if it does not meet the requirements under "Other Eligible Medical Expenses"

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Routine examinations	except as provided under “Preventive Services and Certain Other Services”
Services for correction of refractive error	
Cost of hearing aids, eyeglasses, or contact lenses	except for a single pair of eyeglasses or contact lenses required as a result of cataract surgery, medically necessary prosthetic contact lenses, or as provided under “Other Eligible Medical Expenses”
Private duty nursing and home health aide services for respite and all other care	if it is not specifically provided under “Other Eligible Medical Expenses”
Cost of a medibus, cabulance, bus fare, taxi fare, or personal car expense	except as provided in Section 10 under “Organ Transplant, Bariatric Surgery, Knee or Hip Replacement, or Spine Surgery Payments”
Treatments and programs for smoking cessation purposes	unless provided by an Eligible Medical Provider
Weight loss treatments and programs	unless provided by an Eligible Medical Provider
Infertility treatment	unless it meets the requirements under “Other Eligible Medical Expenses” and then only up to the \$10,000 lifetime per Member infertility maximum.
Sperm Banking, donor ova or sperm, services and prescription drugs for, or related to, gender selection services	
Late-term induced abortions	except when the life of the mother is threatened or imminent; or the fetus has lethal fetal abnormalities indicating death is imminent
Drugs taken for the purpose of terminating pregnancy	
Exercise programs and equipment	
Massage therapy	if it does not meet the requirements under “Other Eligible Medical Expenses”
Routine foot care	including cutting and removing corns and calluses, nail trimming, cutting or debriding, and hygienic and preventive maintenance foot care – except for care required due to medical conditions including diabetes or blindness
Treatment for sexual dysfunction or impotence	if it is not the result of organic disease, a medical condition or an act of violence
Expenses for diagnosis and treatment of organic congenital disorders and development disorders	except for stabilization of an acute episode of such disorders or management of medication and except for Medically Necessary treatment and services for autism spectrum disorder are eligible, if prior authorization is obtained from the Care Coordinator.
Services related to surrogate pregnancy	for a Member or any individual, including diagnostic screening, physician services,

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	reproduction treatments, and prenatal, delivery and postnatal services.
Other medical expenses determined ineligible by the Medical and Mental Health Benefits Administrator or Care Coordinator	

Basic Requirements for Mental Health Expenses

Expenses for treatment or diagnosis of mental health or substance abuse diseases are Eligible Mental Health Expenses if they are:

- Medically Necessary as determined by the Care Coordinator,
- Qualified for reimbursement as determined by the Medical and Mental Health Benefits Administrator or Care Coordinator designated by Portico Benefit Services,
- At a Reasonable and Customary cost, charge or expense,
- Considered Eligible Mental Health Expenses, and
- Performed by an Eligible Mental Health Provider and/or in a Hospital or Facility.

Mental Health Providers

An Eligible Mental Health Provider must be one of the following types of providers, licensed by the state where the services are performed and the services must be within the scope of their license:

- A licensed psychiatrist who is either a Medical Doctor or Doctor of Osteopathy,
- A licensed doctoral-level psychologist who holds a Ph.D., Ed.D or Psy.D degree,
- A Masters-prepared therapist, provided the therapist possesses:
 - a Master’s degree from an accredited institution in a licensable mental health discipline, and
 - a license to practice independently in the state the services are provided,
- A pastoral counselor who meets the requirements provided above for a licensed doctoral-level psychologist or a Masters-prepared therapist, or
- Any other provider considered eligible by the Medical and Mental Health Benefits Administrator or Care Coordinator.

Hospital and Facility Mental Health Expenses

A Hospital or alternative specialized treatment Facility is a hospital or facility that qualifies for reimbursement and meets the standards and requirements of the Medical and Mental Health Benefits Administrator or Care Coordinator. The following costs for Medically Necessary treatment provided in a Hospital or Facility are Eligible Mental Health Expenses:

- Reasonable and Customary expenses for Medically Necessary mental health treatment if approved in advance by Care Coordinator:
 - While admitted to a Hospital or Facility that provides a 24-hour secure and protected, medically staffed and psychiatrically supervised environment, if the admission is made under the orders and supervision of a licensed physician or psychiatrist.
The expenses include room, meals, 24-hour skilled psychiatric nursing care, psychotherapy, a structured treatment environment for the administration of necessary mental health services, daily medical care and supplies, as well as charges for professionals and ambulance services. Pre-certified Medically Necessary practitioner, Facility and anesthesia charges for Electroconvulsive Therapy (ECT) are Eligible Mental Health Expenses.

- While admitted as a patient in a Hospital or Facility for diseases of substance abuse. The expenses include room, meals, 24-hour general nursing care, psychotherapy, a structured environment for the administration of necessary medical services, daily medical care and supplies, as well as professional and practitioner charges.
 - At a halfway house that is licensed for mental health/substance abuse services by the state where the care is provided if it includes out-patient individual, group and family treatment and requires abstinence. Halfway house room and board costs are ineligible expenses.
 - At a residential treatment facility that is licensed by the Joint Commission and/or an appropriate state licensing board for residential mental health/substance abuse treatment if it has both 24/7 on-call medical availability and 24/7 on-site mental health specialists trained in responding to emergency psychiatric situations.
 - In a partial hospitalization treatment program that provides coordinated, intense, comprehensive, multi-disciplinary treatment utilized when there is not a need for 24-hour intensive psychiatric/nursing care. Partial hospitalization programs may be used as an initial level of care, as an alternative to, or as a step-down from inpatient level of care.
 - In an intensive outpatient therapy treatment that provides comprehensive, multi-disciplinary treatment for participants who can maintain the ability to fulfill family, student or work activities outside of the treatment setting, provided that the severity of psychosocial stressors and family dysfunction are such that this level of care is necessary to stabilize the Member and despite these stressors the Member is not at imminent risk to self or others. The expenses include clinical interventions for individual, family and group sessions along with medication management. Intensive outpatient therapy treatment will be considered for complex or refractory clinical situations instead of more restrictive levels of care.
- Reasonable and Customary costs for outpatient services including, but not limited to, emergency room, laboratory, ambulance and electroconvulsive services, if Medically Necessary.
 - The following expenses are Eligible Mental Health Expenses, if Medically Necessary:
 - Outpatient mental health therapy sessions,
 - Medication management,
 - Outpatient assessments to confirm a (DSM-V or ICD-10) Mental Health disorder,
 - Reasonable and Customary expenses for:
 - Detoxification and treatment of substance abuse or addiction, and
 - Expenses for marital counseling.
 - Early intensive behavioral intervention for autism spectrum disorders, subject to prior authorization by the Care Coordinator, including, but not limited to:
 - Intensive Early Intervention Behavioral Therapy Services (IEIBTS),
 - Intensive Behavioral Intervention (IBI), and
 - Lovaas Therapy.
 - Any other mental health expenses the Care Coordinator or Medical and Mental Health Benefits Administrator determines are Medically Necessary.

Exclusions from Eligible Mental Health Expenses

The Medical and Dental Benefits Plan does not cover Mental Health Expenses for treatment that is:

- Court ordered unless it is a covered Eligible Mental Health Expense.
- Experimental, investigational, primarily for research, or not in keeping with national standards of practice, including:
 - Treatment of sexual addiction, codependency, or other behavior that does not have a DSM-V diagnosis,
 - Regressive therapy,
 - Megavitamin therapy, and
 - Biofeedback.
- Educational or vocational testing or services, including treatments for personal growth and development.
- For the treatment of social or economic problems or physical health without a concurrent DSM-V or ICD-10 diagnosis.
- Residential mental health care services as a diversion from juvenile or adult justice system incarceration.
- Required under law to be provided to a child by the school system.
- Required to maintain employment or insurance, or professional continuing education or credentialing criteria (except as covered under EAP).
- Obtained as part of a treatment plan (except as covered under EAP) for:
 - Smoking cessation, and
 - Weight reduction.
- An alternative type of substance abuse treatment, including:
 - Nutritionally-based therapies,
 - Non-abstinence based treatment,
 - Aversion therapy, and
 - Individual therapy in the absence of a structured outpatient program.
- Custodial in nature, including but 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.
- For diagnosis and treatment of organic congenital disorders and development disorders except for stabilization of an acute episode of such disorder or management of medication; however, Medically Necessary treatment and services for autism spectrum disorder are eligible if prior authorization is received by the Care Coordinator.
- Not a cost-effective alternative to a treatment that would be an Eligible Mental Health Expense, including but not limited to:
 - Therapeutic foster care
 - Group homes
 - Supervised apartments

- Three-quarter houses
- Wilderness programs
- Residential/therapeutic schools
- Camps
- Treatment that is not reasonably expected to improve an individual's condition or level of functioning, including but not limited to, treatment for the following conditions or diagnoses:
 - Obesity (except as covered under EAP services)
 - 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
 - Tobacco dependence (except as covered under EAP)
 - Chronic pain (except for pre-certified psychotherapy, biofeedback or hypnotherapy incurred in connection with a DSM-V disorder)
 - Sleep/wake schedule disorders
- Treatment or diagnosis of any disease, illness, injury, or condition determined to be an Eligible Dental Expenses or Eligible Prescription Drug Expense.

Medical and Mental Health Precertification and Review Requirements

Hospital or Facility Admission — The Care Coordinator administers precertification and Medical Necessity reviews.

If a Member is to be admitted to a Hospital or Facility as an inpatient, the following rules apply:

- Before admission, other than for a medical or mental health emergency, the Member or the Member's representative or attending physician must notify the Care Coordinator at least 7 days before the admission of:
 - The reason that the confinement is Medically Necessary, and
 - The planned length of time for the confinement.
- If an admission for a medical or mental health emergency occurs, the Member or the Member's representative or attending physician must notify the Care Coordinator within 48 hours after the admission of:
 - The reason for the confinement, and
 - The planned length of time for the confinement.

Upon notification, the Care Coordinator will review the Member's condition and the proposed treatment plan to determine if the confinement is Medically Necessary.

If the Care Coordinator certifies that the confinement is Medically Necessary, it will:

- Assign a length of stay for the admission, and
 - Notify the Member, the physician, or the Hospital or Facility with the certified length of stay it assigns.
- The Care Coordinator's decision may be appealed as provided in Section 16.
 - In no event will the Care Coordinator recommend that benefits be restricted for any length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, to less than 48 hours, or benefits be restricted for any length of stay in connection with childbirth for the mother or newborn child, following a cesarean section, to less than 96 hours.

If a Member is to receive specific other services, the following rules apply:

- If a Member is scheduled to receive nursing home or convalescent care for recuperative purposes or other alternative specialized treatment facility care, or is scheduled to receive an outpatient service or procedure that the Care Coordinator requires precertification as provided below, the Member, or the Member's representative or attending physician, must notify the Care Coordinator at least 7 days prior to the service or procedure.
- Upon notification, the Care Coordinator will review the Member's condition and the proposed treatment plan to determine if the service or procedure is Medically Necessary. If the Care Coordinator certifies that the service or procedure is Medically Necessary, it will notify the Member or the physician of certification.
- The Care Coordinator's decision may be appealed as provided in Section 16.
- The Care Coordinator monitors claims data for Members. If the Care Coordinator evaluates the Member's use of services and supplies and determines that the services and supplies are not Medically Necessary because of inappropriate use, misuse or overuse, the Care Coordinator may review, limit, coordinate and/or deny the services and supplies.

Precertification — To be Eligible Medical and Mental Health Expenses, the following medical and mental health services require pre-certification by the Care Coordinator including, but not limited to:

- Inpatient and skilled nursing facility admissions
- Outpatient surgeries
- MRI/MRA and PET scans
- Oncology care and services (Chemotherapy and radiation therapy)
- Genetic testing
- Home health care
- Hospice care
- Durable medical equipment (DME) – all rentals and any purchase over \$500
- Organ, tissue and bone marrow transplants
- Dialysis
- Intensive outpatient treatment for mental health and substance abuse
- Partial hospitalization for mental health and substance abuse
- Autism spectrum disorder services

Out-of-network Eligible Medical and Mental Health Expenses

Eligible Medical and Mental Health Services that are provided by an Out-of-network Provider will receive Out-of-network benefits. However, for Eligible Medical and Mental Health Services received at an In-network setting from an Out-of-network Provider including a radiologist, anesthesiologist, pathologist, hospitalist and emergency room provider, such services will be treated as In-network.

For Eligible Medical and Mental Health Services provided by an Out-of-network Provider when there is no In-network provider within a 50-mile radius, as determined by the Care Coordinators, that can provide medically necessary services, such services will be treated as In-network.

Section 13 Dental Benefits and Expenses

A Member who is eligible for ELCA-Primary Benefits or ELCA Medicare-Primary Benefits will be provided Dental Benefits, except that Retired Members who elected not to add dental coverage under a one-time option in 1996 will not have Dental Benefits.



ELCA-Primary Members



ELCA Medicare-Primary Members

Except for the Deductibles and Coinsurance and subject to the Plan's limits shown in the Appendix, the Plan will reimburse a Member or pay the provider directly for the Eligible Dental Expenses incurred by the Member while he or she has Dental Benefits.

Deductibles and Coinsurance for Eligible Dental Expenses

Eligible Preventive Dental Expenses:

100% paid by the Plan
0% Coinsurance by the Member
No deductible

Eligible Basic Dental Expenses:

Deductible Amount as stated in Appendix
80% paid by the Plan after Deductible
20% Coinsurance by the Member after Deductible

Eligible Major Restorative Dental Expenses:

50% paid by the Plan after Deductible
50% Coinsurance by the Member after Deductible

Eligible Orthodontia Expenses:

50% paid by the Plan
50% Coinsurance by the Member
No deductible

Reimbursement of Eligible Dental Expenses will not be made until the amount of the Eligible Dental Expenses incurred in a calendar year exceeds the Deductible Amount, except for Eligible Preventive Dental Expenses and Eligible Orthodontia Expenses. Dental Deductible Amounts for the Member and individual Family Members will not be more than the Family Maximum Dental Deductible Amount as shown in the Appendix.

Eligible Dental Expenses will be reimbursed up to the annual limit for Eligible Preventive, Basic and Major Restorative Dental Expenses. Eligible Orthodontia Expenses will be reimbursed up to the lifetime limit for Eligible Orthodontia Expenses. See Appendix for limits.

Reimbursement for Members living outside of the United States — A Member whose primary residence is outside of the United States will be entitled to a maximum reimbursement for Eligible Dental Expenses incurred in the United States for a particular year that is equal to the sum of:

- The maximum reimbursement applicable in the particular year, plus
- The maximum reimbursement applicable in the preceding year, provided that no Eligible Dental Expenses had been incurred in the preceding calendar year or in the portion of the year immediately preceding the first date that the Eligible Dental Expenses in the United States were incurred.

Eligible Dental Expenses

Subject to the requirements below, Eligible Dental Expenses include:

- Eligible Preventive Dental Expenses
- Eligible Basic Dental Expenses
- Eligible Major Restorative Dental Expenses
- Eligible Orthodontia Expenses

The procedures, services and suppliers will be considered Eligible Dental Expenses only if all of the following requirements are met:

- The procedures, services or supplies are furnished by a legally qualified dentist or licensed dental care practitioner acting within the scope of his/her license or under the supervision of a legally qualified dentist or physician,
- The charges are within Reasonable and Customary limits,
- The charges are for procedures, services and supplies that are customarily used for treatment of the dental condition, and that are provided in accordance with generally accepted standards of dental practice, and
- The expenses are Medically Necessary (except for Eligible Preventive Dental Expenses).

Preventive Dental Expenses — The following preventive and diagnostic services and supplies are Eligible Preventive Dental Expenses:

- Cleaning of teeth, twice per calendar year.
- Periodontal maintenance, twice per calendar year.
- Topical application of fluoride, once per calendar year at age 18 or younger.
- Oral Examinations, twice per calendar year.
- Supplementary bite-wing x-rays, once every 24 months for adults and every 12 months at age 18 or younger.
- Full mouth x-rays or Panorex, once every 60 months.
- Sealants for permanent molars, once per lifetime at age 18 or younger.
- Space maintainers for extracted posterior primary teeth and the installation and fitting thereof, at age 18 or younger.
- Oral hygiene instruction as prescribed by the dentist, once per lifetime.

Basic Dental Expenses — Eligible Basic Dental Expenses are the following diagnostic, therapeutic and restorative services:

- Oral examinations including emergency treatment for the relief of pain and specialist exams.
- Test and laboratory examination including bacteriologic cultures and pulp vitality tests.
- Dental x-rays including full mouth x-rays and other dental x-rays as required in connection with the diagnosis of a specific condition requiring treatment.
- Oral surgery including charges for:
 - Tooth removal including alveolectomy where indicated and pre- and post-operative care.

- All other oral surgery such as alveoloplasty, vestibuloplasty, removal of cysts, tumors, growths, neoplasms, and treatment of simple fractures that can be managed within the qualified dentist's or licensed dental care practitioner's office.
- Periodontics 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-planning, repeat non-surgical treatment every 24 months and repeat surgical treatment every 36 months.
- Endodontics treatment, including root canal therapy, pulpotomies on primary and permanent teeth. There is no coverage for re-treatment of pulpotomies.
- The following services and supplies:
 - Anesthetics (conscious sedation) when medically necessary and administered in connection with cutting procedures in the oral cavity,
 - Injection of antibiotic drugs by attending dentist, and
 - Application of desensitizing medicaments.
- Restoration of lost tooth structure as a result of tooth decay or fracture, when restored with amalgams (silver alloys), resin (white filling colored) restorations or pre-formed crowns for primary teeth.
- Removable appliances for the treatment of Bruxism and other harmful habits.

Major Restorative Dental Expenses. Eligible Major Restorative Dental Expenses are the following services and supplies:

- Repair or recementing of crowns, inlays, onlays, fixed or removable dentures; or relining or rebasing of dentures more than 6 months after the installation of an initial or replacement denture, but not more than one relining or rebasing in any 36 consecutive months.
- Crowns, onlays or porcelain inlays when the amount of lost tooth structure cannot be restored with filling restoration.
- Bridges, standard partial and full dentures for the replacement of fully extracted permanent teeth. Eligible expenses are limited to the commonly performed method of tooth replacement.
- Repairs and adjustments to prosthetic appliances when they are serving as the permanent prosthetic appliance.
- Replacement of existing prosthetic appliance, but only if it has been 5 years since last benefitted, and then only if the existing appliance is not and cannot be made satisfactory. Services required to make an appliance satisfactory will be eligible.
- Endosteal implants, but only if it has been 5 years since last benefitted, and then only if the existing implant is not and cannot be made satisfactory.

Orthodontia Expenses — The treatment necessary for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies.

Exclusions from Dental Benefits

This Plan does not cover the following:

- The extra cost of a treatment that is an alternative to, or more expensive than, what is required for adequate treatment (according to accepted standards of dental practice), and the alternative is selected by the insured or dentist.

The cost of an alternate procedure will be considered Eligible Dental Expenses up to the amount of the Reasonable and Customary charge for what is required for adequate treatment, procedure, service or supply.

- Costs for procedures, services or supplies:
 - Primarily for cosmetic reasons and beautification. This also includes charges for personalization and characterization of dentures.
 - That are not necessary according to accepted standards of dental practice.
 - That do not meet accepted standards of dental practice, including charges for procedures, services, or supplies that are experimental in nature.
 - That exceed the frequency limits, including retreatments, established by the Dental Benefits Administrator.
 - That are medical in nature, including but not limited to, oral surgery services performed in a hospital.
- Costs for:
 - The replacement of a lost, missing or stolen orthodontic or prosthetic device, or any dental appliance.
 - Precision attachments.
 - Dental veneers and related services and supplies.
 - Prescription drug expenses.
 - Emergency dental care within the first 24 hours after accidental injury to teeth or supporting structures, which are eligible for reimbursement as Eligible Medical Expenses.
- Inpatient and outpatient hospital expenses.

Section 14 Supporting Services

Only individuals who are members of the ELCA Medical and Dental Benefits Plan may participate in the Supporting Services programs. Participation is voluntary.

Based on the Member's health insurance enrollment option, the following are included as additional Supporting Services:



ELCA-Primary Benefits Member

- Hearing Discount Program
- Care Coordinators
- Smoking Cessation Program
- Identity Protection Services
- Employee Assistance Program
- Diabetes Management Program
- Online Mental Health Program
- Text-based Primary Care Program

ELCA Medicare-Primary Benefits Member

- Hearing Discount Program
- SilverSneakers® Fitness Program
- Extra Health and Wellness Benefits

Section 15 Prescription Drug Benefit

This Plan includes the ELCA Prescription Drug Benefit and the ELCA Part D Prescription Drug Benefit.

- ELCA-Primary Members
- ELCA Medicare-Primary Members

ELCA Prescription Drug Benefit	
<p>The Prescription Drug Benefit provides reimbursement for Eligible Prescription Drug Expenses. This Plan will pay for Eligible Prescription Drugs, subject to the Plan’s Cost-Share and limitations by the Prescription Drug Benefits Administrator to ensure Medical Necessity and appropriate use.</p>	
<p>The following Members will have the ELCA Prescription Drug Benefit:</p>	<ul style="list-style-type: none"> • Members and their Dependents who have ELCA-Primary Benefits.
<p>ELCA Prescription Drug Benefit eligible expenses:</p>	<ul style="list-style-type: none"> • Limited to a 31-day supply, except when purchased from the Prescription Drug Mail Order Pharmacy, in which case eligible expenses will be limited to a 90-day supply • Limited to a 31-day supply for drugs defined as Specialty Drugs by and purchased from the specialty drug pharmacy operated by the Prescription Drug Benefits Administrator
ELCA Part D Prescription Drug Benefit	
<p>The ELCA Part D Prescription Drug Benefit, provided to Eligible Members through an agreement between Portico and an insurance company, is subject to Medicare’s rules and regulations for Medicare prescription drug plans. Additional drugs may be determined to be Eligible Prescription Drugs by the Plan.</p>	
<p>The following Members will have the ELCA Part D Prescription Drug Benefit:</p>	<ul style="list-style-type: none"> • Retired Members, Sponsored Members, On Leave from Call Members and their family members who have ELCA Medicare-Primary Benefits and who live in the United States or Puerto Rico • Coverage Continuation Members and Disabled Members and their family members who have ELCA Medicare-Primary Benefits and who live in the United States or Puerto Rico
<p>Under the ELCA Part D Prescription Drug Benefit, eligible expenses are:</p>	<ul style="list-style-type: none"> • Limited to a 30-day supply, except when purchased from the Prescription Drug Mail Order Pharmacy, in which case eligible expenses will be limited to a 90-day supply • Limited to a 30-day supply, except when purchased from a retail pharmacy approved by Medicare and contracted with the Prescription Drug Benefits Administrator to provide up to a 90-day supply

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Exclusions from Eligible Prescription Drug Expenses

This Plan excludes the following from Eligible Prescription Drug Expenses:

Exclusions ELCA Prescription Drug Benefit
Drugs that are not considered Medically Necessary by the Prescription Drug Benefits Administrator for the condition, diagnosis or symptoms of the Member based on FDA-specific indications, outcome data from clinical trials, and national care and treatment standards
Drugs that are determined to be investigational or experimental by the Prescription Drug Benefits Administrator because FDA approval for marketing has not been granted
Over-the-counter medications, except insulin
Drugs for cosmetic treatment of hair loss or other cosmetic treatment
Herbal, mineral and nutritional supplements
Vitamins for preventive purposes
Drugs taken in preparation of, or in conjunction with, artificial insemination
Drugs taken for the purpose of terminating pregnancy
Expenses for drugs that are covered under any other group coverage
Drugs excluded from the formulary
Expenses for Specialty Drugs not purchased from the Specialty Drug Pharmacy operated by the Prescription Drug Benefits Administrator for Members with the ELCA Prescription Drug Benefit

Cost-Share for Prescription Drugs

Member Cost-Share for Eligible Prescription Drugs will be determined in accordance with the following:

Prescription Drug Cost-Share <u>ELCA Medicare-Primary Benefits</u> ELCA Part D Prescription Drug Benefit
<p>The Member Cost-Share, shown in the Appendix, for each prescription depends on its formulary tier as determined by the ELCA Part D Prescription Drug Benefits Administrator and whether the Prescription Drug is from an In-network:</p> <ul style="list-style-type: none">• Participating Retail Pharmacy,• Specialty Drug Pharmacy, or• Prescription Drug Mail Order Pharmacy. <p>See the Appendix for the Part D Drug Benefit Member Cost-Share. If the Prescription Drug is from a pharmacy that does not participate in the approved pharmacy network or the Member fails to use the prescription drug identification card, the Member Cost-Share will be as provided in the Appendix.</p>

Prescription Drug Cost-Share

ELCA-Primary Benefits

ELCA-Primary Gold+, ELCA-Primary Platinum+

ELCA Prescription Drug Benefit

The Member Cost-Share for each prescription depends on if it is a generic drug, a preferred (formulary) brand-name or a non-preferred (non-formulary) brand-name drug when the Prescription Drug is from:

- a Participating Retail Pharmacy,
- the Specialty Drug Pharmacy, or
- the Prescription Drug Mail Order Pharmacy.

If the Eligible Prescription Drug is from a pharmacy that does not participate in the approved pharmacy network or the Member does not use the prescription drug identification card, the Member Cost-Share will be as provided in the Appendix, plus any difference between the per-prescription amount charged by such pharmacy and the contracted amount established by the Prescription Drug Benefits Administrator for that prescription drug.

If the Eligible Prescription Drug is from a pharmacy that is outside the United States, the Member will be responsible for the Plan's formulary Cost-Share for each 31-day supply, plus any difference between the Cost-Share and the per-prescription amount charged by the pharmacy.

The cost of certain specialty prescription drugs, considered nonessential drugs under the Patient Protection and Affordable Care Act of 2010, will not have a Member Cost-Share and will not apply toward satisfying the Out-of-Pocket Amount.

Maximum Out-of-Pocket Amount. For Members with family coverage, unless the individual Maximum Out-of-Pocket Amount is met, the Member will pay the prescription drug Cost-Share until:

- the In-network Eligible Medical and Mental Health Expense Deductible Amounts and Coinsurance and Eligible Prescription Drug Expenses Cost-Share for the Member, Spouse, ESGP and Eligible Children equals the Maximum Out-of-Pocket Amount.
- the Out-of-network Eligible Medical and Mental Health Expenses Deductible Amounts and Coinsurance and Eligible Prescription Drug Expense Cost-Share for the Member, Spouse, ESGP and Eligible Children equal the Maximum Out-of-Pocket Amount.

See Appendix for applicable Deductible, Coinsurance and Maximum Out-of-Pocket amounts.

NOTE: Under the ELCA Prescription Drug Benefit, the Member will not have a Cost-Share or Out-of-Pocket Amount for certain generic Eligible Prescription Drugs, contraceptive methods or immunizations that are determined to be preventive drugs or supplies and that require no patient cost-sharing under the Patient Protection and Affordable Care Act of 2010, for those drugs or supplies:

- Folic acid ages 18 - 50
- Smoking cessation drugs age 18 and older
- Bowel preparation for colonoscopy screening ages 50 - 75

- Breast cancer preventive drugs age 35 and older
- Oral contraceptives age 50 and younger
- Oral fluoride for children ages 6 months - 5 years
- Immunizations
- Aspirin age 60 and younger
- Low-dose and moderate-dose statins ages 40 - 75

This list of preventive drugs and supplies is subject to change.

Prescription Drug Cost-Share

ELCA-Primary Benefits

ELCA-Primary Bronze+ ELCA-Primary Silver+

The Member is responsible for the Eligible Medical, Mental Health and Prescription Drug Deductible Coinsurance until the Medical, Mental Health and Prescription Drug Maximum Out-of-Pocket Limit is met. See Appendix for additional information.

Eligible Prescription Drugs may be purchased from:

- a Participating Retail Pharmacy
- the Specialty Drug Pharmacy
- the Prescription Drug Mail Order Pharmacy

NOTE: Under the ELCA Prescription Drug Benefit, the Member will not have a Cost-Share or Out-of-Pocket Amount for certain generic Eligible Prescription Drugs, contraceptive methods or immunizations that are determined to be preventive drugs or supplies and that require no patient cost-sharing under the Patient Protection and Affordable Care Act of 2010, for those drugs or supplies:

- Folic acid ages 18 - 50
- Smoking cessation drugs age 18 and older
- Bowel preparation for colonoscopy screening ages 50 - 75
- Breast cancer preventive drugs age 35 and older
- Oral contraceptives age 50 and younger
- Oral fluoride for children ages 6 months - 5 years
- Immunizations
- Aspirin age 60 and younger
- Low-dose and moderate-dose statins ages 40 - 75

This list of preventive drugs and supplies is subject to change.

See Appendix for applicable Medical, Mental Health and Prescription Drug Deductible, Coinsurance and Out-of-Pocket amount.

The Plan may start programs that allow reduced Cost-Share for certain drugs in order to manage prescription drug costs. See Appendix.

Section 16 Claims Appeal Procedure

The payment of claims will be made on a uniform basis according to the Plan and any rules, regulations or procedures that Portico may adopt. If a claim is denied or not paid in full, the Member will be notified in writing of the reason the payment was denied, the provision in the Plan or the coverage policies supporting the denial, and the internal appeal procedure.

ELCA-Primary Medical and Mental Health Benefits Appeal — If the Member is not satisfied with the internal appeals decision of the Care Coordinators following the exhaustion of the Care Coordinators' appeal process, the Member must request, through the Care Coordinator, an external independent review. An external independent review will be completed if the issue meets the requirements and conditions provided under the Patient Protection and Affordable Care Act of 2010. If an external independent review is completed, it will be a binding, final decision.

ELCA Prescription Drug Benefits Appeal — If the Member is not satisfied with the internal appeals determination of the Prescription Drug Benefits Administrator, the Member must request, through the Benefits Administrator, an external independent review with an organization contracted to perform independent reviews and to provide a binding, final determination.

ELCA Part D Prescription Drug Benefits Appeal — The ELCA Part D Prescription Drug Benefit is extended to eligible Members through an agreement between Portico and an insurance company. The appeals process will be as specified by the insurance company.

Medicare Advantage Benefits Appeal — The Medicare Advantage Benefit is extended to eligible Members through an agreement between Portico and an insurance company. The appeals process will be as specified by the insurance company.

Appeals of Dental Benefits, Personal Wellness Account Benefits and Matters Not Covered Above (including, but not limited to, enrollment and eligibility to participate in the Plan).

- **Appeal to the President** — For matters involving Dental Benefits, Personal Wellness Account, and matters not covered above such as enrollment, a Member must appeal in writing, within 180 days of the receipt of any unsatisfactory determination, to the President of Portico Benefit Services. The appeal should contain a statement of the facts, including any new or additional information not considered in the initial decision, and a statement of the desired outcome. The President will review the appeal with the advice and counsel of the internal appeals committee that consists of at least 3 staff members who were not involved in the original decision. The President will respond to the appeal within 30 days of receipt of the Member's signed authorization for disclosure of protected health information, unless the President notifies the individual making the appeal of the need for an additional 30 days to consider the appeal. The President may only approve an appeal if it is determined that an error was made in the initial benefits 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 benefit coverage requiring Plan amendments, which may or may not be retroactive.
- **Appeal to the Appeals Committee of the Board of Trustees** — If an individual is dissatisfied with the decision of the President, he/she must appeal to the Appeals Committee of the Board of Trustees of Portico Benefit Services within 60 days of the receipt of the President's written response. The Appeals Committee will consist of 5 to 7 members of the Board of Trustees, at least one of whom is a participant under the Traditional Benefits Program. The Appeals

Committee may also include outside independent consultants with expertise in the area of the appeal who will serve with voice but without vote. The Appeals Committee will schedule a meeting to review the appeal within 30 days of receipt. The final written decision of the Appeals Committee will be sent to the individual making the appeal within 60 days of receipt of receiving a signed authorization for disclosure of protected health information. All decisions of the Appeals Committee are final and will be afforded the maximum deference permitted by law.

- **Court System** — If an individual has exhausted the appeals procedure set forth in the above subsections, he/she must initiate legal action in the Minnesota Fourth Judicial District Court, Hennepin County. Any removal of the action must be to the United States Court for the District of Minnesota. Legal action cannot be taken more than 3 years after the date of the event on which the claim is based. Members and other parties claiming a benefit or right under the Plan irrevocably and unconditionally waive any right to a jury trial in any legal action, proceeding, cause of action, or counterclaim relating to the Plan.

Section 17 Miscellaneous Provisions, Disclosures and Benefit Notices

Adjustment of Certain Amounts Related to Benefits

Certain Coinsurance, Copays, Cost-Share, Deductible Amounts, Out-of-Pocket Amounts and Plan Limit Amounts related to Medicare Advantage, Medical and Mental Health, Dental, and Prescription Drug Benefits will be determined annually by Portico Benefit Services. The annual amounts are shown in the Appendix.

Plan Documents

The Summary Plan Description, along with documents for all other plans, is available by signing in at myPortico.PorticoBenefits.org or contacting the Portico Customer Care Center. The Medical and Dental Benefits Plan document is available by contacting the Portico Customer Care Center. Current versions replace and supersede prior versions. All of the plans are governed and administered individually through separate plan documents. The assets of each plan are held in various trusts and do not allow one plan to fund another plan. The plans are church plans, as defined in Internal Revenue Code § 414(e), and are not subject to the Employee Retirement Income Security Act.

Amendments 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 ELCA Church Council. Any amendment will not reduce any Member's entitlement to reimbursement from this Medical and Dental Benefits Plan for expenses incurred prior to the effective date of the amendment.

Termination

The ELCA Church Council may terminate the Medical and Dental Benefits Plan by following the previously described amendment process. If the Plan is terminated, no employee shall become a Sponsored Member under the Plan and no additional contributions shall be made to the Plan. The existing funds may be distributed to, or for the benefit of, the Members in such manner as Portico, in its sole discretion, determines is fair and equitable. Any excess funds remaining after all Members have received reimbursement for expenses incurred prior to the effective date of the termination may be returned to the ELCA.

Self-Insured Portion of the Plan

With the exception of the Medicare Advantage Benefit, the ELCA Part D Prescription Drug Benefit, and the Aetna health benefits for ELCA Global Mission missionaries, the ELCA Medical and Dental Benefits Plan is self-insured and not provided through an insurance company. Portico Benefit Services' ability to pay claims is dependent on continued contributions, claims experience and market performance. All benefits that a person becomes entitled to under the ELCA-Primary health benefits will only be provided out of the ELCA Medical and Dental Benefits Trust and only to the extent that the ELCA Medical and Dental Benefits Trust is able to cover expenses.

Obligation of Members

A Member must comply with all requirements of Portico regarding enrollment and administration of the Plan including, but not limited to, establishing such Member's date of birth, disabled status, marital status, partnership status, and marital, partnership and family support obligations.

If the Member does not comply with reasonable requirements or knowingly provides false, inaccurate or misleading information to Portico, the Member will be obligated to reimburse Portico for the reasonable expenses and damages incurred by Portico as the result of such failure including, but not limited to, an amount determined by Portico to be the additional expense of its staff in discovering, correcting, or adjusting for such failure. Portico may charge the Member's future benefit payments under this Plan, if any, for the additional expense.

Termination for Fraud/Abuse

If a Member fraudulently or inappropriately uses, misuses or overuses Plan services and/or supplies, or there is Cause for Termination in accordance with Section 6, Portico has the right to terminate the Member's participation in the ELCA Pension and Other Benefits Program. Such Member and his/her dependents will not be eligible for coverage continuation benefits under the ELCA Medical and Dental Benefits Plan.

Non-Assignability of Rights

Except as provided in the Plan or required by law, the interests of persons entitled to benefits under this Plan may not in any manner whatsoever be assigned or alienated, whether voluntarily or involuntarily, or directly or indirectly. Payments of benefits directly to health care providers are a convenience to the Member or Dependent and shall not make the provider an assignee.

Administration by Portico Benefit Services

This Plan is administered by the Board of Pensions of the Evangelical Lutheran Church in America, doing business as Portico Benefit Services. Except as otherwise stated in this Summary Plan Description, Portico will control and manage the operation and administration of the Plan and make all related decisions and determinations. Portico Benefit Services shall also have discretionary authority to interpret the Plan and to determine an individual's eligibility to participate in the Plan and the right to benefit payments under the Plan.

Portico will be paid a reasonable fee from the ELCA Medical and Dental Benefits Trust for the administrative services provided to the Plan and the ELCA Medical and Dental Benefits Trust by Portico, including a fee for informing the employees and employers of the availability of the Plan. The fee charged to the ELCA Medical and Dental Trust will create a lien on the ELCA Medical and Dental Benefits Trust until paid.

During the operation and administration of the Plan, certain mathematical and accounting errors may be made, or mistakes may arise for various reasons including from factual errors in information supplied to Portico. Portico has the power to make an equitable adjustment to correct the errors as Portico, in its sole discretion, considers appropriate. Portico may determine, on a uniform and non-discriminatory basis, to waive recovery of an overpayment if the payee is without fault and recovery would be against equity and good conscience. All adjustments will be final and binding on all persons.

Portico does not provide legal or tax advice. For legal or tax questions, or specific advice, Members should consult with a legal or tax adviser.

Limitation of Liability

Portico will not be liable for a Participating Employer failing to enroll a Member in the Plan or for failing to make contributions to the Plan. Portico is also not liable to any Member or any other person or entity for any of its acts carried out hereunder in good faith and based upon information available at the time.

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 obligation of each Member to determine whether each payment under this Plan is excludable from the Member's gross income for federal, state and local income tax purposes, and to notify Portico if the Member has any reason to believe that such payment is not so excludable.

If an Eligible Same Gender Partner and/or his/her Eligible Children covered under this Plan are not tax dependents as defined under Code § 152, a Participating Employer's contributions to the cost of such Eligible Same Gender Partner's (and children's) coverage must be reported by the Participating Employer as taxable income.

Portico is Not a Party to Contract Between Employer and Employee

An Eligible Employee may have certain employment or contractual rights which, as between the Eligible Employer and the Eligible Employee, may obligate the Eligible Employer to make contributions to the Plan on behalf of the Eligible Employee. Portico is not a party to any such contracts. If the Eligible Employer does not fulfill its obligations under such contract, the Eligible Employee can look only to the Eligible Employer to settle the dispute. Portico will not be liable for a Participating Employer failing to enroll an Eligible Employee in the Plan or for failing to make contributions to the Plan. Portico will not provide coverage under this Plan if it has not received contributions.

Rules of Construction and Applicable Law

The Plan shall be construed and administered according to the laws of the State of Minnesota to the extent that such laws are not preempted by the laws of the United States of America. All controversies, disputes, and claims arising hereunder shall be submitted to the Minnesota Fourth Judicial District Court, Hennepin County. Legal action cannot be taken more than 3 years after the date of the event on which the claim is based. Members and other parties claiming a benefit or right under the Plan irrevocably and unconditionally waive any right to a jury trial in any legal action, proceeding, cause of action, or counterclaim relating to the Plan.

Nondiscrimination in Health Programs and Activities

The provisions of the Plan comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. The provisions of the Plan do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Portico provides, upon request by contacting Portico at **800.352.2876**, free communication assistance services to facilitate effective communication, including:

- Telephone, email, and standard mail options
- Written information in other formats (e.g., large print)
- Free language interpreter services to people whose primary language is not English
- Information written in other languages

If you believe the Plan has failed to provide these services, or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you may file a grievance with Cathy Broady, Health Services Manager, Portico Benefit Services, 7700 France Avenue South, Suite 350, Minneapolis, MN 55435; Phone 612.752.4108; Fax 612.752.5108; or cbroady@PorticoBenefits.org.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; or by phone: 800.368.1019 or 800.537.7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.htm>.

Special Provisions for Members who Reside in Puerto Rico

Sponsored Members enrolled in this Plan who reside in Puerto Rico may be enrolled for coverage in alternate medical benefits coverage in lieu of coverage under this Plan. A Sponsored Member who enrolls in the alternate coverage will remain in such alternate coverage irrevocably thereafter, as long as such Sponsored Member resides in Puerto Rico. A Sponsored Member, however, is eligible to purchase Vision Care Services in accordance with Section 21.

For purposes of this Special Provision, an “Eligible Employer” is a legal entity located within the geographic boundaries of the Commonwealth of Puerto Rico, which meets one of the following criteria:

- The entity is an organization described in Code § 501(c)(3) that is “controlled by, or associated with” the ELCA, as determined by the ELCA within the meaning of Code § 414(e)(3) and ERISA § 3(33)(C),
- The entity is an organization described in Code § 501(c)(3) employing an individual who is performing service in the exercise of his/her ministry as an ELCA Minister of Word and Sacrament, or
- The entity is an educational organization described in Code § 170(b)(1)(A)(ii), employing as a common-law employee an individual who is performing services for such organization in the exercise of his/her ministry as an ELCA Minister of Word and Sacrament.

Eligible Employers in Puerto Rico must provide and pay for the alternative medical coverage for their Sponsored Members. Terms of the alternate medical coverage shall be as specified in a contract entered into between the Eligible Employer and a commercial insurer (“the Contract”).

The ability of each Eligible Employer to enroll Sponsored Members in the above specified benefits will be determined in accordance with the Contract. The eligibility of specific employees for such coverage, the cost of coverage, and all administrative provisions applicable to such coverage, including any claims appeal procedures, will be determined in accordance with the applicable provisions of the Contract.

The provisions above do not affect the Sponsored Member’s participation in the ELCA Retirement Plan, the ELCA Disability Benefits Plan, or the ELCA Survivor Benefits Plan.

Special Provisions for Members who Reside in Hawaii

- Effective January 1, 2003, Members residing in Hawaii who would otherwise be Sponsored Members in this Plan according to Section 3 must, in accordance with Hawaii law, be enrolled in an alternate group insurance plan of medical and dental coverage approved by the State of Hawaii, Department of Labor and Industrial Relations. Such Sponsored Members will not be covered by this Plan after December 31, 2002. A Sponsored Member, however, is eligible to purchase Vision Care Services in accordance with Section 21.
- If a Sponsored Member residing in Hawaii ceases to meet the eligibility requirements of Section 3, he/she may re-enroll in this Plan in accordance with any applicable provisions of Sections 3, 4 or 5.
- Eligible Employers in Hawaii must provide and pay for the alternative medical coverage for their Sponsored Members. Terms of the alternate medical coverage will be as specified in a contract entered into between the Eligible Employer and a commercial insurer (“the Contract”).
- The ability of each Eligible Employer to enroll Sponsored Members in the alternate coverage will be determined in accordance with the Contract.
- The eligibility of specific employees for such alternate coverage, the cost of alternate coverage, and all administrative provisions applicable to such alternate coverage including any claims appeal procedures, will be determined in accordance with the applicable provisions of the Contract.

The provisions above do not affect the Sponsored Member’s participation in the ELCA Retirement Plan, the ELCA Disability Benefits Plan, or the ELCA Survivor Benefits Plan.

Special Provisions for Foreign Missionaries Employed by ELCA Global Mission

- Effective June 1, 2003, ELCA Sponsored Members who are foreign missionaries employed by ELCA Global Mission will have medical, dental, mental health and prescription drug coverage through an agreement between Portico and an insurance company. The terms of the coverage provided to the Sponsored Members and their eligible dependents will be specified in the insurance agreement.

The benefits provided under the insurance agreement will approximate the benefits described in Sections 9 through 15. Deductibles and Coinsurance incurred while covered under this missionary insurance will be applied to the Member who changes mid-year to ELCA-Primary Benefits in accordance with Section 9.

- ELCA Global Mission will remit contributions for their alternative coverage to Portico. Portico will determine the annual contribution rates considering the cost of the insurance coverage and any other factors it deems necessary, and will pay the insurance premiums.

The provisions above do not affect the Sponsored Member’s participation in the ELCA Retirement Plan, the ELCA Disability Benefits Plan, or the ELCA Survivor Benefits Plan, or his/her eligibility for benefits under this Plan before or after a period of employment with ELCA Global Mission.

Special Provisions for Members Employed by an ELCA Seminary

- Notwithstanding the provisions of Section 3, an ELCA seminary shall determine which employees, in a manner approved by Portico Benefit Services, are eligible to participate in the Plan as Sponsored Members.
- During an enrollment period specified by Portico Benefit Services, ELCA seminary and Sponsored Members will elect an option for the following calendar year. Such election cannot be changed midyear while the employee is sponsored by the ELCA seminary.
- Notwithstanding Section 7, the ELCA seminary may require that its Sponsored Members pay a portion of contributions associated with this Plan.

The provisions above do not affect the ELCA seminary Sponsored Member's participation in the ELCA Retirement Plan, the ELCA Disability Benefits Plan, or the ELCA Survivor Benefits Plan, or his/her eligibility for benefits under this Plan before or after a period of employment with an ELCA seminary unless specified above.

Summary of Benefits and Coverage for Members with ELCA-Primary Health Coverage

This is a standardized document required by health care reform legislation. It describes ELCA-Primary health benefits, defines health insurance terms, and gives examples about how 2022 ELCA-Primary health benefits work. To view this document online, go to myPortico.PorticoBenefits.org/summaries. To request a copy by mail, contact the Portico Customer Care Center at **800.352.2876** or mail@PorticoBenefits.org.

Women's Health and Cancer Rights Act Notice (breast reconstruction for Members with ELCA-Primary health coverage)

The ELCA Health Plan provides breast reconstruction benefits to Members and Dependents receiving care in connection with a mastectomy. These benefits are provided in a manner determined in consultation with the attending doctor and the patient. The ELCA Health Plan provides coverage for all stages of 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. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the Plan or coverage. For more information on these benefits, contact Portico Care Coordinators at **877.851.5656**.

Maternity care for members with ELCA-Primary health coverage

The ELCA Health Plan covers maternity expenses, including a hospital stay of 48 hours following a normal vaginal delivery and 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). Consistent with federal law, the ELCA Health Plan does not require authorization for a maternity hospitalization of up to 48 hours (or 96 hours). Any hospitalization that extends beyond 48 hours (or 96 hours) must be authorized. The ELCA Health 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.

Qualified Medical Child Support Order (QMCSO)

A QMCSO is a judgment, decree, or order (issued by a court or through a state administrative process) that requires a health plan to provide coverage to a member's child and meets other specific requirements. Please contact the Portico Customer Care Center at **800.352.2876** or mail@PorticoBenefits.org for additional information if you have a QMCSO that needs to be processed.

Mental Health Parity Act Notice

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. The financial requirements and treatment limits that apply to mental health or substance abuse benefits under the Plan are no more restrictive than for other medical/surgical benefits.

Section 18 HIPAA Privacy Compliance

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans to protect the confidentiality and privacy of Protected Health Information (PHI). PHI is personally identifiable information created, received or transmitted by a health care organization related to a past, present or future physical or mental health condition, treatment or claim.

Required Uses and Disclosure of Protected Health Information — The Benefits Administrator may disclose PHI to Portico for disclosures and administrative functions that include:

- Disclosure to the Secretary of Health and Human Services, when required for an investigation or determination of the Plan's compliance with HIPAA
- Disclosure to a Member when requested by the Member
- Disclosure to a Member's Personal Representative when requested by the Personal Representative
- As required by law

Permitted Uses and Disclosures of Protected Health Information — The PHI received or created by the Benefits Administrator may be disclosed to Portico for purpose of administrative functions that Portico performs for the Plan, including the following:

- Providing care, consultation and referrals between providers
- Determining enrollment, eligibility, premiums and contributions, reimbursements, claims management, appeals, subrogation, collection activities and utilization reviews
- Quality assessments and improvement, advocacy, data analysis, underwriting, contracts, legal services, audits, compliance, management, and administration
- Wellness, prevention, disease management, health coach and health improvement activities aimed at improving the health status of Members with certain health characteristics and managing the costs associated with specific chronic diseases
- Advocacy and assistance to Members
- Benefits appeals and complaints
- Subpoenas and other court orders
- As permitted by law

Requirements of Portico in Using PHI — In accordance with the requirements of HIPAA, Portico certifies that it will:

- Not use or disclose PHI except as permitted by the Plan, and for employment-related actions or decisions, or in connection with any other employee benefit plan or benefit provided by Portico
- Ensure that any agent/subcontractor who receives PHI from Portico agrees to the same restrictions and conditions for the PHI as Portico has under HIPAA
- Ensure that limited access to PHI is supported by security measures
- Report security incident of PHI

- Provide the Member, upon the Member's written request, with the Member's PHI and an accounting of the disclosures of PHI
- Incorporate amendments of Member PHI
- Make its internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of Health and Human Services
- If feasible, return or destroy all PHI that it no longer needs to retain
- Implement and maintain administrative, physical and technical safeguards

Section 19 Personal Wellness Account

The Personal Wellness Account (PWA) is a health reimbursement arrangement into which eligible Health Plan members, spouses, and eligible same gender partners' earned wellness dollars through November 30, 2020, to pay for eligible health care expenses.

Eligibility —

The following individuals are eligible to be a Personal Wellness Account Member:

- A Sponsored Member, or his or her Eligible Spouse, Eligible Same Gender Partner if s/he is a tax dependent as defined in Code § 105(b), or eligible Dependent covered under this Plan in the ELCA-Primary Silver+ Option or Bronze+ Option and the Sponsored Member is not eligible to participate in the Health Savings Account of the ELCA Flexible Benefits Plan due to enrollment in Medicare and, the Sponsored Member's Participating Employer has elected to contribute to Health Savings Accounts of the ELCA Flexible Benefits Plan for Sponsored Members.
- A Sponsored Member, Retired Member, Coverage Continuation Member, Eligible Spouse, Eligible Same Gender Partner if s/he is a tax dependent, or eligible Dependent who was a PWA Member prior to January 1, 2021 and who has a PWA balance on or after January 1, 2021.

Contributions to PWA — Members may not make contributions to the PWA. Participating Employers may make contributions to the PWA for Sponsored Members with the ELCA-Primary Bronze+ Option or ELCA-Primary Silver+ Option who are not eligible for a Health Savings Account under the ELCA Flexible Benefits Plan. Participating Employers may make contributions to Personal Wellness Accounts of Members eligible to receive PWA contributions by remitting contributions to Portico Benefit Services.

Eligible PWA Expenses — Except for the Excluded PWA Expenses provided below, Eligible PWA Expenses are those health care expenses described in Code § 213(d), provided the expenses are:

- Incurred during the Period of Coverage by a PWA Member, his/her Eligible Spouse and PWA Dependents:
 - while the PWA Member, his/her Eligible Spouse and PWA Dependents are covered under the ELCA-Primary Health Benefits, or
 - after the PWA Member has terminated ELCA-Primary Health Benefits.
- Reimbursements are only made for PWA Expenses not reimbursed or reimbursable from another source. If a portion of an Eligible PWA Expense has been reimbursed or is reimbursable by another source, the PWA can reimburse the remaining portion.

PWA Expenses for Members with the ELCA-Primary Bronze+ Option or ELCA-Primary Silver+ Option and a Health Savings Account under the ELCA Flexible Benefits Plan who have a PWA balance from a prior Period of Coverage are limited to vision, dental and post-deductible eligible medical, mental health, prescription drug and other Code § 213(d) expenses.

Excluded PWA Expenses — PWA Expenses do not include long-term care insurance premiums, health insurance premiums, and any other expenses specifically excluded by Portico, the IRS or the PWA Administrator according to the rules, regulations and procedures adopted by Portico for that purpose.

Reimbursements to Highly Compensated Employees or Individuals (as those terms are defined in Code § 105(h)) may be limited or treated as taxable compensation to comply with Code § 105(h), as may be determined by Portico in its sole discretion.

Activation of Account — The PWA Administrator will activate and maintain a PWA for each PWA Member. Each PWA that is established will be an account for keeping track of credits and reimbursements, including any unused carryover from a prior Period of Coverage.

- **Crediting of Accounts** — The PWA for a PWA Member eligible to receive PWA contributions from a Participating Employer will be credited only after the PWA contributions are received.
- **Interest** — No interest will be credited to a PWA Member's Personal Wellness Account.

Carryover of Accounts — If a balance remains in the PWA Member's Personal Wellness Account at the end of a Period of Coverage, the balance will be carried over to reimburse the PWA Member for PWA Expenses incurred during a subsequent Period of Coverage.

PWA Expense Reimbursement Procedure

- **Timing**
 - A PWA Member must submit a reimbursement claim form within 12 months after the end of the Plan Year during which the PWA Expense was incurred.
 - Within 30 days after the PWA Administrator receives the reimbursement claim form, the PWA Administrator will reimburse the PWA Member or notify the PWA Member that his or her claim has been denied.
 - All information for incomplete claims that have been denied must be submitted to the PWA Administrator within 180 days from the date of the initial denial letter.
- **Reimbursement Claim**
 - The PWA balance will be reduced during each Period of Coverage for any reimbursement of PWA Expenses requested and processed.
 - A PWA Member may apply for reimbursement by:
 - Using the debit card supplied by the PWA Administrator,
 - Requesting the claims crossover process for the PWA Administrator, or
 - Submitting a reimbursement claim form to the PWA Administrator and bills, invoices, or other statements from an independent third party showing that the PWA Expenses have been incurred and the amounts of such PWA Expenses, along with any additional documentation that the PWA Administrator may request.
- **Claims Denied** — The appeals procedure for claims that are denied is provided in Section 16.

Termination of ELCA-Primary Benefits — If ELCA-Primary Benefits coverage is terminated, there will not be any further credits to the Member's PWA. A PWA Member may continue to be reimbursed for PWA Expenses incurred after the termination until his/her PWA balance is depleted.

Termination of Participation — A PWA Member will stop being a Member in the PWA portion of the Plan on the earlier of:

- The termination of the PWA portion of the Plan, or
- The date the PWA Member:
 - No longer meets the PWA Member eligibility requirements, and
 - Has depleted his/her Personal Wellness Account balance.

Death of a PWA Member — A PWA Member's Surviving Spouse and/or eligible Dependents who were covered under ELCA-Primary Health Benefits at the time of PWA Member's death may continue to be reimbursed for PWA Expenses incurred while enrolled in ELCA-Primary Health Benefits after the PWA Member's death until the Personal Wellness Account balance is depleted.

PWA Administrative Fee — Effective January 1, 2022, an annual PWA Administrative Fee will be debited from each Member's Personal Wellness Account balance, except for a Personal Wellness Account for:

- A Sponsored Member, or his or her Eligible Spouse, Eligible Same Gender Partner if s/he is a tax dependent as defined in Code § 105(b), or eligible Dependent covered under ELCA-Primary Silver+ Option or Bronze+ Option and the Sponsored Member is not eligible to participate in the Health Savings Account of the ELCA Flexible Benefits Plan due to enrollment in Medicare and, the Sponsored Member's Participating Employer has elected to contribute to Health Savings Accounts of the ELCA Flexible Benefits Plan for its Sponsored Members.
- A Member who is enrolled in a Health Flexible Spending Account, Dependent Care Flexible Spending Account and/or Health Savings Account under the ELCA Flexible Benefits Plan.

Section 20 Glossary

Affordable Care Act

The Patient Protection and Affordable Care Act, commonly called the Affordable Care Act, is a United States federal statute signed into law on March 23, 2010.

Benefits Administrators

The entities that Portico Benefit Services has contracted with to administer benefits under the Plan, including the following:

Dental Benefits Administrator	Delta Dental of Minnesota
Medical and Mental Health Benefits Administrator	BlueLink TPA
Medicare Benefits Administrator	Humana
Prescription Drug Benefits Administrator	Express Scripts, Inc. (for ELCA-Primary)
Part D Prescription Drug Benefits Administrator	Humana (for ELCA Medicare-Primary)
PWA (Personal Wellness Account) Benefits Administrator	Further

Care Coordinator

The entity that Portico Benefit Services has contracted with to provide services for members with ELCA-Primary Benefits including customer service for Members and providers, determinations of Medical Necessity, Prior Authorizations for specific services, and Medical and Mental Health Benefit appeals.

Code

The Internal Revenue Code of 1986, as from time to time amended.

Coinsurance

A percentage that an insured pays.

Copays

A dollar amount that an insured pays.

Cost-share

The costs that an individual pays out of his/her own pocket for deductibles, coinsurance, and copays.

Deductible Amount

The amount of Eligible Expenses a Member incurs in the calendar year before the Plan pays a percentage of Eligible Expenses.

Defined Compensation

Annual gross taxable cash compensation plus the amount of any contribution made to a tax-sheltered annuity plan or a qualified benefit under a salary reduction agreement. Defined Compensation does not include nontaxable reimbursements or expense allowances.

Defined Compensation also includes the amount of any housing allowance or an additional 30% of cash compensation plus furnishings or utility allowances paid directly to the Sponsored Member if housing is furnished by the Participating Employer, in the case of ordained ministers and certain teachers who are recognized as ministers for purposes of Code §107.

Dependent

A person who is covered as a Member of this Plan and meets the Plan's definition of an Eligible Spouse, Eligible Child or Eligible Same Gender Partner.

Disabled Member

A Member who is entitled to receive benefits under the ELCA Disability Benefits Plan.

Eligible Child

An individual described in Section 4.

Eligible Prescription Drugs

Includes FDA-approved drugs available by prescription only and Medically Necessary for the condition, diagnosis or symptoms of the Member based on FDA-specific indications, outcome data from clinical trials, and national care and treatment standards. Such drugs must be purchased for the treatment or prevention of illness.

The ELCA Part D Prescription Drug Benefit is subject to Medicare's rules and regulations for Medicare prescription drug plans (Part D). Medicare determines which prescription drugs and quantities are Eligible Prescription Drugs for the ELCA Part D Prescription Drug Benefit. Notwithstanding the foregoing, certain additional drugs may be deemed Eligible Prescription Drugs by the Plan for the ELCA Part D Prescription Drug Benefit.

Eligible Same Gender Partner (ESGP)

An individual who, together with a member of the ELCA Traditional Benefits Program, properly completed and signed an Affidavit of Partnership prior to June 26, 2015.

Experimental and Investigational

Services, supplies, care and treatment which do not constitute accepted and appropriate medical practice considering the facts and circumstances of the case and by the generally accepted standards of a reasonably substantial, qualified, responsible, relevant segment of the appropriate medical community or government oversight agencies at the time services were rendered, as determined by the Plan's benefit administrators or the Care Coordinators.

In-network Eligible Medical and Mental Health Expenses

Eligible Medical and Mental Health Expenses for services rendered by an In-network Provider that do not exceed the contracted rates for the treatment or services provided.

In-network Provider

An Eligible Medical or Mental Health Provider or entity in accordance with Section 12 that provides treatment or services that are eligible for reimbursement under this Plan as Eligible Medical and Mental Health Expenses, and who has contracted with the Medical and Mental Health Benefits Administrator to provide treatment or services to Members who have Medical and Mental Health Benefits and to accept contracted rates as payment in full for such treatment or services. For Members living in Wisconsin, an In-network Provider is a provider that has contracted with the Medical and Mental Health Benefits Administrator to participate in an alternative provider network.

Medical Necessity/Medically Necessary

A service or supply furnished by a provider is Medically Necessary (or is considered a Medical Necessity) if the Dental Benefits Administrator, Prescription Drug Benefits Administrator, Care Coordinator, or Medical and Mental Health Benefits Administrator determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved, subject to the following: to be appropriate, it must be a service or supply that a provider, exercising prudent clinical judgment, would provide to a patient for the preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and which is in accordance with generally accepted standards of medical practice and not primarily for the convenience of the patient, physician, or other health care provider; and not more expensive than an alternative service or sequence of services; and at least as likely to produce equivalent results as to the diagnosis or treatment of that patient's illness, injury or disease.

In determining if a service or supply is Medically Necessary, the administrator will take into consideration information provided on the affected person's health status; reports in peer reviewed medical literature generally recognized by the relevant medical community; reports and guidelines published by nationally recognized health care organizations that include supporting scientific data; generally recognized professional standards of safety and effectiveness in the U.S. for diagnosis, care or treatment; the opinion of health professionals in the generally recognized health specialty involved; and any other relevant information.

If a Member has a life-threatening illness or condition (one which is likely to cause death within one year of the request for treatment) the Medical and Mental Health Benefits Administrator or Care Coordinator may, at its discretion, determine that an experimental or investigational service meets the definition of a covered benefit for that illness or condition. For this to take place, the Administrator or Care Coordinator must determine that the procedure or treatment has some available research outcomes, but is unproven, and that the service uses a specific research procedure that meets standards equivalent to those defined by the National Institutes of Health.

Other Valid Health Coverage

The following is coverage that satisfies the waiver of health coverage requirements under this Plan:

- Any group plan that provides medical treatment benefits or services and the group plan is provided by:
 - An employer of the Sponsored Member, other than the Sponsored Member's Participating Employer, provided the employer is not an ELCA congregation, seminary, synod or Churchwide Unit,
 - A former employer of the Sponsored Member,
 - An employer or former employer of:

- A Sponsored Member or his/her Eligible Spouse or Eligible Same Gender Partner,
- A Retired Member or his/her Eligible Spouse or Eligible Same Gender Partner,
- A Member who is On Leave from Call or his/her Eligible Spouse or Eligible Same Gender Partner,
- A parent whose group coverage covers the Sponsored Member or a dependent,
- A government-sponsored program outside the United States,
- Federal Medicaid or state-sponsored Medicaid-like medical assistance programs,
- A post-secondary educational institution attended by a Coverage Continuation Member, Eligible Spouse, Eligible Same Gender Partner, or Eligible Child,
- A Medicare Health Plan Option under a Medicare Advantage, Medicare Supplement, or Medicare Cost Plus plan, if the plans include Medicare Part D or creditable prescription drug coverage,
- The Department of Veteran Affairs for eligible veterans,
- Individual health insurance purchased by a Member who received a premium tax credit on a state, federal or state/federal partnership health insurance exchange according to the Affordable Care Act of 2010.

Out-of-Network Provider

An Eligible Medical or Mental Health Provider or entity in accordance with Section 12 that has not contracted with the Medical and Mental Health Benefits Administrator but provides treatment or services that are eligible for reimbursement under this Plan as Out-of-network Eligible Medical and Mental Health Expenses subject to Reasonable and Customary guidelines. For Members living in Wisconsin, an Out-of-network Provider is a provider that has not contracted with the Medical and Mental Health Benefits Administrator to participate in the alternative provider network.

Period of Coverage

A Period of Coverage, for purposes of the Personal Wellness Account, is the Plan Year, except that for employees who first become eligible to participate, it is the portion of the Plan Year following the date participation starts.

Plan Year

The Plan Year is the calendar year commencing January 1 and ending on December 31.

Reasonable and Customary

A Reasonable and Customary cost, charge, or expense is the allowed amount determined, in the sole discretion of the Medical and Mental Health Benefits Administrator, Dental Benefits Administrator or Prescription Drug Benefits Administrator, for the service, treatment, supply, or drug furnished in a similar locality where the same charges were incurred for a similar disease, illness, injury, or other physical or mental condition, taking into consideration any special skill or experience, or special facilities required to provide the necessary treatment. Specifically, the allowed amount for a service, treatment, supply or drug rendered by an In-network provider is the negotiated amount the Administrator and the In-network provider have agreed upon as full payment for such service, treatment, supply or drug; the allowed amount for a service, treatment, supply or drug rendered by an Out-of-network provider is the maximum amount allowed for such service, treatment, supply or drug by

the Administrator; members are responsible for any expenses that exceed the allowed amount for Out-of-network services, treatments, supplies, and drugs.

Retired Member

A Retired Member is a Sponsored Member who Separated from Service after attaining age 60 or completing a total of 30 years of service with an Eligible Employer.

Separation from Service

The Separation from Service of a Sponsored Member for purposes of this Plan occurs on his/her resignation, discharge, retirement, death, failure to return to active service at the end of an authorized leave of absence (including an ELCA Minister of Word and Sacrament "On Leave from Call" or an ELCA Minister of Word and Service "On Leave from Call"), or the authorized extension or extensions thereof, or on the occurrence of any other event or circumstances that, under the policy of his/her Participating Employer or of Portico, results in a termination of the arrangement for the performance of compensated service; provided, however, that a Separation from Service does not occur upon a transfer between any combination of Participating Employers.

Surviving Spouse

A Surviving Spouse is an individual who was legally married to a Sponsored Member, Retired Member or Coverage Continuation Member on the date of the Sponsored Member, Retired Member or Coverage Continuation Member's death.

Section 21 Vision Care Services

Portico Benefit Services may contract with a vision services organization to provide vision benefits and services to certain Members with ELCA-Primary Health Benefits. Member eligibility to enroll in vision benefits will be determined by Portico Benefit Services. Member Cost-Share for vision benefits will be determined by Portico Benefit Services and will not apply to Deductible Amounts and Out-of-Pocket Limit Amounts described in Section 10 and Section 11. On January 1 or the first day of the month following midyear enrollment, Members will have access to all Vision Care Services described in the Appendix.

Eligibility Information

A Member eligible to enroll in VSP vision benefits is:

- An Eligible Employee eligible for ELCA-Primary Health Benefits or ELCA Medicare-Primary Health Benefits who is sponsored in the ELCA Traditional Benefits Program by an Eligible Employer and:
 - Enrolled in ELCA-Primary Health Benefits or ELCA Medicare-Primary Benefits, or
 - Waiving ELCA health coverage due to enrollment in Other Valid Health Coverage, including Members residing in Hawaii and Puerto Rico.
- An Eligible Spouse or Eligible Child of a Sponsored Member who enrolls in Vision Care Services before selecting coverage for eligible family members.

A Member not eligible to enroll in Vision Care Services is:

- A Member who is not sponsored in the ELCA Traditional Benefits Program by an Eligible Employer, is not eligible for ELCA-Primary or ELCA Medicare-Primary Health Benefits, has terminated employment, has retired, is On Leave from Call or is a Totally Disabled Member in accordance with the ELCA Disability Benefits Plan,
- An Eligible Spouse or Eligible Child of a Sponsored Member who does not enroll himself/herself in Vision Care Services, and
- A Sponsored Member who declines enrollment for himself or herself in Vision Care Services at Annual Enrollment or when initially sponsored in the Traditional Benefits Program midyear is not eligible to enroll for the remainder of the plan year.
- A Member who does not enroll a Dependent at Annual Enrollment or when initially sponsored in the Traditional Benefits Program midyear may not enroll the Dependent during the plan year unless an Election Change Event is experienced.

Enrollment Information

To participate in Vision Care Services, a Sponsored Member must enroll:

- During Annual Enrollment for coverage beginning on January 1, or
- Within 60 days of becoming a new Sponsored Member after January 1 for coverage beginning the first day of the month following enrollment.

A Member who declines Vision Care Services at Annual Enrollment or when initially sponsored in the ELCA Health Plan midyear, cannot enroll in Vision Care Services until the next Annual Enrollment, unless

the Member waived ELCA Health Plan benefits during Annual Enrollment or when initially sponsored midyear, if later than Annual Enrollment, and enrolls in the ELCA Health Plan midyear.

A Sponsored Member is not required to select Vision Care Services for all Dependents enrolled in ELCA-Primary or ELCA Medicare-Primary Benefits.

Election Change Event

The annual election of Vision Care Services remains in effect for the Plan Year unless a Member experiences an Election Change Event and requests an election change within 60 days of the event. The new election takes effect the first day of the month after which Portico receives the change request.

The following are Election Change Events and the permitted changes during the plan year for Members enrolled in Vision Care Services:

- If a Sponsored Member has a change in number of Eligible Children due to birth, adoption, or placement for adoption, the Member can add Vision Care Services for a Dependent if the member is already enrolled in Vision Care Services;
- If a Sponsored Member marries, the Member can add Vision Care Services for the Eligible Spouse if the member is already enrolled in Vision Care Services;
- If a Sponsored Member divorces or has legal separation from his or her spouse, the Member can terminate Vision Care Services for the spouse;
- If a Sponsored Member's Dependent dies, the Member can terminate Vision Care Services for that Dependent; and
- If a Sponsored Member's Dependent no longer meets the eligibility requirements for the ELCA Health Plan, the Member can terminate Vision Care Services for the Dependent.

Termination of Enrollment

The enrollment of a Sponsored Member and Dependents in Vision Care Services will terminate on the earliest of the following dates:

- The date specified in an advance notice to Portico from the Sponsored Member's Participating Employer that it will no longer sponsor the individual.
- The date that the Participating Employer ceased to make contributions on behalf of the Sponsored Member.
- The date that the Participating Employer ceased to provide accurate information requested by Portico for administration of Vision Care Services.
- The date of the required contribution if full payment is not received within the timeframe specified by Portico.

Following termination, the Sponsored Member may be eligible to continue Vision Care Services directly with the Vision Care Services Administrator.

Premiums

The Participating Employer will withhold the premiums from the Member's paycheck throughout the Plan Year for the Sponsored Member and Dependents' Vision Care Services. Portico will bill the Participating Employer for the Member's Vision Care Services premium. Premiums received from the Participating Employer will be remitted by Portico to the Vision Care Services Administrator.

In-Network VSP Vision Benefits

See *vsp.com* for providers in the network.

Contact Information — Plan Administrator

Portico Benefit Services — Plan Administrator

Portico Customer Care Center

Call or email the Portico Customer Care Center with questions about eligibility, contribution rates, or a change of family status, address, or coverage.

Phone: 800.352.2876 or 612.333.7651

Fax: 612.334.5399

Email: mail@PorticoBenefits.org

Website: myPortico.PorticoBenefits.org

Hours: 8 a.m. – 6 p.m. Monday – Thursday, 8 a.m. – 5 p.m. Friday (Central)

Mailing address:

Portico Benefit Services
7700 France Ave. S., Ste. 350
Minneapolis, MN 55435-2802

Portico Benefit Services — Privacy Contact

Call or email for information about the Plan's privacy practice, to exercise your rights, or to file a complaint about how the Plan is handling your protected health information.

Phone: 800.352.2876 or 612.333.7651, ext. 4420

Email: privacycontact@PorticoBenefits.org

Mailing address:

Portico Benefit Services
ATTN: Privacy Contact
7700 France Ave. S., Ste. 350
Minneapolis, MN 55435-2802

Contact Information — ELCA-Primary Benefits

Care Coordinators by Quantum Health

Your first contact for questions or help navigating your health care. Care Coordinators can assist with:

- Navigating health benefits, claims, eligibility or prior authorization
- Finding a doctor or other In-network providers and facilities
- Obtaining authorization for services that require pre-certification
- Navigating a new diagnosis or health event to maximize positive outcomes and minimize out-of-pocket costs
- Managing an existing chronic condition
- Resolving medical, mental health and pharmacy issues
- Securing debit or identification cards
- Any program information regarding EAP, tobacco cessation, personal wellness accounts, FSA, HSA

Phone: 877.851.5656

Website: health.porticobenefits.org

Hours: 7:30 a.m. – 9 p.m. (Central), Monday – Friday

Mailing address for appeals:

Quantum Health
7450 Huntington Park Dr., Ste. 100
Columbus, OH 43235

98point6® — 24/7 Text-Based Primary Care

Use the 98point6 app for on-demand consultation, diagnosis, and treatment from board-certified physicians.

Website: 98point6.com/portico

Hours: 24/7

BurnAlong

Online health, wellness and fitness platform gives access to thousands of live and on-demand classes.

Website: Fit.BurnAlong.com/Portico

Email: CustomerCare@burnalong.com

Delta Dental of Minnesota

Call about the benefit, claims, pretreatment estimates, to request additional identification cards, or to find a participating dentist. Visit online to view claims history or locate a participating provider (choose Delta Dental PPO or Delta Dental Premier providers).

Phone: 800.448.3815 or 651.406.5901

Website: deltadentalmn.org

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

Claims mailing address:

Delta Dental
P.O. Box 9120
Farmington Hills, MI 48333-9120

Appeals mailing address:

Delta Dental
P.O. Box 9124
Farmington Hills, MI 48333-9124

Employee Assistance Program (EAP) — Beacon Health Strategies

You can talk to an EAP professional about stress, relationships, family issues, work issues, substance abuse, resiliency and recovery, or other personal concerns. Eligible EAP services include telephone consultation, assessment, and in-person counseling.

Phone: 800.432.5155

Hours: Accessible 24 hours a day, seven days a week

Express Scripts, Inc.

Prescription Drug Benefit

Call for questions or go online to find participating pharmacies (select Pharmacy Locator). You can set up home delivery service, learn more about drug Cost-Share, how to save money on your prescriptions, transfer a prescription to home delivery service, and find information about medications, what drugs are on the formulary or health conditions. You can also call or go online to get additional identification cards.

Phone: 800.575.8090 / TTY 800.305.5376

Website: express-scripts.com (or sign in to myPortico.PorticoBenefits.org and use any link to access your Express Scripts account)

Hours: Accessible 365 days a year, 24 hours a day, seven days a week

Prescription Prior Authorization for Physicians Only

Sometimes your doctor must request authorization for certain drugs before the prescription can be filled (for example, if the quantity exceeds the limit or if a drug is prescribed before a comparable, less expensive step-one drug has been tried).

Phone: 800.417.8164

Accredo Specialty Pharmacy (an Express Scripts subsidiary)

Call for assistance with all your specialty drug needs, including specialty drug coverage questions, how to purchase injectable and oral drugs, and storage and handling requirements.

Phone: 800.803.2523

Hours: 7 a.m. – 8 p.m. (Central) Monday – Friday, 8 a.m. – 12 p.m. (Central) Saturday

Experian — Identity Protection Services (a partner of BlueLink TPA)

Enroll in identity protection services. Sign in to myPortico to learn more.

Further — Tax-Advantaged Accounts

Visit online or call Further to access your personal wellness account, FSA and HSA, claims, account balance, or reimbursement, to access claim forms, and to order new debit cards. Access tools, calculators, videos and tips about your Further accounts.

Phone: 800.859.2144

Fax: 866.231.0214

Website: hellofurther.com

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

Claims address:

Further

P.O. Box 64193

St. Paul, MN 55164-0193

Omada

Chronic condition prevention digital program designed to help eligible members create modest changes that promote weight loss and help reduce the risk of type 2 diabetes and heart disease.

Phone: 888.409.8687

Website: omadahealth.com/portico

Email: support@omadahealth.com

Hours: 10 a.m. – 8 p.m. (Central), Monday – Friday

Quest Diagnostics — Biometric screening program

Sign in to myPortico.PorticoBenefits.org to access information and schedule biometric screening.

Phone: 855.623.9355

Fax: 844.560.5221

Website: myPortico.PorticoBenefits.org

Hours: 7 a.m. – 8:30 p.m. (Central) Monday – Friday, 7 a.m. – 4:00 p.m. (Central) Saturday

SWORD Health

Virtual therapy program that combines physical therapy, behavioral coaching, and education designed to address chronic and post-surgical pain.

Website: join.swordhealth.com/Portico

Email: help@swordhealth.com

Amplifon Hearing Health Care (a partner of Delta Dental of Minnesota)

Call to get discounts on hearing aids and other hearing services.

Phone: 855.531.4694

Website: amplifonusa.com/deltadentalmn

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

Find the most current version of this Summary Plan Description of the ELCA Medical and Dental Benefits Plan – Traditional Benefits Program on myPortico at myPortico.PorticoBenefits.org/summaries. For questions or to receive a copy of the ELCA Medical and Dental Benefits Plan, contact our Customer Care Center at mail@PorticoBenefits.org or **800.352.2876**.

Contact Information — ELCA Medicare-Primary Benefits

Humana

Contact Humana with questions about Medicare Advantage hospital and medical benefits, prescription drug benefits, claims, and wellness benefits.

Phone: 888.445.4788 TTY: 711

Web: humana.com

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

Claims mailing address:

Humana Claims

P.O. Box 14601

Lexington, KY 40512-4601

Humana Pharmacy

Phone: 800.379.0092 TTY: 711

Web: humana.com

Hours: 7 a.m. – 10 p.m. (Central) Monday – Friday, 7 a.m. – 5:30 p.m. (Central) Saturday

Humana Specialty Pharmacy

Phone: 800.486.2668 TTY: 711

Web: humana.com

Hours: 7 a.m. – 10 p.m. (Central) Monday – Friday, 7 a.m. – 5:30 p.m. (Central) Saturday

Medicare

Contact Medicare with questions about Medicare coverage, 24 hours a day, seven days a week.

Phone: 800.MEDICARE [633.4227] / TTY 877.486.2048

Website: medicare.gov

Delta Dental of Minnesota

Call about the benefit, claims, pretreatment estimates, to request additional identification cards, or to find a participating dentist. Visit online to view claims history or locate a participating provider (choose Delta Dental PPO or Delta Dental Premier providers).

Phone: 800.448.3815 or 651.406.5901

Website: deltadentalmn.org

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

Claims mailing address:

Delta Dental
P.O. Box 9120
Farmington Hills, MI 48333-9120

Appeals mailing address:

Delta Dental
P.O. Box 9124
Farmington Hills, MI 48333-9124

Tivity Health

SilverSneakers® Fitness Program

Contact SilverSneakers with questions about your free basic fitness membership at participating fitness centers.

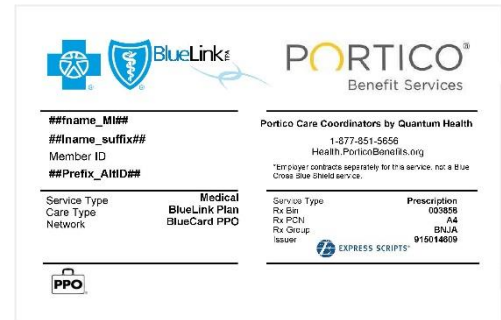
Phone: 888.423.4632

Website: silversneakers.com

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

ID Cards — ELCA-Primary Benefits

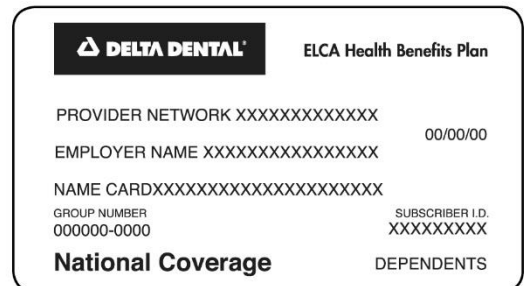
ELCA-Primary Medical and Mental Health Benefits are administered by BlueLink. Show your Portico Health ID card to your medical or mental health care providers. Contact Care Coordinators at **877.851.5656** if you need additional identification cards.



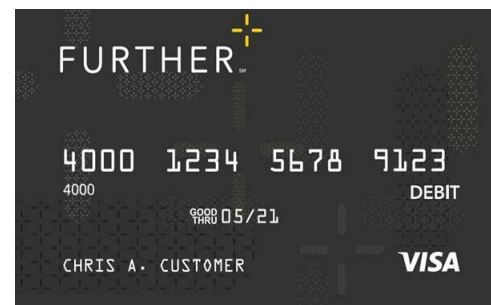
(See Portico Health ID card above)

The ELCA Prescription Drug Benefit is administered by Express Scripts, Inc. Show your Portico Health ID card when you purchase prescriptions at your local pharmacy. Use the card's information when you purchase prescription drugs through Express Scripts' home delivery service. Your first call should be to the Care Coordinators if you need additional identification cards or have questions.

The ELCA Dental Benefit is administered by Delta Dental of Minnesota. Show this card to your dental care provider. Contact Delta Dental at **800.448.3815** if you need additional identification cards.

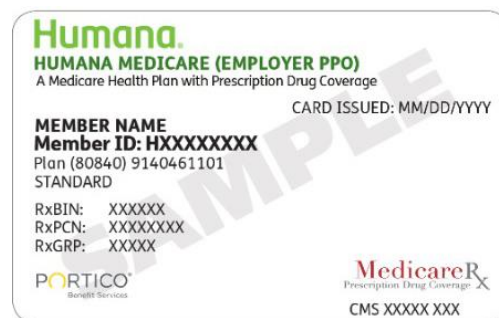


The Further debit card is a convenient way to pay for eligible health care expenses from a personal wellness account, health flexible spending account (FSA), limited-purpose health FSA, or health savings account (HSA). Contact Further at **800.859.2144** or visit hellofurther.com.

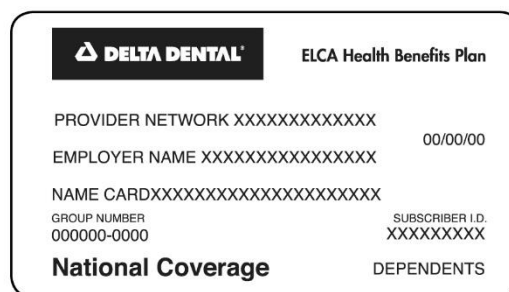


ID Cards — ELCA Medicare-Primary Benefits

The ELCA Medicare Advantage Benefit and ELCA Part D Prescription Drug coverage are insured by Humana. Show this card to your hospital and medical care providers and at your local pharmacy. Contact Humana at **888.445.4788** if you need additional identification cards.



The ELCA Dental Benefit is administered by Delta Dental of Minnesota. Show this card to your dental care provider. Contact Delta Dental at **800.448.3815** if you need additional identification cards.



Appendix – ELCA Traditional Benefits Program

ELCA-Primary (Deductible)		2022	
Section 10	Eligible Medical and Mental Health Expenses	In-Network Deductible	Out-of-Network Deductible
	Platinum+ Option		
	• Per Individual	\$550	\$550
	• Member and child(ren)	\$825	\$825
	• Member/spouse and Member/spouse/child(ren)	\$1,100	\$1,100
	Gold+ Option		
	• Per Individual	\$1,300	\$1,300
	• Member and child(ren)	\$1,950	\$1,950
	• Member/spouse and Member/spouse/child(ren)	\$2,600	\$2,600
Section 10	Eligible Medical and Mental Health Expenses & Prescription Drug Expenses*	In-Network Deductible	Out-of-Network Deductible
	Silver+ Option		
	• Single coverage	\$2,500	\$2,500
	• Family coverage	\$5,000	\$5,000
	Bronze+ Option		
	• Single coverage	\$5,000	\$5,000
	• Family coverage	\$10,000	\$10,000
*The Cost-Share for a 30-day supply of preferred brand-name insulin is \$25.			

ELCA-Primary (Coinsurance)		2022	
Section 10	Eligible Medical and Mental Health Expenses	In-Network Coinsurance	Out-of-Network Coinsurance
	Platinum+ Option		
	• Per Individual	20%	40%
	• Member and child(ren)	20%	40%
	• Member/spouse and Member/spouse/child(ren)	20%	40%
	Gold+ Option		
	• Per Individual	20%	40%
	• Member and child(ren)	20%	40%
	• Member/spouse and Member/spouse/child(ren)	20%	40%
	Silver+ Option		
	• Single coverage	20%	40%
	• Family coverage	20%	40%
	Bronze+ Option		
	• Single coverage	20%	40%
	• Family coverage	20%	40%

ELCA-Primary (Maximum Out-of-Pocket)		2022	
Section 10	Eligible Medical and Mental Health Expenses & Prescription Drug Expenses	In-Network Maximum Out-of-Pocket	Out-of-Network Maximum Out-of-Pocket
	Platinum+ Option		
	• Per individual	\$3,400	\$3,400
	• Member and child(ren)	\$6,800	\$6,800
	• Member/spouse and Member/spouse/child(ren)	\$6,800	\$6,800
	Gold+ Option		
	• Per individual	\$4,300	\$4,300
	• Member and child(ren)	\$8,600	\$8,600
	• Member/spouse and Member/spouse/child(ren)	\$8,600	\$8,600
	Silver+ Option		
	• Per Individual	\$4,300	\$4,300
	• Family coverage	\$8,600	\$8,600
	Bronze+ Option		
	• Per Individual	\$6,800	\$6,800
	• Family coverage	\$13,600	\$13,600

ELCA Medicare-Primary (Cost-Share)		2022		
Section 11	Eligible Hospital and Medical Expenses Under Medicare Advantage	Deductible	Copay	Maximum Out-of-Pocket
	Premium Option — Per individual	\$0	0%	\$0
	Standard Option — Per individual	\$180	0 – 4%	\$3,500
	Economy Option — Per individual	\$180	0 – 5%	\$2,470

ELCA Medicare-Primary (Outside U.S.)		2022
Section 11	Medicare Advantage Worldwide Emergency and Urgent Care Outside the United States and Territories for Services Medicare Would Cover if Performed in the United States	Member Coinsurance; Plan Reimbursement Limits
	Premium Option — Per individual	20% coinsurance; \$50,000 lifetime reimbursement maximum
	Standard Option — Per individual	20% coinsurance; \$50,000 lifetime reimbursement maximum
	Economy Option — Per individual	20% coinsurance after \$250 deductible; \$50,000 lifetime reimbursement maximum

ELCA-Primary ELCA Medicare-Primary		Dental Deductible and Limits
		2022
Section 13	Basic Services and Major Restorative Care	Deductible
	• Per individual	\$150
	• Family Maximum	\$300
Section 13	Annual and Lifetime Limits	Reimbursement Limits
	• <u>Annual</u> Limit Eligible Preventive, Basic and Major Restorative Dental Expenses	\$2,850
	• <u>Lifetime</u> Limit Eligible Orthodontia Expenses	\$2,850

ELCA-Primary ELCA Medicare-Primary		Dental Deductibles & Coinsurance
		2022
Section 13		Plan Pays
	Preventive Services	100%
	Basic Services	80% after Deductible, subject to Annual Limit
	Major Restorative Care	50% after Deductible, subject to Annual Limit
	Orthodontia Care	50%, subject to Lifetime Limit

ELCA-Primary		2022		
Section 15	ELCA Prescription Drug Benefit (Cost-Share Per Script*/**) Gold+ Option+, Platinum+ Option*			
		Generic	Brand Formulary	Brand Non-Formulary
	In-Network Retail (up to a 31-day supply)	\$12	20% subject to \$55 minimum/ \$90 maximum	35% subject to \$90 minimum/ \$180 maximum
	Express Scripts Mail Order Pharmacy (up to a 90-day supply)	\$24	20% subject to \$120 minimum/ \$210 maximum	35% subject to \$210 minimum/ \$300 maximum
	Express Scripts Specialty Pharmacy (up to a 31-day supply)	\$12	20% subject to \$55 minimum/ \$90 maximum	35% subject to \$90 minimum/ \$180 maximum
	*Certain specialty drugs will have \$0 Member Cost-Share **The Copay for a 30-day supply of preferred brand-name insulin is \$25			

ELCA Medicare-Primary		2022			
Section 15	ELCA Part D Prescription Drug (Cost-Share Per Script) Premium Option and Standard Option				
		Member Pays			
		Tier 1	Tier 2	Tier 3	Tier 4
Mail Order or In-Network retail pharmacy Up to 90-day supply	\$20 copay	20% coinsurance subject to \$100 minimum \$175 maximum	35% coinsurance subject to \$175 minimum \$250 maximum	Not Available	
In-Network retail pharmacy Up to 30-day supply	\$10 copay	20% coinsurance subject to \$45 minimum \$75 maximum	35% coinsurance subject to \$75 minimum \$150 maximum	35% coinsurance subject to \$75 minimum \$150 maximum	
Non-participating pharmacy	100% coinsurance	100% coinsurance	100% coinsurance	100% coinsurance	
CATASTROPHIC COVERAGE STAGE	Member pays the following copays/coinsurance after total yearly out-of-pocket drug costs (what Member and others pay on Member's behalf, including manufacturer discounts but excluding payments made by the Medicare prescription drug plan) reach \$7,050				
Mail Order or In-Network retail pharmacy Up to 90-day supply	Member pays the greater of \$3.95 for generic/preferred multi-source drugs/biosimilars and \$9.85 for all other drugs; OR 5% coinsurance (\$10 maximum out-of-pocket per prescription for up to 30-day supply; \$20 maximum out-of-pocket per prescription for up to 90-day supply*)	Member pays the greater of \$3.95 for generic/preferred multi-source drugs/biosimilars and \$9.85 for all other drugs; OR 5% coinsurance (\$75 maximum out-of-pocket per prescription for up to 30-day supply; \$175 maximum out-of-pocket per prescription for up to 90-day supply*)	Member pays the greater of \$3.95 for generic/preferred multi-source drugs/biosimilars and \$9.85 for all other drugs; OR 5% coinsurance (\$150 maximum out-of-pocket per prescription for up to 30-day supply; \$250 maximum out-of-pocket per prescription for up to 90-day supply*)	Member pays the greater of \$3.95 for generic/preferred multi-source drugs/biosimilars and \$9.85 for all other drugs; OR 5% coinsurance (\$150 maximum out-of-pocket per prescription for up to 30-day supply*)	
Non-participating pharmacy	100% coinsurance	100% coinsurance	100% coinsurance	100% coinsurance	

*Revisions 4.11.2022; retroactive to 1.01.2022.

IMPORTANT INFORMATION FOR ELCA PART D PRESCRIPTION DRUG COVERAGE

- **Tier 1: Preferred Generic Drugs.** Generic or brand drugs that are available at the lowest cost share.
- **Tier 2: Preferred Drugs.** Generic or brand drugs that Humana offers at a lower cost than Tier 3 Non-Preferred Drug.
- **Tier 3: Non-Preferred Drugs.** Generic or brand drugs that Humana offers at a higher cost than Tier 2 Preferred Brand.
- **Tier 4: Specialty Drugs.** Some injectables and other higher-cost drugs.
- Consult the formulary for information about the prescription drug tier.
- Not all drugs are available at a 90-day supply. Some prescriptions are available in a 30-day supply only.
- Copays or coinsurance may be less if a Member is receiving “Extra Help” from Medicare due to low income.
- The Member pays the negotiated rate for a drug if the rate is less than the generic copay.
- The Member pays the full cost for drugs received from a non-participating, Out-of-network pharmacy. Out-of-network purchases of eligible drugs are reimbursed in special circumstances only.

ELCA Medicare-Primary		2022			
Section 15	ELCA Part D Prescription Drug (Cost-Share Per Script) Economy Option				
		Member Pays			
		Tier 1	Tier 2	Tier 3	Tier 4
DEDUCTIBLE STAGE	Member pays all drug costs until reaching the yearly \$405 prescription drug deductible				
INITIAL COVERAGE STAGE	Member pays the following copays/coinsurance until the total yearly out-of-pocket drug costs (what Member and Plan pay) reach \$4,430				
Mail Order or In-Network retail pharmacy Up to 90-day supply	\$5 copay	20% coinsurance	45% coinsurance	Not Available (maximum 30-day supply)	
In-Network retail pharmacy Up to 30-day supply	\$5 copay	20% coinsurance	45% coinsurance	25% coinsurance	
Non-participating pharmacy	100% coinsurance	100% coinsurance	100% coinsurance	100% coinsurance	
COVERAGE GAP STAGE	After the total yearly out-of-pocket drug costs reach \$4,430, Member pays the following copays/coinsurance until the total yearly out-of-pocket drug costs (what Member and Plan pay) reach \$7,050				
Mail Order or In-Network retail pharmacy Up to 90-day supply	\$5 copay	25% coinsurance	25% coinsurance	Not Available (maximum 30-day supply)	
In-Network retail pharmacy Up to 30-day supply	\$5 copay	25% coinsurance	25% coinsurance	25% coinsurance	
Non-participating pharmacy	100% coinsurance	100% coinsurance	100% coinsurance	100% coinsurance	
CATASTROPHIC COVERAGE STAGE	After the total yearly out-of-pocket drug costs reach \$7,050 (what Member and others pay on Member's behalf, including manufacturer discounts but excluding payments made by the Medicare prescription drug plan), Member pays the following copays/coinsurance				

Mail Order or In-Network retail pharmacy Up to 90-day supply	Member pays the greater of \$3.95 for generic/preferred multi-source drugs/biosimilars and \$9.85 for all other drugs; OR 5% coinsurance	Member pays the greater of \$3.95 for generic/preferred multi-source drugs/biosimilars and \$9.85 for all other drugs; OR 5% coinsurance	Member pays the greater of \$3.95 for generic/preferred multi-source drugs/biosimilars and \$9.85 for all other drugs; OR 5% coinsurance	Member pays the greater of \$3.95 for generic/preferred multi-source drugs/biosimilars and \$9.85 for all other drugs; OR 5% coinsurance
Non-participating pharmacy	100% coinsurance	100% coinsurance	100% coinsurance	100% coinsurance

IMPORTANT INFORMATION FOR ELCA PART D PRESCRIPTION DRUG COVERAGE

- **Tier 1: Preferred Generic Drugs.** Generic or brand drugs that are available at the lowest cost share.
- **Tier 2: Preferred Drugs.** Generic or brand drugs that Humana offers at a lower cost than Tier 3 Non-Preferred Drug.
- **Tier 3: Non-Preferred Drugs.** Generic or brand drugs that Humana offers at a higher cost than Tier 2 Preferred Brand.
- **Tier 4: Specialty Drugs.** Some injectables and other higher-cost drugs.
- Consult the formulary for information about the prescription drug tier.
- Not all drugs are available at a 90-day supply. Some prescriptions are available in a 30-day supply only.
- Copays or coinsurance may be less if a Member is receiving "Extra Help" from Medicare due to low income.
- The Member pays the negotiated rate for a drug if the rate is less than the generic copay.
- The Member pays the full cost for drugs received from a non-participating, Out-of-network pharmacy. Out-of-network purchases of eligible drugs are reimbursed in special circumstances only.

ELCA-Primary
ELCA-Medicare Primary **Vision Care Services**

PROVIDER NETWORK:
VSP Choice

- The **BASIC OPTION** covers new frames **every other** calendar year.
- The **ENHANCED OPTION** covers new frames **every** calendar year.

EFFECTIVE DATE:
01/01/2022

BENEFIT	DESCRIPTION	COPAY
WellVision Exam	<ul style="list-style-type: none"> • Focuses on your eyes and overall wellness • Every calendar year 	\$0
Routine Retinal Screening	<ul style="list-style-type: none"> • Routine retinal screening as an enhancement to a WellVision Exam 	No more than \$39
CORRECTIVE VISION		
Frame	<ul style="list-style-type: none"> • \$170 featured frame brands allowance • \$150 frame allowance • 20% savings on the amount over your allowance • \$80 Walmart®/Sam's Club®/Costco® frame allowance • BASIC OPTION: Every other calendar year • ENHANCED OPTION: Every calendar year 	\$25
Lenses	<ul style="list-style-type: none"> • Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children • Every calendar year 	
Lens Enhancements	<ul style="list-style-type: none"> • Scratch-resistant coating • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements • Every calendar year 	\$0 \$0 \$50 \$50
Contacts (Instead of Glasses)	<ul style="list-style-type: none"> • \$150 allowance for contacts (copay does not apply) • Contact lens exam (fitting and evaluation) • Every calendar year 	Up to \$45
Primary Eyecare™	<ul style="list-style-type: none"> • \$0 Retinal screening for members with diabetes • Additional exams and services for members with diabetes, glaucoma, or age-related macular degeneration • Treatment and diagnoses of eye conditions, including pink eye, vision loss, and cataracts available for all members • Limitations and coordination with your medical coverage may apply; ask your VSP doctor for details • As needed 	\$20 per exam
Glasses & Sunglasses	<ul style="list-style-type: none"> • Extra \$20 to spend on featured frame brands; go to vsp.com/offers for details • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam 	
Laser Vision Correction	<ul style="list-style-type: none"> • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities 	
YOUR COVERAGE WITH OUT-OF-NETWORK PROVIDERS		
Get the most out of your benefits and greater savings with a VSP network doctor. Call VSP for out-of-network plan details.		
<small>Coverage with a retail chain may be different or not apply. Log in to vsp.com to check your benefits for eligibility and to confirm in-network locations based on your plan type. VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.</small>		

Log in to vsp.com to find a VSP network provider based on your plan type.

VSP, VSP Vision Care for life, Eyeconic, and WellVision Exam are registered trademarks, VSP Diabetic Eyecare Plus Program is servicemark of Vision Service Plan.

* Please note, members currently receiving ELCA disability benefits or on leave from call are not eligible to purchase vision care services coverage. The eligibility for any benefit will be governed by the terms of the applicable plan, program, or policy. Portico Benefit Services (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(s) require for its administration, and to construe and interpret the plan(s) for purposes of determining eligibility and benefits.



Portico Benefit Services

7700 France Ave. S., Ste. 350

Minneapolis, MN 55435-2802

800.352.2876 / 612.333.7651 / F 612.334.5399

mail@PorticoBenefits.org / PorticoBenefits.org