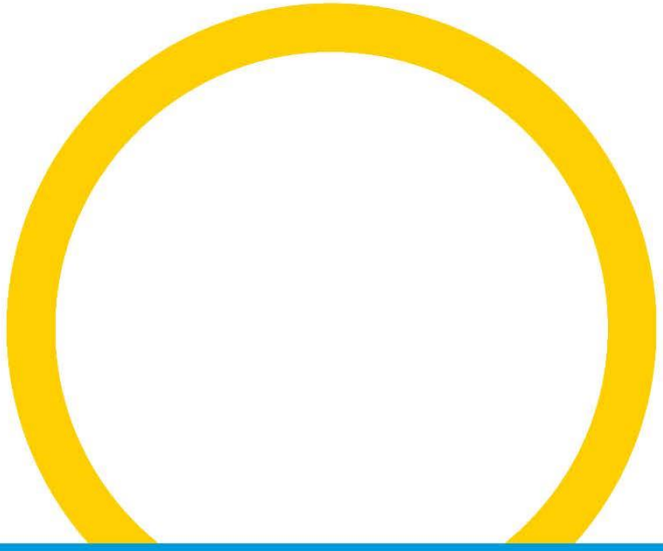
PORTICO®
Benefit Services | A Ministry of the ELCA

ELCA MEDICAL AND DENTAL BENEFITS PLAN

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

Flexible Benefits Program

Summary Plan Description
Effective January 1, 2022



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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 Flexible Benefits Program

The ELCA Flexible Benefits Program helps ELCA employers customize a benefit offering for their lay employees that can include ELCA Medical and Dental Benefits Plan, ELCA Retirement Savings Plan, ELCA Disability Benefits Plan, and ELCA Survivor Benefits Plan. Members enrolled in the ELCA Medical and Dental Benefits Plan may also be eligible to enroll in flexible spending and health savings accounts. Benefit plans are governed and administered individually through separate plan documents.

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 Flexible Benefits Program, Portico maintains the ELCA Retirement Plan for Members in the Traditional 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 11*
- Supporting Services ..... *see Section 13*
- Prescription Drug Benefits ..... *see Section 14*

If Dental Benefits were selected by the Participating Employer, the Sponsored Member can elect or decline Dental Benefits during Annual Enrollment or upon midyear enrollment. A Member enrolled in Dental Benefits may also enroll eligible family members in the Dental Benefits option in which the Member enrolled.

- Dental Benefits ..... *see Section 12*

A Retired Member or Coverage Continuation Member who is enrolled in the ELCA-Primary Benefits package will have the Enhanced Dental Benefits option.

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 10*
- Supporting Services ..... *see Section 13*
- Prescription Drug Benefits ..... *see Section 14*

If Dental Benefits were selected by the Participating Employer, the Sponsored Member can elect or decline Dental Benefits during Annual Enrollment or upon midyear enrollment.

- Dental Benefits ..... *see Section 12*

A Retired Member or Coverage Continuation Member who is enrolled in the ELCA Medicare-Primary Benefits package will have the Enhanced Dental Benefits option.

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 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**	• 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	A common-law-employee, including but not limited to ELCA ordained clergy, non-ELCA ordained clergy, and laypersons, who has completed any probationary waiting period for benefits specified by the Employer.

Section II	**Eligible Employers**	An ELCA "qualified church-controlled organization" as determined by the ELCA within the meaning of Internal Revenue Code § 3121(w). 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 *Section II*.
	Sponsorship Requirement	These Eligible Employers have full discretion in deciding which Eligible Employees to sponsor.
	Eligible Employees	A common-law-employee, including but not limited to ELCA ordained clergy, non-ELCA ordained clergy, and laypersons, who has completed any probationary waiting period for benefits specified by the Employer.

Section III	**Eligible Employers**	An ELCA "church-controlled organization" but not a "qualified church-controlled organization" described in *Section II* above; or an organization described in Code § 501(c)(3) that meets both of the following requirements: (a) it 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); and (b) it is not a "church" or a "qualified church-controlled organization" within the meaning of Code § 3121(w)(3). NOTE: An 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 *Section III*.
	Sponsorship Requirement	These Eligible Employers must sponsor either all or none of its other Eligible Employees.
	Eligible Employees	A common-law-employee, including but not limited to ELCA ordained clergy, non-ELCA ordained clergy, and laypersons, who has completed any probationary waiting period for benefits specified by the Employer.

Section 3 Eligible Employee Enrollment

An Eligible Employee will become a Sponsored Member when he/she is sponsored by his/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.

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 did not complete Timely Enrollment or whose coverage under this Plan was declined and was not replaced with Other Valid Health Coverage, they will not be eligible to enroll until the next Annual Enrollment period with coverage beginning the following January 1. However, a Sponsored Member whose Other Valid Health Coverage terminates may enroll in the ELCA Health Plan within 60 days of losing the other coverage.

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.
- If a Sponsored Member does not elect an option or decline health coverage 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/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 s/he 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.

A Sponsored Member who has waived coverage or whose Other Valid Health Coverage has terminated 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 and Child Enrollment

A Participating Employer may enroll the Sponsored Member's Eligible Spouse and/or Eligible Children. For purposes of being eligible to enroll, below are the criteria for an Eligible Spouse and for Eligible Children.

Eligible Spouse

A spouse or a separated spouse who is legally married to a:

- Sponsored Member,
- Retired Member, or
- Coverage Continuation Member who 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 a Sponsored Member, Retired Member, deceased Member, or a Coverage Continuation Member, provided that the former spouse had been covered or had waived coverage at the time of the dissolution of marriage.

A Surviving Spouse who had been legally married to a Sponsored Member, Retired Member, or a Coverage Continuation Member at the time of the Member's death and had been covered or had waived coverage at the time of the Member's death.

Eligible Child

An Eligible Child who

- Has the following relationship with a Member listed below, and is a:
  - Natural or legally adopted child of the Member, or spouse,
  - 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, or
  - Child living in the Member's home and the Member has been appointed the legal guardian, and
- Is:
  - Under age 26 or within the calendar month in which he/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, or
- Coverage Continuation Member who 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.

Enrollment of Eligible Spouse and Eligible Child

ELCA-Primary Option Coverage
An Eligible Spouse 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 and/or Eligible Child are not eligible for the option provided above as Medicare is the primary coverage, an Eligible Spouse and/or Eligible Child of:

- A Sponsored Member will have the ELCA Medicare-Primary Standard Option.
- A Retired Member or Coverage Continuation Member will have the ELCA Medicare-Primary Option chosen for the Eligible Spouse or Eligible Child by the Coverage Continuation Member.

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

- A Sponsored Member will have the ELCA Medicare-Primary Standard Option. However, if the Eligible Spouse and/or Eligible Child are not eligible for ELCA Medicare-Primary coverage, the Sponsored Member will select an ELCA-Primary option for the Eligible Spouse and/or Eligible Child.
- A Retired Member or Coverage Continuation Member will have the ELCA Medicare-Primary Option chosen for the Eligible Spouse and/or Eligible Child by the Coverage Continuation Member, if eligible. However, if the Eligible Spouse 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 and/or Eligible Child of a Sponsored Member:

- 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.
- For whom Timely Enrollment was not completed or whose coverage under this Plan was declined and was not replaced with Other Valid Health Coverage, they will not be eligible to

enroll until the next Annual Enrollment period with coverage beginning the following January 1, except for the following situations:

- **Termination of Other Valid Health Coverage**: Coverage for an Eligible Spouse 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 and Child

Waiving Coverage and Re-enrollment — A Sponsored Member may waive coverage for his/her Eligible Spouse and/or Eligible Child any time the Eligible Spouse 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, Spouse and Child Enrollment

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.

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 or 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, 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.

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.

Starting or Resuming Coverage if Waived — Coverage that has been waived may be started or resumed without a 90-day waiting period if the Retired Member 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 or Child of a Retired Member

An Eligible Spouse 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 other coverage has terminated and the re-enrollment is requested.

An Eligible Spouse 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 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.

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

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

A Retired Member may waive coverage for his or her Eligible Spouse and/or Eligible Child any time the Eligible Spouse 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.

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 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 date Portico received the acceptable request.

Section 6 Termination & 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, or
  - Providing accurate information needed for the Plan administration.
- The date of the required contribution if full payment is not received within the timeframe specified in Portico's Past-Due Account Management 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.

Termination of a Spouse or Child's Enrolled Status

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

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:

- **Disabled Member** – A Sponsored Member who was enrolled in the ELCA Medical and Dental Benefits Plan and the ELCA Disability Benefits Plan immediately preceding the date of Total Disability according to the ELCA Disability Benefits Plan, may continue coverage at his or her own expense for up to 18 months after the 2-month waiting period for ELCA disability benefits.

  The Participating Employer shall pay the monthly contributions for this Plan's coverage for the Sponsored Member and his/her Dependents for the 2-month disability waiting period. If the Participating Employer does not make the contribution payments for the first 2 months, the Member may make the contribution on his/her own behalf and/or on behalf of his/her Dependents to prevent a lapse in coverage.
- **Terminated Member/No Longer Sponsored** – A Sponsored Member enrolled in the ELCA Medical and Dental Benefits Plan may elect an ELCA health benefits package which includes Dental Benefits, in accordance with Portico's administrative practices, at his/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/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 or Child's Enrolled Status" may remain enrolled at his/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** of a Sponsored Member or Retired Member enrolled in ELCA health coverage may elect an ELCA health benefits package which includes Dental Benefits, in accordance with Portico's administrative practices, at his/her own expense for his/her remaining lifetime. A Surviving Spouse who is eligible for and requests enrollment in ELCA-Primary

Benefits 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.

- A **Surviving Spouse** who is eligible for and requests enrollment in ELCA Medicare-Primary Benefits within 60 days of the termination of his/her Other Valid Health Coverage will be enrolled in ELCA Medicare-Primary Benefits on the first day of the month following the request.
- A **former spouse** of a living or deceased Sponsored Member or Retired Member, enrolled in ELCA health coverage may elect an ELCA health benefit package which includes Dental Benefits, in accordance with Portico's administrative practices, at his/her own expense for up to 36 months.
- An **Eligible Child** of a Surviving Spouse of a Sponsored Member or Retired Member enrolled in ELCA health coverage may elect an ELCA health benefit package which includes Dental Benefits, in accordance with Portico's administrative practices, at his/her own expense during the time period the Surviving Spouse 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.
- An **Eligible Child** who is eligible for and requests enrollment within 60 days of the termination of his/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.

  NOTE: If an Eligible Child is no longer totally and permanently disabled as determined by the Social Security Administration or turns age 26, he/she may continue coverage at his/her own expense for 36 months beginning when he/she is no longer disabled or the first day of the month following the month he/she turns 26.
- An **Eligible Child** of a former spouse of a living or deceased Sponsored Member or Retired Member may continue coverage at his/her own expense until the earlier of:
  - The end of the time period the former spouse 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/her own expense.

  NOTE: If an Eligible Child is no longer totally and permanently disabled as determined by the Social Security Administration or turns age 26, he/she may continue coverage at his/her own expense for 36 months beginning when he/she is no longer disabled or the first day of the month following the month the Eligible Child turns 26.
- An **Eligible Child** of a deceased Sponsored Member, a deceased Retired 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 elect ELCA health

coverage, in accordance with Portico's administrative practices, at his/her own expense as long as he/she is an Eligible Child when coverage is continued.

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

- If a **Sponsored Member** is not eligible to continue coverage, then the Sponsored Member's Eligible Spouse and Eligible Child are not eligible to continue coverage.

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 Account Management Practice.

Section 7 Contributions for Sponsored Members, Coverage Continuation Members, Retired Members and Dependents

A Participating Employer chooses the ELCA-Primary Option for Sponsored Members and determines employer and Sponsored Member contribution rate cost-sharing. Contributions depend on benefits and the cost-sharing chosen by the Participating Employer.

A Participating Employer is responsible for remitting to Portico:

- The Participating Employer and Sponsored Member's cost-sharing portions of the ELCA health coverage contribution for the Sponsored Member, and
- The Participating Employer and Sponsored Member's cost-sharing portions of the ELCA health benefits coverage contributions for an Eligible Spouse 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 take into account factors that affect the cost of coverage including, but not limited to, the Member's age, the Member's gender, claims experience for all Sponsored Members of the Participating Employer or the expected claims experience, the extent that Dependents are enrolled, variations in the level of medical and dental costs by geographic area, and the Member's eligibility for primary medical coverage under Medicare.

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 remitted the full contribution within 60 days after the due date, except that the Sponsored Member may make both the Sponsored Member's and the Participating Employer's contributions 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 the Participating Employer's portion of the contribution, 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 reinstated 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.

Contribution Rates for Coverage Continuation Members, Retired Members and Dependents — The contribution rates for Coverage Continuation Members, Retired Members, and Retired Members' Eligible Spouses 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.

Section 8 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. 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.

- 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

Coverage	**Changing from:** • ELCA-Primary Gold+ Option • ELCA-Primary Platinum+ Option • ELCA-Primary Select Copay Option or • ELCA-Primary Value Copay Option	**Changing to:** • ELCA-Primary Gold+ Option • ELCA-Primary Platinum+ Option • ELCA-Primary Select Copay Option or • ELCA-Primary Value Copay Option
Effect of Changes	• 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, Coinsurance, and Copays, if applicable, 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.	
Coverage	**Changing from:** • ELCA-Primary Gold+ Option • ELCA-Primary Platinum+ Option • ELCA-Primary Select Copay Option or • ELCA-Primary Value Copay Option	**Changing to:** • ELCA-Primary Bronze+ Option or • ELCA-Primary Silver+ Option
Effect of Changes	• 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, Coinsurance, and Copays, if applicable, 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.	

Coverage	**Changing from:** • ELCA-Primary Bronze+ Option or • ELCA-Primary Silver+ Option	**Changing to:** • ELCA-Primary Bronze+ Option or • ELCA-Primary Silver+ Option
Effect of Changes	• 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.	
Coverage	**Changing from:** • ELCA-Primary Bronze+ Option or • ELCA-Primary Silver+ Option	**Changing to:** • ELCA-Primary Gold+ Option • ELCA-Primary Platinum+ Option • ELCA-Primary Select Copay Option or • ELCA-Primary Value Copay Option
Effect of Changes	• 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.	
Coverage	**Changing from:** • ELCA-Primary Option	**Changing to:** • ELCA Medicare-Primary Option
Effect of Changes	The Deductible Amount, Coinsurance and Cost-Shares will not be applied to the new option.	
Coverage	**Changing from:** • ELCA Medicare-Primary Option	**Changing to:** • ELCA-Primary Option
Effect of Changes	The Deductible Amount, Coinsurance and Cost-Shares will not be applied to the new option.	

B. 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.		
Coverage	**Changing from:** • ELCA-Primary Benefits, or • ELCA Medicare-Primary Benefits	**Changing to:** • 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 Plan year if the Member is sponsored by the new Participating Employer and remains eligible for the option.	

C. 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, 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.		
Coverage	**Changing from:** • ELCA-Primary Benefits or • ELCA Medicare-Primary Benefits	**Changing to:** • ELCA-Primary Benefits or • ELCA Medicare-Primary Benefits
Effect of Changes	• A Retired Member or Coverage Continuation Member can elect a different ELCA-Primary Option than originally chosen. Deductible, Coinsurance, Copays, if applicable, and the Prescription Drug 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 non-sponsored Member eligible for Coverage Continuation or Retired Member can elect, for the remainder of the calendar year, a different ELCA Medicare-Primary Option than the ELCA Medicare-Primary Standard Option. Deductible, Coinsurance, Cost-Share and Maximum Out-of-Pocket Amounts will apply to the new ELCA Medicare-Primary Option.	

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, the 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/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):
  - 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 items (1) and (2) above to establish the order of benefits, then the rule set forth in the plan of other group coverage will determine the order of benefits.

- In the case of an Eligible Child whose parents are divorced:
  - 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, then where 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 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 benefit 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 9 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. ELCA-Primary Benefits includes the following benefits:

- Medical and Mental Health Benefits ..... *see Section 11*
- Supporting Services ..... *see Section 13*
- Prescription Drug Benefits ..... *see Section 14*

If Dental Benefits were selected by the Participating Employer, the Sponsored Member can elect or decline Dental Benefits during Annual Enrollment or upon midyear enrollment. A Member enrolled in Dental Benefits may also enroll eligible family members in the Dental Benefits option in which the Member enrolled. A Retired Member or Coverage Continuation Member who is enrolled in the ELCA-Primary health benefits package will have the Enhanced Dental Benefits option.

- Dental Benefits ..... *see Section 12*

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

- ELCA-Primary Platinum+
- ELCA-Primary Gold+
- ELCA-Primary Silver+ (high deductible health plan as defined by the IRS)
- ELCA-Primary Bronze+ (high deductible health plan as defined by the IRS)
- ELCA-Primary Select Copay
- ELCA-Primary Value Copay

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 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 11 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 11, 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 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 for 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 for 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.

Deductibles, Coinsurance and Copays 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, 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, 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+ Option 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 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 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 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, 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 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, 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.

ELCA-Primary Value Copay and Select Copay 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, 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 as shown in the Appendix. The 20% Coinsurance will continue until the In-network Maximum Out-of-Pocket Amount has been reached for the year.
- **Copays**

- The Member will pay the applicable Copay for certain In-Network Eligible Expenses as shown in the Appendix. The Copays 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, 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 Value Copay and Select Copay 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 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 20% Coinsurance for Eligible Expenses that are more than the Out-of-network Deductible Amount as shown in the Appendix. The 20% 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 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.

Section 10 ELCA Medicare-Primary Benefits

Eligibility of ELCA Medicare-Primary Member

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. If a Retired Member and family members should be eligible for Medicare Part A and Part B as primary coverage due to age 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, the Retired Member and family members who are not eligible for Medicare coverage are also not eligible for coverage under this Plan.

A Retired Member and family members who are an 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,
- 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 10*
- Supporting Services .....*Section 13*
- Part D Prescription Drug Benefits.....*Section 14*

If Dental benefits were selected by the Participating Employer, the Sponsored Member can elect or decline Dental Benefits during Annual Enrollment or upon midyear enrollment. A Member enrolled in Dental Benefits may also enroll eligible family members in the Dental Benefits option in which the Member enrolled. A Retired Member or Coverage Continuation Member who is enrolled in the ELCA Medicare-Primary health benefits package will have the Enhanced Dental Benefits option.

- Dental Benefits..... *Section 12*

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 including the Enhanced Dental Benefits option:

- 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 — A Sponsored Member will have the ELCA Medicare-Primary Standard Option.

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

Eligible Spouse 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 the ELCA-Primary Benefits for his or her Dependents who are not eligible for ELCA Medicare-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 Medical Expenses that are incurred while the Member is enrolled with 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 Medicare Advantage Benefit" below) equal to the Deductible Amount, the Member will pay Coinsurance of 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 Hospital and Medical Expenses include:

- **Hospital and Medical Services Covered under Medicare Part A and Part B** — Hospital and medical services covered under Medicare Hospital Insurance (Part A) or Medicare Medical Insurance (Part B), reduced by the amounts paid (or payable) by Medicare.
- **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 11 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:

☑ **ELCA-Primary Members**

☐ **ELCA Medicare-Primary Members**

- 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 11, 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 under 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

Medical and Mental Health Visits

The Plan covers eligible expenses for medically necessary care, including visits and services:

- An **Acupuncture Visit** is an acupuncture services visit performed for treatment of chronic pain lasting 6 months or longer when other treatment has failed, or for nausea associated with surgery, chemotherapy and pregnancy, limited to 12 visits per year.
- A **Chiropractic Visit** means any services provided on the same day by a chiropractor including diagnosis, management, and treatment of musculoskeletal system conditions.
- An **Emergency Room Visit** is a session at an emergency room or observation unit during which the Member receives treatments or services for a medical or mental health emergency.
- **Laboratory Testing** means a medical procedure that involves testing a sample of blood, urine, microbiological cultures, or other substance from the body. A separate copay applies for laboratory testing performed in conjunction with an office visit, urgent care visit, retail clinic visit, specialist visit, chiropractic visit, outpatient mental health or substance use visit, or when billed separately.
- A **Massage Therapy Visit** is any service provided by a licensed massage therapist and massage therapy received from another eligible medical provider, limited to 12 visits per year.
- An **Outpatient Medical Therapy Visit** includes: physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, and pulmonary rehabilitation services provided on the same day in an outpatient setting.
- An **Outpatient Mental Health** means services for a mental health condition provided on one day in an outpatient setting.
- An **Outpatient Substance Use Abuse Visit** means services for a substance use condition provided on one day in an outpatient setting.
- A **Primary Care Provider Office Visit** is an office visit with a general practice, family practice, internal medicine, obstetrics/gynecology or pediatrics provider.
- A **Retail Health Clinic Visit** is a session at a clinic located in a retail establishment or worksite during which medical services are provided for a limited list of eligible symptoms (e.g., sore throat, cold).
- A **Specialist Office Visit** is an office visit for diagnosis, management or treatment with a provider who provides specialized services and limits his or her practice to a particular branch of medicine or group of patients.
- A **Telemedicine Provider Visit** is a medical and mental health treatment or services using text, video and audio features on a computer, smartphone, or tablet that connect a Member with licensed providers offering telemedicine visits through a telemedicine company, where permitted by state law. Expenses for a Telemedicine Provider Visit are Eligible Expenses only if the telemedicine visit is provided by an In-network Medical and Mental Health telemedicine provider.
- An **Urgent Care Visit** is a session at an urgent care center or clinic during which the Member receives treatments or services for which the provider bills an urgent care visit.
- **X-rays and Imaging** means diagnostic x-rays, MRI/MRA, CT/CTA scans, PET scans. Deductible and Coinsurance apply for x-rays and imaging performed in conjunction with an office visit, urgent care visit, retail clinic visit, specialist visit, chiropractic visit, outpatient mental health or substance use visit, or when billed separately.

Outpatient care is care billed by the provider as an outpatient service, including ambulatory surgery centers. Inpatient care is care billed by the provider as an inpatient service.

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.

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 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 9.

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 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 below one time per year, in accordance with Preventive Services and Certain Other Services in Section 9. 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 9.

• 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 Services and Certain Other Services in accordance with Section 9.

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: • 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	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: • 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: • to the nearest hospital with adequate facilities is to be considered an Eligible Medical Expense when the patient's condition requires treatment and facilities are not available at the hospital where he/she is confined; • 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 9.
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	by a home hospice care agency if approved in advance by Care Coordinator: • 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 enrolled in Dental Benefits 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: • 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: • 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: • 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
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
Autism spectrum disorder	Medically Necessary treatment and services if approved in advance by Care Coordinator
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	• 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 or investigational	as determined by the Medical and Mental Health Benefits Administrator or the Care Coordinator.
Treatment that: • is not provided or prescribed by an Eligible Medical Provider, • that is provided or prescribed outside of a 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"
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 9 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, 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.
  - In a halfway house that is licensed for mental health/substance abuse services by the state where the care is provided if it (i) includes out-patient individual, group and family treatment, and (ii) 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 (i) 24/7 on-call medical availability, and (ii) 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 determine are Medically Necessary.

Exclusions from Eligible Mental Health Expenses

The Medical and Dental Benefits Plan does not cover 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.
- 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 provided 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 Expense or Eligible Prescription Drug Expense.

Medical and Mental Health Precertification and Medical Necessity 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 15.

  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 15.
- 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 12 Dental Benefits and Expenses

A Sponsored Member who is eligible for ELCA-Primary Benefits or ELCA Medicare-Primary Benefits will be provided Dental Benefits if the Participating Employer selected Dental Benefits and the Member enrolled in either the Enhanced or Basic Dental Benefits option.

☑ **ELCA-Primary Members**

☑ **ELCA Medicare-Primary Members**

A Member enrolled in Dental Benefits may enroll eligible family members in the Dental Benefits option in which the Member enrolled. A Retired Member or Coverage Continuation Member who is enrolled in the ELCA-Primary or ELCA Medicare-Primary health benefits package will have the Enhanced Dental Benefits option.

Except for the Enhanced and Basic Option 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.

The following Dental Benefits options are provided under the Plan:

- Enhanced Dental Benefits Option
- Basic Dental Benefits Option

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. Enhanced and Basic Option Dental Deductible Amounts for the Member and individual covered 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 Enhanced and Basic Option annual limits.

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, and
- 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
- Except for Eligible Preventive Dental Expenses, the expenses are Medically Necessary.

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. There is no age limit for orthodontia treatment for Members enrolled in the Enhanced Option. Orthodontia expenses are only covered for Members and covered family members, age 18 and younger, who are enrolled in the Basic Option.

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.
  - Orthodontia treatment for Members older than age eighteen (18) who are enrolled in the Basic Option.

- Inpatient and outpatient hospital expenses.

Section 13 Supporting Services

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

☑ **ELCA-Primary Members**

☑ **ELCA Medicare-Primary Members**

Based on the Member's health insurance enrollment option, the following are the 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 Aid Discount Program
- SilverSneakers® Fitness Program
- Extra Health and Wellness Benefits

Section 14 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 The Prescription Drug Benefit provides reimbursement for Eligible Prescription Drug Expenses. This Plan will pay for Eligible Prescription Drugs, subject to the Plan's Copayments Cost-Share and limitations by the Prescription Drug Benefits Administrator to ensure Medical Necessity and appropriate use.	
The following Members will have the ELCA Prescription Drug Benefit:	• Members and their Dependents who have ELCA-Primary Benefits.
ELCA Prescription Drug Benefit, eligible expenses:	• 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; and • 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 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.	
The following Members will have the ELCA Part D Prescription Drug Benefit:	• Retired Members and Sponsored 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 their family members who have ELCA Medicare-Primary Benefits and who live in the United States or Puerto Rico.
Under the ELCA Part D Prescription Drug Benefit, eligible expenses are:	• 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; and • 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.

Exclusions 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 **ELCA Medicare-Primary Benefits** **ELCA Part D Prescription Drug Benefit**
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: • Participating Retail Pharmacy, • Specialty Drug Pharmacy, or • Prescription Drug Mail Order Pharmacy. See the Appendix for the Part D Prescription 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.

Prescription Drug Cost-Share

ELCA-Primary Benefits

ELCA-Primary Gold+ , Platinum+, Value Copay or Select Copay Options

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, and Eligible Children equal the Maximum Out-of-Pocket Amount for In-network family coverage.
- 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 and Eligible Children equal the Maximum Out-of-Pocket Amount for the Out-of-network family coverage.

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+ and Silver+ Options

ELCA Prescription Drug Benefit

The Member is responsible for the Eligible Medical, Mental Health and Prescription Drug Deductible Amount and 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; or
- 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 15 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. The external independent review will be with an organization contracted to perform independent reviews and to provide 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 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 member 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 and member eligibility, 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 ELCA 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 16 Miscellaneous Provisions, Disclosures and Benefit Notices

Adjustment of Certain Amounts Related to Benefits

Certain Copays, Coinsurance, 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, are 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, and marital 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 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 benefits payment 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.

Portico is Not a Party to Contract Between an Employer and an 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 must 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 *ttps://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). Forms: *http://www.hhs.gov/ocr/office/file/index.htm*.

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 17 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, and
- 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, and
- 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 18 Personal Wellness Account

The Personal Wellness Account (PWA) is a health reimbursement arrangement into which eligible Health Plan members and spouses 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, 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, or
- A Sponsored Member, Retired Member, Coverage Continuation Member Eligible Spouse, 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 or if the Participating Employer's PWA contribution is approved by Portico. Participating Employers may make contributions to Personal Wellness Account 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.
- Reimbursed only 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.

NOTE: 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 15.

Termination of ELCA-Primary Benefits — If ELCA-Primary Benefits coverage is terminated, there will not be any further credits to the Member's Personal Wellness Account. 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, 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 19 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 Advantage 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 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.

Copay
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 under Code §107.

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

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.

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 11 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

Coverage that satisfies the waiver of health coverage requirements under this Plan and is:

- 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,
    - A Retired Member or his/her Eligible Spouse,
    - 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 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 11 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, exception 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, or the authorized extension(s) 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. However, 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 20 Vision Care Services

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 whose Employer has elected to offer this benefit. 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 9 and Section 10. 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 Flexible 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 Sponsored 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 Flexible Benefits Program by an Eligible Employer, is not eligible for ELCA-Primary or ELCA Medicare-Primary Health Benefits, has terminated employment, has retired, 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 Member who declines enrollment for himself or herself in Vision Care Services at Annual Enrollment or when initially sponsored in the Flexible 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 Flexible 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 Sponsored Member can add Vision Care Services for a Dependent if the Sponsored Member is already enrolled in Vision Care Services;
- If a Sponsored Member marries, the Sponsored Member can add Vision Care Services for the Eligible Spouse if the Sponsored Member is already enrolled in Vision Care Services;
- If a Sponsored Member divorces or has legal separation from his or her spouse, the Sponsored Member can terminate Vision Care Services for his or her spouse;
- If a Sponsored Member's Dependent dies, the Sponsored 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 Sponsored 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.

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

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

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

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 copayments, 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

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 MN)

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

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

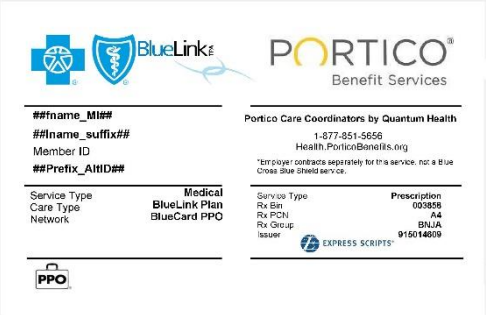
Tivity Health

SilverSneakers® Fitness Program
Contact Healthways 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

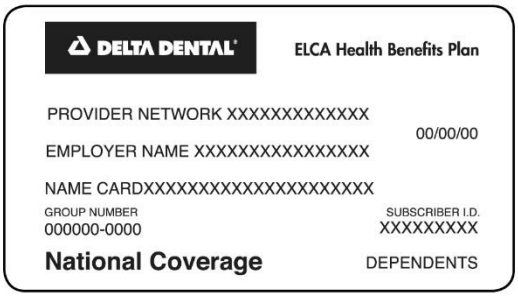
ELCA-Primary Medical and Mental Health Benefits are administered by BlueLink. Show your Portico Health ID card to your medical or mental health care providers. Contact Care Coordinators at **877.851.5656** if you need additional identification cards.



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.

(See Portico Health ID card above)

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.

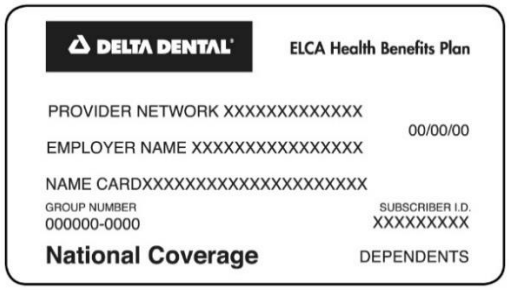


The Further debit card is a convenient way to pay for eligible health care expenses from a personal wellness account, health flexible spending account (FSA), limited-purpose health FSA, or health savings account (HSA). Contact Further at **800.859.2144** or visit *hellofurther.com*.

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-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
	Select Copay Option		
	• Per Individual	$1,500	$2,250
	• Member/spouse, Member/children, and Member/spouse/child(ren)	$3,000	$4,500
	Value Copay Option		
	• Per Individual	$2,500	$3,750
	• Member/spouse, Member/children, and Member/spouse/child(ren)	$5,000	$7,500
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 (Copay)		2022
Section 10	**Eligible Medical and Mental Health Expenses**	**In-Network Copay**
	Select Copay Option	
	• Retail Health Clinic Visit	$10
	• Telemedicine Provider Visit	$10
	• Primary Care Provider Office Visit	$25
	• Specialist Office Visit	$50
	• Chiropractic Visit	$50
	• Laboratory Exams and Testing	$75
	• Outpatient Medical Therapy Visit	$30
	• Massage Therapy, Acupuncture Visits	$30
	• Outpatient Mental Health Visit	$25
	• Outpatient Substance Use Visit	$25
	• Urgent Care Visit[1]	$50
	• Emergency Room Visit[1]	$300 copay, waived if admitted
	Value Copay Option	
	• Retail Health Clinic Visit	$10
	• Telemedicine Provider Visit	$10
	• Primary Care Provider Office Visit	$35
	• Specialist Office Visit	$70
	• Chiropractic Visit	$70
	• Laboratory Exams and Testing	$125
	• Outpatient Medical Therapy Visit	$50
	• Massage Therapy, Acupuncture Visits	$50
	• Outpatient Mental Health Visit	$35
	• Outpatient Substance Use Visit	$35
	• Urgent Care Visit[1]	$70

[1] Copay also applies to Out-of-network visit.

NOTE: For retail health visit, telemedicine visit, primary care visit, specialist visit, chiropractic visit, outpatient mental health or substance use visit, and urgent care visit, deductible and coinsurance apply to x-rays and imaging performed in conjunction with such visits; a separate lab exam/testing copay will apply to lab work performed in conjunction with such visits.

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%
	Select Copay Option		
	• Per Individual	20%	20%
	• Member/spouse and Member/spouse/child(ren)	20%	20%
	Value Copay Option		
	• Per Individual	20%	20%
	• Member/spouse, Member/children, and Member/spouse/child(ren)	20%	20%
	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
	Select Copay Option		
	• Per Individual	$6,000	$6,000
	• Member/spouse, Member/children, and Member/spouse/child(ren)	$12,000	$12,000
	Value Copay Option		
	• Per Individual	$6,000	$6,000
	• Member/spouse, Member/children, and Member/spouse/child(ren)	$12,000	$12,000
	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 theUnited 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	Flexible Benefits Program Dental Deductible and Limits		
		2022	
Section 13	**Basic Services and Major Restorative Care**	**Basic Option Deductible**	**Enhanced Option Deductible**
	• Per individual	$50	$150
	• Family Maximum	$150	$300
Section 13	**Eligible Dental Benefits Expenses**	**Reimbursement Limits**	**Reimbursement Limits**
	• Annual Limit Eligible Preventive, Basic and Major Restorative Dental Expenses, per individual	$1,000	$2,850
	• Lifetime Limit Eligible Orthodontia Expenses, per individual	$1,000*	$2,850
*Coverage for Dependents 18 and younger only.			

ELCA-Primary ELCA Medicare-Primary	Flexible Benefits Programs 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, Select Copay Option and Value Copay 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

EFFECTIVE DATE:
01/01/2022

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

BENEFIT	DESCRIPTION	COPAY
WellVision Exam	• Focuses on your eyes and overall wellness • Every calendar year	$0
Routine Retinal Screening	• Routine retinal screening as an enhancement to a WellVision Exam	No more than $39
CORRECTIVE VISION		
Frame	• $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	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children • Every calendar year	
Lens Enhancements	• 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)	• $150 allowance for contacts (copay does not apply) • Contact lens exam (fitting and evaluation) • Every calendar year	Up to $45
Primary Eyecare™	• $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	• 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	• 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.		
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.		

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

* 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.

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