

CHURCHWIDE ASSEMBLY ASSIGNMENTS
ELCA Church Council Members
2013 Churchwide Assembly
Pittsburgh, Pennsylvania

Memorials Committee

Susan McArver co-chair
Stephen Herr, co-chair
Mark Johnson
Laurie Skow-Anderson

Committee for Reference and Counsel

Bill Horne, co-chair
Louise Hemstead, co-chair
Paul Archer
Vicki Garber

Ad-hoc Committee: Social Statement on Criminal Justice

Previous assemblies have permitted the presiding bishop, in accordance with the Rules of Procedure, to name members to “ad hoc” committees to receive and process any amendments proposed to items on the assembly agenda. The members of this committee work in consultation with the Committee of Reference and Counsel and with voting members who have brought amendments for consideration by the assembly to bring a report and recommendations to the assembly regarding implementation of the amendments.

CC Program and Services Committee

Yvonne Marshall
Jack Munday, chair
Pamela Pritt

Conference of Bishops

Julian Gordy

Theological Discernment Staff

Marcus Kunz
Roger Willer

Social Statement Task Force

Cynthia Osborne

Hearings

Hearings will be held on Tuesday, August 13. There are two sessions. It is the responsibility of the chair to introduce the staff and any resource persons present and to facilitate the discussion. In all instances, there will be one or more resource persons who are responsible for answers. Please start the hearing promptly so that the hour can be used efficiently. Since the hearings are not legislative, no action will be forthcoming. It is wise to establish guidelines for discussion, including a two-minute time limit on

speeches. According to the rules of the assembly, persons with voice include: voting members, advisory members, resource persons, and official visitors. Other guests may attend *only if space permits*, but have no voice.

Recorders are responsible for recording the tone of the meeting, the approximate number of persons present, and any helpful ideas that come forward. The informal report can be turned in to Carlos Peña at his place in the plenary hall. Handwritten notes are fine.

Session I: Tuesday, August 13 (5:00 – 6:00 p.m.)

25th Anniversary Campaign

Chair: Louise Hemstead
Recorder: Vicki Garber
Resource people: Christina Jackson-Skelton

Budget

Chair: John Emery
Recorder: Gary Gabrielson
Resource People: Linda Norman, Wyvetta Bullock, Gary Brugh

Social Statement on Criminal Justice

Chair: Jack Munday
Recorder: Nick Barber
Resource People: Marcus Kunz, Roger Willer and David Frederickson

World Hunger

Chair: Phil Wold
Recorder: Mark Myers
Resource People: Daniel Rift

Healthcare Reform – Portico

Chair: Mark Johnson
Recorder: John Pederson
Resource People: Jeff Thiemann

Session II: Tuesday, August 13 (7:00 – 8:00 p.m.)

25th Anniversary Campaign

Chair: Louise Hemstead
Recorder: Vicki Garber
Resource people: Christina Jackson-Skelton

Healthcare Reform – Portico

Chair: Mark Johnson
Recorder: John Pederson
Resource People: Jeff Thiemann

Social Concerns Review

Chair: Becky Brakke
Recorder: Yvonne Marshall
Resource People: Marcus Kunz and Kit Kleinhans

LIFT: Congregational Mission Planning

Chair: Deb Chenoweth
Recorder: Stephen Herr
Resource People: Wyvetta Bullock, Bill Horne, Karl Reko and Amy Walter Peterson

Women and Justice social statement listening event

Chair: Pamela Pritt
Recorder: Robert Moore
Resource People: Roger Willer, Mary Streufert

ELCA Malaria Campaign

Chair: Elizabeth Ekdale
Recorder: Raymond Miller
Resource People: Jessica Nipp Hacker, Elizabeth Eaton and Dan Rift

Communal Discernment

Chair: Susan Langhauser
Recorder: Kathryn Tiede
Resource People: TBD

Officers' Elections: Hosts

Church Council members are assigned to accompany nominees for presiding bishop and secretary. Their role is to:

- Be aware of and provide information about process, scheduling, and details related to the election of the presiding bishop.
- Be available to answer questions, run errands, seek information, and accompany the nominee, as desired.
- Express gratitude on behalf of the Church Council to nominees who do not continue on succeeding ballots.
- Letty Villalon will conduct an orientation session with the officers' elections hosts on Monday, August 12.

Presiding Bishop Hosts*

Nominee 1	Christine Connell
Nominee 2	Susan McArver
Nominee 3	Rachel Connelly
Nominee 4	Laurie Skow-Anderson
Nominee 5	Marjorie Ellis
Nominee 6	Paul Archer

Nominee 7	Bill Horne
Nominee 8	Marit Bakken (possible alternate)
Nominee 9	Gary Gabrielson (possible alternate)

*Secretary Hosts**

Nominee 1	Kathryn Tiede
Nominee 2	Karin Graddy
Nominee 3	Raymond Miller
Nominee 4	Mark Myers
Nominee 5	John Pederson
Nominee 6	Phil Wold
Nominee 7	Becky Brakke
Nominee 8	Feronika Raming (possible alternate)
Nominee 9	Nick Barber (possible alternate)

* Based on vote totals for the second ballot

Presiding Bishop Officer Election Process

Two chaplains, Pr. Bill Diehm and Pr. Sandy Kessinger, will be present to pray and be of pastoral support for the nominees as we go through the election process. According to Part 16, people will submit questions for the question and answer forums for the election of the presiding bishop. By Tuesday, August 13, the Executive Committee will select questions from those received.

The nominees schedule is as follows:

- Biographical information and disclosure forms need to be collected and received by the seven nominees on Tuesday, August 13 by 8 p.m. Our preference is to receive the biographical information form electronically. Other forms will need to be received as a hard copy because of the confidentiality and the necessity of a wet signature on the form. All forms should be delivered to Letty Villalon, ELCA Director, Human Resources and Staffing, letty.villalon@elca.org. She will be present at CWA.
- A rehearsal for the nominees will likely be scheduled for Wednesday morning, August 14.
- Nominees Forum for Presiding Bishop (Plenary Session Four, Wednesday morning, August 14) will occur prior to the third ballot.
- Speeches will be given immediately following the first Q&A.
- The second question and answer forum with Nominees for Presiding Bishop (Plenary Session Five, Wednesday afternoon, August 14) will also be moderated by Vice President Peña. The questions will be randomly selected by the Executive Committee and may be chosen from the questions previously submitted by the voting members. They may be revised to reflect current issues or concerns.

Secretary Officer Election Process

Pr. Bill Diehm and Pr. Sandy Kessinger will also be present to pray and be of pastoral support for the secretary nominees.

Currently, the nominees schedule is as follows:

- Biographical information and disclosure forms need to be collected and received by the seven nominees on Thursday, August 15 by 8 p.m. Our preference is to receive the biographical information form electronically. Other forms will need to be received as a hard copy because of the

confidentiality and the necessity of a wet signature on the form. All forms should be delivered to Letty Villalon, ELCA Director, Human Resources and Staffing, letty.villalon@elca.org. She will be present at CWA.

- Question and Answer Forum for Secretary Nominees (Plenary Session Nine, Friday morning, August 16) will be moderated by a person to be named by Vice President Peña. The questions will be based upon the 2007 questions for secretary, but will be revised by the Executive Committee to reflect the responsibilities of the Office of the Secretary. They may also be revised to reflect current issues or concerns.
- Speeches by the top 3 nominees (including ties) will be held Plenary Session Eight, Friday afternoon, August 16.

Prayers at the Beginning and Closing of Sessions

Church Council members in their last term on the Council normally have been invited to lead these brief times for singing and prayer. The persons planning worship will select a hymn and write a brief prayer to be read by the council member. Prior to each prayer, Bishop Hanson will light a candle and ring a bell, inviting the assembly to a time of silence.

There will be a brief rehearsal during the pre-assembly Church Council meeting. If you have questions, please contact Scott Weidler (773-380-2554).

Monday, August 12 Plenary 1 (5:45p.m.)

Hymn and Prayer Rebecca Jo Brakke

Tuesday, August 13 Plenary 2 (8:00 a.m.)

Morning Prayer

Rachel Connelly

Plenary 2 (10:25 a.m.) Closing Prayer

Rachel Connelly

Plenary 3 (3:55 p.m.) Hymn and Prayer

Raymond Miller

Wednesday, August 14 Plenary 4 (8:00 a.m.)

Morning Prayer

Susan Langhauser

Plenary 4 (10:25 a.m.) Closing Prayer

Susan Langhauser

Plenary 5 (5:55 p.m.) Hymn and Prayer

Mark Johnson

Thursday, August 15 Plenary 6 (8:00 a.m.)

Morning Prayer

Phil Wold

Plenary 6 (10:25 a.m.) Closing Prayer

Phil Wold

Plenary 7 (5:40 p.m.) Hymn and Prayer

Becky Brakke

Friday, August 16 Plenary 8 (8:00 a.m.)

Morning Prayer
Jack Munday
Plenary 8 (10:25 a.m.) Closing Prayer
Jack Munday
Plenary 9 (5:40 p.m.) Hymn and Prayer
John Emery

Saturday, August 13 Plenary 10 (8:30 a.m.)

Morning Prayer
Deb Chenoweth
Plenary 10 (10:25 a.m.) Closing Prayer
Mark Myers

Prayer Team

The Churchwide Assembly “prayer team” is prepared to pray periodically throughout the assembly, particularly before major votes. The team will include synod bishops, synod vice presidents, and members of the Church Council. The Prayer Team consists of the following people:

Church Council

Paul Archer
Rebecca Jo Brakke
Rachel Connelly
John Emery
Vicki Garber
Raymond Miller
Robert Moore
John Munday
Philip Wold

Conference of Bishops

Elizabeth Eaton
Marie Jerge
Ralph Jones
Felipe Lozada-Montañez

Synod Vice Presidents

Albert Asfour
Melba Bangert

Revised August 6, 2013

Church Council Ready Bench (New since July 11, 2013 Church Council meeting)

The following is a list of "ready bench" council members who can respond to questions or concerns from Churchwide Assembly voting members on the following topics.

Budget	John Emery
LIFT II	Deb Chenoweth
Criminal Justice Social Statement	Jack Munday
Justice for Women Social Statement	Robert Moore and Pamela Pritt
ELCA Malaria Campaign	Elizabeth Ekdale
25th Anniversary Campaign	Louise Hemstead and Bill Horne
Communal Discernment	Susan Langhauser
Healthcare	Paul Archer

EVANGELICAL LUTHERAN CHURCH IN AMERICA
CHURCH COUNCIL
August 11, 2013
Exhibit A
Page 8

This page left intentionally blank

En Bloc Items

I. Church Council Items

I.A Authorization of Executive Committee

At its pre-council meeting on August 11, the Executive Committee considered how the functions of the Executive Committee will be carried out between the Churchwide Assembly in August 2013 and the first regular meeting of the newly constituted Church Council in November 2013.

To facilitate the work of the Executive Committee between regular meetings by ensuring input and perspective from each of its standing committees, the chairs of the committees will be elected to the Executive Committee. Four committee chairs were elected in April 2013 and will serve as members of the Executive Committee: Louise Hemstead, Budget and Finance Committee; Raymond Miller, Legal and Constitutional Review Committee; Bill Horne, Planning and Evaluation Committee; and Susan McArver, Program and Services Committee.

Additional at-large members will be elected at the November 2013 Church Council meeting.

CC ACTION [EN BLOC]

Recommended:

To authorize the continuing members of the Executive Committee to serve as the Executive Committee of the Church Council between the close of the Churchwide Assembly on August 17, 2013 and the November 2013 meeting of the Church Council; and

To declare that the newly elected chairs of the Budget and Finance Committee, the Legal and Constitutional Review Committee, the Planning and Evaluation Committee, and the Program and Services committee shall be members of the Executive Committee of the Church Council beginning at the close of the Churchwide Assembly on August 17, 2013.

I.B Ratification of Church Council Committees

In preparation for the August 2013 meeting of the ELCA Church Council, continuing members of the Church Council were invited to indicate their preferences for service on one of the four standing committees of the Church Council, plus the Board Development Committee: Budget and Finance; Legal and Constitutional Review; Planning and Evaluation; and Program and Services. At its August 2013 meeting, the Church Council will ratify the provisional membership for the four standing committees.

Following the elections at the Churchwide Assembly, newly elected members will indicate their preferences prior to the November 2013 meeting. A final listing of committee membership for the time period until the 2016 Churchwide Assembly will be ratified by the Church Council at its November 2013 meeting upon recommendation by the Executive Committee.

At its November 2013 meeting, the Church Council also will appoint members to related advisory committees for the time period until the 2016 Churchwide Assembly. Members of the Board Development Committee also will be appointed by the Executive Committee in November 2013.

CC ACTION [EN BLOC]

Recommended:

To ratify the following appointments of continuing members of the ELCA Church Council to Church Council committees for the 2013–2016 time period:

Budget and Finance Committee: Elizabeth Ekdale; Gary Gabrielson; Vicki Garber; and Louise Hemstead (chair);

Legal and Constitutional Review Committee: Marjorie Ellis; Stephen Herr; Raymond Miller (chair); and Robert Moore;

Planning and Evaluation Committee: Marit Bakken; Christine Connell; Amsalu Geleta; William Horne (chair); John Pederson; and Feronika Raming;

Program and Services Committee: Paul Archer; Nicholas Barber; Jessica Crist; Yvonne Marshall; Susan McArver (chair); Pamela Pritt; Laurie Skow-Anderson; and Kathryn Tiede.

II. Nominating Committee

In preparation for each Churchwide Assembly, the Church Council places in nomination the names of two people for each position on the Nominating Committee to be elected by the Churchwide Assembly. At its July 2013 meeting, the Church Council restricted the tickets to the following: clergy [four positions]; lay female [two positions, including one restricted to youth/young adult]; and lay male [two positions, including one restricted to person of color/language other than English]. Since the July meeting, one person has decided to remove his name from the ticket. A replacement for one of the lay male positions is put forward here.

Biographical information is provided in Exhibit C.

CC ACTION [EN BLOC]

Recommended:

To receive the written report of the Office of the Secretary on nominees for the churchwide Nominating Committee;

To note that bylaw 19.21.01. states in regard to the Nominating Committee: “The Church Council shall place in nomination the names of two persons for each position. The committee shall consist of at least one member but no more than three members from any region. Nominations from the floor shall be permitted, but each floor nomination shall be presented as an alternative to a specific category named by the Church Council and shall therefore meet the same criteria as the persons against whom the nominee is nominated. In the materials provided in advance to each member of the assembly, the Church Council shall set forth the criteria applicable to each category that must be met by persons nominated from the floor”; and

To request that the Church Council transmit the following replacement to the slate of nominees previously forwarded to the 2013 Churchwide Assembly:

CHURCHWIDE NOMINATING COMMITTEE

Lay Male

A. Mr. Brandon Graves (to replace the resignation of Mr. David Hawkins)

B. Mr. Jordan Krey

**This Exhibit included
personal information
provided solely to the
Church Council for its
deliberations.**



Evangelical Lutheran Church in America

God's work. Our hands.

ELCA PHILOSOPHY OF BENEFITS

INTRODUCTION

Since the inception of the Evangelical Lutheran Church in America (ELCA), the health and well-being of ordained ministers, rostered lay leaders, and other lay employees have been underlying priorities of this whole church and a principal focus of the work of Portico Benefit Services, a ministry of the ELCA, (Portico) (formerly known as the Board of Pensions of the ELCA). These priorities carry with them a foundation in the theology of this church, a legacy from predecessor church bodies, and a history involving the evolution of benefit programs. In an effort to identify foundational principles undergirding its benefit programs and to recognize changes in this church and in society, the Board of Pensions in 2004 approved an ELCA Philosophy of Benefits Report. Since then even more dramatic changes have occurred, and Portico has revisited and revised the ELCA Philosophy of Benefits to reflect these new realities.

The ELCA Philosophy of Benefits consists of four interrelated parts:

- Introduction
- Statement of Purpose
- Guiding Principles
- History and Context

The ELCA Philosophy of Benefits is intended to inform and assist all expressions of this church and related institutions and agencies (including social ministry organizations, seminaries, colleges, universities, and separately incorporated ministries) as they evaluate and implement benefit programs – both those provided by Portico and others – from the perspective of the sponsoring organization and the plan participant. The Guiding Principles are intended as just that – they are *not* mandated requirements, but principles that recognize the importance of benefits to the health and wellness of this whole church and its leaders.

STATEMENT OF PURPOSE

“The Church is a people created by God in Christ, empowered by the Holy Spirit, called and sent to bear witness to God’s creative, redeeming, and sanctifying activity in the world.”¹ To participate in God’s mission, the ELCA engages in ministry that includes calling forth, equipping, and supporting rostered leaders and others for service in this church and related institutions. As part of its ministry, the ELCA is committed to seek a sufficient, sustainable livelihood for all and believes that employers have a responsibility to treat employees with dignity and respect. These basic principles should be reflected in employees’ remuneration, including benefits.² This church also believes that “health is central to our well-being, vital to relationships, and helps us live out our vocations in family, work, and community.”³ Thus, this

¹ ELCA constitutional provision 4.01.

² ELCA Social Statement, “Sufficient, Sustainable Livelihood for All”, p. 9.

³ ELCA Social Statement, “Caring for Health: Our Shared Endeavor”, p. 1.

church is committed to the principle that “healthy leaders enhance lives” and the recognition that benefits are an investment in the ministry of this church.⁴ Therefore, ELCA congregations, synods, the churchwide organization, and related institutions and agencies are called upon to provide rostered church leaders (both clergy and lay) and lay employees with health, retirement, disability, death, and other benefits that will enhance health and well-being and protect employees and their families against significant financial loss.

In implementing this Philosophy of Benefits, the design and administration of benefit programs should respond to changing societal and economic realities affecting the ministry of this church, as well as national trends in financial markets, the cost and delivery of medical care and other benefits, and the regulatory landscape. Benefits also should be administered efficiently in order to both enhance the well-being of rostered leaders and lay employees and capture value and savings where possible. At the same time, rostered leaders and lay employees are stewards of benefits provided to them and are called upon to use them wisely to improve their health and well-being for the sake of ministry.

Portico, a separately incorporated ministry of the ELCA, has the responsibility “to provide church retirement and other benefit plans.”⁵ These plans and all benefits provided to rostered leaders and lay employees should reflect the ELCA Philosophy of Benefits.

GUIDING PRINCIPLES

1. Benefits are an investment in God’s ministry as carried out through the lives of rostered leaders and lay employees.
 - Healthy pastors, diaconal ministers, associates in ministry, deaconesses, and other lay employees contribute constructively to healthy congregational life and ministry in this church. Healthy leaders with adequate benefits are an asset to this whole church.
 - This church is in partnership with those who carry out its work and is committed to “compensate all people we call or employ at an amount sufficient for them to live in dignity”⁶ during their working lifetime. This commitment to dignity continues into retirement.
2. Benefits should support and enhance the unique needs of this church.
 - It is important that rostered leaders are able to respond to the call of God in their lives wherever they are located. As a result, to the extent reasonably possible, benefits should be designed and administered to facilitate the call process.
 - Mobility is facilitated when the person responding to a call knows what his/her benefits will be and how they will be provided.

⁴ In this context, “health” includes not only physical well-being, but also social/interpersonal well-being, emotional well-being, intellectual well-being, spiritual well-being, and financial well-being. The ELCA Philosophy of Benefits recognizes that appropriately designed and administered benefits programs facilitate health and wellness of the whole person.

⁵ ELCA constitutional provision 17.20.

⁶ ELCA Social Statement, “Sufficient, Sustainable Livelihood for All”, p. 10.

- By providing benefit plans that operate consistently on a national scope, the ELCA, through Portico, helps those responding to a call from a different geographical area and provides consistency in the design and administration of plan characteristics.
3. Benefits should include retirement, health, disability, death, and other benefits, and be available to rostered leaders and lay employees.
 - Benefit plans should seek to guard against significant loss, recognizing that no benefit program can provide complete protection against all risks and negative financial outcomes.
 - Other benefits may be provided by employers, consistent with the letters of call, terms of employment, and these guiding principles.
 - Part-time employment is a reality in many contexts and poses challenges in the provision of benefits. If full benefits cannot be provided, benefit options should be negotiated and adjusted fairly to recognize the needs of both the employer and the rostered leader or lay employee.
 4. Benefits should include coverage for the immediate family members of rostered leaders and lay employees.
 - Healthy leaders -- both rostered and lay -- presuppose healthy families.
 5. Retirement, health, disability, death, and other benefit plans should be bundled.
 - A “bundled” approach involves providing a program of benefits, including retirement, health, disability, death, and other benefits, as an integrated package; a bundled approach helps to ensure that rostered leaders and lay employees are protected against significant financial loss from a variety of risks.
 - A bundled approach provided by Portico enhances mobility by providing consistency across this church.
 - A bundled approach also protects the financial integrity and viability of the health and other benefit plans.
 - In some circumstances, health coverage may be waived. Such waivers should occur based upon informed choice and consistent with the other guiding principles, particularly principles 3 and 4.
 6. Employers and plan members should share the cost of retirement, health, and other benefits.
 - Although employers are expected to pay the majority of benefit costs through plan contributions, plan members are expected to participate in the benefit costs through plan design and features.
 - Plan members are encouraged to take an active stewardship role in managing their financial well-being by contributing their own funds, in addition to those contributed by the employer, toward accumulating retirement income.
 - Both employers and plan members should take into consideration and balance their respective needs with regard to the ministry and health and wellness of covered individuals and this church.

7. Plan design and features should provide flexibility and options which recognize both the needs of the employer and plan members.
 - The overall goal of this church's benefits program "is to provide adequate coverage for all employees within a cost structure that is manageable by congregations and other employers."⁷
 - Although plan design and features should provide flexibility, they should be consistent with these guiding principles and not be used to achieve savings by simply shifting benefit costs to employees.
 - A call to rostered leaders and terms of employment for lay employees should include other benefits (such as vacation and continuing education) consistent with synod or other applicable guidelines.

8. Pricing for health, disability, death, and other benefits should reflect both the community nature of the plans as well as risk variation among plan members.
 - Pricing for health, disability, death, and other benefits should directly reflect the benefit costs (claims and administration) incurred by plan members. By pooling these costs, Portico enables both large and small employers to benefit from the more stable experience of a large group.
 - Pricing should be sufficient to pay plan benefits and expenses and to maintain an appropriate level of plan surplus.
 - Benefit costs generally vary by the risk characteristics of plan members, such as age, family size, and geographic location. It may be necessary to reflect these variations in the plan pricing schedules.

9. Benefits should be communicated to employers and plan members in an understandable and timely manner.
 - An understanding regarding coverages and options is important for both employers and plan members to make informed choices and to evaluate how benefits contribute to furthering member health and well-being.
 - Benefit changes should be clearly communicated so that plan members have an opportunity to acknowledge, ask questions, and adapt to the changes.
 - Employers and plan members should avail themselves of opportunities to obtain information about benefits in order to understand and utilize them in a manner that practices good stewardship and enhances health and well-being.

10. Benefit plans should be administered efficiently in order to achieve savings where possible.
 - Professional skills should be employed to design and implement efficient benefit plans consistent with legal requirements and competitive with the marketplace.
 - Professional skills should be employed in contracting with qualified external administrative partners and providers who deliver services efficiently and consistent with the values of the ELCA.
 - The ELCA should explore partnering with other churches when beneficial, forming purchasing coalitions to obtain best market administrative pricing. When mutually

⁷ Report and Recommendations of the Commission for a New Lutheran Church, June 25, 1986, p. 178

beneficial to all parties, the ELCA should offer benefits to other faith based organizations, thereby helping to manage its administrative effectiveness.

HISTORY AND CONTEXT

The historic record of Lutherans in the United States reflects a commitment to the compassionate care of clergy and lay employees through the provision of benefit programs. These programs evolved over time. In the earliest days, benefits focused primarily on the financial needs of elderly clergy who were no longer able to serve, as well as widows and orphans of deceased clergy. Subsequently, benefits evolved into a package of health, disability, survivor, retirement, as well as other benefits that are in place today in the ELCA. In order to provide context for the updated ELCA Philosophy of Benefits, it is useful to review the evolution of benefit programs and the current context in this church and society as a whole.

A. The Legacy

The ELCA Philosophy of Benefits is rooted in the legacy of ELCA predecessor church bodies. This legacy evolved in a number of stages.⁸

The first stage involved developing funded programs of retirement benefits for clergy and their spouses to replace aid to needy pastors. To achieve this goal, predecessor church bodies adopted defined contribution plans. These plans reflected the principle that seeking to meet a pastor's need for income in retirement was not an act of charity, but rather a benefit that had been earned through the pastor's active ministry. During this stage of development, disability coverage and a term-insurance "family protection benefit" also were incorporated into many plans. Plans covering lay church workers also were developed.

The second stage in the evolution of the ELCA Philosophy of Benefits involved health plans. Medical benefits were provided in both The American Lutheran Church plan, beginning in 1961, and the Lutheran Church in America, starting in 1963. The goal in both plans was to provide adequate medical coverage for clergy and lay workers in every setting of service to prevent catastrophic losses.

The third stage in shaping of the ELCA Philosophy of Benefits involved protection of assets for the well-being of plan members. This stage emerged as the result of work accomplished by the Commission for a New Lutheran Church. As a result of its efforts, the new Board of Pensions was incorporated separately from the ELCA in order to provide asset protection of members' plans.

The fourth stage in the evolution of the ELCA Philosophy of Benefits was shaped by the development of a more unified set of plans. This was manifested in several ways. Prior to the merger that formed the ELCA, levels of benefits and contribution methods in the predecessor churches differed for clergy and laity. The ELCA began with a goal of providing the same level of benefits for clergy and lay plan members. In addition, the various plans offered by the Board

⁸ The history of benefit programs in the ELCA and its predecessor church bodies is described in detail in Lowell G. Almen, *More to the Story: The Legacy and Promise of Lutheran Pension and Benefit Plans* (2010).

of Pensions were bundled in order to protect plan members as well as the ELCA Pension and Other Benefits Program itself.

The fifth stage in the evolution of the ELCA Philosophy of Benefits involved a conceptual shift in the Board of Pensions from being a transaction based organization to being a relationship-based organization. Increasing emphasis was placed on service responsiveness to the concerns and needs of members. This transition saw the creation of a greater range of investment funds as options for members and the end of mandatory annuitization. This stage also saw an increasing emphasis on health and wellness. Through the leadership of Portico and collaborative efforts in this church, the focus on individual relationships and the health and wellness of plan members has continued to increase.

B. The 2004 ELCA Philosophy of Benefits Report

With this background, the Board of Pensions beginning in 2003 initiated a review of the history and governing documents of this church in order to articulate a foundational philosophy of benefits. In addition to a review of documents, input was obtained from a wide variety of leaders in this church, including the churchwide organization, synod bishops, seminary presidents and finance directors, and others. The result of this effort was a paper entitled “ELCA Philosophy of Benefits Report, 2004”.

The 2004 ELCA Philosophy of Benefits Report articulated five guiding principles which the Board of Pensions’ staff had been using in the administration of the ELCA’s comprehensive benefit program. The guiding principles were described as follows:

1. Plan participation – All church workers should be sponsored in the ELCA benefits program. The ELCA churchwide office, ELCA synods, ELCA seminaries and the Board of Pensions set an example for the whole church by sponsoring all employees, lay as well as clergy, in the program. ELCA synods also set a standard for benefits by encouraging congregations to sponsor their rostered leaders. For other ELCA employers, sponsorship is at the discretion of the individual employer.
2. Level of benefits – The benefits program should provide adequate financial protection in the event of illness, injury, disability, retirement or death. The program’s cost-sharing features should recognize the relatively low salaries paid to many church workers. Benefits should compare favorably to those available to professionals in other denominations and in secular employment.
3. Bundled program – The Board of Pensions should bundle four plans – health, retirement, disability and survivor – and offer them as a package.
4. Contribution policy – The monthly cost of the program should be affordable and paid entirely by congregations and other sponsoring employers.
5. Sharing of health costs – The cost of the health benefits program should be shared on a basis that takes into account differences in congregations’ and other employers’ ability to pay, with employers of greater means paying more in order to help employers of lesser means within their synods.

These guiding principles provided a framework for the work of the Board of Pensions in 2004. However, in their application, benefit programs have not remained fixed. Thus, in applying these principles, ELCA congregations, synods, the churchwide organization, other employers, and plan members have had to grapple with a number of realities involving both the contexts of individual ministries and the ever-evolving marketplace. For example, contribution rates for the retirement plan were adjusted, with different rates authorized for different employers and categories of employees. In the health plan, a multiple-tier structure was developed (for member, member and spouse, and member, spouse, and children), coverages were added and modified, and out-of-pocket limits were adjusted for various types of benefits. As the result of efficient management, contributions for health care has increased over time, but not at the rate of the escalation of health costs in American society as a whole. Contribution rates and benefits in the survivor and disability plans also have evolved over time.

C. The Need for Review in 2013

While considerations in society and in the ELCA have raised questions regarding the need to re-visit the 2004 ELCA Philosophy of Benefits Report, the enactment of the Patient Protection and Affordable Care Act in March 2010 represents a sea change in the environment for providing health care benefits. Key provisions of this legislation take effect on January 1, 2014, and these necessitate revision of that document. Under health care reform, taxpayers will be required to have health coverage; health insurance exchanges will become operational at the state or regional level; and federal subsidies will be available to help qualifying individuals and families purchase coverage in a health insurance exchange. These changes will cause ELCA employers, and employers in related agencies and institutions, to think differently about how health benefits are provided to employees. Furthermore, individual circumstances will vary depending on the size of the employer, employee household income, the local marketplace in the exchanges, and other factors.

Even without health care reform, employer provided health coverage has evolved significantly since 1987—and markedly so in the past decade. Employees of corporations now routinely choose a health plan that meets their family needs from among several options. The marketplace has seen a shift in economic responsibility to employees—either through higher deductibles or higher cost (premium) sharing requirements.

Additionally, economic turmoil in the United States beginning in 2008 and the uneven recovery since then, as well as the changing demographics of the ELCA, have put increasing economic pressure on congregations, synods, the churchwide organization and other institutions and agencies related to this church. Portico frequently receives inquiries about adding more flexibility to plan design and reducing costs. In response to a request from ELCA seminary presidents, Portico developed a pilot program in 2012 involving options for health care coverage in anticipation of the implementation of health care reform. This experience has informed the development of the revised ELCA Philosophy of Benefits.

Neither the vocation of rostered leaders and lay employees nor the mission of congregations and other ministries that they serve has changed. Nor has the mission of Portico.

Current realities, however, call for re-visiting and updating the ELCA Philosophy of Benefits. In doing so, this church and Portico are committed to providing benefits that both address the needs of ELCA congregations, synods, the churchwide organization, related institutions and agencies, and rostered leaders, lay employees, and their families and recognize the realities of the contexts of their ministries. The ELCA Philosophy of Benefits provides the framework for that work.



Benefit Services | A Ministry of the ELCA

ATTACHMENTS

MEMO

DATE: August 7, 2013

TO: ELCA Church Council

FROM: Rev. Jeffrey Thiemann, President & CEO

SUBJECT: ELCA Philosophy of Benefits and 2014 Plan Changes

Executive Summary

In preparation for bringing plan changes and the ELCA Philosophy of Benefits (POB) for ELCA Church Council (CC) approval, we received approval for these changes from the Portico Board of Trustees (BOT) at our meeting on August 1-3, 2013, and support from the ELCA Legal & Constitutional Review Committee (LCRC) on August 6, 2013.

The POB has been widely presented at synod assemblies and made available through our website and through social media. Based on the feedback we've received, we are proposing minimal clarifying wording changes to define "bundling" and otherwise the same content as the CC approved in concept in April 2013.

Health Plan changes are consistent with the direction presented in April 2013 and include:

- Creating four benefit options named Platinum+, Gold+, Silver+ and Bronze+, with the Gold+ having a very similar design and value to the current 2013 ELCA health plan design.
- Adding age rating to our pricing methodology, with a 2:1 spread from youngest to oldest to retain a healthy risk pool.

Aligning the ELCA Retiree Medical Plan Economy Option (this is a replication of Medicare Supplement Plan L) with the Plan L 2013 out-of-pocket maximum (\$2,400 instead of \$2,330).

Changing the ELCA Survivor Benefits Plan to a group life insurance plan adds new supplemental insurance options for members to buy additional coverage for themselves, their spouses and dependents at attractive group rates with no underwriting.

Extending the seminary pilot instituted in 2013 for one additional year for Luther Seminary responds to their request to keep benefits stable during a time of significant change.

Introduction

Throughout 2013 we have engaged the BOT, the Conference of Bishops (COB), the CC, and other ELCA stakeholders regarding the updated POB and proposed 2014 sponsored health benefit options. Listed below are key milestones.

In February, we presented to the BOT the draft ELCA Philosophy of Benefits that had been created in consultation with the POB Advisory Task Force that was formed and started its work in 2012. We also proposed a 2014 health plan strategy, enhancing the long-term sustainability of the ELCA health plan. We discussed the reasons for continuing to offer an ELCA health plan (wellness programs that promote long-term well-being, short- and long-term price advantages, call mobility, etc.) and the anticipated market changes as a result of the Patient Protection and Affordable Care Act of 2010 (PPACA). The BOT affirmed the value of continuing to provide a viable ELCA health plan. We concluded the presentation by asking the BOT for their opinions on the health plan design options, employer requirements and age-rating concepts that are integral to our 2014 strategy. The BOT recommended our proposals be taken to key ELCA stakeholders in preparation for making a proposal to the CC.

In March, we met with the COB and the ELCA Administrative Team in Chicago to present the health plan strategy and the updated POB. These conversations were supportive of Portico's work, the POB and the 2014 strategy.

In March, the BOT Products and Services Committee unanimously approved the direction of the health plan design options, employer requirements and age rating concepts that are integral to our 2014 strategy.

In April, the CC confirmed that Portico's role in offering a church-sponsored health plan was in the best interest of ministry. In order to offer a plan that supported ministry, they unanimously approved the strategy of offering four health plan design options. In addition, the CC asked Portico to design one of the health benefit options to be similar in value to the current 2013 health plan design and recommended that ELCA-sponsoring employers provide that option to members. The CC charged Portico with taking the POB and 2014 strategy to synod assemblies to get feedback and begin to prepare the ELCA for change, prior to final approval of the POB and 2014 plans in August.

Now in August, we are asking for approval of the final proposed plan design names, plan design options and age-rating structure. In addition, we are proposing a one-year extension of the seminary pilot for Luther Seminary.

In preparation for the August 11, 2013, CC meeting, we met with the LCRC on Tuesday, August 6, 2013, to review the proposed changes that were approved by the Portico BOT to be sent to the CC for your review and approval. This information was also sent to the COB and will be reviewed with them at the joint meeting on August 11, 2013, in Pittsburgh.

Health Plan Design Names

We realize that requiring sponsoring organizations and plan members to choose a health benefit option for the first time will create some anxiety. In order to reduce anxiety, we are creating communication materials that are as clear as possible in explaining the differences between our proposed four health benefit options. The names of the benefit options is one way to avoid confusion.

We had two goals when we developed the proposed benefit option names. The first goal was to avoid any confusion when sponsoring organizations are trying to compare the ELCA primary-plan options to the new state exchange options. The second goal was to allow sponsoring organizations and plan members to easily understand the benefits that are consistent across all four benefit options, but that may be unique to non-ELCA plans (access to a broad provider network, dental benefits, wellness benefits, etc.).

Our proposed benefit options names are as follows:

- Platinum+
- Gold+
- Silver+
- Bronze+

Beginning this fall and into 2014, we believe the metallic (Platinum, Gold, Silver, and Bronze) names will be the common vernacular that is used in the market. Given that our health benefit options were designed to compete with the exchange plans, we want to create names that are comparable.

While the actuarial value of the metallic plans will be similar to the current ELCA options, there are some additional benefits that make our church-sponsored health plan unique. These benefits are portrayed through the consistent "+" in each of the benefit option names. The "+" stands for the same great benefits that are included with any of the four options. Benefits that include a broad access network of doctors and hospitals, a formulary that our members have grown accustomed to, a plan that is focused on wellness and well-being and other products (dental, hearing discount) and services (health advocates, Employee Assistance Program, ELCA NurseLineSM, fitness discount, etc.) that are critical to the health of our plan members. In addition, the consistent benefits across all four health benefit options allows for a much easier transition during the call process.

Health Plan Design Changes

The proposed health benefits are similar in structure to the current ELCA health plan, but the value of each design option will vary. Each of the four options will be similar in actuarial value to the open market exchange metallic plans (Bronze, Silver, Gold, and Platinum). At the request of the CC, we have developed a plan (Gold+) that is very similar to our current ELCA-primary design. Plan provisions are shown on the next page.

ELCA Philosophy of Benefits and 2014 Plan Changes
 August 7, 2013
 Page 4

FOUR NEW OPTIONS, SAME HEALTH BENEFITS All ELCA-Primary Members Receive These Benefits ¹	2014				
	2013	Platinum+ Lowest deductible and out-of-pocket limit	Gold+ ELCA-recommended option	Silver+ High deductible, paired with HSA	Bronze+ Highest deductible and out-of-pocket limit, paired with HSA
BENEFITS					
Medical & Mental Health — Administered by Blue Cross Blue Shield. Broad provider network, 100% preventive services, plus hospital, specialized facility, surgical, office visit, urgent care, emergency room, lab work, X-rays, imaging, individual and group counseling	Deductible: \$1,000 per person \$1,500 member and child(ren) \$2,000 member and spouse; or member, spouse, and child(ren) Costs after deductible: 15% Out-of-pocket limit: \$3,600 individual \$7,200 family	Deductible: \$500 per person \$750 member and child(ren) \$1,000 member and spouse; or member, spouse, and child(ren) Costs after deductible: 20% Out-of-pocket limit: \$3,000 per person \$6,000 family	Deductible: \$1,000 per person \$1,500 member and child(ren) \$2,000 member and spouse; or member, spouse, and child(ren) Costs after deductible: 20% Out-of-pocket limit: \$3,600 per person \$7,200 family	Combined deductible: \$2,000 individual \$4,000 family Costs after deductible: 20% Out-of-pocket limit: \$3,600 single \$7,200 family	Combined deductible: \$4,500 individual \$9,000 family Costs after deductible: 20% Out-of-pocket limit: \$6,000 single \$12,000 family
Prescription Drugs — Administered by Express Scripts. Extensive formulary, broad pharmacy network, home delivery pharmacy	Prescription drug copayment: \$8/\$43/\$69	Prescription drug copayment: \$8/\$43/\$69 — Applies toward out-of-pocket limit	Prescription drug copayment: \$8/\$43/\$69 — Applies toward out-of-pocket limit		
Dental — Administered by Delta Dental. Preventive, basic and restorative care, orthodontia	Dental deductible: ² \$150 per person \$300 family	Dental deductible: ² \$150 per person \$300 family	Dental deductible: ² \$150 per person \$300 family	Dental deductible: ² \$150 per person \$300 family	Dental deductible: ² \$150 per person \$300 family
SUPPORT SERVICES					
Employee Assistance Program — 24/7 counseling for family, legal, substance abuse, other issues	✓	✓	✓	✓	✓
Mayo Clinic Health Solutions — Health assessment, online resources, newsletter, health coaching	✓	✓	✓	✓	✓
ELCA NurseLineSM — 24/7 support from a registered nurse	✓	✓	✓	✓	✓
Health Care Advocacy Team — Help navigating benefits and resolving problems	✓	✓	✓	✓	✓
WAYS TO MANAGE COSTS					
Tax-Advantaged Account — Administered by SelectAccount. Plan members make pretax contributions to pay for eligible health care expenses	Health Care Flexible Spending Account (FSA)	Health Care Flexible Spending Account (FSA)	Health Care Flexible Spending Account (FSA)	Health Savings Account (HSA) Employers can contribute \$600 or \$1,200 per individual, or \$1,200 or \$2,400 per family annually	Health Savings Account (HSA) Employers can contribute \$600 or \$1,200 per individual, or \$1,200 or \$2,400 per family annually
Wellness Dollars — Administered by SelectAccount. Financial incentives earned for completing wellness activities	Member and spouse each earn up to \$500 Personal Wellness Account credits	Member and spouse each earn up to \$500 Personal Wellness Account credits	Member and spouse each earn up to \$500 Personal Wellness Account credits	Member and spouse each earn up to \$500 in an HSA	Member and spouse each earn up to \$500 in an HSA
Fitness Center Discount — Administered by Blue Cross Blue Shield. Up to \$20 discount for visiting a participating location eight days per month	✓	✓	✓	✓	✓
Hearing Discount — Administered by HearPO. Discounts on diagnostic tests, hearing aids, hearing aid batteries	✓	✓	✓	✓	✓
Vision Discount — Administered by EyeMed. Discounts on eyeglasses, contact lenses, laser surgery	✓	Discontinued by EyeMed; routine vision exams remain covered 100% in-network under the medical and mental health benefit			

As requested by the CC, we have developed the Gold+ option to be similar in value and structure to the current offering. We made two changes that, combined, provide for very similar value to members as the current 2013 ELCA health plan. First, pharmacy copays will now count towards a plan member out-of-pocket maximum. As part of PPACA, pharmacy copays must be factored into the out-of-pocket maximum in all plans beginning in 2015. While we could have waited and instituted a separate pharmacy out-of-pocket maximum in 2014, this additional work and potential member confusion was avoided by making this change in 2014.

Second, the coinsurance (costs after deductible) was increased from 15% to 20% for plan members. This change allows us to be competitive with the exchange plans and helps offset the cost impact of the pharmacy copay/out-of-pocket maximum change described above. In addition, the consistent coinsurance at 20% across all four benefit options creates an easier communication message to our plan members during this great time of change. Please note that this change does not impact plan members that stay below their deductible limit or plan members that exceed their out-of-pocket maximum during the year.

Age-rating Methodology

Our strategy for retaining a broad spectrum of risk in the PPACA environment is the expansion from one to four benefit options described earlier that are similar to, but more wellness-focused, than the four metallic plans defined in the law. In addition, we are introducing age rating in order to retain young members who might logically be among those with access to lower cost age-rated commercial insurance. The exchange plans are limited to a maximum relationship of 3:1 between the cost for the highest age and the cost for the lowest age. Since we have never used age rating before, and we know it will have an adverse impact on some sponsors, we have chosen to adopt a 2:1 straight-line ratio for 2014.

We have analyzed the impact of alternative age-rating schedules and are recommending a 2:1 ratio between the oldest age and youngest age. The rates will change with each age in a straight-line manner, and the actual rate charged will be determined by multiplying the rate for the plan option (Platinum+, Gold+, Silver+ or Bronze+), the type of coverage (Member Only, Member & Spouse, Member & Children or Member, Spouse & Children) and geographic rate class by the age specific factor for the member's age. The proposed age-specific rating factors are:

<u>Age</u>	<u>Factor</u>	<u>Age</u>	<u>Factor</u>
<30	0.609	48	0.932
30	0.609	49	0.950
31	0.627	50	0.968
32	0.645	51	0.986
33	0.663	52	1.003
34	0.681	53	1.021
35	0.699	54	1.039
36	0.717	55	1.057
37	0.735	56	1.075
38	0.753	57	1.093
39	0.771	58	1.111
40	0.788	59	1.129
41	0.806	60	1.147
42	0.824	61	1.165
43	0.842	62	1.183
44	0.860	63	1.201
45	0.878	64	1.219
46	0.896	>64	1.219
47	0.914		

ELCA Retiree Medical Plan (Medicare-primary)

In 2013, Portico offered three medical options to our Medicare-primary plan members. Each plan option included the same pharmacy, dental and NurseLineSM benefits, but the amount of out-of-pocket medical costs differed depending on the medical option elected by the member. The options include the:

- Economy Option, which is a replication of Medicare Supplement Plan L: Generally lower medical benefits than the Standard Option.
- Standard Option, which has a \$180 annual deductible and a \$3,500 out-of-pocket maximum per covered life for Medicare-primary members.
- Premium Option, which is a replication of Medicare Supplement Plan F: Generally higher medical benefits than the Standard Option.

Overall, we saw an increased enrollment rate in our Medicare-primary plan in 2013 (compared to enrollment rates in 2012). We believe the additional plan options contributed to this success. As a result, we are not proposing any material changes to the Medicare-primary plan for 2014.

Note – While not material, we are proposing a small change to the Economy Option. The out-of-pocket maximum was \$2,330 in 2013, and we are proposing an increase to \$2,400 in 2014. This will allow our plan to match the 2013 Medicare Supplement Plan L. I expect that we will have a small increase each year in order to keep pace with the annual changes to the Medicare Supplement Plan L.

ELCA Survivor Benefits Plan

Proposed changes in the ELCA Survivor Benefits Plan include:

- The basic lump sum benefit for survivors of sponsored members, which varies with defined compensation (minimum of \$6,000 and maximum of \$50,000), and is paid for by employer contributions, is continuing, and is enhanced in two ways:
 - The new formula for determining the lump sum death benefit is two (2) times defined compensation, subject to the minimum and maximum benefit limits. At some compensation levels, the new formula will provide larger lump sum death benefits for members ages 46 and older.
 - The new benefit design will include an accidental death and dismemberment feature that pays double benefits if death is due to an accidental injury, as well as benefits in the event an accidental injury results in loss of certain physical abilities (limb, eye, etc.).
- We are replacing the monthly financial assistance to surviving spouses, eligible same gender partners, and children of some sponsored members (depending on their age of enrollment, age of death and family situation) with the opportunity to purchase supplemental life insurance. This benefit provides additional income to replace the member's income, which active plan members will be able to purchase at group rates without underwriting. This predictable option, available to all active plan members is a significant enhancement and can be more advantageous to members because:
 - The payment amount is predictable.
 - The benefit can be received either as a lump sum (in addition to the basic lump sum amount) or in the form of an income stream over time, or both.
 - In some cases, this predictable income stream is higher than the amount payable under the current plan.
 - Note: For those members that don't purchase supplemental life insurance and would have received monthly payments for their beneficiaries in the current plan, the new plan will provide less benefit than the current plan. Currently, this benefit does serve a small portion of our membership. By replacing it with the opportunity to purchase supplemental life insurance, we are better able to serve the needs of current sponsored members as well as the future needs of 20,000 current and future retirees and their families.
- This paid-up benefit for beneficiaries of retired members to receive a lump sum death benefit upon the member's death will continue at its current level. Retirees do not pay for this benefit. Rather, it is paid for by their former sponsoring organizations during their working lifetime. The lump sum amount grades down from a formula-derived amount at retirement to a minimum of \$6,000 at age 70.

Extension of Seminary Pilot for Luther Seminary

In 2013, an alternative health plan design was offered to ELCA seminaries. The alternative plan is a high-deductible health plan with a health savings account feature funded by adopting seminaries. In this plan, medical, behavioral health, and pharmacy claims are all aggregated under a common deductible. The design is nearly identical to the Silver+ option described above, with the only difference being a lower out-of-pocket maximum (\$2,500 for single, \$5,000 for family).

The individual seminaries were able to offer employees the comprehensive plan, the high-deductible plan, or both. In 2013, Luther Seminary was the only seminary to offer the high-

ELCA Philosophy of Benefits and 2014 Plan Changes
August 7, 2013
Page 8

deductible plan to plan members. Luther faculty and staff were not given the option to select the comprehensive plan.

Throughout the summer and spring, we met with Luther to discuss how the 2013 pilot prepared Portico to offer four health options (two of which are high-deductible health options) to all ELCA-primary health plan members in 2014. During our meetings, it became very clear that although the Silver+ option was very similar to the current pilot high-deductible plan for Luther, the out-of-pocket maximum change for members would create significant disruption at a time of significant change. In response to Luther Seminary leadership's request for keeping benefits stable, we are proposing to extend the Seminary pilot benefit plan option for Luther Seminary for one more year.

Next Steps

We are asking the CC to approve the plan option names, four plan design options, age-rating factors, Seminary pilot health plan design extension for Luther Seminary, Medicare-primary plan designs and the new ELCA Survivor Benefits Plan. These changes will allow Portico to continue to meet the unique short- and long-term needs of the ELCA for the sake of ministry.

Attached for your review are the proposed ELCA Philosophy of Benefits, plan documents and more detailed explanations of the changes. These changes have been approved by the Portico BOT.

Thank you for your time to address these changes. I look forward to discussing this important topic with you at your meeting on Sunday, August 11, 2013.

Plan Document

**ELCA Medical and Dental
Benefits Plan**

January 1, 201~~4~~3

**EVANGELICAL LUTHERAN CHURCH IN AMERICA
MEDICAL AND DENTAL BENEFITS PLAN**

Table of Contents

ARTICLE I. INTRODUCTION	1
Section 1.01 <u>Name of Plan</u>	1
Section 1.02 <u>History of the Medical and Dental Benefits Plan</u>	1
Section 1.03 <u>“Church Plan” Status</u>	1
Section 1.04 <u>Definitions</u>	1
Section 1.05 <u>Administration of the Plan</u>	1
ARTICLE II. ELIGIBLE EMPLOYERS	1
Section 2.01 <u>Eligible Employer</u>	1
Section 2.02 <u>Participating Employer</u>	2
Section 2.03 <u>General Obligations of a Participating Employer</u>	2
Section 2.04 <u>Discontinuance of Status as a Participating Employer</u>	3
ARTICLE III. ENROLLMENT OF AN ELIGIBLE EMPLOYEE	3
Section 3.01 <u>Eligible Employees</u>	3
Section 3.02 <u>Sponsored Member</u>	4
Section 3.03 <u>Special Rule for Self-Employed Ministers</u>	5
Section 3.04 <u>Sponsoring of an Eligible Employee as a Sponsored Member is Subject to Rules, Regulations and Procedures of Portico Benefit Services</u>	5
Section 3.05 <u>Waiver of Coverage and Re-enrollment</u>	6
Section 3.06 <u>Miscellaneous Enrollment Provisions</u>	6
ARTICLE IV. COVERAGE FOR SPOUSE, SAME GENDER PARTNER AND CHILD	6
Section 4.01 <u>In General</u>	6
Section 4.02 <u>Eligible Spouse</u>	7
Section 4.03 <u>Eligible Same Gender Partner</u>	8
Section 4.04 <u>Enrollment of an Eligible Child</u>	8
Section 4.05 <u>Eligible Child</u>	8
Section 4.06 <u>Age or Disability Requirements</u>	10
Section 4.07 <u>Waiver of Coverage and Re-enrollment</u>	10
Section 4.08 <u>Open Enrollment</u>	10
ARTICLE V. ENROLLMENT OF A RETIRED MEMBER, ELIGIBLE SPOUSE, ELIGIBLE SAME GENDER PARTNER AND ELIGIBLE CHILDREN	10
Section 5.01 <u>Enrollment of a Retired Member</u>	10
Section 5.02 <u>Waiver of Coverage and Re-enrollment of a Retired Member</u>	12
Section 5.03 <u>Open Enrollment for a Retired Member</u>	12
Section 5.04 <u>Enrollment of Eligible Spouse or Eligible Same Gender Partner or Eligible Child of a Retired Member</u>	12

Section 5.05	<u>Waiver of Coverage and Re-enrollment of Eligible Spouse or Eligible Same Gender Partner or Eligible Child of a Retired Member</u>	13
Section 5.06	<u>Open Enrollment for Eligible Spouse or Eligible Same Gender Partner or Eligible Child of a Retired Member</u>	13
ARTICLE VI. ENROLLED STATUS: TERMINATION AND CONTINUATION IN CERTAIN SITUATIONS		
		14
Section 6.01	<u>Termination of Sponsored Member’s Enrolled Status</u>	14
Section 6.02	<u>Termination of Retired Member’s Enrolled Status</u>	14
Section 6.03	<u>Termination of a Spouse’s Enrolled Status</u>	14
Section 6.04	<u>Termination of an Eligible Same Gender Partner’s Enrolled Status</u>	15
Section 6.05	<u>Termination of a Child’s Enrolled Status</u>	15
Section 6.06	<u>Coverage Continuation for Sponsored Members</u>	16
Section 6.07	<u>Coverage Continuation for Dependents</u>	17
Section 6.08	<u>Waiver of Coverage and Re-enrollment for Certain Coverage Continuation Members</u>	18
Section 6.09	<u>Other Eligible Individuals</u>	18
ARTICLE VII. COST OF MEDICAL AND DENTAL COVERAGE FOR SPONSORED MEMBERS AND THEIR DEPENDENTS		
		18
Section 7.01	<u>In General</u>	18
Section 7.02	<u>Amount of Contribution for Participation in the Medical and Dental Benefits Plan</u>	19
Section 7.03	<u>Special Rules Where Two (2) Members are Married to Each Other or are in an Eligible Same Gender Partnership and are Employed by Participating Employers; or Where a Sponsored Member is Employed by Two (2) or More Participating Employers</u>	19
Section 7.04	<u>Failure of Participating Employer to Make Required Contributions</u>	20
Section 7.05	<u>Waiver of Medical and Dental Benefits Contributions</u>	20
ARTICLE VIII. CONTRIBUTION RATES FOR COVERAGE CONTINUATION MEMBERS AND RETIRED MEMBERS		
		21
Section 8.01	<u>Coverage Continuation Members</u>	21
Section 8.02	<u>Eligible Child of a Deceased Member</u>	21
Section 8.03	<u>Retired Members</u>	21
Section 8.04	<u>Subsidies for Certain Retired Members Based on Predecessor ALC Subsidy Schedule</u>	21
Section 8.05	<u>Subsidies for Certain Retired Members Based on Predecessor LCA Subsidy Schedule</u>	22
Section 8.06	<u>Subsidies for Certain Retired Members Based on ELCA Subsidy Schedule</u>	24
Section 8.07	<u>Sources of Subsidies for Certain Retired Members</u>	25

ARTICLE IX. BENEFITS COVERAGE AND GENERAL PROVISIONS	26
Section 9.01 <u>Members Who Have ELCA-Primary Benefits Coverage</u>	26
Section 9.02 <u>Members Who Have Medicare-Primary Benefits Coverage</u>	26
Section 9.03 <u>Reimbursement of Medicare Premiums for Certain Medicare- Primary Members</u>	27
Section 9.04 <u>Mid-Year Changes in Coverage</u>	27
Section 9.05 <u>Maximum Reimbursement Amount</u>	30
Section 9.06 <u>Adjustment of Certain Amounts Related to Benefits</u>	30
Section 9.07 <u>Coordination of Benefits</u>	30
Section 9.08 <u>Subrogation</u>	32
Section 9.09 <u>Claim Filing Deadline</u>	33
ARTICLE X. ELCA-PRIMARY MEDICAL AND MENTAL HEALTH BENEFITS	33
Section 10.01 <u>In General</u>	33
Section 10.02 <u>ELCA-Primary Medical and Mental Health Benefits</u>	33
Section 10.03 <u>Benefits for Eligible Expenses for Preventive Services</u>	33
Section 10.04 <u>Deductibles and Percent Copayments for In-network Eligible Medical and Mental Health Expenses Other Than Preventive Services</u>	34
Section 10.05 <u>Maximum Out-of-Pocket Amount for In-network Eligible Medical and Mental Health Expenses</u>	34
Section 10.06 <u>Deductibles and Percent Copayments for Out-of-network Eligible Medical and Mental Health Expenses Other Than Preventive Services</u>	35
Section 10.07 <u>Maximum Out-of-Pocket Amount for Out-of-network Eligible Medical and Mental Health Expenses</u>	36
Section 10.08 <u>Members Outside of the United States</u>	37
Section 10.09 <u>Certain Definitions Applicable to ELCA-Primary Medical and Mental Health Benefits</u>	37
Section 10.10 <u>Transitional Medical and Mental Health Care</u>	39
Section 10.11 <u>Center of Excellence</u>	39
ARTICLE XI. MEDICARE SUPPLEMENT BENEFITS	40
Section 11.01 <u>Medicare Supplement Benefits</u>	40
Section 11.02 <u>Deductible and Percent Copayments for Eligible Medical Expenses Under Medicare Supplement Benefits</u>	40
Section 11.03 <u>Maximum Out-of-Pocket Amount for Eligible Medical Expenses Under Medicare Supplement Benefits</u>	40
Section 11.04 <u>Medicare Supplement Benefits Administrator</u>	40
Section 11.05 <u>Eligible Medical Expenses Under Medicare Supplement Benefits</u>	40
Section 11.06 <u>Medicare Supplement Benefit Options</u>	41
ARTICLE XII. ELIGIBLE ELCA-PRIMARY MEDICAL AND MENTAL HEALTH EXPENSES	42
Section 12.01 <u>Basic Requirement for Medical and Mental Health Expenses</u>	42
Section 12.02 <u>Eligible Medical Providers</u>	42

Section 12.03	<u>Hospital and Facility Medical Expenses</u>	43
Section 12.04	<u>Surgical Expenses</u>	43
Section 12.05	<u>Transplants</u>	43
Section 12.06	<u>Preventive Services</u>	44
Section 12.07	<u>Other Eligible Medical Expenses</u>	46
Section 12.08	<u>Exclusions from Eligible Medical Expenses</u>	49
Section 12.09	<u>Basic Requirements for Mental Health Expenses</u>	51
Section 12.10	<u>Eligible Mental Health Providers</u>	51
Section 12.11	<u>Eligible Hospital and Facility Mental Health Expenses</u>	51
Section 12.12	<u>Other Eligible Mental Health Expenses</u>	53
Section 12.13	<u>Exclusions from Eligible Mental Health Expenses</u>	53
Section 12.14	<u>Medical and Mental Health Review</u>	55
Section 12.15	<u>Employee Assistance Program Benefits</u>	56
 ARTICLE XIII. DENTAL BENEFITS		57
Section 13.01	<u>Dental Benefits</u>	57
Section 13.02	<u>Deductibles and Percent Copayments for Eligible Dental Expenses</u>	58
Section 13.03	<u>Limits on Eligible Dental Benefits Expenses</u>	58
Section 13.04	<u>Eligible Dental Expenses</u>	58
Section 13.05	<u>Specific Requirements for Eligible Dental Expenses</u>	59
Section 13.06	<u>Eligible Preventive Dental Expenses</u>	59
Section 13.07	<u>Eligible Basic Dental Expenses</u>	59
Section 13.08	<u>Eligible Major Restorative Dental Expenses</u>	60
Section 13.09	<u>Eligible Orthodontia Expenses</u>	61
Section 13.10	<u>Exclusions from Dental Benefits</u>	61
Section 13.11	<u>Dental Benefits Administrator</u>	62
 ARTICLE XIV. SUPPORTING SERVICES		62
Section 14.01	<u>Health Support Program</u>	62
Section 14.02	<u>Nurse Line Program</u>	62
Section 14.03	<u>Health Coach Services</u>	63
Section 14.04	<u>Fitness Center Programs</u>	63
 ARTICLE XV. PRESCRIPTION DRUG BENEFITS		63
Section 15.01	<u>Eligibility for Prescription Drug Benefits</u>	63
Section 15.02	<u>Eligible Prescription Drug Expenses</u>	63
Section 15.03	<u>Definition of Eligible Prescription Drugs</u>	64
Section 15.04	<u>Exclusions from Eligible Prescription Drug Expenses</u>	64
Section 15.05	<u>Copayments for Prescription Drugs</u>	65
Section 15.06	<u>Prescription Drug Benefits Administrator</u>	66
 ARTICLE XVI. CLAIMS APPEAL PROCEDURE.....		66
Section 16.01	<u>In General</u>	66
Section 16.02	<u>Appeals Procedure</u>	67
Section 16.03	<u>Court System</u>	68

ARTICLE XVII. MISCELLANEOUS PROVISIONS	68
Section 17.01 <u>Administration by Portico Benefit Services</u>	68
Section 17.02 <u>Administrative Fee Paid to Portico Benefit Services</u>	68
Section 17.03 <u>Rules of Construction and Applicable Law</u>	69
Section 17.04 <u>Correction of Errors</u>	69
Section 17.05 <u>Fiduciary Standards</u>	69
Section 17.06 <u>No Other Benefits</u>	69
Section 17.07 <u>Source of Benefits</u>	69
Section 17.08 <u>Portico Benefit Services is Not a Party to Contract Between an Eligible Employer and an Eligible Employee</u>	69
Section 17.09 <u>Limitation of Liability</u>	70
Section 17.10 <u>Obligation of Members</u>	70
Section 17.11 <u>Amendments</u>	70
Section 17.12 <u>Termination</u>	71
Section 17.13 <u>Special Provisions for Members who Reside in Puerto Rico</u>	71
Section 17.14 <u>Special Provisions for Members who Reside in Hawaii</u>	72
Section 17.15 <u>Special Provisions for Foreign Missionaries Employed by ELCA Global Mission</u>	73
Section 17.16 <u>No Guarantee of Tax Consequences</u>	73
Section 17.17 <u>Non-Assignability of Rights</u>	74
Section 17.18 <u>Plan Provisions Controlling</u>	74
Section 17.19 <u>Termination for Fraud/Abuse</u>	74
Section 17.20 <u>Special Provisions for Members Employed by an ELCA Seminary</u>	74
ARTICLE XVIII. DEFINITIONS	75
Section 18.01 <u>AELC</u> 75	
Section 18.02 <u>ALC</u> 75	
Section 18.03 <u>Church Institution</u>	75
Section 18.04 <u>Churchwide Unit</u>	75
Section 18.05 <u>Code</u> 75	
Section 18.06 <u>Coverage Continuation Member</u>	75
Section 18.07 <u>Defined Compensation</u>	76
Section 18.08 <u>Dependent</u>	76
Section 18.09 <u>ELCA</u> 76	
Section 18.10 <u>ELCA Board of Pensions</u>	76
Section 18.11 <u>ELCA Ordained Minister</u>	76
Section 18.12 <u>ELCA Rostered Layperson</u>	76
Section 18.13 <u>Eligible Child</u>	76
Section 18.14 <u>Eligible Same Gender Partner</u>	76
Section 18.15 <u>Eligible Employee</u>	76
Section 18.16 <u>Eligible Employer</u>	76
Section 18.17 <u>Eligible Spouse</u>	77
Section 18.18 <u>ERISA</u>	77
Section 18.19 <u>Family</u> ⁷⁷	
Section 18.20 <u>Former Spouse</u>	77
Section 18.21 <u>Inter-Lutheran Agency</u>	77

Section 18.22	<u>LCA</u>	77
Section 18.23	<u>Medical Necessity/Medically Necessary</u>	77
Section 18.24	<u>Member</u>	79
Section 18.25	<u>Other Employer-Provided Group Coverage</u>	79
Section 18.26	<u>Portico Benefit Services</u>	79
Section 18.27	<u>Predecessor Churches</u>	79
Section 18.28	<u>Reasonable and Customary</u>	79
Section 18.29	<u>Retired Member</u>	80
Section 18.30	<u>Separation from Service</u>	80
Section 18.31	<u>Sponsored Member</u>	80
Section 18.32	<u>Surviving Child</u>	80
Section 18.33	<u>Surviving Spouse</u>	80
ARTICLE XIX. HIPAA PRIVACY COMPLIANCE		80
Section 19.01	<u>In General</u>	80
Section 19.02	<u>Inconsistent Provisions</u>	81
Section 19.03	<u>HIPAA Definitions</u>	81
Section 19.04	<u>Required Uses and Disclosures of Protected Health Information</u>	81
Section 19.05	<u>Permitted Uses and Disclosures of Protected Health Information</u>	82
Section 19.06	<u>Requirements of Portico Benefit Services</u>	83
Section 19.07	<u>Access to Protected Health Information, including Electronic Protected Health Information</u>	84
Section 19.08	<u>Non-compliance</u>	85
Section 19.09	<u>Action by Portico Benefit Services</u>	85
Section 19.10	<u>Consistency with HIPAA and HIPAA Regulations</u>	86
ARTICLE XX. PERSONAL WELLNESS ACCOUNT		86
Section 20.01	<u>Personal Wellness Account</u>	86
Section 20.02	<u>Definitions</u>	86
Section 20.03	<u>Eligibility</u>	88
Section 20.04	<u>Enrollment and Participation</u>	88
Section 20.05	<u>PWA Members Electing Continuation Coverage under the ELCA Medical and Dental Benefits Plan</u>	88
Section 20.06	<u>Termination of Participation</u>	88
Section 20.07	<u>Reinstatement Following Termination of Employment</u>	89
Section 20.08	<u>Termination of ELCA-Primary Benefits Coverage under the ELCA Medical and Dental Benefits Plan</u>	89
Section 20.09	<u>Death of a PWA Member</u>	89
Section 20.10	<u>Benefits Offered</u>	89
Section 20.11	<u>Contributions</u>	90
Section 20.12	<u>No Benefits Other than Reimbursement Benefits</u>	90
Section 20.13	<u>Eligible PWA Expenses</u>	90
Section 20.14	<u>Maximum Benefits</u>	91
Section 20.15	<u>Activation of Account</u>	91
Section 20.16	<u>Carryover of Accounts</u>	92

Section 20.17 **PWA Expense Reimbursement Procedure**..... 92
Section 20.18 **Coordination of Benefits; ELCA Health FSA to Reimburse**
First 93

**EVANGELICAL LUTHERAN CHURCH IN AMERICA
MEDICAL AND DENTAL BENEFITS PLAN**

**ARTICLE I.
INTRODUCTION**

Section 1.01 **Name of Plan.** The name of the medical and dental benefits plan set out in this document is the Evangelical Lutheran Church in America Medical and Dental Benefits Plan (“ELCA Medical and Dental Benefits Plan”). It is referred to in this document as the “Medical and Dental Benefits Plan,” the “ELCA Health Benefits Plan” or the “Plan.”

Section 1.02 **History of the Medical and Dental Benefits Plan.** The Medical and Dental Benefits Plan was designed to replace the medical and dental benefit plans of the Predecessor Churches. The effective date of commencement of this Plan is January 1, 1988. The ELCA Continuation of The ALC Medical-Dental Plan for Retired Participants and the ELCA Continuation of the LCA Ministerial Health Benefits Plan for Retired Members were merged with this Plan effective January 1, 1997. The Personal Wellness Account portion of the Plan was established effective January 1, 2008. The Plan was expanded to include coverage for Eligible Same Gender Partners and their Eligible Children in May 2010. [To provide benefit designs comparable to the national health care marketplace, benefit options were added to ELCA Medicare-Primary Benefits effective January 1, 2013 and to ELCA-Primary Benefits effective January 1, 2014.](#)

Section 1.03 **“Church Plan” Status.** The Medical and Dental Benefits Plan is exempt from ERISA because it meets the requirements of a “church plan” within the meaning of IRS Code § 414(e) and ERISA § 3(33).

Section 1.04 **Definitions.** Terms that are capitalized throughout this Medical and Dental Benefits Plan are defined terms, the definitions for which are set forth in the various Plan sections.

Section 1.05 **Administration of the Plan.** This Plan is administered by the Board of Pensions of the Evangelical Lutheran Church in America, doing business as Portico Benefit Services (“Portico Benefit Services” or “Portico”).

**ARTICLE II.
ELIGIBLE EMPLOYERS**

Section 2.01 **Eligible Employer.** An “Eligible Employer” is a legal entity which meets the requirements and conditions the Portico Benefit Services imposes, provided it meets one (1) of the following criteria:

- (a) The ELCA, or an ELCA synod, seminary or Churchwide Unit that is part of a “church, or a convention or association of churches” within the meaning of Code § 414(e)(3) and ERISA § 3(33)(C).
- (b) Church congregations.

(i) An ELCA congregation that is part of a “church, or a convention or association of churches” within the meaning of Code § 414(e)(3) and ERISA § 3(33)(C); or

(ii) A former ELCA congregation other than a congregation included in (iv) below that sponsored one (1) or more Eligible Employees in this Plan on or after January 1, 2005; or

(iii) A congregation of a denomination that is in a full communion relationship with the ELCA; or

(iv) A congregation or qualified church-controlled organization described in Code § 3121(w) of a non-ELCA church body that has common religious bonds with the ELCA and has petitioned to and been approved by Portico Benefit Services to be the church body’s sole benefits provider.

(c) An organization that is an ELCA “qualified church-controlled organization” as determined by the ELCA within the meaning of Code § 3121(w).

(d) An organization that is an ELCA “church-controlled organization” but not a “qualified church-controlled organization” as determined by the ELCA within the meaning of Code § 3121(w).

(e) A 501(c)(3) organization, other than an organization described in (a) through (d) above, that employs an individual who is performing service in the exercise of her/his ministry as an ELCA Ordained Minister or an ELCA Rostered Layperson.

(f) A non-501(c)(3) organization that employs an individual who is performing service in the exercise of her/his ministry as an ELCA Ordained Minister.

(g) An individual who is performing service in the exercise of her/his ministry as an ELCA Ordained Minister who is self-employed or who is employed by an organization described in (e) or (f) above but is not sponsored by her/his employer. Such individual shall be treated as her/his own employer.

Notwithstanding the above, an ELCA elementary or secondary school, day-care center, camp or conference center that is ~~not~~ a separately incorporated legal entity shall be treated as a separate “Eligible Employer” under subsection (c) or (d) above provided the employer otherwise meets the requirements of such subsection.

Section 2.02 **Participating Employer**. An Eligible Employer shall become a Participating Employer by enrolling an individual, whom it employs, as a Sponsored Member under the Medical and Dental Benefits Plan in such manner as Portico Benefits Services shall specify.

Section 2.03 **General Obligations of a Participating Employer**. By enrolling an Eligible Employee in the Medical and Dental Benefits Plan, each Participating Employer shall become obligated as follows:

(a) The Participating Employer shall be bound by the terms of the Medical and Dental Benefits Plan including future amendments and shall comply with any rules, regulations and procedures adopted by Portico Benefit Services; provided, however, that the Participating Employer has the right to discontinue its participation as provided in Section 2.04 (a).

(b) The Participating Employer shall be obligated to promptly advise Portico Benefit Services of any change that would cause it to cease to be an Eligible Employer, any change in status under Code § 501(c)(3) or an audit by the Internal Revenue Service that involves an examination of its status under Code § 501(c)(3) or, if the Participating Employer is an organization described in Section 2.01 (c) or (d), any change in status that could cause it to cease to be “controlled by, or associated with” the ELCA.

(c) The Participating Employer shall provide any information in such form as requested by the Portico Benefit Services which is necessary for the administration of the Medical and Dental Benefits Plan. This obligation shall continue after the Participating Employer ceases to be a Participating Employer in the Medical and Dental Benefits Plan.

Section 2.04 **Discontinuance of Status as a Participating Employer.**

(a) A Participating Employer may discontinue its participation in the Medical and Dental Benefits Plan by providing notice in an acceptable manner to Portico Benefit Services and complying with any rules, regulations and procedures adopted by Portico Benefit Services with respect to such discontinuance of participation.

(b) Portico Benefit Services may discontinue the participation of any Participating Employer in the Medical and Dental Benefits Plan if Portico Benefit Services, in its sole discretion, determines that such Participating Employer is no longer an Eligible Employer as defined in Section 2.01, or that such Participating Employer has failed to comply with any of the provisions of this Medical and Dental Benefits Plan.

**ARTICLE III.
ENROLLMENT OF AN ELIGIBLE EMPLOYEE**

Section 3.01 **Eligible Employees.** The following individuals shall be Eligible Employees for purposes of participation in this Medical and Dental Benefits Plan:

(a) A common-law employee of an Eligible Employer described in Section 2.01(a), (b), (c), (d), (e) or (f) who is an ELCA Ordained Minister serving under a letter of call and who is regularly scheduled to work fifteen (15) or more hours per week for six (6) or more months per year.

(b) A common-law employee of an Eligible Employer described in Section 2.01(a), (b), (c), (d) or (e) who is an ELCA Rostered Layperson serving under a letter of call and who is regularly scheduled to work fifteen (15) or more hours per week for six (6) or more months per year.

(c) Any other common-law employee of an Eligible Employer described in Section 2.01(a), (b), (c) or (d) who is regularly scheduled to work twenty (20) or more hours per week for six (6) or more months per year and has completed any probationary period specified by the Employer not to exceed ninety (90) days.

(d) An ELCA Ordained Minister who is described in Section 2.01(g).

Notwithstanding the foregoing, an ELCA seminary shall determine which of its employees are eligible to participate in this Plan in accordance with Section 17.20(c).

Section 3.02 **Sponsored Member.** A Participating Employer may sponsor any Eligible Employee as a Sponsored Member in this Medical and Dental Benefits Plan. The determination regarding which of its Eligible Employees it shall sponsor shall be solely within the discretion of the Participating Employer (provided such discretion is exercised without regard to a health status related factor within the meaning of applicable federal law), subject to the following:

(a) **Churchwide Unit, Synod or Seminary.** An Eligible Employer described in Section 2.01(a) (other than the ELCA Publishing House), shall sponsor all of its Eligible Employees. Notwithstanding the requirements of this Section 3.02(a), an ELCA Synod, ELCA seminary or Churchwide Unit shall not be required to sponsor employees who are non-ELCA Ordained Ministers, or who are employees deemed to be temporary employees.

(b) **Other Participating Employers.**

(i) A Participating Employer described in Section 2.01(d) may sponsor any of its Eligible Employees who are ELCA Ordained Ministers. In addition, it may elect to sponsor all or none of its other Eligible Employees.

(ii) A Participating Employer described in Section 2.01(e) may sponsor any of its Eligible Employees who are ELCA Ordained Ministers. In addition, it may elect to sponsor all or none of its Eligible Employees who are ELCA Rostered Laypersons.

(iii) A Participating Employer described in Section 2.01(f) may sponsor any of its Eligible Employees who are ELCA Ordained Ministers.

(c) **Participation in Other Plans.** A Participating Employer may sponsor an Eligible Employee as a Sponsored Member of the Medical and Dental Benefits Plan only if it also sponsors such individual in the other three (3) plans of the ELCA Pension and Other Benefits Program, namely:

- (i) The ELCA Retirement Plan;
- (ii) The ELCA Disability Benefits Plan; and
- (iii) The ELCA Survivor Benefits Plan.

An Eligible Employee who is subject to an Applicable Waiting Period described in Section 3.02(f) shall be a Sponsored Member for purposes of this Section 3.02(c).

(d) **Timely Enrollment.** An individual may become a Sponsored Member in accordance with the provisions of Section 3.02 and by making application in an acceptable manner to Portico Benefit Services within sixty (60) days of becoming an Eligible Employee. Coverage will become effective on the date designated by the individual's Eligible Employer, provided such date is within the sixty (60) day application period. Newly ordained ELCA pastors who worked for an Eligible Employer before ordination but who were not sponsored in the ELCA Pension and Other Benefits Program shall be considered to have enrolled on a timely basis if they make application for coverage in an acceptable manner to Portico Benefit Services to become a Sponsored Member within sixty (60) days of ordination.

(e) **Special Enrollment.** An Eligible Employee who had Other Employer-Provided Group Coverage may become a Sponsored Member in accordance with the provisions of Section 3.02 by making an application for coverage in an acceptable manner to Portico Benefit Services within sixty (60) days of the termination of Other Employer-Provided Group Coverage. Coverage will become effective on the date designated by the individual's Eligible Employer, provided such date is within the sixty (60) day application period.

(f) **Other Enrollment.** An individual described in Section 3.02(a) who is required to be sponsored in this Plan, but who does not enroll within sixty (60) days of becoming an Eligible Employee, will become a Sponsored Member on the day that her/his acceptable application is received by Portico Benefit Services. Any other Eligible Employee who does not become a Sponsored Member within sixty (60) days of becoming an Eligible Employee, and an Eligible Employee by or for whom coverage under this Plan is terminated and not replaced (in accordance with the waiver provision of Section 3.05) with Other Employer-Provided Group Coverage, shall become eligible for coverage under this Plan as of the first day of the calendar month following the end of the Applicable Waiting Period or, if earlier, the date specified under the annual open enrollment provisions in Section 3.06(b).

For purposes of this Section, Applicable Waiting Period shall mean the ~~six (6) month~~ninety (90) day period beginning on the day that her/his acceptable application for coverage is received by Portico Benefit Services.

Section 3.03 **Special Rule for Self-Employed Ministers.** An individual described in Section 2.01(g) may sponsor her/himself and be both a Sponsored Member and a Participating Employer.

Section 3.04 **Sponsoring of an Eligible Employee as a Sponsored Member is Subject to Rules, Regulations and Procedures of Portico Benefit Services.** The sponsoring of an Eligible Employee as a Sponsored Member shall be subject to such rules, regulations and procedures as Portico Benefit Services, in its sole discretion, may adopt. Such rules, regulations

and procedures may be amended at any time without notice to any Eligible Employer, Participating Employer, Eligible Employee or Sponsored Member.

Section 3.05 **Waiver of Coverage and Re-enrollment.** A Sponsored Member may waive coverage under this Plan during any period such Member has Other Employer-Provided Group Coverage as described in Section 18.25. Waiver of coverage will become effective on the first day of the calendar month following the date the acceptable request to waive coverage is received by Portico Benefit Services. A Member who has waived coverage under this Plan may initiate or resume such coverage on any subsequent date, provided that such coverage is requested ~~in writing~~ in an acceptable manner from Portico and initiated or resumed no later than sixty (60) days after the Other Employer-Provided Group Coverage is terminated. An individual who waived coverage in accordance with this Section 3.05 shall be a Sponsored Member for purposes of this Plan while s/he continues to be an Eligible Employee.

Section 3.06 **Miscellaneous Enrollment Provisions.**

(a) **Transfers from Other Church Plans.** Portico Benefit Services may enter into reciprocal agreements with other churches or church pension boards under which an Eligible Employee who transfers from another church health benefit plan may become a Sponsored Member.

(b) **Open Enrollment.** The annual open enrollment period in this Plan shall be in November 1-30 of each calendar year, with specific dates determined by Portico Benefit Services with coverage becoming effective the following January 1.

(i) Eligible Employees enrolling in this Plan during this period shall have no Applicable Waiting Period. Coverage will be effective the following January 1.

(ii) Eligible Employees may elect an ELCA-Primary Option or ELCA Medicare-Primary Option during the open enrollment period in accordance with Portico's provisions for open enrollment. If a Member fails to elect an option during open enrollment, the Plan will assign a default option in accordance with Portico's administrative provisions. The elected or default option will be effective the following January 1.

ARTICLE IV.
COVERAGE FOR SPOUSE, SAME GENDER PARTNER AND CHILD

Section 4.01 **In General.** The Participating Employer may enroll the Eligible Spouse or Eligible Same Gender Partner and/or Eligible Child(ren) of a Sponsored Member. The Participating Employer is responsible for remitting contributions for enrolled dependents to Portico Benefit Services in accordance with Article VII. Coverage for dependents who are enrolled within the Sponsored Member's timely enrollment period will commence on the same date as the Sponsored Member or any subsequent date within the Sponsored Member's timely enrollment period, as requested by the Sponsored Member. Dependents eligible for ELCA-Primary Benefits will have the same ELCA-Primary Option as the Sponsored Member, Retired Member or Coverage Continuation Member who is enrolled in an ELCA-Primary Option. A

Sponsored Member, Retired Member or Coverage Continuation Member who is enrolled in ELCA Medicare-Primary Benefits will choose, in accordance with the procedures established by Portico Benefit Services, the ELCA-Primary Option for Dependents who are not eligible for ELCA Medicare-Primary Benefits.

Coverage for dependents who are enrolled after the Sponsored Member's timely enrollment period ends will commence on the first day of the calendar month following the end of the Applicable Waiting Period. This Applicable Waiting Period is defined as the ~~six (6) month~~ninety (90) day period beginning on the date the dependent's acceptable application is received by Portico Benefit Services. Notwithstanding the preceding sentence:

(a) Coverage for a dependent who is enrolled within sixty (60) days of the termination of her/his Other Employer-Provided Group Coverage will commence on the date designated by the Participating Employer, provided such date is within sixty (60) days of the termination of the dependent's Other Employer-Provided Group Coverage.

(b) Coverage for a dependent who is enrolled during an annual open enrollment period described in Section 4.08 will commence on the first day of the calendar year following the end of such open enrollment period.

(c) Coverage for an individual who becomes an Eligible Spouse or Eligible Same Gender Partner or Eligible Child of a Sponsored Member as a result of marriage, satisfaction of the same gender partnership requirements established by Portico Benefit Services, birth, adoption or placement for adoption, will commence on the date designated by the Participating Employer, provided such date is within sixty (60) days of the date the individual becomes an Eligible Spouse, Eligible Same Gender Partner or Eligible Child.

Section 4.02 **Eligible Spouse**. For purposes of eligibility for enrollment, each of the following persons who is the opposite sex of the Member shall be defined as an Eligible Spouse:

(a) The spouse of a Sponsored Member, Coverage Continuation Member described in Section 18.06(a) or (b), or Retired Member (including a separated spouse). The spouse must be or must have been legally married to the Sponsored, Coverage Continuation, or Retired Member under the laws of one (1) of the states of the United States or a foreign country. Common law marriages are not recognized.

(b) The Former Spouse of a living or deceased Sponsored Member, Coverage Continuation Member described in Section 18.06(a) or (b), or Retired Member, provided that such Former Spouse was covered or had waived coverage under this Plan at the time of the marriage dissolution.

(c) A Surviving Spouse of a Sponsored Member, Coverage Continuation Member described in Section 18.06(a) or (b), or Retired Member, provided that such spouse was covered or had waived coverage under this Plan at the time of such Sponsored Member, Coverage Continuation Member or Retired Member's death.

(d) The Former Spouse of an individual who was covered under a plan maintained by a Predecessor Church, provided that the Former Spouse was covered under such plan on December 31, 1987, and continuously thereafter.

(e) The spouse of a Coverage Continuation Member described in Section 6.06(c) of this Medical and Dental Benefits Plan.

A Former Spouse or Surviving Spouse described in (b), (c) or (d) above shall be considered a Coverage Continuation Member.

Section 4.03 **Eligible Same Gender Partner.** For purposes of eligibility for enrollment, an “Eligible Same Gender Partner” described in this Section 4.03, is an individual who satisfies Portico Benefit Services’ same gender partnership requirements as attested to on a completed Affidavit of Partnership and submits the affidavit within sixty (60) days of the affidavit’s completion to Portico Benefit Services. Each of the following persons shall be defined as an Eligible Same Gender Partner:

(a) The partner of a Sponsored Member, Coverage Continuation Member described in Section 18.06(a) or (b), or Retired Member. The partner must be or must have been in a Portico Benefit Services’ recognized partnership to the Sponsored, Coverage Continuation or Retired Member.

(b) The former partner of a living or deceased Sponsored Member, Coverage Continuation Member described in Section 18.06(a) or (b), or Retired Member, provided that such partner was covered or had waived coverage as an Eligible Same Gender Partner under this Plan at the time of the dissolution of partnership.

(c) A surviving partner of a Sponsored Member, Coverage Continuation Member described in Section 18.06(a) or (b), or Retired Member, provided that such partner was covered or had waived coverage as an Eligible Same Gender Partner under this Plan at the time of such Sponsored Member, Coverage Continuation Member or Retired Member’s death.

(d) The partner of a Coverage Continuation Member described in Section 6.06(c) of this Medical and Dental Benefits Plan, provided the Member and partner were in a Portico Benefit Services’ recognized partnership at the time coverage continuation began.

A former or surviving Eligible Same Gender Partner described in (b) or (c) above shall be considered a Coverage Continuation Member.

Section 4.04 **Enrollment of an Eligible Child.** The provisions set forth in this Section 4.04 apply to any Eligible Child who is enrolled as a Member on or after January 1, 1998. With respect to an Eligible Child who was a Member on December 31, 1997, and who has continued to be a Member since that date, the provisions of this Section 4.04 as in effect on the date the Eligible Child became a Member, shall continue to apply.

Section 4.05 **Eligible Child.**

(a) **Eligible Child under the Patient Protection and Affordable Care Act.** For purposes of eligibility for enrollment, each of the following individuals who meets the requirements of Section 4.06 is defined as an “Eligible Child.”

(i) A natural child of a Sponsored Member, Retired Member, or Coverage Continuation Member described in Section 18.06(a), (b) or (c), or Section 6.07(a) or (b).

(ii) A legally adopted child of a Sponsored Member, Retired Member, or Coverage Continuation Member described in Section 18.06(a), (b) or (c), or Section 6.07(a) or (b).

(iii) A natural or legally adopted child of the spouse of a Sponsored Member, Retired Member, or Coverage Continuation Member described in Section 18.06(a), (b) or (c), or Section 6.07(a) or (b).

(iv) A child placed in the household of a Sponsored Member, Retired Member, or Coverage Continuation Member described in Section 18.06(a), (b) or (c), or Section 6.07(a) or (b), as a step towards legal adoption by the Member.

(b) **Other Eligible Child.** For purposes of eligibility for enrollment, each of the following never-married individuals who meets the requirements of Section 4.06, receives primary support from the Sponsored Member, Retired Member, or Continuation Coverage Member, and is eligible to be claimed as such Member’s dependent for federal income tax purposes (as specified in § 152 of the Internal Revenue Code without regard to § 152(d)(1)(B)) is defined as an “Eligible Child”:

(i) A grandchild of a Sponsored Member, Retired Member, or Coverage Continuation Member described in Section 18.06(a), (b) or (c), or Section 6.07(a) or (b), provided the grandchild is living in the same household as the Member.

(ii) A child who has as her/his principal place of abode the home of a Sponsored Member, Retired Member, or Coverage Continuation Member as defined in Section 18.06(a), (b) or (c), or Section 6.07(a) or (b), if the child is living in the Member’s household and the Member has been appointed the legal guardian of the child.

(iii) A child not described previously in this Section who was covered on December 31, 1987, in accordance with the terms of a medical/dental plan maintained by a Predecessor Church.

(c) **Eligible Child of an Eligible Same Gender Partner.** For purposes of eligibility for enrollment, each natural or legally adopted child of an Eligible Same Gender Partner who meets the requirements of Section 4.06 is defined as an “Eligible Child.” If such child is enrolled in this Plan, the Sponsored Member, Retired Member, or Coverage Continuation Member is responsible for any taxes incurred as a result of coverage under the Plan.

Section 4.06 **Age or Disability Requirements.** In addition to the relationship requirements stated in Section 4.05, an individual must satisfy one (1) of the following age or disability requirements to be considered an Eligible Child:

- (a) is under age twenty-six (26); or
- (b) regardless of age,
 - (i) is totally and permanently disabled as determined by the Social Security Administration, and
 - (ii) has been continuously enrolled (or has waived coverage) in the Plan since age twenty-six (26).

Section 4.07 **Waiver of Coverage and Re-enrollment.** A Sponsored Member may waive coverage under this Plan for her/his Eligible Spouse or Eligible Same Gender Partner and/or Eligible Child during any period such Eligible Spouse or Eligible Same Gender Partner and/or Eligible Child has Other Employer-Provided Group Coverage, as described in Section 18.25. Waiver of coverage will become effective on the first day of the calendar month following the date the acceptable request to waive coverage is received by Portico Benefit Service. Coverage that has been waived pursuant to this Section 4.07 may be initiated or resumed on any subsequent date, provided that the individual is eligible for such coverage, and such coverage is requested in an acceptable manner and initiated or resumed no later than sixty (60) days after the Other Employer-Provided Group Coverage is terminated.

Section 4.08 **Open Enrollment.** A Sponsored Member may enroll an Eligible Spouse or Eligible Same Gender Partner and/or Eligible Child [is not enrolled in this Plan](#) during the annual open enrollment period described in Section 3.06(b), with coverage becoming effective the following January 1, provided the Sponsored Member is not waiving coverage. An Eligible Spouse or Eligible Same Gender Partner and/or Eligible Child enrolling during this open enrollment period shall have no Applicable Waiting Period.

[In accordance with Sec. 3.06\(b\), when a Sponsored Member elects an ELCA-Primary Option during the open enrollment period to be effective the following January 1, the same ELCA-Primary Option will also apply to an Eligible Spouse or Eligible Same Gender Partner and/or Eligible Child if such Eligible Spouse or Eligible Same Gender Partner and/or Eligible Child is eligible for the same ELCA-Primary Option as the Sponsored Member.](#)

ARTICLE V. ENROLLMENT OF A RETIRED MEMBER, ELIGIBLE SPOUSE, ELIGIBLE SAME GENDER PARTNER AND ELIGIBLE CHILDREN

Section 5.01 **Enrollment of a Retired Member.** An individual may enroll in this Plan as a Retired Member, subject to the following conditions:

- (a) Any individual who is a Sponsored Member on the date of the Member's Separation from Service will be eligible to enroll as a Retired Member under this Medical and Dental Benefits Plan if the Member has (i) attained age sixty (60), or (ii) completed a

total of thirty (30) years of service with an Eligible Employer. A Retired Member's coverage under this Plan will commence on the date immediately following the Member's Separation from Service, provided that such coverage is requested in an acceptable manner within sixty (60) days of the date of Separation from Service. If coverage is requested more than sixty (60) days following Separation from Service, s/he will be entitled to enroll in this Plan as a Retired Member on the first day of the calendar month following the end of the Applicable Waiting Period. A Retired Member whose coverage has terminated may re-enroll in this Plan on the first day of the calendar month following the end of the Applicable Waiting Period. For purposes of this Section, Applicable Waiting Period shall mean the ~~six (6) month~~ninety (90) day period beginning on the day that her/his acceptable application for coverage is received by Portico Benefit Services.

(b) An individual who is an Eligible Employee but not a Sponsored Member on the date of the Individual's Separation from Service, and who otherwise satisfies the requirements of Section 5.01(a), will be eligible to become a Retired Member in this Medical and Dental Benefits Plan, provided:

(i) immediately prior to Separation from Service, the individual was employed by an Eligible Employer described in Section 2.01(c) or (d) that 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;

(ii) immediately prior to Separation from Service, 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; and

(iii) the individual had employer-provided group health coverage immediately prior to the individual's Separation from Service and continuously from the date of the individual's Separation from Service to a date no more than sixty (60) days prior to the commencement of coverage as a Retired Member.

(c) An individual not included in (a) or (b) who was a participant in The American Lutheran Church Major Medical-Dental and Disability Plan or the Ministerial Health Benefits Plan of the Lutheran Church in America on December 31, 1987, will be eligible to become a Retired Member in this Medical and Dental Benefits Plan, provided:

(i) the former participating employer is eligible to be a Participating Employer in the ELCA Master Institutional Retirement Plan;

(ii) the individual was employed continuously by the former participating employer from December 31, 1987 to her/his date of retirement; and

(iii) the individual had employer-provided group health coverage immediately prior to the individual's Separation from Service and continuously

from the date of the individual's date of retirement to a date no more than sixty (60) days prior to the commencement of coverage as a Retired Member.

(d) An ELCA Ordained Minister or ELCA Rostered Layperson who is an Eligible Employee but not a Sponsored Member on the date of her/his Separation from Service, and who otherwise satisfies the requirements of Section 5.01(a), will be eligible to become a Retired Member in this Medical and Dental Benefits Plan provided:

(i) immediately prior to Separation from Service, the individual was employed by an Eligible Employer; and

(ii) immediately prior to Separation from Service, 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; and

(iii) the individual had Other Employer-Provided Group Coverage immediately prior to Separation from Service and continuously from the date of her/his date of Separation from Service to a date no more than sixty (60) days prior to the commencement of coverage as a Retired Member.

Section 5.02 **Waiver of Coverage and Re-enrollment of a Retired Member**. A Retired Member may waive coverage under this Plan during any period such Retired Member has Other Employer-Provided Group Coverage as described in Section 18.25. Waiver of coverage will become effective on the first day of the calendar month following the date the acceptable request to waive coverage is received by Portico Benefit Services. A Retired Member who has waived coverage under this Plan may initiate or resume such coverage [under this Plan](#) on any subsequent date, provided that such coverage is requested in an acceptable manner ~~from~~ [from](#) Portico Benefit Services and initiated or resumed no later than sixty (60) days after the Other Employer-Provided Group Coverage is terminated. Any Retired Member initiating or resuming coverage under this Plan who had Other Employer-Provided Group Coverage within sixty (60) days of the effective date of coverage will be deemed to have waived coverage.

Section 5.03 **Open Enrollment for a Retired Member**. A Retired Member may enroll during the annual open enrollment period described in Section 3.06(b), with coverage effective the following January 1, provided the Retired Member is not fulfilling an Applicable Waiting Period on that January 1. A Retired Member enrolling during this open enrollment period shall have no Applicable Waiting Period.

Section 5.04 **Enrollment of Eligible Spouse or Eligible Same Gender Partner or Eligible Child of a Retired Member. An Eligible Spouse or Eligible Same Gender Partner or an Eligible Child of a Retired Member may enroll in this Plan.** Coverage for dependents who are enrolled concurrently with the Retired Member or within sixty (60) days of the Retired Member's Separation from Service will commence on the date the Retired Member's coverage commences.

Coverage for dependents who are enrolled more than sixty (60) days following the Retired Member's Separation from Service will commence on the first day of the calendar month

following the end of the Applicable Waiting Period. This Applicable Waiting Period is defined as the ~~six (6) month~~ ninety (90) day period beginning on the date the dependent's acceptable application for coverage is received by Portico Benefit Services. Notwithstanding the preceding sentence:

(a) Coverage for a dependent who is enrolled within sixty (60) days of the termination of her/his Other Employer-Provided Group Coverage will commence on the date designated by the Retired Member provided such date is within sixty (60) days of the termination of the dependent's Other Employer-Provided Group Coverage.

(b) Coverage for a dependent who is enrolled during an annual open enrollment period described in Section 5.06 will commence on the first day of the calendar year following the end of such open enrollment period.

(c) Coverage for an individual who becomes an Eligible Spouse or Eligible Same Gender Partner or Eligible Child of a Retired Member as a result of marriage, satisfaction of the same gender partnership requirements established by Portico Benefit Services, birth, adoption or placement for adoption will commence on the date designated by the Retired Member, provided such date is within sixty (60) days of the date the individual becomes an Eligible Spouse, Eligible Same Gender Partner or Eligible Child.

Section 5.05 Waiver of Coverage and Re-enrollment of Eligible Spouse or Eligible Same Gender Partner or Eligible Child of a Retired Member. A Retired Member may waive coverage under this Plan for her/his Eligible Spouse or Eligible Same Gender Partner and/or Eligible Child during any period such Eligible Spouse or Eligible Same Gender Partner and/or Eligible Child has Other Employer-Provided Group Coverage, as described in Section 18.25. Waiver of coverage will become effective on the first day of the calendar month following the date the acceptable request to waive coverage is received by Portico Benefit Services. Coverage that has been waived pursuant to this Section 5.05 may be initiated or resumed on any subsequent date, provided that the individual is eligible for such coverage, and such coverage is requested from Portico Benefit Services in an acceptable manner and initiated or resumed no later than sixty (60) days after the Other Employer-Provided Group Coverage is terminated.

Section 5.06 Open Enrollment for Eligible Spouse or Eligible Same Gender Partner or Eligible Child of a Retired Member. A Retired Member may enroll an Eligible Spouse or Eligible Same Gender Partner and/or Eligible Child during the annual open enrollment period described in Section 3.06(b), with coverage becoming effective the following January 1, provided the Retired Member is not waiving coverage. An Eligible Spouse or Eligible Same Gender Partner and/or Eligible Child enrolling during this period shall have no Applicable Waiting Period.

ARTICLE VI.
ENROLLED STATUS: TERMINATION AND CONTINUATION IN CERTAIN SITUATIONS

Section 6.01 **Termination of Sponsored Member's Enrolled Status**. Unless coverage is continued in accordance with Section 6.06, the enrolled status of a Sponsored Member is terminated on the earliest of the following dates:

(a) The date specified in an advance notice in an acceptable manner from the individual's Participating Employer that it will no longer sponsor the individual as a Sponsored Member.

(b) In the case of a Participating Employer that is subject to the requirements of Section 3.03(a), the date determined by Portico Benefit Services, in its sole discretion, to be the date that the Participating Employer ceased to sponsor all of its Eligible Employees.

(c) Such date determined by Portico Benefit Services to be the date that the Participating Employer ceased to make contributions on behalf of such Sponsored Member as required by this Medical and Dental Benefits Plan or any of the following plans:

- (i) The ELCA Retirement Plan;
- (ii) The ELCA Disability Benefits Plan; or
- (iii) The ELCA Survivor Benefits Plan.

(d) Such date determined by Portico Benefit Services to be the date that the Participating Employer ceased to provide accurate information requested by it for the administration of this Medical and Dental Benefits Plan.

(e) The date of the required contribution if full payment is not received within the time frame specified in Portico Benefit Services' Past-Due Account Management Policy.

Section 6.02 **Termination of Retired Member's Enrolled Status**. The enrolled status of a Retired Member is terminated on the date determined by Portico Benefit Services as the date that the Retired Member ceased making contributions in accordance with Section 8.03.

Section 6.03 **Termination of a Spouse's Enrolled Status**. Unless coverage is continued in accordance with Section 6.07, the enrolled status of an Eligible Spouse is terminated on the earliest of the following dates:

(a) The date the individual is no longer an Eligible Spouse.

(b) In the case of a spouse of a Sponsored Member, the date the spouse is no longer sponsored for enrollment by the Participating Employer.

(c) In the case of a spouse of a Sponsored Member, Coverage Continuation Member or Retired Member, the date the enrolled status of such Member ends.

(d) In the case of a spouse of a Sponsored Member or Coverage Continuation Member, the date such Member waives coverage.

(e) In the case of a spouse of a Retired Member who waives coverage but is not covered by a Medicare Advantage Plan, the date such Member waives coverage.

(f) In the case of a spouse 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 Benefit Services' Past-Due Account Management Policy.

Section 6.04 **Termination of an Eligible Same Gender Partner's Enrolled Status.** Unless coverage is continued in accordance with Section 6.07, the enrolled status of an Eligible Same Gender Partner is terminated on the earliest of the following dates:

(a) The date the individual is no longer an Eligible Same Gender Partner (as evidenced by submitting a completed Affidavit of Dissolution of Partnership to Portico Benefit Services).

(b) In the case of an Eligible Same Gender Partner of a Sponsored Member, the date the Eligible Same Gender Partner is no longer sponsored for enrollment by the Participating Employer.

(c) In the case of an Eligible Same Gender Partner of a Sponsored Member, Coverage Continuation Member or Retired Member, the date the enrolled status of such Member ends.

(d) In the case of an Eligible Same Gender Partner of a Sponsored Member or Coverage Continuation Member, the date such Member waives coverage.

(e) In the case of an Eligible Same Gender Partner of a Retired Member who waives coverage but is not covered by a Medicare Advantage Plan, the date such Member waives coverage.

(f) In the case of an Eligible Same Gender Partner of a Sponsored or Retired Member, the date of the required contribution if full payment is not received within the time frame specified in Portico Benefit Services' Past-Due Account Management Policy.

Section 6.05 **Termination of a Child's Enrolled Status.** Unless coverage is continued in accordance with Section 6.07, the enrolled status of an Eligible Child is terminated on the earliest of the following dates:

(a) The date the individual is no longer an Eligible Child.

(b) In the case of a dependent of a Sponsored Member, Coverage Continuation Member or Retired Member, the date the enrolled status of such Member ends.

(c) In the case of a dependent of a Sponsored Member or Coverage Continuation Member, the date such Member waives coverage.

(d) In the case of a dependent of a Retired Member who waives coverage but is not covered by a Medicare Advantage Plan, the date such Member waives coverage.

(e) In the case of a dependent 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 Benefit Services' Past-Due Account Management Policy.

Section 6.06 **Coverage Continuation for Sponsored Members.** In certain situations, a Sponsored Member whose enrolled status would otherwise terminate in accordance with Section 6.01 may remain enrolled as a Coverage Continuation Member by submitting an acceptable election to continue coverage to Portico Benefit Services within sixty (60) days of the date of the change in status, subject to the following:

(a) A Sponsored Member who is an ELCA Ordained Minister or Rostered Layperson may continue coverage at her/his own expense during any period the Member is "On Leave from Call" provided coverage is also continued in accordance with Section 4.03 of the ELCA Survivor Benefits Plan. At the end of such period the Member may continue medical and dental coverage for an additional period of up to eighteen (18) months.

(b) A Sponsored Member who becomes disabled and entitled to benefits from the ELCA Disability Plan may continue coverage during such period of disability. The Participating Employer shall pay the monthly contributions under this Medical and Dental Benefits Plan for coverage of the Sponsored Member and Dependents for each of the first two (2) months of disability. If the Participating Employer fails to pay any monthly contribution for the Member or Dependents for such period, the Member may make such contribution on her/his own behalf and/or on behalf of her/his Dependents to prevent a lapse in coverage. Thereafter the contributions for such coverage shall be paid to this Medical and Dental Benefits Plan on behalf of the Member from the ELCA Disability Benefits Trust until s/he is no longer disabled, s/he is a Retired Member or s/he dies. If the Member is no longer disabled and does not return to work as a Sponsored Member, the Member may continue medical and dental coverage at her/his own expense for an additional eighteen (18) months.

(c) Any other Sponsored Member may continue coverage at her/his own expense for a period of up to eighteen (18) months following a termination of employment (other than for reasons of gross misconduct), a reduction in hours of employment which causes the Sponsored Member to no longer be eligible for coverage under the Plan, taking a leave of absence without pay, 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 (USERRA) may continue coverage at her/his own expense for a period of up to twenty-four (24) months. Such coverage shall be terminated as of the due date of the required contribution if full payment is not received within the time frame specified in Portico Benefit Services' Past-Due Account Management Policy.

Section 6.07 **Coverage Continuation for Dependents**. A Dependent whose enrolled status would otherwise terminate in accordance with Section 6.03 or Section 6.05 may remain enrolled at his/her own expense as a Coverage Continuation Member by submitting an acceptable election to continue coverage to Portico Benefit Services within sixty (60) days of the date of the change in status and by making required payments within the time frame specified by Portico Benefit Services, subject to the following:

(a) A Surviving Spouse or surviving Eligible Same Gender Partner of a Sponsored Member, Retired Member, or Coverage Continuation Member described in Section 18.06(a) or (b), may continue coverage at her/his own expense for her/his remaining lifetime.

(b) A Former Spouse or former Eligible Same Gender Partner of a living or deceased Sponsored Member, Retired Member, or Coverage Continuation Member described in Section 18.06(a) or (b), may continue coverage at her/his own expense for a period of up to thirty-six (36) months. However, if such Former Spouse began Coverage Continuation on or before May 1, 2010, such coverage may continue at the Former Spouse's expense until remarriage. Following remarriage, the Former Spouse may continue ~~medical and dental~~ coverage for an additional period of up to thirty-six (36) months.

(c) An Eligible Child of a Surviving Spouse or surviving Eligible Same Gender Partner described in Section 6.07(a) may continue coverage at her/his own expense during the period the Surviving Spouse or surviving Eligible Same Gender Partner continues coverage in this Plan. At the end of such period, the Eligible Child may continue ~~medical and dental~~ coverage at her/his own expense as long as s/he meets the requirements set forth in Section 4.06.

(d) A Surviving Child of a deceased Sponsored Member, Retired Member, or Coverage Continuation Member described in Section 18.06(a), (b) or (c), or Section 6.06(a) or (b), may continue coverage at her/his own expense as long as s/he meets the requirements set forth in Section 4.06.

(e) An Eligible Child of a Former Spouse or former Eligible Same Gender Partner described in Section 6.07(b) may continue coverage at her/his own expense until the earlier of the end of the period described in Sec. 6.07(b) for which the Former Spouse or former Eligible Same Gender Partner was eligible to continue coverage in this Plan or until the Eligible Child no longer meets the requirements set forth in Section 4.06.

(f) Any Eligible Child who had not waived coverage and who no longer meets the requirements of Section 4.06 may continue coverage at her/his own expense for a period of up to thirty-six (36) months.

(g) A Dependent of a Member who is not eligible to continue coverage in accordance with Section 6.06 is also not eligible to continue coverage.

Coverage shall be terminated as of the due date of the required contribution if full payment is not received within the time frame specified in Portico Benefit Services' Past Due Account Management Policy.

Notwithstanding the above, an individual described in Section 6.07(a), (b), (c) or (d), who met that status before January 1, 2004, may re-enroll in this Plan at any date. S/he will not be subject to the Applicable Waiting Period if Other Employer-Provided Group Coverage as described in Section 18.24 was in effect immediately prior to re-enrollment.

Section 6.08 **Waiver of Coverage and Re-enrollment for Certain Coverage Continuation Members.** A Member who has continued coverage under Section 6.06(a) or (b) may waive coverage under this Plan during any period such Member has Other Employer-Provided Group Coverage as described in Section 18.25. Additionally, a Member who has continued coverage under Section 6.06(a) or (b) may waive coverage for her/his Eligible Spouse or Eligible Same Gender Partner and/or Eligible Child during any period such Eligible Spouse or Eligible Same Gender Partner or Eligible Child has Other Employer-Provided Group Coverage as described in Section 18.25. Waiver of coverage will become effective on the first day of the calendar month following the date the acceptable request to waive coverage is received by Portico Benefit Services. A Member, Eligible Spouse or Eligible Same Gender Partner or Eligible Child who has waived coverage under this Plan may resume such coverage on any subsequent date, provided that such coverage is requested in an acceptable manner from Portico Benefit Services and initiated or resumed no later than sixty (60) days after the Other Employer-Provided Group Coverage is terminated. An individual who waived coverage in accordance with this Section 6.08 is also a Coverage Continuation Member. A Member who has continued coverage under Section 6.06(c) or Section 6.07 may not waive coverage under this Plan. Once coverage ends, such Member shall be eligible to re-enroll only if s/he once again meets the requirements of Articles III or IV.

Section 6.09 **Other Eligible Individuals.** Other individuals may be eligible for health coverage based on Portico Benefit Services' health coverage administrative rules.

ARTICLE VII. COST OF MEDICAL AND DENTAL COVERAGE FOR SPONSORED MEMBERS AND THEIR DEPENDENTS

Section 7.01 **In General.** ~~The Medical and Dental Benefits Plan is non-contributory for a Sponsored Member. The A Participating Employer of a Sponsored Member is responsible for the payment of all Plan contributions associated with membership of for the:~~

~~(a) ELCA-Primary Option such Participating Employer elects for its Sponsored Member~~Sponsored Members with ELCA-Primary Benefits, or

(b) ~~_____~~ -ELCA Medicare-Primary Standard Option such Participating Employer offers to its Sponsored Members with ELCA Medicare-Primary Benefits.

The Participating Employer is also responsible for remitting to Portico Benefit Services the Sponsored Member's portion of the contribution amount when the Sponsored Member elects contributions for an ELCA-Primary Health Option with a higher contribution amount than the ELCA-Primary Option elected by the Participating Employer, and cContributions for coverage of the Eligible Spouses or Eligible Same Gender Partners and Eligible Children which it elects to enroll in this Medical and Dental Benefits Plan.

Section 7.02 Amount of Contribution for ~~Participation~~ Members Sponsored in the Medical and Dental Benefits Plan. Contributions will be determined annually by Portico Benefit Services, in its sole discretion, based on actuarial studies in such a manner that the Medical and Dental Benefits Plan will be self-sustaining, both as to benefit costs and administrative expenses.

Contributions will be expressed as a percentage of the Sponsored Member's Defined Compensation with minimum and maximum amounts. To achieve equitable sharing of total cost, contributions will take into account factors; ~~other than the Sponsored Member's age or sex,~~ that affect the cost of coverage. Such factors may include, but are not limited to:

(a) ~~_____~~ The Member's age

~~(a)~~(b) ~~_____~~ The extent to which a Sponsored Member's Eligible Dependents are enrolled-

~~(b)~~(c) ~~_____~~ Variations in the level of medical and dental costs by geographic area-

~~(c)~~(d) ~~_____~~ The availability to such Member of primary medical coverage under Medicare-

Section 7.03 Special Rules for Contribution Rates Where Two (2) Members are Married to Each Other or are in an Eligible Same Gender Partnership and are Employed by Participating Employers; or Where a Sponsored Member is Employed by Two (2) or More Participating Employers.

(a) ~~_____~~ Two (2) Members are Married to Each Other or in an Eligible Same Gender Partnership and are Employed by Participating Employers - If both are employed by Participating Employers, the Members shall designate which one (1) is to be enrolled as the Sponsored Member and which one (1) is to be enrolled as the Eligible Spouse or Eligible Same Gender Partner. If the Members fail to make a designation, Portico Benefit Services will make the designation as follows:

(i) For spouses who were both employed by Participating Employers on December 31, 2000, the spouse who was designated as the Sponsored Member as of that date will continue to be so designated.

(ii) Otherwise, the one (1) with the earlier birthday in the calendar year will be designated as the Sponsored Member.

Contributions shall be made for both Members who are married to each other or who are in an Eligible Same Gender Partnership and are ~~Employed~~employed by Participating Employers. The total contribution shall be based on the couple's total Defined Compensation, geographic location and each person's age and allocated equally between the respective Participating Employers in a manner determined by Portico Benefit Services.

Notwithstanding the foregoing, when two Members married to each other or in an Eligible Same Gender Partnership are employed by more than two Participating Employers, such Participating Employers will pay their respective share of contribution rates in a manner determined by Portico Benefit Services.

(b) ~~When a~~ Sponsored Member ~~is~~ employed concurrently by two (2) or more Participating Employers, ~~- each~~Each employer shall contribute based on geographic location, Member's age, and the Defined Compensation it pays to the Member, provided, however, that minimum and maximum contributions shall be based on the Member's combined Defined Compensation and allocated equally between the respective Participating Employers in a manner determined by Portico Benefit Services ~~to each Employer in proportion to the Defined Compensation paid by that Employer.~~

Section 7.04 Failure of Participating Employer to Make Required Contributions.

The enrolled status of a Sponsored Member and Dependents will be terminated if the Participating Employer has not remitted the full contribution for the Sponsored Member and Dependents to the Medical and Dental Benefits Plan within sixty (60) days after the due date for a given period, except that in the event the Participating Employer cannot or will not remit the full contribution to the Medical and Dental Benefits Plan, the Sponsored Member may make the contribution to continue coverage for the Sponsored Member and Dependents for up to eighteen (18) months, in accordance with Section 6.06(a). If, after eighteen (18) months of payment by the Sponsored Member, the Participating Employer does not resume remitting contributions, the coverage of the Sponsored Member and her/his Dependents under this Medical and Dental Benefits Plan will terminate.

Section 7.05 Waiver of Medical and Dental Benefits Contributions. In the event that a Sponsored Member terminates employment with one (1) Participating Employer and, within thirty-one (31) days thereafter, becomes a Sponsored Member with another Participating Employer, contributions will not be required to continue coverage for the Sponsored Member and Dependents during the period between employment. If the period between covered employment by two (2) separate Participating Employers exceeds thirty-one (31) days, the Sponsored Member must continue coverage in accordance with Section 6.06 to remain eligible for benefits.

**ARTICLE VIII.
CONTRIBUTION RATES FOR COVERAGE CONTINUATION MEMBERS AND
RETIRED MEMBERS**

Section 8.01 **Coverage Continuation Members.** The contribution rates for Coverage Continuation Members will be determined annually by Portico Benefit Services, in its sole discretion, based on actuarial studies in such a manner that the Medical and Dental Benefits Plan will be self-sustaining, both as to benefit costs and administrative expenses.

Section 8.02 **Eligible Child of a Deceased Member.** An Eligible Child who is predeceased by both parents prior to 2004, and who was covered under this Medical and Dental Benefits Plan as an Eligible Child at the time of the death of the second parent to die, shall continue to receive coverage at no cost as long as s/he meets the requirements set forth at Section 4.06.

Section 8.03 **Retired Members.** The contribution rates for Retired Members and Eligible Spouses or Eligible Same Gender Partners and Eligible Children of Retired Members will be determined annually by Portico Benefit Services, in its sole discretion, based on actuarial studies in such a manner that the Medical and Dental Benefits Plan will be self-sustaining, both as to benefit costs and administrative expenses.

Section 8.04 **Subsidies for Certain Retired Members Based on Predecessor ALC Subsidy Schedule.** The contribution for a Retired Member described in subsection (a) shall be reduced by the amount determined in subsection (b) to the extent that such amount is paid to the ELCA Medical and Dental Benefits Trust pursuant to Section 8.07.

(a) A Retired Member shall be eligible for a subsidy pursuant to this Section 8.04 if s/he:

(i) was a retired participant in the ELCA Continuation of The ALC Medical Dental Plan for Retired Participants as of December 31, 1996, or

(ii) is a Retired Member who had been a participant in The American Lutheran Church Major Medical-Dental and Disability Plan, and who retired prior to January 1, 1991, or who retired after that date but was "Retirement Eligible" on December 31, 1987. An individual was "Retirement Eligible" on December 31, 1987 if the individual had at least one (1) full year of active participation in The ALC Major Medical-Dental Plan prior to January 1, 1983, and met one (1) of the following requirements on December 31, 1987:

(A) the individual had attained age sixty-two (62);

(B) the individual had attained emeritus status on the Clergy Roster of the ALC; or

(C) the individual had completed three hundred sixty (360) months of service with an employer controlled by, or associated with the ALC within the meaning of ERISA § 3(33)(C).

(b) The amount of the subsidy shall be the contribution rate applicable to the ~~Medicare Supplement Benefit~~ ELCA Medicare-Primary Standard Option described in ~~Article XI~~ Section 9.02 that is chosen by the Retired Member (and the Retired Member's Eligible Spouse and Eligible Children, if applicable) multiplied by the ratio of (i) the number of the Retired Member's full years of active participation in The ALC Major Medical-Dental and Disability Plan prior to January 1, 1983, to (ii) the number of full years from the date the Retired Member first became a participant in such ALC Plan to the date the Retired Member attained age sixty-five (65). For purposes of this subsection (b), all years prior to 1961 shall be disregarded.

Notwithstanding the above, no subsidy shall be paid unless the Retired Member meets all of the following requirements:

(i) the individual has attained age sixty-five (65),

(ii) the individual was a Member of the ELCA Medical and Dental Benefits Plan or the ELCA Institutional Welfare Benefits Plan through The Travelers Insurance Company, or was a participant in The American Lutheran Church Major Medical-Dental and Disability Plan continuously from December 31, 1982, until the later of (i) the date that the individual attains age sixty-five (65), or (ii) the date that the individual has a Separation from Service under such plans, and

(iii) the individual was a Member on whose behalf contributions were made to this ELCA Medical and Dental Benefits Plan, the ELCA Institutional Welfare Benefits Plan through The Travelers Insurance Company, or The American Lutheran Church Major Medical-Dental and Disability Plan, continuously for the five (5) year period immediately preceding her/his Separation from Service. Only a four (4) year period is required if the individual was a participant on January 31, 1981, and continuously thereafter, until her/his retirement.

A Member shall not fail the continuous coverage requirements in (ii) and (iii) above for any period during which the Member had other substantial medical coverage in effect.

Section 8.05 Subsidies for Certain Retired Members Based on Predecessor LCA Subsidy Schedule. The contribution for a Retired Member described in subsection (a) shall be reduced by the amount determined in subsection (b) to the extent that such amount is paid to the ELCA Medical and Dental Benefits Trust pursuant to Section 8.07.

(a) A Retired Member shall be eligible for a subsidy pursuant to this Section 8.05 if s/he:

(i) was a Retired Member of the ELCA Continuation of the LCA Ministerial Health Benefits Plan for Retired Members as of December 31, 1996, or

(ii) is a Retired Member who had been a participant in the Ministerial Health Benefits Plan of the Lutheran Church in America (as amended effective December 31, 1987, to include lay employees who were employed by the LCA synods or churchwide agencies, or by an Inter-Lutheran Agency) or was a lay employee of an LCA seminary who would have been a participant in the Ministerial Health Benefits Plan, had such employees been included in the December 31, 1987 Amendment, and who retired prior to January 1, 1991, or who retired after that date but was “Retirement Eligible” on December 31, 1987. An individual was “Retirement Eligible” on December 31, 1987 if the individual was covered under the Ministerial Health Benefits Plan of the Lutheran Church in America (as amended effective December 31, 1987 to include lay employees who were employed by the LCA synods or churchwide agencies, or by an Inter-Lutheran Agency) on December 31, 1987, and on that date, either (A) had attained age sixty (60) and, if that individual was a lay employee, also had completed ten (10) years of service with an employer controlled by, or associated with the LCA within the meaning of ERISA § 3(33)(C), or (B) had been an ordained minister listed on the LCA Clergy Roster for at least thirty (30) years, or had thirty (30) years of service with an employer controlled by, or associated with the LCA within the meaning of ERISA § 3(33)(C).

(b) The amount of the subsidy shall be the contribution rate applicable to the ELCA Medicare Medicare-Primary-Supplement-Benefit Standard Option, without the ELCA dental benefit, described in Article XI ~~that is chosen by the Retired Members who do not have dental coverage~~, multiplied by the percentage determined in accordance with the following table, based on the year in which the Retired Member attained age sixty (60) or, if earlier, became permanently and totally disabled, and is receiving benefits from the ELCA Disability Benefits Plan as determined by Portico Benefit Services, in its sole discretion:

Year Individual Attained Age Sixty (60) or Became Disabled	Percentage*
1985 or before	100.00%
1986	97.37%
1987	94.74%
1988	92.11%
1989	89.47%
1990	86.84%
1991	84.21%
1992	81.58%
1993	78.95%
1994	76.32%
1995	73.68%
1996	71.05%
1997	68.42%
1998	65.79%

1999	63.16%
2000	60.53%

*The percentage for former lay employees of the LCA churchwide agencies and synods or of an Inter-Lutheran agency included in subsection (a)(i) shall be one hundred percent (100%).

For a Retired Member described in paragraph (ii) of subsection (a) above who is eligible for Medicare, the amount of the subsidy determined in subsection (b) above shall be increased by the premium payable by such Retired Member for ~~Supplementary Medical Insurance under Medicare~~ Medicare Part B (up to a maximum of forty dollars (\$40) per month), multiplied by the applicable percentage from subsection (b) above; provided, however, that the total subsidy in subsection (b) above shall not exceed the total contribution for such Retired Member and her/his Eligible Spouse and Eligible Children.

For a Retired Member described in paragraph (i) of subsection (a) above who is eligible for Medicare, the Plan will reimburse such Member for a portion of the premium paid by the Member for ~~Supplementary Medical Insurance under Medicare~~ Medicare Part B. The reimbursement shall be equal to the ~~SMI~~ Medicare Part B premium paid by the Member (up to a maximum of forty dollars (\$40) per month), multiplied by the applicable percentage from subsection (b) above.

Section 8.06 Subsidies for Certain Retired Members Based on ELCA Subsidy Schedule. The contribution for a Retired Member described in subsection (a) shall be reduced by the amount determined in subsection (b) to the extent that such amount is paid to the ELCA Medical and Dental Benefits Trust pursuant to Section 8.07.

(a) A Retired Member shall be eligible for a subsidy pursuant to this Section 8.06 if s/he is:

(i) a Retired Member who had been a participant in The American Lutheran Church Major Medical-Dental and Disability Plan other than a Retired Member described in Section 8.04(a)(i) or (ii),

(ii) a Retired Member who had been a participant in the Ministerial Health Benefits Plan of the Lutheran Church in America (as amended effective December 31, 1987, to include lay employees who were employed by the LCA synods or churchwide agencies, or by an Inter-Lutheran Agency) and lay employees of LCA seminaries who would have been in the Ministerial Health Benefits Plan of the Lutheran Church in America, had seminaries been included in the December 31, 1987 Amendment, other than a Retired Member described in Section 8.05(a)(i) or (ii), or

(iii) a Retired Member who is a former employee of the AELC who (i) was an ordained minister of the AELC on December 31, 1987, (ii) was a participant in the medical program sponsored by the AELC on December 31,

1987, and (iii) is a retired ELCA Ordained Minister on the date s/he enrolls as a Retired Member under this Plan.

(b) The amount of the subsidy shall be the contribution rates for the ELCA Medicare Medicare-Primary Supplement Benefit Standard Option described in Article XI ~~that is chosen by the Retired Member and Eligible Spouse~~ multiplied by the percentage(s) determined in (i), (ii) or (iii) below:

(i) For a Retired Member, a percentage equal to:

175 - (2 x year of birth) -
(1 x year of original eligibility for coverage under the Plan).

(ii) For an Eligible Spouse of a Retired Member, the percentage calculated in subparagraph (i) multiplied by five-tenths (.5), provided, however, that for purposes of this Section 8.06, only a spouse who was legally married to the Retired Member eligible for a subsidy on the date of her/his retirement shall be eligible to receive a subsidy. A subsidy will be provided to no more than one (1) Eligible Spouse of a Retired Member.

(iii) For a Surviving Eligible Spouse, the percentage calculated in subparagraph (i) multiplied by seventy-five one-hundredths (.75).

For purposes of calculating the above percentages, a “year” shall be expressed by omitting the first two (2) digits (e.g., the “year of birth” of an individual born in 1950 is fifty (50)). The “year of original eligibility for coverage under the plan” is the year the individual was first eligible for coverage under the benefit program of a Predecessor Church, increased by the number of complete years during which the individual was not a Sponsored Member in the benefit program of the ELCA, a participant in the benefit program of a Predecessor Church or an eligible chaplain as defined by the ELCA Supplemental Retirement Plan for Government Chaplains.

Section 8.07 **Sources of Subsidies for Certain Retired Members**. The contribution reductions (subsidies) provided under Sections 8.04, 8.05 and 8.06 shall be paid from the ELCA Benefit Contribution Trust or by the ELCA to the ELCA Medical and Dental Benefits Trust at the time the Member pays a contribution that is entitled to such a subsidy.

If the payments provided for in this Section 8.07 are not paid when due or Portico Benefit Services that future payments of such amounts are doubtful, Portico Benefit Services may reduce the subsidy for future months in such manner as it determines is fair and equitable by taking into account administrative considerations and the general principle that the subsidies described in Sections 8.04, 8.05 and Section 8.06 are generally intended to be provided only to the extent that it is reasonable to expect that the payments described in this Section 8.07 will be paid to the ELCA Medical and Dental Benefits Trust, when and as due.

ARTICLE IX.
BENEFITS ~~COVERAGE~~ AND GENERAL PROVISIONS

Section 9.01 **Members Who Have ELCA-Primary Benefits Coverage**. Except as provided in Sections 9.02, 17.13, 17.14 and 17.15, a Member who meets the eligibility requirements of the Plan is an ELCA-Primary Member and shall have ELCA-Primary Benefits Coverage. Dependents eligible for ELCA-Primary Benefits will have the same ELCA-Primary Option as a Sponsored Member, Retired Member or Coverage Continuation Member who is covered by an ELCA-Primary Option. A Sponsored Member, Retired Member or Coverage Continuation Member who is covered by ELCA Medicare-Primary Benefits will choose the ELCA-Primary Option for her or his Dependents who are not eligible for ELCA Medicare-Primary Benefits in accordance with the procedures established by Portico Benefit Services.

The ELCA Medical and Dental Benefits Plan provides 4 (four) ELCA-Primary Options for eligible Members: ELCA-Primary Platinum+ Option, ELCA-Primary Gold+ Option, ELCA-Primary Silver+ Option and ELCA-Primary Bronze+ Option. The ELCA-Primary Silver+ Option and ELCA-Primary Bronze+ Option are high deductible health plans as defined by the IRS. See Appendix for details of each ELCA-Primary Option. ELCA-Primary Benefits ~~Coverage~~ includes ELCA Medical and Mental Health Benefits, Prescription Drug Benefits and Dental Benefits described in Articles X, XII, XIII and XV. A Member with ELCA-Primary Benefits Member who is eligible for a Personal Wellness Account who is a PWA Member is eligible to participate in a Personal Wellness Account in accordance with Article XX.

Section 9.02 **Members Who Have ELCA Medicare-Primary Benefits Coverage**. A Member is a ELCA Medicare-Primary Member if the Member is eligible for primary coverage under Medicare, or would have been eligible for primary coverage if the Member had not opted out of Social Security or waived participation in all or part of Medicare. An Eligible Same Gender Partner, described in Section 4.03, is not eligible for benefits under the Plan if s/he does not qualify for Medicare benefits on and after Medicare's age of eligibility.

The ELCA Medical and Dental Benefits Plan provides 3 (three) ELCA Medicare-Primary Options for eligible Members: ELCA Medicare-Primary Premium Option, ELCA Medicare-Primary Standard Option and ELCA Medicare-Primary Economy Option.

An ELCA Medicare-Primary Member shall have Medicare Supplement Benefits as described in Article XI, ELCA Prescription Drug Benefits as described in Article XV, and Dental Benefits as described in Article XIII, provided, however, that:

(a) A Member who is an ELCA Medicare-Primary Member ~~who and~~ enrolls in a Medicare Prescription Drug Program plan (Part D) that is not provided by the ELCA Medical and Dental Benefits Plan or opts out of the ELCA Part D Drug Benefit Coverage shall not also have ELCA Prescription Drug Benefits; and

(b) A Member described in Section 8.05(a)(i) who elected not to add dental coverage pursuant to a one-time option in 1996 to add retiree-paid dental, shall not have Dental Benefits.

Section 9.03 **Reimbursement of Medicare Premiums for Certain Members with ELCA Medicare-Primary Members Benefits.** The Plan will reimburse certain Members with ELCA Medicare-Primary Benefits Members for the premiums paid by the Members for Medicare Medical Insurance (Part B). However, the Plan will not reimburse the late enrollment penalty or other penalties imposed by Medicare. Members eligible for reimbursement are Sponsored Members and Disabled Sponsored Members and their Eligible Dependents who have primary coverage under Medicare until the Member is no longer a Sponsored Member or Disabled Sponsored Member.

Section 9.04 **Mid-Year Changes in Coverage.** Members may have mid-year changes in coverage due to changes in employment or status.

(a) If a Member has a mid-year change of benefits coverage and the change occurs without a break in coverage, due to (i) the Eligible Spouse or Eligible Same Gender Partner becomes the designated Sponsored Member and the Sponsored Member becomes the Eligible Spouse or Eligible Same Gender Partner in accordance with Section 7.03(a), or (ii) a child is no longer the designated Sponsored Member's Eligible Child but becomes the Eligible Child of another Member, or (iii) a child of the designated Sponsored Member becomes a Sponsored Member, or (iv) a termination of employment with ELCA Global Mission as a foreign missionary, Eligible Medical and Mental Health Expenses incurred prior to such mid-year change shall be ascribed to the Member and applied during the same calendar year for such Member as follows:

(i) From ELCA-Primary Benefits—Gold+ or Platinum+ Options Coverage to ELCA-Primary Gold+ or Platinum+ Options Benefits Coverage for (i), (ii) and (iii) above:

(A) The aggregate of the Deductible Amount and Percent Copayments for Eligible In-network Eligible Medical and Mental Health Expenses shall be applied toward the Deductible Amount and Maximum Out-of-Pocket Amount for In-network Eligible Medical and Mental Health Expenses.

(B) The Out-of-Pocket Amount for Eligible In-network Medical and Mental Health Expenses and Eligible Prescription Drug Member Copayments shall be applied toward the Maximum Out-of-Pocket Amount for In-network Eligible Medical and Mental Health Expenses and Eligible Prescription Drug Member Copayments.

(ii) From ELCA-Primary Gold+ or Platinum+ Options to ELCA-Primary Bronze+ or Silver+ Options for (i), (ii) and (iii) above:

(A) The Deductible Amount for Eligible In-network Medical and Mental Health Expenses shall be applied toward the Deductible Amount for In-network Eligible Medical and Mental Health and Prescription Drug Expenses.

(B) The Out-of-Pocket Amount for Eligible In-network Medical and Mental Health Expenses, and Eligible Prescription Drug Member Copayments shall be applied toward the Maximum Out-of-Pocket Amount for In-network Eligible Medical and Mental Health and Prescription Drug Expenses.

(iii) From ELCA-Primary Bronze+ or Silver+ Options to ELCA-Primary Gold+ or Platinum+ Options for (i), (ii) and (iii) above:

(A) The Deductible Amount for Eligible In-network Medical, Mental Health and Prescription Drug Expenses shall be applied toward the Deductible Amount for In-network Eligible Medical and Mental Health Expenses.

(B) The Out-of-Pocket Amount for Eligible In-network Medical, Mental Health and Prescription Drug Expenses shall be applied toward the Maximum Out-of-Pocket Amount for In-network Eligible Medical and Mental Health Expenses and Eligible Prescription Drug Member Copayments.

(iv) From ELCA-Primary Bronze+ or Silver+ Options to ELCA-Primary Bronze+ or Silver+ Options for (i), (ii) and (iii) above:

(A) The Deductible Amount for Eligible In-network Medical, Mental Health and Prescription Drug Expenses shall be applied toward the Deductible Amount for In-network Eligible Medical, Mental Health and Prescription Drug Expenses.

~~(A)~~(B) The Out-of-Pocket Amount for Eligible In-network Medical, Mental Health and Prescription Drug Expenses shall be applied toward the Maximum Out-of-Pocket Amount for In-network Eligible Medical, Mental Health and Prescription Drug Expenses.

~~(B) The aggregate of the Deductible and Percent Copayments for Out-of-network Eligible Medical and Mental Health Expenses shall be applied toward the Deductible and Maximum Out of Pocket Amount for Out-of-network Eligible Medical and Mental Health Expenses.~~

(v) From an ELCA-Primary Option to an ELCA Medicare-Primary Option, or an ELCA Medicare-Primary Option to an ELCA-Primary Option, Deductible Amounts and Out-of-Pocket Limits shall not be applied from one option to another.

(b) From ELCA Global Mission foreign missionaries benefits described in Section 17.15 to ELCA-Primary Benefits ~~Coverage~~:

(i) The aggregate of the Deductible and Percent Copayments for In-network Eligible Medical and Mental Health Expenses accumulated under the

insurance agreement for foreign missionaries shall be applied toward the Deductible and Maximum Out-of-Pocket Amount for In-network Eligible Medical and Mental Health Expenses with the Medical and Mental Health Benefits Administrator.

(ii) The aggregate of the Deductible and Percent Copayments for Out-of-network Eligible Medical and Mental Health Expenses accumulated under the insurance agreement for foreign missionaries shall be applied toward the Deductible and Maximum Out-of-Pocket Amount for Out-of-network Eligible Medical and Mental Health Expenses with the Medical and Mental Health Benefits Administrator.

(c) From one Participating Employer to another Participating Employer midyear

(i) Sponsored Members with ELCA-Primary Benefits will elect an ELCA-Primary Option at Open Enrollment in accordance with Sec. 3.06(b)(ii) or as an Eligible Employee enrolling midyear due to a midyear employment change and, such election ELCA-Primary Option will remain in effect for the entire plan year for a Member who is sponsored by a Participating Employer, even if the Member's Participating Employer changes midyear.

(ii) Sponsored Members with ELCA Medicare-Primary Benefits will have and retain the ELCA Medicare-Primary Standard Option when changing Participating Employers.

(d) From a Participating Employer as a Sponsored Member to a Member who is no longer sponsored

(i) A non-sponsored Member can elect an ELCA-Primary Option that is different than the ELCA-Primary Option she or he chose at Open Enrollment in accordance with Sec. 3.06(b)(ii) or when enrolled due to a midyear employment change as an Eligible Employee. Deductible and Out-of-Pocket Amounts will apply to the new ELCA-Primary Option as described in Sec. 9.04 (a). Notwithstanding the foregoing, if a non-sponsored period occurs between periods as a Sponsored Member and when the Member again becomes a Sponsored Member within a calendar year, such Member will return to the ELCA-Primary Option initially chosen.

(ii) A Retired Member must retain the ELCA Medicare-Primary Option she or he was enrolled in as a Sponsored member.

~~(ii)~~(iii) An On Leave from Call Member with ELCA Medicare-Primary Benefits will remain in the ELCA Medicare-Primary Standard Option while On Leave From Call

Section 9.05 **Maximum Reimbursement Amount.** Effective January 1, 2011, the Plan no longer has a Maximum Reimbursement Amount with respect to a Member for the following Eligible Expenses incurred after December 31, 2010:

- (a) Eligible Medical and Mental Health Expenses,
- (b) Eligible Medicare Supplement Expenses, and
- (c) Eligible Prescription Drug Expenses.

Section 9.06 **Adjustment of Certain Amounts Related to Benefits.** Certain Copayments, Deductible Amounts, Out-of-Pocket Amounts and Plan Limit Amounts related to Medicare Supplement, Medical and Mental Health, Dental, and Prescription Drug Benefits shall be determined annually by Portico Benefit Services. Such annual amounts are shown in the Appendix, which is incorporated herein and made part of this Plan document (“Appendix”).

Section 9.07 **Coordination of Benefits.**

(a) **Other Group Coverage.** If a Member has other group coverage that is primary to the ELCA Plan, the ELCA Plan will pay an amount equal to the excess, if any, of (i) the benefits that the ELCA Plan would have paid in the absence of such other group coverage over (ii) the benefits provided by the other group coverage, except as provided in subsection (b). However, the ELCA Plan will not pay additional benefits for prescription drug expenses covered by any other group coverage except for ELCA Part D Drug Benefit expenses.

(b) **Other Group Coverage and Medicare.** If an [ELCA Medicare-Medicare-Primary Member](#) has both other group coverage and Medicare hospital and medical (Part A and Part B) coverage that are primary to the ELCA Plan, the ELCA Plan will pay an amount equal to (i) the reimbursement for Eligible Medical Expenses under Medicare that the ELCA Plan would have paid in the absence of such other group coverage, or (ii) the balance due on the medical claim, whichever is less.

(c) **Other Insurance.** If a Member makes a claim for benefits from the ELCA Plan for which s/he received or could have received reimbursement from a claim under Workers’ Compensation, employers’ liability, automobile no-fault insurance, or similar law or act; liability or similar insurance; or on account of the act or omission of a third party, the ELCA Plan shall pay secondary to such source. Then the ELCA Plan shall pay only an amount equal to the excess, if any, of (i) the benefits that the ELCA Plan would have paid in the absence of such insurance or other reimbursement source over (ii) reimbursement received or which could have been received from such insurance or other reimbursements.

(d) **Determination of Responsibility.** When a Member is covered under two (2) or more group health plans, the primary responsibility for payment of benefits shall be determined by the Medical and Mental Health Benefits Administrator or Dental Benefits Administrator, based on national coordination of benefits insurance guidelines. Generally,

(i) The plan which has no provision for coordination of benefits will have primary responsibility.

(ii) The plan which covers the Member as an employee will have primary responsibility.

(iii) The plan which has covered the person for the longer period of time will have primary responsibility.

(iv) In the case of an Eligible Child (other than an Eligible Child whose parents are divorced or whose eligible same gender partnership is terminated as evidenced by an Affidavit of Dissolution of Partnership submitted to Portico Benefit Services):

(A) The plan which covers such child as a dependent of the parent whose month and day of birth occurs earlier in a calendar year shall have primary responsibility.

(B) If the month and day of birth of the parents are identical, the earliest-effective- date rule set forth in subsection (iii) shall apply.

(C) 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 shall determine the order of benefits.

(v) In the case of an Eligible Child whose parents are divorced or whose eligible same gender partnership is terminated as evidenced by an Affidavit of Dissolution of Partnership submitted to Portico Benefit Services:

(A) The plan which 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.

(B) 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 (2) or more plans:

(1) the plan which covers the child as a dependent of the parent with custody shall have primary responsibility; or

(2) the plan which covers the child as a dependent of the stepparent will have secondary responsibility; and

(3) the plan which covers the child as a dependent of the parent without custody shall have tertiary responsibility.

(vi) If the parents have joint custody of the child, the plan that has primary responsibility shall be determined under (iii) above.

Section 9.08 **Subrogation.**

(a) **Application of Subrogation Rules.** Upon the payment of benefits under the Medical and Dental Benefits Plan, Portico Benefit Services shall be subrogated to any Member's rights of recovery against any person or entity including, but not limited to, recoveries from tortfeasors, underinsured/uninsured motorist coverage, employers and/or workers' compensation insurers, other substitute coverage or any other right of recovery, whether based in tort, contract, or any other theory of recovery. For purposes of this Section 9.08, Member includes the Member and any person claiming through or on behalf of the Member, including trustees, personal representatives, executors, assigns and successors, next of kin, relatives, heirs, assigns and successors, or their representatives.

(b) **Assignment of Right to Recovery.** Portico Benefit Services may require the Member to assign her/his right of recovery to Portico Benefit Services to the extent of the reasonable value of the health benefits, services and payments provided to the Member plus reasonable costs of collection.

(c) **Member Cooperation.** The Member shall cooperate fully with Portico Benefit Services in assisting it to protect its legal rights under these subrogation provisions. The Member shall promptly inform Portico Benefit Services in writing of any situation or circumstance which may allow Portico Benefit Services to invoke its rights under this Section 9.08.

(d) **First Priority.** Portico Benefit Services' subrogation rights are the first priority claim against any person or entity as described in this Section 9.08, to be paid before any other claims are paid, whether or not the Member has been made whole or has recovered her/his total amount of damages. The right to be a first priority claim against any person or entity means that Portico Benefit Services shall be reimbursed from any recovery before payment of any other existing claims, including any claim by the Member for general damages. The entire amount of any damages recovered, not only the part specifically allocated to medical and dental expenses, is treated by this Medical and Dental Benefits Plan as reimbursement for Eligible Expenses.

(e) **Settlement Generally.** In the event that the Member settles any claim or action against any third party, the Member shall be deemed to have been made whole by the settlement and Portico Benefit Services shall be entitled to immediately collect the present value of its subrogation rights as the first priority claim from the settlement proceeds. The Member shall do nothing to prejudice Portico Benefit Services' rights under this provision, either before or after the time that the need for services or benefits under this Plan has elapsed. Portico Benefit Services may, at its option, immediately collect the present value of such amounts from the proceeds of any settlement or judgment that may be recovered by such Member or the Member's legal representative. Any such proceeds of settlement or judgment shall be held in trust by the Member for the benefit of Portico Benefit Services under these subrogation provisions, and Portico

Benefit Services shall be entitled to recover reasonable attorneys' fees from the Member when incurred in collecting proceeds held by the Member.

(f) **Settlement Without Consent of Portico Benefit Services.** In the event that a Member voluntarily accepts a lump-sum amount or other settlement without the consent of Portico Benefit Services, and this settlement results for any reason, including applicable state law, in a waiver or abrogation of Portico Benefit Services' subrogation rights against the employer or third party, then Portico Benefit Services is relieved of any obligation it may have or will acquire to pay past, present, or future benefits or expenses relating to such illness or injury.

(g) **Failure of Member to Obtain Mandated Insurance.** If the Member failed to obtain any type of state or federal mandated insurance coverage, including, but not limited to, no-fault coverage, Portico Benefit Services shall be allowed to fully assert its subrogation rights even though the Member's right to recover for those losses is limited in whole or in part because of the failure to obtain the mandated coverages.

(h) **Failure of Member to Reimburse Portico Benefit Services.** If a Member fails to remit to Portico Benefit Services any amount to which it is entitled in accordance with this Article IX, Portico Benefit Services may withhold future payments from this Medical and Dental Benefits Plan in satisfaction of the Member's obligation to remit such amount.

Section 9.09 **Claim Filing Deadline.** No reimbursement or direct payment will be made for Eligible Expenses unless a claim for reimbursement is submitted within twelve (12) months of the date on which such expenses were incurred; provided, however, that Portico Benefit Services, in its sole discretion, may waive the application of this provision due to circumstances beyond the control of the Member and/or the provider.

ARTICLE X.

ELCA-PRIMARY MEDICAL AND MENTAL HEALTH BENEFITS

Section 10.01 **In General.** A Member's eligibility for ELCA-Primary Benefits Coverage is set forth in Section 9.01.

Section 10.02 **ELCA-Primary Medical and Mental Health Benefits.** ELCA-Primary Medical and Mental Health Benefits provides reimbursement for In-network and Out-of-network Eligible Medical and Mental Health Expenses subject to the ELCA Medical and Dental Plan benefits, the billing practices of medical and mental health providers and the internal claims payment rules of Medical and Mental Health Benefits Administrators. Except for the Deductibles and Percent Copayments set forth in Sections 10.03, 10.04 and 10.06, the Medical and Dental Benefits Plan will pay the provider directly or will reimburse the Member for the In-network and Out-of-network Eligible Medical and Mental Health Expenses that are incurred for such Member while such Member (i) is enrolled as a Member, and (ii) has ELCA-Primary Benefits ~~Coverage~~.

Section 10.03 **Benefits for Eligible Expenses for Preventive Services.** For services specified in Section 12.06 and rendered by an In-network Eligible Medical Provider, the Plan

will pay one hundred percent (100%). The Member will pay no Copayment for In-network Eligible Preventive Services Expenses.

The Member will pay a Percent Copayment equal to ~~thirty-five~~forty percent (~~35~~40%) of Out-of-network Eligible Medical and Mental Health Expenses for Preventive Services specified in Section 12.06 until the Maximum Out-of-Pocket Amount for Out-of-network Eligible Medical and Mental Health Expenses has been met.

Section 10.04 **Deductibles and Percent Copayments for In-network Eligible Medical and Mental Health Expenses Other Than Preventive Services.** The Deductible Amount is the amount of covered expenses a Member incurs in the calendar year before the Plan pays a percentage of Eligible Expenses. For all Eligible Medical and Mental Health Expenses other than Preventive Services, after the Member has incurred In-network Eligible Medical and Mental Health Expenses equal to the In-network Deductible Amount in the calendar year, the Member will pay a Percent Copayment equal to ~~fifteen-twenty~~ percent (~~15~~20%) of such expenses in excess of the In-network Deductible Amount until the Maximum In-network Out-of-Pocket Amount has been reached.

The Member is responsible for the applicable per-Member In-network Medical and Mental Health Deductible Amount for which the Member is responsible is shown in the Appendix.

a) For the ELCA-Primary Gold+ Option and the ELCA-Primary Platinum+ Option, The an individual Member can incur Eligible Medical and Mental Health Expenses that meet the individual In-network Deductible Amount before the entire family In-network Deductible Amount is met. For Members with family coverage, the sum of the In-network Medical and Mental Health Deductible Amounts for the Member, Spouse or Eligible Same Gender Partner and eligible children of the Member's Family shall not exceed must equal the maximum In-network Deductible Amount for the type of family coverage elected by the Member before the Plan pays a percentage of Eligible Expenses. Deductible Amounts are specified in the Appendix.

a)b) ~~See Appendix for applicable amount.~~ For the ELCA-Primary Bronze+ Option and the ELCA-Primary Silver+ Option, the In-network Deductible Amount for Members with individual (single) coverage is specified in the Appendix. For Members with family coverage (i.e. more than one family member is covered), there is no individual Deductible Amount; the sum of In-network Medical, Mental Health and Prescription Drug Eligible Expenses for the Member, Spouse or Eligible Same Gender Partner and eligible children of the Member's family must equal the family In-network Deductible Amount before the Plan pays a percentage of Eligible Expenses. Deductible Amounts are specified in the Appendix.

Notwithstanding the foregoing, the Hospital and Facility Medical Expenses for organ transplant, bariatric surgery, knee replacement surgery, hip replacement surgery, or spine surgery, shall receive benefits for such expenses in accordance with Section 10.11.

Section 10.05 **Maximum Out-of-Pocket Amount for In-network Eligible Medical and Mental Health and Prescription Drug Expenses.** The Maximum In-network Out-of-

Pocket Amount the Member must pay pursuant to Section 10.04 for Deductibles and Member Copayments or and Percent Copayments for In-network Eligible Medical and Mental Health and Prescription Drug Expenses incurred in a calendar year is shown in the Appendix.

The Member is responsible for the applicable per-Member In-network Medical and Mental Health Out-of-Pocket Amount listed in the Appendix.

- a) For the ELCA-Primary Gold+ Option and the ELCA-Primary Platinum+ Option, an individual family Member can incur Eligible Medical and Mental Health Expenses and Prescriptions Drug Copayments that meet the individual Out-of-Pocket Amount before the entire family Out-of-Pocket Amount is met. For Members with family coverage, the sum of the In-network Medical and Mental Health Out-of-Pocket Amounts and Prescription Drug Copayments for each Member, Spouse or Eligible Same Gender Partner and eligible children of the Member's family must equal the maximum Out-of-Pocket Amount for the family coverage elected by the Member before the Plan pays 100% of Eligible Expenses. Out-of-Pocket Amounts are specified in the Appendix.
- b) For the ELCA-Primary Bronze+ Option and the ELCA-Primary Silver+ Option the In-network Out-of-Pocket Amount for Members with individual (single) coverage is specified in the Appendix. For Members with family coverage (i.e. more than one family member is covered), there is no individual Out-of-Pocket Amount; the sum of In-network Medical and Mental Health and Prescription Drug Out-of-Pocket Amounts for the Member, Spouse or Eligible Same Gender Partner and eligible children of the Member's family must equal the family Out-of-Pocket Amount before the Plan pays 100% of Eligible Expenses. Out-of-Pocket Amounts are specified in the Appendix.

~~The sum of the In-network Medical and Mental Health Out-of-Pocket Amounts for the Member, Spouse or Eligible Same Gender Partner and eligible children of the Member's Family shall not exceed the Maximum Out-of-Pocket Amount for the type of family coverage elected by the Member. See Appendix for applicable amount.~~

Section 10.06 **Deductibles and Percent Copayments for Out-of-network Eligible Medical and Mental Health Expenses Other Than Preventive Services.** The Out-of-Pocket Amount is the amount of covered expenses a Member incurs in the calendar year before the Plan pays a percentage of Eligible Expenses. For all Eligible Medical and Mental Health Expenses other than Preventive Services, after the Member has incurred Out-of-network Eligible Medical and Mental Health Expenses equal to the Out-of-network Deductible Amount in the calendar year, the Member will pay a Percent Copayment equal to ~~thirty-five~~forty percent (~~35~~40%) of such expenses in excess of the Out-of-network Deductible Amount until the Maximum Out-of-network Out-of-Pocket Amount has been reached.

The Member is responsible for the applicable per-Member Out-of-network Medical and Mental Health Out-of-Pocket Amount listed in the Appendix.

- a) For the ELCA-Primary Gold+ Option and the ELCA-Primary Platinum+ Option an individual family Member can incur Eligible Medical and Mental Health Expenses that meet the individual Deductible Amount before the entire family Deductible Amount is met. For Members with family coverage, the sum of the Out-of-network Medical and Mental Health Deductible Amounts for each Member, Spouse or Eligible Same Gender Partner and eligible children of the Member's Family must equal the maximum Deductible Amount for the type of family coverage elected by the Member before the Plan pays a percentage of Eligible Expenses. Deductible Amounts are specified in the Appendix.
- b) For the ELCA-Primary Bronze+ Option and the ELCA-Primary Silver+ Option, the Out-of-network Deductible Amount for Members with individual (single) coverage is specified in the Appendix. For Members with family coverage (i.e. more than one family member is covered), there is no individual Deductible Amount; the sum of Out-of-network Medical and Mental Health and Prescription Drug Deductible Amounts for the Member, Spouse or Eligible Same Gender Partner and eligible children of the Member's family must equal the family Out-of-network Deductible Amount before the Plan pays a percentage of Eligible Expenses. Deductible Amounts are specified in the Appendix.

~~The applicable per Member Out-of-network Medical and Mental Health Deductible Out-of-Pocket Amount for which the Member is responsible is shown in the Appendix. The sum of the Out-of-network Medical and Mental Health Deductible Out-of-Pocket Amounts for the Member, Spouse or Eligible Same Gender Partner and eligible children of the Member's Family shall not exceed the maximum Deductible Out-of-Pocket Amount for the type of family coverage elected by the Member. See Appendix for applicable amount.~~

Notwithstanding the foregoing, in accordance with Section 10.11, the Member will pay a Percent Copayment equal to one hundred percent (100%) of expenses for Out-of-network Hospital and Facility Medical Expenses for organ transplant, bariatric surgery, knee replacement surgery, hip replacement surgery, or spine surgery.

Section 10.07 **Maximum Out-of-Pocket Amount for Out-of-network Eligible Medical and Mental Health and Prescription Drug Expenses**. The maximum Out-of-network Out-of-Pocket Amount the Member must pay pursuant to Section 10.06 for ~~Deductible Out-of-Pockets~~ and Percent Copayments for Out-of-network Eligible Medical and Mental Health Expenses and Member Copayments or Percent Copayments incurred in the calendar year for Out-of-network Eligible Medical and Mental Health and Prescription Drug Expenses is shown in the Appendix. ~~is shown in the Appendix. The sum of the Out-of-network Medical and Mental Health Out-of-Pocket Amounts for the Member, Spouse or Eligible Same Gender Partner and eligible children of the Member's Family shall not exceed the Maximum Out-of-Pocket Amount for the type of family coverage elected by the Member. See Appendix for applicable amount.~~

The Member is responsible for the applicable per-Member Out-of-network Medical and Mental Health Out-of-Pocket Amount listed in the Appendix.

- a) For the ELCA-Primary Gold+ Option and the ELCA-Primary Platinum+ Option, an individual family Member can incur Eligible Medical and Mental Health Expenses and prescription Drug Copayments that meet the individual Out-of-Pocket Amount before the entire family Out-of-Pocket Amount is met. For Members with family coverage, the sum of the Out-of-network Medical and Mental Health Out-of-Pocket Amounts and Prescription Drug Copayments for each Member, Spouse or Eligible Same Gender Partner and eligible children of the Member's family must equal the maximum Out-of-Pocket Amount for the family coverage elected by the Member before the Plan pays 100% of Eligible Expenses. Out-of-Pocket Amounts are specified in the Appendix.
- a)b) For the ELCA-Primary Bronze+ Option and the ELCA-Primary Silver+ Option, the Out-of-network Out-of-Pocket Amount for Members with individual (single) coverage is specified in the Appendix. For Members with family coverage (i.e. more than one family member is covered), there is no individual Out-of-Pocket Amount; the sum of Out-of-network Medical and Mental Health and Prescription Drug Out-of-Pocket Amounts for the Member, Spouse or Eligible Same Gender Partner and eligible children of the Member's family must equal the family Out-of-Pocket Amount before the Plan pays 100% of Eligible Expenses. Out-of-Pocket Amounts are specified in the Appendix.

Section 10.08 **Members Outside of the United States**. If a Member who has ELCA-Primary Benefits Coverage receives Medically Necessary Medical and Mental Health Expenses while outside of the United States, the following shall apply:

(a) **Except for Preventive Services, Emergency Room Visit/Urgent Care Visit.** Eligible Medical and Mental Health Expenses incurred outside the United States, an Emergency Room Visit or Urgent Care Visit, and appropriate follow-up care as determined by the Benefits Administrator shall be considered In-network Eligible Medical and Mental Health Expenses.

(b) **Other Medical Services.** All other Eligible Medical and Mental Health Expenses incurred outside the United States shall receive In-network benefits for services received from an In-network provider. Services received from an Out-of-network provider outside the United States will be processed as billed ~~at eighty-five percent (85%)~~ after the deductible and considered Out-of-network Eligible Medical and Mental Health Expenses.

Section 10.09 **Certain Definitions Applicable to ELCA-Primary Medical and Mental Health Benefits**.

(a) "Medical and Mental Health Benefits Administrator" means the entity(ies) that has contracted with Portico Benefit Services to administer Medical and Mental Health Benefits in one (1) or more identified geographic areas. Pursuant to such contract, the Administrator shall, within each geographic area:

(i) credential and contract with In-network Medical and Mental Health Providers to provide treatment and services and to accept negotiated rates as payment in full for such treatment and services to Members who have Medical and Mental Health Benefits;

(ii) administer claims for In-network and Out-of-network Eligible Medical and Mental Health Expenses, including Reasonable and Customary limitations for Out-of-network Medical and Mental Health Providers;

(iii) administer precertification and Medical Necessity requirements with respect to Medical and Mental Health Benefits; and

(iv) administer or contract with an Employee Assistance Program (EAP) administrator to administer EAP services for the Plan.

(b) “In-network Provider” means an Eligible Medical or Mental Health Provider or entity in accordance with Article XII 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.

(c) “Out-of-network Provider” means an Eligible Medical or Mental Health Provider or entity in accordance with Article XII 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.

(d) “In-network Eligible Medical and Mental Health Expenses” means 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.

(e) “Out-of-network Eligible Medical and Mental Health Expenses” means Eligible Medical and Mental Health Expenses that are not In-network Eligible Medical and Mental Health Expenses.

(f) “Emergency Room Visit” means a session at an emergency room during which the Member receives treatments or services for an Emergency, as defined by the Medical and Mental Health Benefits Administrator. Eligible emergency room expenses are considered as In-network Medical and Mental Health Expenses.

(g) “Urgent Care Visit” means 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 and such visit is defined as an urgent care visit by the Medical and Mental Health Benefits Administrator. Eligible urgent care expenses are considered as In-network Medical and Mental Health Expenses.

(h) “Retail Health Clinic Visit” means a session at a clinic located in a retail establishment or worksite, staffed by eligible nurse practitioners or other eligible providers that have a practice arrangement with a physician, during which the Member receives medical services for a limited list of eligible symptoms (e.g., sore throat, cold). Eligible Retail Health Clinic expenses are considered In-network Medical and Mental Health Expenses if the clinic is an In-network Provider and Out-of-network Medical and Mental Health Expenses if the clinic is an Out-of-network Provider.

Section 10.10 **Transitional Medical and Mental Health Care**. If the Benefits Administrator changes as a result of action taken by Portico Benefit Services, Out-of-network Eligible Medical and Mental Health Expenses for Transitional Medical and Mental Health Care shall be considered In-network Eligible Medical and Mental Health Expenses for a Member who has Medical and Mental Health Benefits on the Transition Date. Transitional Care is Eligible Medical and Mental Health care that began prior to the Transition Date and is authorized for a specified Transitional Time Period by the Medical and Mental Health Benefits Administrator. Portico Benefit Services will specify the Transition Date. The Administrator will determine the Transitional Time Period.

For purposes of this Section 10.10, the “Transition Date” is January 1, 2011.

Section 10.11 **Center of Excellence**. If a Member who is age eighteen (18) or older requires an organ transplant in accordance with Section 12.05, bariatric surgery, knee replacement surgery, hip replacement surgery, or spine surgery, the transplant or surgery must be approved in advance by the Medical and Mental Health Benefits Administrator. Such transplant or surgery must be performed at a Center of Excellence, as defined by the Medical and Mental Health Benefits Administrator or at an In-network Hospital or Facility, in order to be an Eligible Medical Expense. All Hospital and Facility Medical Expenses related to an approved transplant, bariatric surgery, knee replacement surgery, hip replacement surgery, or spine surgery for such Member will be reimbursed as follows:

(a) For a Center of Excellence, the Member will pay a Percent Copayment equal to ~~fifteen-twenty~~ percent (~~1520~~%) of eligible Hospital and Facility Medical Expenses in excess of the In-network Deductible Amount until the Maximum In-network Out-of-Pocket Amount has been reached.

(b) For a Hospital or Facility that is an In-network Provider but is not a Center of Excellence in accordance with Section 10.11, the Member will pay a Percent Copayment equal to ~~thirty-fiveforty~~ percent (~~3540~~%) of eligible Hospital and Facility Medical Expenses in excess of the In-network Deductible Amount until the Maximum In-network Out-of-Pocket Amount has been reached.

(c) For a Hospital or Facility that is an Out-of-network Provider, the Member will pay a Percent Copayment equal to one hundred percent (100%) of expenses.

In addition, the Plan will reimburse up to ten thousand dollars (\$10,000) for travel and lodging expenses, except meals, for the Member and companion if approved in advance by the Medical and Mental Health Benefits Administrator.

ARTICLE XI.

**MEDICARE-ELCA MEDICARE-PRIMARY OPTION -- SUPPLEMENT TO
MEDICARE PART A AND PART B BENEFITS**

Section 11.01 **Medicare Supplement to Medicare Part A and Part B Benefits.** ~~The Medicare Supplement Benefits provides reimbursement for Eligible Medical Expenses under Medicare as defined in Section 11.05~~ this Plan. A Member's Eligibility for Medicare Supplement Benefits is set forth in Section 9.02. Except for the Deductible Amount and the Percent Copayments set forth in Section 11.02, the Plan will pay the provider directly or reimburse a Member for ~~the~~ Eligible Medical Expenses ~~under Medicare~~ that are incurred for treatment of the Member while such Member (i) is enrolled as a Member, and (ii) has Medicare-Primary Benefits Coverage.

Section 11.02 Deductible and Percent Copayments for Eligible Medical Expenses Under Medicare the Supplement to Medicare Benefits. No reimbursement of Eligible Medical Expenses under ~~the~~ Medicare Supplement Benefits will be made until the amount of such Eligible Medical Expenses incurred by the Member in a calendar year exceeds the Deductible Amount shown in the Appendix.

After the Member has incurred Eligible Medical Expenses under ~~the~~ Supplement to Medicare Supplement Benefits, subject to the provisions in Section 11.05, equal to the Deductible Amount specified, the Member will pay a Percent Copayment of the Eligible Medical Expenses in excess of the Deductible Amount as shown in the Appendix.

Section 11.03 Maximum Out-of-Pocket Amount for Eligible Medical Expenses Under the Medicare Supplement to Medicare Benefits. ~~The maximum Out-of-Pocket amount that a Member must pay pursuant to Section 11.02 for Deductible and Percent Copayments for Eligible Medical Expenses incurred in a calendar year under the Plan's Medicare Supplement to Medicare Benefits is shown in the Appendix. The sum of such Out-of-Pocket Amounts paid by the Member and all other members of the Member's Family with Medicare Supplement Benefits shall not exceed the family Out-of-Pocket Maximum Amount. See Appendix for applicable amount.~~

Section 11.04 Supplement to Medicare Supplement Benefits Administrator. ~~Medicare Supplement to Medicare Benefits Administrator~~ means the entity that has contracted with Portico Benefit Services to manage and administer ~~the Supplement to Medicare Supplement Coverage Benefit.~~ the Supplement to Medicare Supplement Benefits Administrator shall administer ~~the Supplement to Medicare Supplement Benefits,~~ including the reimbursement of Eligible Medical Expenses.

Section 11.04 **Eligible Medical Expenses Under the Supplement to Medicare Supplement Benefits.** Subject to Section 9.02, Eligible Medical Expenses under Medicare Supplement Benefits shall be:

- (a) 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.

(b) — For the ELCA Medicare-Primary Standard Option, Medically Necessary hospital and medical expenses incurred outside of the United States that would have been eligible under Medicare Hospital Insurance (Part A) or Medicare Medical Insurance (Part B) had the services been rendered within the territory covered by the Medicare program. For purposes of Section 11.02, such hospital expenses shall be deemed to be covered by Part A, and such medical expenses shall be deemed to be covered by Part B. For the ELCA Medicare-Primary Premium Option, Medically Necessary hospital and medical expenses incurred outside of the United States that would have been eligible under Medicare Hospital Insurance (Part A) or Medicare Medical Insurance (Part B) had the services been rendered within the territory covered by the Medicare program shall be covered at eighty (80) percent coinsurance after a Deductible Amount of \$250, up to a lifetime maximum of \$50,000. For the ELCA Medicare-Primary Economy Option, Medically Necessary hospital and medical expenses incurred outside of the United States that would have been eligible under Medicare Hospital Insurance (Part A) or Medicare Medical Insurance (Part B) had the services been rendered within the territory covered by the Medicare program are not Eligible Expenses under this Plan.

(e)(b) Medically Necessary inpatient services provided to a Member in a qualified skilled nursing facility for up to ninety (90) days of continuous care after Medicare became primary health coverage for the Member, if such care began and was authorized by the Medical and Mental Health Benefits Administrator while the Member was covered under ELCA-Primary Benefits Coverage and continued without interruption after the date when Medicare became primary coverage for the Member.

(d)(c) Other services shown in the Appendix for specific ELCA Medicare-Primary Supplement Benefit Options.

Notwithstanding the foregoing, expenses that would have been covered by Medicare if a Member had not voluntarily elected to waive participation in Medicare are not Eligible Medical Expenses under the Supplement to Medicare Supplement Benefits.

Section 11.05 ELCA Medicare-Primary Supplement Benefit Options. The Plan shall provide for Members the ELCA Medicare-Primary Supplement Benefit Options in accordance with Sec. 9.02 for Members as shown in the Appendix. A Retired Member or Coverage Continuation Member may choose from ELCA Medicare-Primary Medicare Supplement Benefit Options for the following calendar year during an annual enrollment period designated by the Plan or for the remainder of the calendar year upon new eligibility for ELCA Medicare-Primary Benefits midyear. Once an ELCA Medicare-Primary Supplement Benefit Option is selected, such option cannot be changed midyear. Notwithstanding the above, a Sponsored Member, Sponsored Disabled Member or a Member who is On Leave from Call will have the ELCA standard-Medicare-Primary Standard Supplement Benefit Option only.

Members who do not choose an ELCA -Medicare-Primary Supplement Benefit Option during the designated enrollment period or within sixty (60) days of new midyear eligibility for ELCA Medicare-Primary Benefits shall be enrolled in the standard Medicare Supplement Benefit.

Deductible Amounts and Out-of-pocket Limits incurred by an Member with ELCA-Primary Benefits shall not be applied to the Member's Supplement to Medicare Benefit.

ARTICLE XII.
ELIGIBLE ELCA-PRIMARY MEDICAL AND MENTAL HEALTH EXPENSES

Section 12.01 **Basic Requirement for Medical and Mental Health Expenses.** Expenses for treatment or diagnosis of an illness, injury or physical condition are Eligible Medical and Mental Health Expenses only if they are:

- (a) Medically Necessary; and
- (b) qualified for reimbursement as determined by the Medical and Mental Health Benefits Administrator; and
- (c) at a Reasonable and Customary cost, charge or expense; and
- (d) considered Eligible Medical and Mental Health Expenses as defined in Article XII; and
- (e) performed by an Eligible Medical or Mental Health Plan Provider and/or in a Hospital or Facility in accordance with Section 12.03.

Section 12.02 **Eligible Medical Providers.** An Eligible Medical Provider must be one (1) of the following types of providers, licensed by the state in which they perform services and such services must be within the scope of their license.

- (a) Medical doctor
- (b) Osteopath
- (c) Podiatrist
- (d) Nurse practitioner
- (e) Optometrist
- (f) Dentist, only for services set forth in Sections 12.04 and 12.07
- (g) Chiropractor
- (h) Naturopath
- (i) Acupuncturist
- (j) Physician's assistant
- (k) Registered nurse

- (l) Licensed practical nurse
- (m) Physical therapist
- (n) Occupational therapist
- (o) Audiologist
- (p) Speech therapist
- (q) Respiratory care practitioner
- (r) Dietician
- (s) Massage therapist

Eligible Medical Plan Providers listed in Section 12.02(j) through (s), providing treatment or services to a Member, must provide such services under the orders and/or supervision of a medical doctor, osteopath, podiatrist, nurse practitioner, optometrist or chiropractor.

Section 12.03 **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, including review requirements in Section 12.14. The following costs for Medically Necessary treatment incurred in a Hospital or Facility are Eligible Medical Expenses:

- (a) Semi-private room including charges for 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 when confinement is in a Hospital or Facility that has private room accommodations only.
- (b) 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 such necessary Hospital or Facility services and supplies.
- (c) Skilled nursing, convalescent, or extended care in an alternative specialized treatment Facility not to exceed one hundred twenty (120) days per calendar year.

Section 12.04 **Surgical Expenses**. Surgeon's fees for procedures performed by a physician legally authorized to practice surgery.

Section 12.05 **Transplants**. Cornea, kidney, heart, heart-lung, bone marrow, liver, lung (single or double) and pancreas transplants are covered by the Medical and Dental Benefits Plan in accordance with Section 10.11. In addition, the Medical and Mental Health Benefits

Administrator may approve transplant procedures which involve body organs other than those listed. Such approval must be received prior to surgery.

Section 12.06 **Preventive Services**. The following services are covered by the Medical and Dental Benefits Plan as Eligible Medical Expenses for Preventive Services when billed as routine and/or Preventive Services:

- (a) Preventive care visit, including depression screening and hypertension screening, and, if age-appropriate, skin, testicular, prostate-digital rectal, rectal-digital and breast examination.
- (b) Laboratory tests and screenings, including cholesterol/lipid profile, thyroid, and diabetes.
- (c) Well woman visit including preconception counseling and routine, low-risk prenatal care.
- (d) Vision examination, including glaucoma, acuity and refraction screenings.
- (e) Hearing examination and related screenings.
- (f) Well-child care including medical history, height, weight and body mass index; developmental/autism, lead and tuberculosis screening.
- (g) Pediatric and adult immunizations.
- (h) Radiological osteoporosis screening.
- (i) Colorectal cancer screening: occult blood test, proctosigmoidoscopy, barium enema sigmoidoscopy, and colonoscopy.
- (j) Cervical cancer screening: pap smear, Human papillomavirus screening.
- (k) Breast cancer screening: mammogram.
- (l) Counseling related to chemo-prevention of breast cancer; counseling about BRCA breast cancer gene screening; [testing for BRCA gene](#).
- (m) Ovarian cancer screenings: CA-125 test, trans-vaginal ultrasound.
- (n) Prostate cancer screening: prostate specific antigen (PSA).
- (o) Abdominal aortic aneurysm screening.
- (p) Urine microalbumin screening.
- (q) FDA approved contraceptive methods (except those methods covered under Prescription Drug Benefits described in Article XV); sterilization by certain

intratubal occlusion device and delivery systems; and contraceptive counseling for women.

- (r) Gestational diabetes screening for pregnant women.
- (s) Sexually transmitted infection counseling and screening, including human immunodeficiency virus (HIV).
- (t) Iron-deficiency anemia, bacteriuria, hepatitis B virus and Rh incompatibility screening in pregnant women.
- (u) Breast-feeding support, counseling and supplies, including costs for renting or purchasing specified manual breast-feeding equipment from a network provider or national durable medical equipment supplier.
- (v) Domestic violence screening and counseling.
- (w) Human papillomavirus DNA testing for all women thirty (30) years and older.
- (x) Screening and certain counseling services for alcohol or substance abuse, tobacco use, obesity, diet and nutrition.
- (y) Newborn screening for hearing, thyroid disease, phenylketonuria and sickle cell anemia and standard metabolic screening panel for inherited enzyme deficiency diseases.
- (z) Other tests, screenings and services considered Eligible Preventive Services by the Medical and Mental Health Benefits Administrator.

Notwithstanding the foregoing, the following services billed with a non-preventive diagnosis shall be paid in accordance with Section 10.03, provided, however, that the Plan will pay for only one (1) such service listed in this Section 12.06 per year in accordance with Section 10.03. Subsequent occurrences during the calendar year of services in this Section 12.06 billed as preventive or non-preventive services will be paid in accordance with Section 10.04 or Section 10.05.

- (a) Lipid profile
- (b) Prostate specific antigen (PSA) test
- (c) PAP smear
- (d) Colonoscopy
- (e) Mammogram
- (f) Hemoglobin A1c test

- (g) Vision examination
- (h) Urine microalbumin screening

Section 12.07 **Other Eligible Medical Expenses**. Expenses for the following are Eligible Medical Expenses, if Medically Necessary:

- (a) Casts and surgical dressings.
- (b) X-rays, CAT scans, magnetic resonance imaging, or other similar diagnostic imaging procedures.
- (c) Laboratory examinations and tests, including pre-admission testing on an outpatient basis for an illness or injury requiring hospital confinement.
- (d) 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.
- (e) Rental or purchase of durable medical equipment, provided that the equipment is:
 - (i) prescribed by a physician to treat an illness or injury,
 - (ii) essentially medical in nature,
 - (iii) usable only in the presence of an illness or injury,
 - (iv) usable only by the patient for whom it was prescribed, and
 - (v) able to withstand repeated use.
- (f) 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, if determined to be Medically Necessary.
- (g) Ambulance service is limited to:
 - (i) emergency ambulance service;
 - (ii) local transfers to the Member's home when ambulance service is requested by the attending physician;
 - (iii) transfers to the nearest hospital with adequate facilities, if the patient's condition requires treatment, and facilities are not available at the hospital at which s/he 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 at which s/he is confined, or to the nearest hospital on an emergency basis from a remote geographical area; and

(iv) medical transportation to the patient's home or a medical rehabilitation facility when prescribed by the attending physician following knee or hip replacement surgery, spine surgery or transplant performed at a Center of Excellence, in accordance with Section 10.11.

(h) Emergency care and up to twelve (12) months of follow-up care for treatment of accidental injury to teeth or their supporting structures, including care provided by a dentist.

(i) Midwifery, if licensed or certified by the state in which the services are performed or acting under the supervision of a medical doctor and the services are rendered in a qualified Hospital or Facility.

(j) Hospice care provided to a Member during the final six (6) months of terminal illness by a home hospice care agency, as follows:

(i) Up to eight (8) hours in any one (1) day of part-time or intermittent nursing care by a registered or licensed practical nurse.

(ii) Medical social services, including assessment of the patient's social, emotional and medical needs, and identification of community resources available to the patient.

(iii) Psychological and dietary counseling.

(iv) Consultation or case management services by a physician.

(v) Physical and occupational therapy.

(vi) Up to eight (8) hours in any one (1) day of part-time or intermittent care by a licensed home health aide.

(vii) Medical supplies, drugs and medicines prescribed by a physician.

(k) Home health care, including private duty or visiting nurse care, or home health aide services as an alternative to confinement in a Hospital or Facility.

(l) Treatment for oral cancer.

(m) Hospital and anesthesiologist services rendered in connection with eligible dental services as defined under Article XIII Dental Benefits Coverage.

(n) Speech therapy performed by a licensed or registered speech therapist, and limited to the following situations:

- (i) Adults. Speech therapy, in the event of (a) vocal cord surgery, (b) stroke, (c) accidental injury, or (d) speech-related illness. Such adult must originally have had speech ability.
- (ii) Children. In addition to the situations applicable for adults, speech therapy for Medically Necessary speech development.
- (o) Initial diagnostic x-rays prior to initiation of chiropractic manipulation treatment.
- (p) Smoking cessation treatment rendered by an Eligible Medical Provider.
- (q) Over-the-counter nicotine replacement products for Members who have enrolled in and are participating in the Medical and Mental Health Benefits Administrator's smoking cessation program.
- (r) Weight loss treatment and services rendered by an Eligible Medical Provider.
- (s) Up to ten thousand dollars (\$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, and infertility counseling for, or related to, artificially assisted fertilizations when approved in advance by the Medical and Mental Health Benefits Administrator.
- (t) Treatment for cleft lip and palate, including oral surgery and orthodontia.
- (u) Treatment for temporomandibular joint disorder and craniomandibular disorder, including orthodontia.
- (v) Up to twelve (12) visits per calendar year for acupuncture performed by an Eligible Medical Provider for:
 - (i) treatment of chronic pain with a duration of six (6) months or more when other forms of therapy have failed, or
 - (ii) prevention and treatment of nausea associated with surgery, chemotherapy and pregnancy.
- (w) Up to twelve (12) massage therapy visits per calendar year massage therapy visits include any service provided by a licensed massage therapist and massage therapy received from another eligible medical provider.
- (x) Certain routine care for approved cancer clinical trials by approved investigators at qualified performance sites if authorized by the Medical and Mental Health Benefits Administrator in advance of treatment.

(y) Such other medical expenses as determined to be Medically Necessary by the Medical and Mental Health Benefits Administrator.

Section 12.08 **Exclusions from Eligible Medical Expenses**. Notwithstanding the foregoing provisions of this Article XII, the Medical and Dental Benefits Plan does not cover the following as Eligible Medical Expenses:

(a) Medical care, supplies or treatment received in facilities owned or operated by or furnished at the expense of the United States Government or any agency thereof, or the Government of any state or local government or agency thereof, or received elsewhere for which the Member is not, in the absence of the Medical and Dental Benefits Plan, legally obligated to pay, provided, however, that the Plan shall pay for benefits received at governmental medical facilities as required by law.

(b) Charges for services or supplies that are experimental or investigational, as determined by the Medical and Mental Health Benefits Administrator.

(c) Treatments which are not provided or prescribed by an Eligible Medical Provider in accordance with Section 12.02 or are outside the scope of the provider's license or are not Medically Necessary, as described in Section 18.22.

(d) Services by unlicensed physicians, practitioners or providers of service, or by providers of service not listed as Eligible Medical Providers in Section 12.02.

(e) Costs for treatment or diagnosis of any disease, illness, injury, or physical or mental condition deemed to be an Eligible Dental or Prescription Drug expense under Articles XIII or XV of this Plan.

(f) Additional costs for private rooms, unless isolation or intensive care is prescribed by the attending physician.

(g) All acupuncture treatment that does not meet the requirements of Section 12.07(w).

(h) Costs incurred by a Member for services in a Hospital or Facility which does not meet the requirements established for a Hospital or Facility as determined by the Medical and Mental Health Benefits Administrator.

(i) Personal comfort services such as radio, television, beauty and barber services, guest services, and similar incidental services.

(j) Nursing home or convalescent Facility care, except up to one hundred twenty (120) days per calendar year if solely for recuperative purposes and determined to be Medically Necessary by the Medical and Mental Health Benefits Administrator.

(k) Cosmetic surgery, except when necessary for prompt treatment and correction made necessary by accidental injury.

- (l) Oral surgery or any other services provided by a dentist or dental care practitioner, other than services listed in Section 12.07.
- (m) Routine examinations, except as included as Preventive Services pursuant to Section 12.06.
- (n) Services for correction of refractive error.
- (o) 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, or medically necessary prosthetic contact lenses.
- (p) Private duty nursing and home health aide services for respite and all other care, except as expressly provided for under Section 12.07.
- (q) Cost of a medibus, cabulance, bus fare, taxi fare, or personal car expense except as provided in Section 10.11.
- (r) Treatments and programs for smoking cessation purposes unless rendered by an Eligible Medical Provider.
- (s) Weight loss treatments and programs, unless rendered by an Eligible Medical Provider.
- (t) All infertility treatment that exceeds the \$10,000 lifetime per Member infertility maximum, including physician visits and services, tests, imaging procedures, physician administered medications, all methods of artificially assisted fertilization, including in vitro fertilization, Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), embryo transfer procedures, and infertility counseling for, or related to, artificially assisted fertilizations.
- (u) Sperm Banking, donor ova or sperm, services and prescription drugs for, or related to, gender selection services.
- (v) Late-term induced abortions, except when:
 - (i) The life of the mother is threatened; or imminent.
 - (ii) The fetus has lethal fetal abnormalities indicating death is imminent.
- (w) Drugs taken for the purpose of terminating pregnancy.
- (x) Exercise programs and equipment.
- (y) Costs related to sex reassignment surgery and related services.
- (z) All massage therapy that does not meet the requirements of Section 12.07(x).

(aa) Such other medical expenses determined ineligible medical expenses by the Medical and Mental Health Benefits Administrator.

Section 12.09 **Basic Requirements for Mental Health Expenses**. Expenses for treatment or diagnosis of mental health or substance abuse diseases are Eligible Mental Health Expenses only if they are:

- (a) Medically Necessary; and
- (b) qualified for reimbursement as determined by the Medical and Mental Health Benefits Administrator; and
- (c) at a Reasonable and Customary cost, charge or expense; and
- (d) considered Eligible Mental Health Expenses as defined in Article XII; and
- (e) performed by an Eligible Mental Health Provider and/or in a Hospital or Facility in accordance with Sections 12.10 and 12.11.

Section 12.10 **Eligible Mental Health Providers**. An Eligible Mental Health Provider must be one (1) of the following types of providers, licensed by the state in which they perform services and such services must be within the scope of their license.

- (a) A licensed psychiatrist who is either a Medical Doctor or Doctor of Osteopathy.
- (b) A licensed doctoral-level psychologist who holds a Ph.D., Ed.D or Psy.D degree.
- (c) A Masters-prepared therapist, provided the therapist possesses:
 - (i) a Masters degree from an accredited institution in a licensable mental health discipline; and
 - (ii) a license to practice independently in the state in which the services are rendered.
- (d) A pastoral counselor who meets the requirements of Sections 12.10(b) or (c).
- (e) Any other Provider considered eligible by the Medical and Mental Health Benefits Administrator.

Section 12.11 **Eligible 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 including review requirements in Section 12.14. The following costs for

Medically Necessary treatment incurred in a Hospital or Facility are Eligible Mental Health Expenses.

(a) Reasonable and Customary expenses for Medically Necessary mental health treatment while admitted to a twenty-four (24) hour secure and protected, medically staffed and psychiatrically supervised environment, accredited Hospital or a specialized care Facility, provided that (i) the admission is made under the orders and supervision of a duly licensed physician/psychiatrist. Such expenses include cost of room, meals, twenty-four (24) hour skilled psychiatric nursing care, psychotherapy, a structured treatment milieu for the administration of necessary Mental Health services, daily medical care and supplies, as well as charges for attending professionals and ambulance services. Medically Necessary practitioner, Facility and anesthesia charges for Electroconvulsive Therapy (ECT) are Eligible Mental Health Expenses.

(b) Reasonable and Customary costs for the Medically Necessary treatment of the diseases of substance abuse including room, meals, twenty-four (24) hour general nursing care, psychotherapy, a structured milieu for the administration of necessary medical services, daily medical care and supplies incurred while admitted as a patient in an accredited Hospital or specialized care Facility, as well as professional and practitioner charges.

(c) Reasonable and Customary costs for Medically Necessary treatment provided in a halfway house that is licensed for mental health/substance abuse services by the state in which the care is provided, must include out-patient individual, group and family treatment, require abstinence and has on-site supervision 24/7 by licensed staff.

(d) Reasonable and Customary costs for Medically Necessary treatment provided in a residential treatment facility that is licensed by JCAHO and/or an appropriate state licensing board for residential mental health/substance abuse treatment, 24/7 on call medical availability and 24/7 on-site mental health specialists trained in responding to emergency psychiatric situations.

(e) Reasonable and Customary costs for Medically Necessary partial hospitalization program treatment that provides coordinated, intense, comprehensive, multi-disciplinary treatment utilized when there is not a need for twenty-four (24) hour intensive psychiatric/nursing care. Partial hospitalization programs may be utilized as an initial level of care, as an alternative to or as a step-down from inpatient level of care.

(f) Reasonable and Customary costs for Medically Necessary intensive outpatient therapy treatment that provides coordinated, intense, comprehensive, multi-disciplinary treatment for participants who can maintain the ability to fulfill family, student or work activities outside of the treatment setting. Clinical interventions include individual, family and group sessions along with medication management. 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. Intensive outpatient therapy treatment will be considered for complex or refractory clinical situations in lieu of more restrictive levels of care.

(g) Reasonable and Customary costs for outpatient services that are not Other Eligible Outpatient Mental Health expenses in accordance with Section 12.12, however, are Medically Necessary, including but not limited to, emergency room, laboratory, ambulance and electroconvulsive services.

Section 12.12 **Other Eligible Mental Health Expenses**. Expenses for the following are Eligible Mental Health Expenses, if Medically Necessary:

- (a) outpatient mental health therapy sessions;
- (b) medication management;
- (c) outpatient assessments to confirm the presence of a (DSM-IV or ICD-9) Mental Health disorder;
- (d) reasonable and Customary expenses for detoxification and treatment of substance abuse or addiction; and
- (e) reasonable and Customary expenses for marital counseling.

Section 12.13 **Exclusions from Eligible Mental Health Expenses**. Notwithstanding the foregoing provisions of this Article XII, the Medical and Dental Benefits Plan does not cover the following as Eligible Mental Health Expenses:

- (a) Court ordered, including adjudication of marital and child support, and child custody, unless assessed and certified to be Medically Necessary.
- (b) Experimental, investigational, primarily for research, or not in keeping with national standards of practice, including but not limited to:
 - (i) treatment of sexual addiction, codependency, or any other behavior that does not have a DSM-IV diagnosis;
 - (ii) regressive therapy; and
 - (iii) megavitamin therapy.
- (c) Educational or vocational testing or services, including treatments for personal growth and development.
- (d) For the treatment of social or economic problems or physical health without a concurrent DSM-IV or ICD-9 diagnosis.
- (e) Residential mental health care services as a diversion from incarceration of the juvenile or adult justice system.
- (f) Required under law to be provided to a child by the school system.

(g) Required to maintain employment or insurance, or professional continuing education or credentialing criteria, except as covered under EAP services.

(h) Except as covered under EAP services, treatment incurred as part of a treatment plan for:

- (i) smoking cessation; or
- (ii) weight reduction.

(i) Alternative types of substance abuse treatment, including but not limited to:

- (i) nutritionally-based therapies;
- (ii) non-abstinence based treatment;
- (iii) aversion therapy; and

(iv) individual therapy in the absence of a structured outpatient program, unless deemed Medically Necessary by the Medical and Mental Health Benefits Administrator.

(j) 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.

(k) Not Medically Necessary because the treatment 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:

- (i) obesity, except as covered under EAP services;
- (ii) stammering or stuttering;
- (iii) mental retardation (except initial diagnosis);
- (iv) chronic organic brain syndrome;
- (v) delirium, dementia, amnesia, and other cognitive disorders;
- (vi) mental disorders due to a general medical condition;
- (vii) learning disabilities;
- (viii) transsexualism;
- (ix) biofeedback;

- (x) tobacco dependence, except as covered under EAP services;
- (xi) chronic pain, except for pre-certified psychotherapy, biofeedback or hypnotherapy incurred in connection with a DSM-IV disorder;
- (xii) sleep/wake schedule disorders;
- (xiii) therapeutic foster care;
- (xiv) group homes;
- (xv) supervised apartments;
- (xvi) three-quarter houses;
- (xvii) wilderness programs;
- (xviii) residential/therapeutic schools; and
- (xix) camps.

(l) Early intensive behavioral intervention for pervasive development disorders and autism spectrum disorders.

(m) Costs for treatment or diagnosis of any disease, illness, injury, or condition deemed to be an Eligible Dental or Prescription Drug expense under Article XIII or XV of this Plan.

Notwithstanding the foregoing, Eligible Mental Health Expenses may include the cost of any of the foregoing treatments listed in this Section 12.13 if the Medical and Mental Health Benefits Administrator determines that such treatment is Medically Necessary, can likely demonstrate benefit to the recipient of care, and is a cost-effective alternative to a treatment that would be an Eligible Mental Health Expense.

Section 12.14 **Medical and Mental Health Review**. The Medical and Mental Health Benefits Administrator administers precertification and Medical Necessity reviews.

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

(i) Prior to any admission other than for a medical or mental health emergency, the Member, or the Member's representative or attending physician, must notify the Medical and Mental Health Benefits Administrator at least seven (7) days prior to such admission of (i) the reason that the confinement is Medically Necessary, and (ii) the planned duration of such confinement.

(ii) In the event of an admission for a medical or mental health emergency, the Member, or the Member's representative or attending physician, must notify the Administrator within forty-eight (48) hours following such

admission of the reason that the confinement is Medically Necessary and the planned duration of such confinement.

(iii) Upon notification, the Administrator shall review the Member's condition and the proposed treatment plan to determine if the confinement is Medically Necessary. If the Administrator certifies that the confinement is Medically Necessary, it will assign a length of stay for such admission. The Administrator will notify the Member, the physician, or the Hospital or Facility as to the certified length of stay it has assigned. The Administrator's determination may be appealed as provided in Section 16.02. In no event, however, will the Administrator recommend that (i) 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 forty-eight (48) hours, or (ii) 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 ninety-six (96) hours.

(b) If a Member is to receive certain other services, the following rules apply:

(i) 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 for which the Medical and Mental Health Benefits Administrator requires precertification, the Member, or the Member's representative or attending physician, must notify the Medical and Mental Health Benefits Administrator at least ten (10) days prior to receipt of such service or procedure.

(ii) Upon notification, the Medical and Mental Health Benefits Administrator shall review the Member's condition and the proposed treatment plan to determine if the service or procedure is Medically Necessary. If the Administrator certifies that the service or procedure is Medically Necessary, it will notify the Member or the physician of certification. The Administrator's adverse determination may be appealed as provided in Section 16.02.

(iii) The Medical and Mental Health Benefits Administrator monitors claims data for Members. If the Medical and Mental Health Administrator evaluates the Member's use of services and supplies, and determines that such services and supplies are not Medically Necessary due to inappropriate use, misuse or overuse, the Medical and Mental Health Benefits Administrator may review, limit, coordinate and/or deny the Member's use of services and supplies.

Section 12.15 **Employee Assistance Program Benefits**. In addition to the reimbursement of Eligible Mental Health Expenses, the Plan will pay for Eligible Employee Assistance Program (EAP) services, including counseling, support and referral services, that have been pre-approved by the EAP administrator contracted to provide EAP services by the Medical and Mental Health Benefits Administrator. Eligible EAP Services include telephone consultation and office visits by or on behalf of a Member in connection with personal, financial or legal concerns, or in connection with any of the following:

- (a) Spouse or partner relational problem
- (b) Parent-child relational problem
- (c) Child abuse or neglect
- (d) Sibling relational problem
- (e) Relational problem related to a mental disorder or general medical condition
- (f) Occupational problem
- (g) Academic problem
- (h) Acculturation problem
- (i) Religious or spiritual problem/ phase of life problem
- (j) Relational problem not otherwise specified
- (k) Bereavement
- (l) Adult anti-social behavior
- (m) Childhood or adolescent anti-social behavior
- (n) Overweight or obesity
- (o) Tobacco dependence
- (p) Any other concern or issue that is pre-approved by the EAP administrator

“Eligible EAP Services” are services provided by the staff of the EAP administrator or by an In-network Mental Health Provider or other professional to which the Member is referred by the EAP administrator. The Member shall pay no Member Copayment for up to six (6) Eligible EAP office sessions per identified issue listed in subsections 12.15(a) through (p). An initial telephone consultation for legal and financial issues is offered to Members at no cost to the Member.

ARTICLE XIII. DENTAL BENEFITS

Section 13.01 **Dental Benefits**. Dental Benefits provide reimbursement for Eligible Dental Expenses. A Member’s eligibility for Dental Benefits is set forth in Sections 9.01 and 9.02. Except for the Deductibles and Percent Copayments set forth in Section 13.02, the Plan will reimburse a Member or pay the provider directly for the Eligible Dental Expenses that are incurred for the treatment of the Member while such Member (i) is enrolled as a Member, and (ii) has Dental Benefits.

Section 13.02 **Deductibles and Percent Copayments for Eligible Dental Expenses.**

No reimbursement of Eligible Dental Expenses will be made until the amount of such Eligible Dental Expenses incurred in a calendar year exceeds the Deductible Amount. The applicable per-Member Dental Deductible Amount for which the Member is responsible is shown in the Appendix. The sum of the Dental Deductible Amounts for the Member and all other members of the Member's Family shall not exceed the family Deductible Amount maximum. See Appendix for applicable amount.

After the Member has incurred Eligible Dental Expenses equal to the Deductible Amount specified above, the Member will pay a Percent Copayment equal to twenty percent (20%) of Eligible Basic Dental Expenses and fifty percent (50%) of Eligible Major Restorative Dental Expenses in excess of the Deductible Amount. For Preventive Dental services specified in Section 13.06, the Plan will pay one hundred percent (100%) of Eligible Expenses. The Member will pay no Copayment for Eligible Preventive Expenses and fifty percent (50%) for Eligible Orthodontia expenses with no deductible.

Section 13.03 **Limits on Eligible Dental Benefits Expenses.** Reimbursements for Eligible Dental Expenses shall be subject to the following annual and lifetime limits:

<u>Type of Eligible Dental Expense</u>	<u>Reimbursement Limit</u>
Eligible Preventive, Basic and Major Restorative Dental Expenses	See Appendix for applicable annual limit
Eligible Orthodontia Expenses	See Appendix for Applicable lifetime limit

Notwithstanding the above annual limit for Eligible Dental Expenses, a Member whose primary residence is outside of the United States, shall be entitled to a maximum reimbursement for Eligible Dental Expenses in the United States incurred for a particular year equal to the sum of the maximum reimbursement applicable in the particular year and the maximum reimbursement applicable in the preceding year, but only if no Eligible Dental Expenses had been incurred in the preceding calendar year or in the portion of the year immediately preceding the first date on which such Eligible Dental Expenses in the United States were incurred.

Section 13.04 **Eligible Dental Expenses.** Subject to the requirements of Section 13.05 and Section 13.10, Eligible Dental Benefit Expenses include the following:

- (a) Eligible Preventive Dental Expenses described in Section 13.06.
- (b) Eligible Basic Dental Expenses described in Section 13.07.
- (c) Eligible Major Restorative Dental Expenses described in Section 13.08
- (d) Eligible Orthodontia Expenses described in Section 13.09.

Section 13.05 **Specific Requirements for Eligible Dental Expenses**. The procedures, services and suppliers set forth in Sections 13.06 through 13.09 shall be considered Eligible Dental Expenses only if all of the following requirements are met:

- (a) the procedures, services or supplies are furnished by a legally qualified dentist or licensed dental care practitioner acting within the scope of her/his license or under the supervision of a legally qualified dentist or physician;
- (b) the charges are within Reasonable and Customary limits as defined in Section 18.27;
- (c) the charges are for procedures, services and supplies which are customarily employed for treatment of the dental condition, and which are rendered in accordance with generally accepted standards of dental practice; and
- (d) except for Eligible Preventive Dental Expenses, the expenses are Medically Necessary as defined in Section 18.23.

Section 13.06 **Eligible Preventive Dental Expenses**. The following preventive and diagnostic services and supplies are covered by this Plan as Eligible Preventive Dental Expenses:

- (a) Cleaning of teeth, twice per calendar year.
- (b) Periodontal maintenance, twice per calendar year.
- (c) Topical application of fluoride, once per calendar year at age eighteen (18) or younger.
- (d) Oral Examinations, twice per calendar year.
- (e) Supplementary bite-wing x-rays, once every twenty-four (24) months for adults and every twelve (12) months at age eighteen (18) or younger.
- (f) Full mouth x-rays or Panorex, once every sixty (60) months.
- (g) Sealants for permanent molars, once per lifetime at age eighteen (18) or younger.
- (h) Space maintainers for extracted posterior primary teeth and the installation and fitting thereof, at age eighteen (18) or younger.
- (i) Oral hygiene instruction as prescribed by the dentist, once per lifetime.

Section 13.07 **Eligible Basic Dental Expenses**. Eligible Basic Dental Expenses are expenses for the following diagnostic, therapeutic and restorative services:

- (a) Oral Examinations - including emergency treatment for the relief of pain and specialist exams.

(b) Test and Laboratory Examination - including bacteriologic cultures, and pulp vitality tests.

(c) Dental X-rays - full mouth x-rays and such other dental x-rays as are required in connection with the diagnosis of a specific condition requiring treatment.

(d) Oral Surgery - including charges for the following services or treatments:

(i) Routine oral surgery, provides for tooth removal (including alveolectomy where indicated), including pre- and post-operative care.

(ii) 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.

(e) 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 twenty-four (24) months and repeat surgical treatment every thirty-six (36) months.

(f) Endodontics - endodontic treatment, including root canal therapy, including pulpotomies on primary teeth and on permanent teeth. No coverage for re-treatment of pulpotomies.

(g) The following services and supplies:

(i) anesthetics (conscious sedation) when medically necessary and administered in connection with cutting procedures in the oral cavity;

(ii) injection of antibiotic drugs by attending dentist; and

(iii) application of desensitizing medicaments.

(h) 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.

(i) Removable appliances for the treatment of Bruxism and other harmful habits.

Section 13.08 **Eligible Major Restorative Dental Expenses**. Eligible Major Restorative Dental Expenses are expenses for the following services and supplies:

(a) Repair or recementing of crowns, inlays, onlays, fixed or removable dentures; or relining or rebasing of dentures more than six (6) months after the installation of an initial or replacement denture, but not more than one (1) relining or rebasing in any period of thirty-six (36) consecutive months.

(b) Crowns, onlays or porcelain inlays when the amount of lost tooth structure cannot be restored with filling restoration, as defined in Section 13.07(h).

(c) Bridges, standard partial dentures and full dentures for the replacement of fully extracted permanent teeth. Eligible expenses are limited to the commonly performed method of tooth replacement.

(d) Repairs and adjustments to prosthetic appliances when they are serving as the permanent prosthetic appliance.

(e) Replacement of existing prosthetic appliance, but only if five (5) years have elapsed from when last benefitted, and then only in the event that the existing appliance is not and cannot be made satisfactory. Services which are necessary to make an appliance satisfactory will be eligible.

(f) Endosteal implants, but only if five (5) years from when last benefitted, and then only in the event the existing implant is not and cannot be made satisfactory.

Section 13.09 **Eligible Orthodontia Expenses**. Treatment necessary for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies.

Section 13.10 **Exclusions from Dental Benefits**. Notwithstanding the foregoing provisions of this Article XIII, the Medical and Dental Benefits Plan does not cover the following:

(a) The excess cost of any treatment which is an alternative to, or more expensive than, that which is required for adequate treatment of the dental condition, in accordance with accepted standards of dental practice, and which alternative is elected by the insured or by the dentist. The cost of such an alternate procedure will be considered Eligible Dental Expenses only to the extent of the Reasonable and Customary charge for the required procedure, service, or supply, as the case may be.

(b) Costs for procedures, services or supplies primarily for cosmetic reasons and beautification. This also includes charges for personalization and characterization of dentures.

(c) Costs for procedures, services, or supplies which are not necessary, according to accepted standards of dental practice.

(d) Costs for procedures, services, or supplies which do not meet accepted standards of dental practice, including charges for procedures, services, or supplies which are experimental in nature.

(e) Costs for the replacement of a lost, missing or stolen orthodontic or prosthetic device, or any dental appliance.

(f) Costs for precision attachments.

- (g) Costs incurred for emergency dental care within the first twenty-four (24) hours of accidental injury to teeth or their supporting structures which are eligible for reimbursement as Eligible Medical Expenses.
- (h) Costs for dental veneers and related services and supplies.
- (i) Costs for procedures, services or supplies, including retreatment, that exceed the frequency limits established by the Dental Benefits Administrator.
- (j) Costs for procedures, services or supplies that are medical in nature, including but not limited to, oral surgery services performed in a hospital.
- (k) Inpatient and outpatient hospital expenses.
- (l) Costs for prescription drug expenses.

Section 13.11 **Dental Benefits Administrator**. “Dental Benefits Administrator” means the entity that has contracted with Portico Benefit Services to manage and administer Dental Benefits Coverage. The Dental Benefits Administrator shall:

- (a) credential and contract with PPO Dental providers to provide treatment or services to Members who have Dental Benefits Coverage and to accept negotiated rates as payment in full for such treatment or services;
- (b) contract with dental providers other than PPO dental providers to provide treatment and services to Members who have Dental Benefits Coverage and to limit fees to the lesser of the fees filed in advance or the Dental Benefits Administrator’s Reasonable and Customary fees;
- (c) administer claims for Eligible Dental Expenses; and
- (d) administer Medical Necessity requirements and Reasonable and Customary limitations with respect to Dental Benefits Coverage.

ARTICLE XIV. SUPPORTING SERVICES

Section 14.01 **Health Support Program**. Portico Benefit Services may contract with Health Support Program Administrators to provide services to Members. “Health Support Program Administrator” means the entity that has contracted with Portico Benefit Services to manage and administer Health Support Programs that could include coordinated health care interventions, plan of care, support, counseling, communication or any other services related to chronic conditions, smoking cessation or pregnancy, deemed appropriate by Portico Benefit Services, with the goal of improving Members’ health.

Section 14.02 **Nurse Line Program**. Portico Benefit Services may contract with a Nurse Advice Program Administrator that will provide decision support and health information services to Members. “Nurse Advice Program Administrator” means the entity that has contracted with

Portico Benefit Services to assist Members with questions about illnesses and injuries, understanding of diagnosed conditions, managing chronic diseases, evaluation of treatment options, and referrals to other plan programs.

Section 14.03 **Health Coach Services**. Portico Benefit Services may contract with a Health Coach Services Administrator that will provide health coaching and support services to Members with certain health risk profiles. “Health Coach Services Administrator” means the entity that has contracted with Portico Benefit Services to provide health coaching services to Members.

Section 14.04 **Fitness Center Programs**. Portico Benefit Services may contract with a Fitness Center Program Administrator that will provide discounted services to Members who utilize certain fitness centers with a specific frequency.

ARTICLE XV. PRESCRIPTION DRUG BENEFITS

Section 15.01 **Eligibility for Prescription Drug Benefits**. A Member’s eligibility for Prescription Drug Benefits is set forth in Sections 9.01, 9.02 and this Section 15.01. The ELCA Medical and Dental Benefits Plan includes the ELCA Prescription Drug ~~Coverage-Benefit~~ and the ELCA Part D Drug Benefit ~~Coverage~~. Members who have ELCA-Primary Benefits, ~~Coverage~~ and Sponsored Members and On Leave From Call Members and their family members who have ELCA Medicare-Primary Benefits Coverage shall have the ELCA Prescription Drug ~~Coverage~~Benefit. Retired Members or Coverage Continuation Members and their family members with Medicare-Primary Benefits Coverage who live in the United States or Puerto Rico, shall have the ELCA Part D Drug Benefit ~~Coverage~~.

Section 15.02 **Eligible Prescription Drug Expenses**. The Prescription Drug Benefits provides reimbursement for Eligible Prescription Drug Expenses. The Medical and Dental Benefits Plan will pay for the cost of Eligible Prescription Drugs prescribed for a Member by a provider of service licensed to prescribe medications, subject to limitations imposed by the Prescription Drug Administrator to ensure Medical Necessity and appropriate use in accordance with Section 18.22, and the Copayments set forth in Section 15.05.

Eligible expenses for the ELCA Prescription Drug ~~Coverage-Benefit~~ shall be limited to a thirty-one (31) day supply except when purchased from the Prescription Drug Mail Order Pharmacy, in which case eligible expenses shall be limited to a ninety (90) day supply. Eligible expenses for drugs defined as Specialty Drugs by the Prescription Drug Benefits Administrator shall be limited to a thirty-one (31) day supply. “Specialty Drugs” means the list of drugs defined by the Prescription Drug Administrator as Specialty Drugs, including injectable and oral drugs.

Eligible expenses for the ELCA Part D Drug Benefit ~~Coverage~~ shall be limited to a thirty-one (31) day supply except when purchased from the Prescription Drug Mail Order Pharmacy, in which case eligible expenses shall be limited to a ninety (90) day supply, or from a retail pharmacy approved by Medicare and contracted with the Prescription Drug Administrator to provide up to a ninety (90) day supply.

Section 15.03 **Definition of Eligible Prescription Drugs.** Prescription Drugs include ~~FDA-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. Disposable diabetic supplies are included as Eligible Prescription Drugs under ELCA Prescription Drug ~~Coverage~~**Benefit**.

~~The~~ ELCA Part D Drug Benefit ~~Coverage~~ 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 Drug Benefit ~~Coverage~~. Notwithstanding the foregoing, certain additional drugs may be deemed Eligible Prescription Drugs by the Plan for ~~the~~ ELCA Part D Drug Benefit ~~Coverage~~.

Section 15.04 **Exclusions from Eligible Prescription Drug Expenses.** Notwithstanding the provisions of Sections 15.02 and 15.03, the Medical and Dental Benefits Plan does not cover the following as Eligible Prescription Drug Expenses:

- (a) ~~drugs-Drugs~~ that are considered not 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;
- (b) ~~drugs-Drugs~~ that are deemed investigational or experimental by the Prescription Drug Benefits Administrator because FDA approval for marketing has not been granted;
- (c) ~~over~~**Over**-the counter medications, except insulin;
- (d) ~~drugs-Drugs~~ for cosmetic treatment of hair loss or other cosmetic treatment;
- (e) ~~herbal~~**Herbal**, mineral and nutritional supplements;
- (f) ~~vitamins-Vitamins~~ for preventive purposes;
- (g) ~~drugs-Drugs~~ taken in preparation of, or in conjunction with, artificial insemination;
- (h) ~~drugs-Drugs~~ taken for the purpose of terminating pregnancy;
- (i) ~~expenses-Expenses~~ for drugs that are covered under any other group coverage, including drugs covered under a Medicare Part D plan for a Member enrolled in such Part D plan that is not ~~the~~ ELCA Part D Drug Benefit ~~Coverage~~;
- (j) ~~expenses-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 ~~Coverage~~**Benefit**. However, Members with ~~the~~ ELCA

Part D Drug Benefit ~~Coverage~~ may purchase eligible Specialty Drugs from a Medicare-approved pharmacy;

(k) ~~expenses—Expenses~~ for drugs and supplies that are covered as medical expenses under Medicare Hospital Insurance (Part B) for Members with the ELCA Part D Drug Benefit ~~Coverage~~; and

(l) ~~drugs—Drugs~~ determined ineligible by Medicare for the ELCA Part D Drug Benefit ~~Coverage~~ unless otherwise deemed Eligible Prescription Drugs by the Plan.

Section 15.05 **Copayments for Prescription Drugs**. Member Copayments for Eligible Prescription Drugs shall be determined in accordance with the following:

(a) If a Member with the ELCA-Primary Gold+ Option, the ELCA-Primary Platinum+ Option or ELCA Medicare-Primary Benefits- who purchases Member

(i) ~~purchases—~~Prescription Drugs from a retail pharmacy that participates in the pharmacy network of the Prescription Drug Benefits Administrator, from the Specialty Drug Pharmacy, or from the Prescription Drug Mail Order Pharmacy, the Member shall pay a copayment for each prescription. Such copayment is dependent upon whether the Prescription Drug is a generic drug, a preferred (formulary) brand-name drug or a non-preferred (non-formulary) brand-name drug, as determined by the Prescription Drug Administrator (See Appendix for applicable copayment amounts). In addition, the plan may institute programs that allow reduced copayments for certain drugs in order to manage prescription drug costs.

(ii) ~~If a Member purchases—~~Prescription Drugs from a pharmacy that does not participate in the pharmacy network of the Prescription Drug Administrator or fails to use the Prescription Drug identification card, the Member shall pay the copayment(s) determined in Section 15.05(a) above, plus any difference between the per-prescription amount charged by such pharmacy and the contracted amount established by the Prescription Drug Administrator for that prescription drug.

(iii) ~~If a Member purchases—~~Prescription Drugs from a pharmacy that is outside the United States, the Member shall be responsible for the Plan's formulary brand-name copayment for each thirty-one (31) day supply, plus any difference between the copayment and the per-prescription amount charged by such pharmacy. (See Appendix for applicable retail formulary, brand-name copayment amount).

(iv) If a Member purchases—certain generic Prescription Drugs, contraceptive methods or immunizations that are deemed preventive drugs or supplies that require no patient cost-sharing under the Patient Protection and Affordable Care Act of 2010, the Member shall pay no copayment for such drugs or supplies.

(b) A Member with the ELCA-Primary Bronze+ Option or Silver+ Option who purchases

(i) Eligible Prescription Drugs from a retail pharmacy, from the Specialty Drug Pharmacy, or from the Prescription Drug Mail Order Pharmacy, the Member is responsible for the Medical, Mental Health and Prescription Drug Deductible Amount and Percent Copayment until the Out-of-Pocket Limit is met. (See Appendix for applicable amounts).

(iv)(ii) Certain generic Eligible Prescription Drugs, contraceptive methods or immunizations that are deemed preventive drugs or supplies that require no patient cost-sharing under the Patient Protection and Affordable Care Act of 2010, the Member shall pay no Out-of-Pocket Amount for such drugs or supplies.

Section 15.06 **Prescription Drug Benefits Administrator.** Prescription Drug Benefits Administrator means the entity that has contracted with Portico Benefit Services to manage and administer the ELCA Prescription Drug Coverage Benefit and the ELCA Part D Drug Benefit. The Prescription Drug Benefits Administrator shall:

- (a) Contract with Participating Network Pharmacies to provide Prescription Drugs to Members who have Prescription Drug Coverage Benefits and accept negotiated rates as payment in full.
- (b) Operate the Prescription Drug Mail Order Pharmacy.
- (c) Determine the list of eligible Specialty Drugs and operate the Specialty Drug Pharmacy.
- (d) Establish and administer Medical Necessity criteria.
- (e) Administer claims for Eligible Prescription Drug Expenses.
- (f) Administer Medicare prescription drug plans.

ARTICLE XVI. CLAIMS APPEAL PROCEDURE

Section 16.01 **In General.** The payment of claims will be made on a uniform basis in accordance with the terms of the Medical and Dental Benefits Plan and any rules, regulations and procedures as Portico Benefit Services may adopt. If a claim for benefits is denied or not paid in full, a Member eligible for benefits may appeal the denial of benefits in accordance with the provisions of this Article XVI. In the event a claim is denied, the Member will be provided with a written explanation setting forth:

- (a) the specific reasons for denial;
- (b) a reference to the provision in the Medical and Dental Benefits Plan or the Medical and Mental Health Benefits Administrator, Prescription Drug Benefits

Administrator or Dental Benefits Administrator coverage policies supporting the denial;
and

- (c) the procedures available for further review of a claim.

Section 16.02 **Appeals Procedure**. The initial decision on the merits of a claim or request for benefits is made by the Medical and Mental Health Benefits Administrator, Prescription Drug Benefits Administrator or Dental Benefits Administrator that has contracted with Portico Benefit Services to manage and administer a particular portion of the Plan. In the event that the Member is dissatisfied with the initial decision of the benefits administrator, that the Member may pursue the administrator's internal appeals procedures. If the benefits administrator's internal appeals process has been exhausted, the Member may proceed as follows:

- (a) **Medical and Mental Health Benefits.** In compliance with the Patient Protection and Affordable Care Act of 2010, if the Member is not satisfied with the internal appeals determination of the Medical and Mental Health Benefits Administrator, the Member can request, through the benefits administrator, an external independent review with an organization contracted by the benefits administrator to perform independent reviews and to provide a binding, final determination.

- (b) **Prescription Drug Benefits.** In compliance with the Patient Protection and Affordable Care Act of 2010, if the Member is not satisfied with the internal appeals determination of the Prescription Drug Benefits Administrator, the Member can request, through the benefits administrator, an external independent review with an organization contracted by the benefits administrator to perform independent reviews and to provide a binding, final determination.

- (c) **Dental and ~~Medicare~~ Supplement to Medicare Benefits.** A Member may appeal in writing, within one hundred eighty (180) days of the receipt of any adverse 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. Upon receipt of the Member's appeal and signed authorization for disclosure of Protected Health Information, as defined in Section 19.03(c), to the internal appeals committee, the President will review the appeal with the advice and counsel of the internal appeals committee which shall consist of at least three (3) staff members who were not involved in the original decision. The President will respond within thirty (30) days of receipt of the appeal and signed authorization, unless the President notifies the Member of the need for an additional thirty (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. All such Plan amendments must be approved by the President, the Board of Trustees and/or the Church Council as described in Section 17.11.

In the event a Member is dissatisfied with the decision of the President, the Member may appeal to the Appeals Committee of the Board of Trustees of Portico Benefit Services sixty (60) days of the receipt of the President's written response. The Appeals Committee will consist of not less than five (5) nor more than seven (7) members of the Board of Trustees, at least one (1) of whom must be a participant in the ELCA Pension and Other Benefits Program. Additionally, the Appeals Committee may include outside independent consultants with special expertise in the area of the appeal who shall serve with voice but without vote. Upon receipt of the Member's appeal and signed authorization for disclosure of Protected Health Information, as defined in Section 19.03(c), to the Appeals Committee and designated independent consultants, the Appeals Committee shall schedule a meeting to review the appeal within thirty (30) days. The final written decision of the Appeals Committee shall be forwarded to the Member within sixty (60) days of receipt of the appeal and authorization. All decisions of the Appeals Committee are final and shall be afforded the maximum deference permitted by law.

Section 16.03 **Court System**. In the event a Member has exhausted the appeals procedure set forth in the above sections, the Member may initiate legal action in the Minnesota Fourth Judicial District Court, Hennepin County. Any removal of such action must be to the United States District Court for the District of Minnesota.

ARTICLE XVII. MISCELLANEOUS PROVISIONS

Section 17.01 **Administration by Portico Benefit Services**. In carrying out its Medical and Dental Benefits Plan responsibilities, Portico Benefit Services shall have discretionary authority to construe the terms of the Medical and Dental Benefits Plan. Except as expressly otherwise provided herein, Portico Benefit Services shall control and manage the operation and administration of the Medical and Dental Benefits Plan, and make all decisions and determinations incident thereto. Except for specified actions which Portico Benefit Services determines must be taken by it only in a duly called meeting, action on behalf of Portico Benefit Services may be taken by any of the following:

- (a) Portico Benefit Services in a duly called meeting or by written action.
- (b) The Executive Director who shall be President of Portico Benefit Services or such other corporate officer as may be designated by Portico Benefit Services.
- (c) Any person or persons, natural or otherwise, or committee to whom responsibilities for the operation and administration of the Plan are allocated by the Bylaws or a resolution of Portico Benefit Services, but action of such person(s) or committees shall be within the scope of said allocation. If allocated by resolution, a copy of each such resolution shall be retained by the Executive Director of Portico Benefit Services and filed with the permanent records of Portico Benefit Services.

Section 17.02 **Administrative Fee Paid to Portico Benefit Services**. Portico Benefit Services shall be paid a reasonable fee by the Medical and Dental Benefits Trust for the administrative services provided by Portico Benefit Services to the Medical and Dental Benefits

Plan and the Medical and Dental Benefits Trust, including a fee for informing the employees and employers of the availability of the Medical and Dental Benefits Plan. The fee charged to the Medical and Dental Benefits Trust shall constitute a lien upon the Medical and Dental Benefits Trust until paid.

Section 17.03 **Rules of Construction and Applicable Law**. The Medical and Dental Benefits Plan shall be construed and administered according to the laws of the State of Minnesota to the extent that such laws are not preempted by the laws of the United States of America. All controversies, disputes, and claims arising hereunder shall be submitted to the Minnesota Fourth Judicial District Court, Hennepin County.

Section 17.04 **Correction of Errors**. It is recognized that, in the operation and administration of the Medical and Dental Benefits Plan, certain mathematical and accounting errors may be made or mistakes may arise for various reasons, including factual errors in information supplied to the agencies that have contracted with Portico Benefit Services to manage and administer particular portions of the Plan or to the Trustee. Portico Benefit Services shall have the power to cause such equitable adjustments to be made to correct such errors as Portico Benefit Services, in its sole discretion, considers appropriate. Such adjustments shall be final and binding on all persons.

Section 17.05 **Fiduciary Standards**. Each fiduciary shall discharge her/his duties with respect to the Medical and Dental Benefits Plan, solely in the interests of the Members, and in accordance with the following requirements:

- (a) for the exclusive purpose of providing benefits to Members, and defraying reasonable expenses of administering the Medical and Dental Benefits Plan,
- (b) with the care, skill, prudence and diligence under the circumstances then prevailing, that a prudent person acting in a like capacity and familiar with such matters, would use in the conduct of an enterprise of a like character and with like aims,
- (c) by diversifying the investments of the Medical and Dental Benefits Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so, and
- (d) in accordance with the provisions of this Medical and Dental Benefits Plan and the ELCA Medical and Dental Benefits Trust.

Section 17.06 **No Other Benefits**. No benefits other than those specifically provided for herein are to be provided under the Medical and Dental Benefits Plan.

Section 17.07 **Source of Benefits**. All benefits to which a person becomes entitled hereunder shall be provided only out of the Medical and Dental Benefits Trust and only to the extent that such Trust is adequate therefor.

Section 17.08 **Portico Benefit Services is Not a Party to Contract Between an Eligible Employer and an Eligible Employee**. An Eligible Employee may have acquired certain employment or contractual rights which as between the Eligible Employer and the

Eligible Employee, may obligate the Eligible Employer to continue to sponsor the Eligible Employee or to continue to make contributions. Portico Benefit Services is not a party to any such contracts. If the Eligible Employer fails to comply with the obligations under such contract, the Eligible Employee can look only to the Eligible Employer for redress. Portico Benefit Services will not continue to provide coverage if it has not received contributions.

Section 17.09 **Limitation of Liability**. Portico Benefit Services shall not be liable to any Member for the failure of any Participating Employer to sponsor an individual as a Sponsored Member in accordance with the policies and practices of such Participating Employer, or in accordance with Section 3.02(a), whether or not Portico Benefit Services or any representative of any part of the ELCA has actual knowledge of such failure to enroll. The sole remedy of Portico Benefit Services is to involuntarily terminate the status of the entity as a Participating Employer pursuant to Section 2.04(b). Furthermore, Portico Benefit Services shall not be liable to any Member for any claim based on its failure to involuntarily discontinue such entity's status as a Participating Employer, whether or not Portico Benefit Services or any other part of the ELCA had actual knowledge of the facts that would justify the involuntary termination of the entity's status as a Participating Employer. Portico Benefit Services shall not be 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.

Section 17.10 **Obligation of Members**. A Member shall comply with all requirements of Portico Benefit Services regarding enrollment and administration of the Medical and Dental Benefits Plan including, but not limited to, establishing such Member's date of birth, marital status, partnership status, and marital, partnership and family support obligations. If the Member fails to comply with reasonable requirements or knowingly provides false, inaccurate or misleading information to Portico Benefit Services, the Member shall be obligated to reimburse Portico Benefit Services for the reasonable expenses and damages incurred by Portico Benefit Services as the result of such failure including, but not limited to, an amount determined by Portico Benefit Services to be the additional expense of its staff in discovering, correcting, or adjusting for such failure. Portico Benefit Services may charge the Member's future benefit payments under this Medical and Dental Benefits Plan, if any, for such additional expense. If a Member fraudulently or inappropriately uses, misuses or overuses Plan services and/or supplies, Portico Benefit Services has the right to terminate the Member's participation in the ELCA Pension and Other Benefits Program. Such Member will not be eligible for coverage continuation benefits under the ELCA Medical and Dental Benefits Plan.

Section 17.11 **Amendments**. The Medical and Dental Benefits Plan may be amended at any time and from time to time as follows:

(a) **Initiation of Amendments (in accordance with Section 17.61 of the ELCA Constitution, Bylaws and Continuing Resolutions).**

- (i) The ELCA Churchwide Assembly may initiate amendments which shall be submitted to Portico Benefit Services for recommendation before final action by the ELCA Church Council,

(ii) The ELCA Church Council may initiate amendments which shall be submitted to Portico Benefit Services for recommendation before final action by the ELCA Church Council, or

(iii) Portico Benefit Services may initiate amendments which shall be submitted to the ELCA Church Council for final action.

(b) **Approval of Amendments.**

(i) The President of Portico Benefit Services shall approve amendments involving no change in policy and little or no change in cost or benefits.

(ii) The ELCA Church Council shall approve amendments involving a significant change in policy or a significant change in cost or benefits. When the ELCA Church Council, in its sole discretion, deems it appropriate, proposed amendments shall be submitted to the ELCA Churchwide Assembly for final action.

(iii) The Board of Trustees of Portico Benefit Services shall approve all other amendments.

(c) **Reporting of Amendments.**

(i) Amendments approved by the President of Portico Benefit Services shall be reported to the Board of Trustees of Portico Benefit Services.

(ii) Amendments approved by the Board of Trustees of Portico Benefit Services shall be reported to the ELCA Church Council.

(d) No amendment shall 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.

Section 17.12 **Termination**. The ELCA Church Council may terminate the Medical and Dental Benefits Plan at any time in accordance with the amendment procedure set forth in Section 17.11. After such termination, no employee shall become a Sponsored Member under the Medical and Dental Benefits Plan and no additional contributions shall be made to the Medical and Dental Benefits Plan. The existing funds may be distributed to, or for the benefit of, the Members in such manner as Portico Benefit Services, in its sole discretion, shall determine 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.

Section 17.13 **Special Provisions for Members who Reside in Puerto Rico.**

(a) Sponsored Members enrolled in this Plan who reside in Puerto Rico may be enrolled for coverage in the alternate medical benefits coverage described in this Section in lieu of coverage under this Plan. A Sponsored Member who enrolls in the

alternate coverage will remain in such alternate coverage irrevocably thereafter, as long as such Sponsored Member resides in Puerto Rico.

(b) For purposes of this Section, an “Eligible Employer” is a legal entity located within the geographic boundaries of the Commonwealth of Puerto Rico, which meets one (1) of the following criteria:

(i) the entity is an organization described in Code § 501(c)(3) that is “controlled by, or associated with” the ELCA, as determined by the ELCA within the meaning of Code § 414(e)(3) and ERISA § 3(33)(C),

(ii) the entity is an organization described in Code § 501(c)(3) employing an individual who is performing service in the exercise of her/his ministry as an ELCA Ordained Minister, or

(iii) the entity is an educational organization described in Code § 170(b)(1)(A)(ii), employing as a common-law employee an individual who is performing services for such organization in the exercise of her/his ministry as an ELCA Ordained Minister.

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

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

(d) The provisions of this Section do not affect the Sponsored Member’s participation in the ELCA Retirement Plan, the ELCA Disability Benefits Plan, or the ELCA Survivor Benefits Plan.

Section 17.14 **Special Provisions for Members who Reside in Hawaii.**

(a) Effective January 1, 2003, Members residing in Hawaii who would otherwise be Sponsored Members in this Plan according to Section 3.01 must, in accordance with Hawaii law, be enrolled in an alternate group insurance plan of medical and dental coverage approved by the State of Hawaii, Department of Labor and Industrial Relations. Such Sponsored Members will not be covered by the ELCA Medical and Dental Benefits Plan after December 31, 2002.

(b) If a Sponsored Member residing in Hawaii ceases to meet the eligibility requirements of Section 3.01, s/he may re-enroll in this Plan in accordance with any applicable provisions of Articles III, IV, and V.

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

The ability of each Eligible Employer to enroll Sponsored Members in the alternate coverage shall be determined in accordance with the Contract.

The eligibility of specific employees for such alternate coverage, the cost of alternate coverage, and all administrative provisions applicable to such alternate coverage including any claims appeal procedures, shall be determined in accordance with the applicable provisions of the Contract.

(d) The provisions of this Section do not affect the Sponsored Member’s participation in the ELCA Retirement Plan, the ELCA Disability Benefits Plan, or the ELCA Survivor Benefits Plan.

Section 17.15 Special Provisions for Foreign Missionaries Employed by ELCA Global Mission.

(a) Effective June 1, 2003, ELCA Sponsored Members who are foreign missionaries employed by ELCA Global Mission will have medical, dental, mental health and prescription drug coverage through an agreement between Portico Benefit Services and an insurance company. The terms of the coverage provided to such Sponsored Members and their eligible dependents will be specified in the insurance agreement. The benefits provided under the insurance agreement will approximate the benefits described in Articles IX through XV of this Plan. Deductibles and Percent Copayments incurred while covered under this missionary insurance shall be applied to the Member who changes mid-year to ELCA-Primary Benefits ~~Coverage~~ in accordance with Section 9.04.

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

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

Section 17.16 No Guarantee of Tax Consequences. Portico Benefit Services 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 shall be 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 Benefit Services if the Member has any reason to believe that such payment is not so excludable.

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

Section 17.17 **Non-Assignability of Rights**. The right of any Member to receive any reimbursement under this Plan shall not be alienable by the Member by assignment or any other method and shall not be subject to claims by the Member's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

Section 17.18 **Plan Provisions Controlling**. In the event that the terms or provisions of any summary or description of this Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

Section 17.19 **Termination for Fraud/Abuse**. If a Member fraudulently or inappropriately uses; misuses or overuses Plan services and/or supplies, Portico Benefit Services has the right to terminate the member's participation in the ELCA Pension and Other Benefits Program. Such Member and her/his dependents will not be eligible for coverage continuation benefits under the ELCA Medical and Dental Benefits Plan.

Section 17.20 **Special Provisions for Members Employed by an ELCA Seminary**.

(a) Effective January 1, 2013, Sponsored Members who are employed by an ELCA seminary may have benefit option(s), including [an ELCA-Primary high deductible health coverage option](#), provided by the Plan which may have different Deductible Amounts, Percent Copayments, Copayments and Out-of-Pocket Amounts than those described in Article X. The Deductible Amounts, Percent Copayments, Copayments and Out-of-Pocket Amounts for ELCA seminary options are specified in the Appendix.

(b) Deductible Amounts and Percent Copayments incurred while covered under an ELCA seminary option that is not [an ELCA-Primary ~~Medical and Mental Health Benefits Option described in Sec. 9.01~~](#) shall be applied to the Member who changes mid-year, [due to a change in employment, to an ELCA-Primary ~~Benefits Coverage Option described in Sec. 9.01~~ due to a change in employment](#).

(c) Notwithstanding the provisions of Section 3.01, an ELCA seminary shall determine which employees, in a manner approved by Portico Benefit Services, are eligible to participate in the Plan as Sponsored Members.

(d) During an enrollment period specified by Portico Benefit Services, ELCA seminary Sponsored Members will elect an option for the following calendar year. Such

election cannot be changed midyear while the employee is sponsored by the ELCA seminary.

(e) Notwithstanding Section 7.01, the ELCA seminary may require that its Sponsored Members pay a portion of contributions associated with this Plan.

(f) The provisions of this Section 17.20 do not affect ELCA seminary Sponsored Member's participation in the ELCA Retirement Plan, the ELCA Disability Benefits Plan, or the ELCA Survivor Benefits Plan, or his/her eligibility for benefits under this Plan before or after a period of employment with an ELCA seminary.

(g) An ELCA seminary may make contributions to a Personal Wellness Account described in Article XX for an eligible Sponsored Member, if such Member has ELCA-Primary high deductible health coverage and is not eligible to participate in a Health Savings Account described in the ELCA Flexible Benefits Plan.

ARTICLE XVIII. DEFINITIONS

Section 18.01 **AELC**. The "AELC" is The Association of Evangelical Lutheran Churches, including its antecedent bodies.

Section 18.02 **ALC**. The "ALC" is The American Lutheran Church, including its antecedent bodies.

Section 18.03 **Church Institution**. A "Church Institution" is an entity that is an Eligible Employer within the meaning of Section 2.01(c) or (d).

Section 18.04 **Churchwide Unit**. For purposes of this Medical and Dental Benefits Plan, "Churchwide Unit" means each of the following: ELCA Churchwide Organization, Women of the ELCA, ELCA Publishing House, ELCA Mission Investment Fund, ELCA Foundation, and Portico Benefit Services.

Section 18.05 **Code**. "Code" means the Internal Revenue Code of 1986, as from time to time amended.

Section 18.06 **Coverage Continuation Member**. A "Coverage Continuation Member" is an individual who:

- (a) Is an ELCA Ordained Minister or ELCA Rostered Layperson who continues coverage while On Leave from Call under Section 6.06(a).
- (b) Continues coverage under Section 6.06(b) as a disabled Member.
- (c) Continues coverage under Section 6.06(c).
- (d) Is a Dependent who continues coverage under Section 6.07.

Section 18.07 **Defined Compensation**. “Defined Compensation” includes actual gross taxable cash compensation, plus the amount of any contribution made to a tax sheltered annuity plan, as defined in Code § 402(g)(3)(C), or for a qualified benefit as provided for in Code § 125 or § 132, pursuant to a salary reduction agreement entered into by the Participating Employer and the Sponsored Member. “Defined Compensation” does not include nontaxable reimbursements or expense allowances. In the case of certain teachers who are recognized as ministers for purposes of Code § 107, “Defined Compensation” also includes the amount of the individual’s housing allowance as defined in Code § 107, if any, or an additional thirty percent (30%) of cash compensation plus any furnishings or utilities allowance paid directly to the Sponsored Member if housing is furnished by the Participating Employer.

Section 18.08 **Dependent**. A “Dependent” is a person who is covered as a Member of this Medical and Dental Benefits Plan and meets the definition of either:

- (a) “Eligible Spouse” as set forth at Section 4.02(a);
- (b) “Eligible Child” as set forth at Section 4.05 (also meeting the “Age or Disability Requirements” set forth at Sec. 4.06); or
- (c) “Eligible Same Gender Partner” as set forth in Section 4.03.

Section 18.09 **ELCA**. The “ELCA” is the Evangelical Lutheran Church in America, a Minnesota nonprofit corporation.

Section 18.10 **ELCA Board of Pensions**. The “ELCA Board of Pensions” is the Board of Pensions of the Evangelical Lutheran Church in America, a Minnesota nonprofit corporation. The ELCA Board of Pensions began doing business as Portico Benefit Services in November 2011.

Section 18.11 **ELCA Ordained Minister**. An “ELCA Ordained Minister” is an individual listed on the roster of ordained ministers of the ELCA.

Section 18.12 **ELCA Rostered Layperson**. An “ELCA Rostered Layperson” is an associate in ministry, deaconess or diaconal minister listed on one (1) of the official rosters of the ELCA.

Section 18.13 **Eligible Child**. An “Eligible Child” is an individual described in Section 4.05 who also meets the “Age or Disability Requirements” of Section 4.06.

Section 18.14 **Eligible Same Gender Partner**. An “Eligible Same Gender Partner” is an individual described as such in Section 4.03.

Section 18.15 **Eligible Employee**. An “Eligible Employee” is an individual described as such in Section 3.01.

Section 18.16 **Eligible Employer**. An “Eligible Employer” is an entity described as such in Section 2.01.

Section 18.17 **Eligible Spouse**. An “Eligible Spouse” is an individual who meets the requirements of Section 4.02.

Section 18.18 **ERISA**. “ERISA” means the Employee Retirement Income Security Act of 1974, as from time to time amended.

Section 18.19 **Family**. “Family” includes a Sponsored, Coverage Continuation or Retired Member and the Member’s Dependents. Notwithstanding the preceding sentence, two (2) or more Coverage Continuation Members who are Eligible Children of the same deceased Sponsored, Coverage Continuation or Retired Member shall be considered one (1) Family.

Section 18.20 **Former Spouse**. A “Former Spouse” is an individual who was legally married to and is now divorced from an opposite sex Sponsored Member, Coverage Continuation Member described in Section 6.06 or Retired Member, provided such Former Spouse was covered or had waived coverage under this Plan at the time of the marriage dissolution. An individual described in Section 4.02(d) is also a Former Spouse.

Section 18.21 **Inter-Lutheran Agency**. For purposes of this Medical and Dental Benefits Plan, “Inter-Lutheran Agency” includes the Lutheran Council in the USA and other inter-Lutheran agencies that function under Lutheran Council in the USA personnel policies. The determination of which inter-Lutheran agencies shall function under Lutheran Council in the USA’s personnel policies shall be made by Portico Benefit Services, in its sole discretion.

Section 18.22 **LCA**. The “LCA” is the Lutheran Church in America, including its antecedent bodies.

Section 18.23 **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 Administrator, 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:

(a) To be appropriate, the health care service or supply must be a service or supply that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and which is:

(i) in accordance with generally accepted standards of medical practice, standards that are based on creditable scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, specialty society recommendations and the views of providers practicing in relevant clinical areas and any other relevant factors; and

(ii) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and

(iii) not primarily for the convenience of the patient, physician, or other health care provider; and

(iv) not more costly than an alternative service or sequence of services;
and

(v) at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

(b) In determining if a service or supply is Medically Necessary, the administrator will take into consideration:

(i) information provided on the affected person's health status;

(ii) reports in peer reviewed medical literature generally recognized by the relevant medical community;

(iii) reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;

(iv) generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;

(v) the opinion of health professionals in the generally recognized health specialty involved; and

(vi) any other relevant information.

(c) In no event will the following services or supplies be considered to be Medically Necessary:

(i) those that do not require the technical skills of a licensed provider of service covered under this Plan who is acting within the scope of her/his license; or

(ii) those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility; or

(iii) those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or

(iv) those services and supplies which could safely and adequately be provided in a less costly setting; or

(v) those services and supplies which are determined by the Plan's Benefits Administrators to be inappropriately used, misused or overused.

Notwithstanding the foregoing, if a Member has a life-threatening illness or condition (one which is likely to cause death within one (1) year of the request for treatment) the Medical and

Mental Health Benefits Administrator 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 must determine that the procedure or treatment has some available research outcomes, but is unproven, and that such service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Section 18.24 **Member.** “Member” means any Sponsored Member, any Retired Member, any Dependent, or any other person who is entitled to a benefit from this Medical and Dental Benefits Plan.

Section 18.25 **Other Employer-Provided Group Coverage.** “Other Employer-Provided Group Coverage” is any group plan providing benefits or services for or by reason of medical care treatment, which benefits or services are provided by (a) an employer or former employer of the Sponsored Member’s Eligible Spouse or Eligible Same Gender Partner as the result of the Eligible Spouse’s or Eligible Same Gender Partner’s employment; (b) a former employer of the Sponsored Member as a result of the Sponsored Member’s previous employment; (c) an employer, former employer of a Retired Member or Eligible Spouse or Eligible Same Gender Partner of a Retired Member; (d) an employer or former employer of a Member who is “On Leave from Call” or Eligible Spouse or Eligible Same Gender Partner of a Member who is “On Leave from Call;” (e) an employer of the Sponsored Member (other than the Sponsored Member’s Participating Employer), provided such employer is not an ELCA congregation, seminary, synod or Churchwide Unit; (f) an employer or former employer of a parent whose employer-provided group coverage covers the Sponsored Member as a dependent; (g) a government-sponsored program outside the United States; (h) Federal Medicaid or state-sponsored Medicaid-like medical assistance programs; (i) a post-secondary educational institution attended by a Coverage Continuation Member, Eligible Spouse or Eligible Same Gender Partner or Eligible Child; (j) a Medicare Health Plan Option under a Medicare Advantage plan or Medicare Cost Plus plan; or (k) the Department of Veteran Affairs to veterans eligible to enroll in VA health care benefits. [In addition, health insurance purchased by a Member on a state, federal or state/federal partnership health insurance exchange in accordance with the Patient Protection and Affordable Care Act of 2010 will be allowed to satisfy the waiver of health coverage requirements of this Plan.](#)

Section 18.26 **Portico Benefit Services.** The Board of Pensions of the Evangelical Lutheran Church in America is doing business as Portico Benefit Services (“Portico Benefit Services” or “Portico”), a Minnesota non-profit corporation. Portico Benefit Services is also referred to as, “we,” “us,” or “our.”

Section 18.27 **Predecessor Churches.** Each of the following is a “Predecessor Church”: The American Lutheran Church, The Association of Evangelical Lutheran Churches, and Lutheran Church in America, including their antecedent bodies.

Section 18.28 **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 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; provided, however, the allowed amount shall not exceed the actual charge billed by the provider. Specifically,

(a) 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;

(b) 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.

Section 18.29 **Retired Member**. A “Retired Member” is an individual described as such in Article V.

Section 18.30 **Separation from Service**. The “Separation from Service” of a Sponsored Member for purposes of this Medical and Dental Benefits Plan shall be deemed to occur upon her/his resignation, discharge, retirement, death, failure to return to active service at the end of an authorized leave of absence (including an ELCA Ordained Minister “On Leave from Call” or an ELCA Rostered Layperson “On Leave from Call”), or the authorized extension or extensions thereof, or upon the occurrence of any other event or circumstances which, under the policy of her/his Participating Employer or of Portico Benefit Services, as in effect from time to time, results in a termination of the arrangement for the performance of compensated service; provided, however, that a Separation from Service shall not be deemed to occur upon a transfer between any combination of Participating Employers.

Section 18.31 **Sponsored Member**. A “Sponsored Member” is an individual described as such in Section 3.02.

Section 18.32 **Surviving Child**. A “Surviving Child” is a child, described in Sections 4.05 and 4.06, of a deceased Sponsored Member, Retired Member, or Coverage Continuation Member described in Section 18.06(a), (b) or (c).

Section 18.33 **Surviving Spouse**. A “Surviving Spouse” is an individual who was legally married to a Sponsored Member, Retired Member or Coverage Continuation Member of the opposite sex on the date of the Sponsored Member, Retired Member, or Coverage Continuation Member’s death.

ARTICLE XIX. HIPAA PRIVACY COMPLIANCE

Section 19.01 **In General**. The provisions of this Article XIX are intended to comply with the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations promulgated thereunder, as they may be amended from time to time (collectively, “HIPAA”) and, in particular, the rules under HIPAA pertaining to the privacy of Protected Health Information set forth in 45 C.F.R. Subtitle A, Part 164, Subpart E, as it may be amended from time to time (the “Privacy Rule”) and the

rules under HIPAA pertaining to the security of Electronic Protected Health Information as set forth in 45 C.F.R. Subtitle A, Subchapter C, parts 160, 162 and 164, as they may be amended from time to time (the “Security Rule”).

Section 19.02 **Inconsistent Provisions**. This Article XIX shall supersede any provisions of the Plan to the extent those provisions are inconsistent with this Article.

Section 19.03 **HIPAA Definitions**. Each capitalized term used in this Article XIX that is not otherwise defined in this document or Article shall have the meaning ascribed to it under HIPAA. HIPAA-specific definitions include the following:

(a) **Health Care Operations**. “Health Care Operations” of the Plan include quality assessments and improvement, advocacy, data analysis, underwriting, contracts, legal services, audits, compliance, management and administration, and such other activities set forth in the Privacy Rule.

(b) **Payment**. “Payment” means activities undertaken by the Plan to determine eligibility, premiums and contributions, reimbursements, billing, claims management, appeals, subrogation, collection activities, and utilization reviews, and such other activities set forth in the Privacy Rule.

(c) **Protected Health Information**. “Protected Health Information” is individually 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.

(d) **Personal Representative**. A “Personal Representative” means an individual who is legally designated, chosen by the Member, or determined by the Plan, as acting in the best interests of the Member.

(e) **Treatment**. “Treatment” is the provision of care, consultation and referrals between providers, and such other activities set forth in the Privacy Rule.

(f) **Electronic Protected Health Information**. “Electronic Protected Health Information” means Protected Health Information that is transmitted by or maintained in electronic media.

(g) **Summary Health Information**. “Summary Health Information” means information about individual Members that summarizes claims history, claims expenses, or type of claims experienced by those Members; and which has been stripped of individual identifiers other than a five (5) digit zip code.

Section 19.04 **Required Uses and Disclosures of Protected Health Information**. Except as otherwise set forth herein, the Plan or any Benefits Administrator providing benefits under the Plan may disclose Protected Health Information of the Plan to Portico Benefit Services for the following uses and disclosures:

(a) for disclosure to the Secretary of Health and Human Services, when required by the Secretary for its investigation or determination of the compliance of the Plan with the Privacy Rule;

(b) for disclosure to a Member of that Member's Protected Health Information upon the Member's request or in appropriate response to an exercise by the Member of any other of his or her individual rights with respect to Protected Health Information, all in accordance with the requirements of the Privacy Rule;

(c) for disclosure to a Personal Representative of the Member's Protected Health Information upon the Personal Representative's request or in appropriate response to an exercise by the Personal Representative of any other individual rights with respect to Protected Health Information, all in accordance with the requirements of the Privacy Rule; and

(d) for use or disclosure to other persons, as required by applicable law other than HIPAA, provided that nothing in this Section 19.04(d) and Section 19.06(h) shall permit or require the use by or disclosure of Protected Health Information to Portico Benefit Services to the extent such disclosure is prohibited by HIPAA.

Section 19.05 Permitted Uses and Disclosures of Protected Health Information.

Except as otherwise set forth herein, the Protected Health Information created or received by the Plan or any Benefits Administrator providing benefits under the Plan shall be permitted to be disclosed to Portico Benefit Services (upon receipt from Portico Benefit Services of a certification that it shall comply with the restrictions as to the use of Protected Health Information and the other provisions set forth in this Article) for purposes of the administrative functions that Portico Benefit Services performs on behalf of the Plan, or as otherwise required by HIPAA, including without limitation:

(a) for Treatment, Payment or Health Care Operations;

(b) for wellness, prevention, nurse line, disease management programs, health coach services, 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;

(c) for purposes of advocacy and assistance to Plan Members;

(d) for benefits appeals and complaints;

(e) for purposes relating to subpoenas and other court orders; and

(f) pursuant to and in accordance with a valid authorization under the Privacy Rule.

Nothing in this Section 19.05 shall permit or require the disclosure of Protected Health Information to Portico Benefit Services to the extent such disclosure is prohibited by HIPAA.

In addition, the Plan may disclose Summary Health Information to Portico Benefit Services if Portico Benefit Services requests the Summary Health Information for the purpose of modifying, amending or terminating the Plan. The Plan may also disclose to Portico Benefit Services information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from the Plan.

Section 19.06 **Requirements of Portico Benefit Services**. The Plan is permitted to disclose Protected Health Information to Portico Benefit Services because the Plan includes the provisions in this Section 19.06. The execution of this Plan document shall constitute any certification that may be required under HIPAA that the Plan includes the following provisions. Portico Benefit Services shall:

(a) not use or disclose Protected Health Information received from the Plan or any Benefits Administrator providing benefits under the Plan, other than as permitted by the Plan document, for Plan administration, or as otherwise required by law;

(b) ensure that any agent (including a subcontractor) to whom Portico Benefit Services provides Protected Health Information received from the Plan, any Program Administrator, or any Benefits Administrator providing benefits under the Plan, agrees to the same restrictions and conditions with respect to Protected Health Information as apply to Portico Benefit Services under this Article XIX;

(c) not use or disclose Protected Health Information received from the Plan or any Benefits Administrator providing benefits under the Plan, for employment-related actions or decisions or in connection with any employee benefit plan or benefit provided by Portico Benefit Services other than the Plan or a health benefit provided under the Plan;

(d) report to the Plan or Benefits Administrator providing benefits thereunder, as applicable, any use or disclosure of Protected Health Information received from the Plan or any Benefits Administrator providing benefits under the Plan, that is inconsistent with the uses or disclosures required or permitted under this Article XIX and of which Portico Benefit Services becomes aware;

(e) make the Protected Health Information of a Member available to that individual, upon the individual's written request, in accordance with the requirements of the Privacy Rule;

(f) incorporate amendments of Protected Health Information of a Member as and to the extent required by the Privacy Rule;

(g) make available to a Member upon the individual's written request, the information necessary to provide an accounting of the disclosures of Protected Health Information as and to the extent required by the Privacy Rule;

(h) make Portico Benefit Services' internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan or any Benefits Administrator providing benefits under the Plan, available to the

Secretary of Health and Human Services for determinations as to the compliance of the Plan with HIPAA;

(i) if feasible, return or destroy all Protected Health Information received from the Plan or from any Benefits Administrator providing benefits under the Plan, that Portico Benefit Services in any form, and retain no copies thereof; or if such return or destruction is not feasible, limit further uses and disclosures of Protected Health Information to the purposes that make the destruction or return infeasible;

(j) ensure that the requirements set forth in Section 19.07 are satisfied with respect to Protected Health Information;

(k) implement and maintain administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of Electronic Protected Health Information which Portico Benefit Services creates, receives, maintains or transmits on behalf of the Plan;

(l) ensure that limited access to Protected Health Information (including Electronic Protected Health Information) as described in Section 19.07 is supported by reasonable and appropriate security measures;

(m) ensure that any agent, including a subcontractor, to whom Electronic Protected Health Information is provided agrees to implement reasonable and appropriate security measures to protect such information; and

(n) report to the Plan any security incident of which it becomes aware.

Section 19.07 Access to Protected Health Information, including Electronic Protected Health Information.

(a) **Access.** Access to and use of Protected Health Information, including Electronic Protected Health Information, shall be limited to employees or agents of Portico Benefit Services who perform the functions relating to Plan administration on behalf of or in connection with the Plan, as described in Sections 19.04 and 19.05, in order to perform such activities.

(b) **Minimum Necessary.** Except as to use or disclosure of information related to the treatment of a Member, when using or disclosing Protected Health Information or when requesting Protected Health Information from another entity, the Plan or any individual acting on behalf of the Plan, including Portico Benefit Services, must make reasonable efforts to limit Protected Health Information to the minimum necessary to accomplish the intended purpose of the use, disclosure or request. Adherence to policies established by the Plan with respect to the use, disclosure or request of Protected Health Information shall be deemed to constitute such an effort.

(c) **Plan Administration Activities.** Employees of Portico Benefit Services are responsible for such Plan administration activities in accordance with Sections 19.07(a) and (b), include employees from:

- (i) Finance;
- (ii) General Counsel;
- (iii) Health Care;
- (iv) Information Solutions;
- (v) Internal Appeals Committee;
- (vi) Internal Audit;
- (vii) Marketing and Communications;
- (viii) ~~Member Services~~[Service Center](#);
- (ix) Office Services;
- (x) President's Unit;
- (xi) Products & Services; and
- (xii) Trustees' Appeals Committee.

Section 19.08 **Non-compliance**. If the Plan becomes aware of any issues relating to non-compliance with the requirements of this Article XIX, the Plan's privacy and/or security official shall undertake an investigation to determine the extent, if any, of such non-compliance; the individuals, policies or practices responsible for the non-compliance; and appropriate means for curing or mitigating the effects of non-compliance and preventing such non-compliance in the future. Any individual or entity who is determined by the Plan to be responsible for such non-compliance, shall be subject to disciplinary action, as determined by the Plan and Portico Benefit Services, in their sole discretion, including but not limited to one (1) or more of the following: termination of Plan-related responsibilities, required additional training and education with respect to the use or disclosure of or request for Protected Health Information (including Electronic Protected Health Information), limitations on or revocation of access to Protected Health Information (including Electronic Protected Health Information), reprimand, diminution of duties, suspension, disqualification for bonus or other pay or promotion, demotion in pay or status, or removal from position or discharge. [Portico Benefit Services will report any breach as required by HIPAA.](#)

Section 19.09 **Action by Portico Benefit Services**. Portico Benefit Services may act as prescribed in this Article XIX or may delegate, in writing and in its sole discretion, any and all of its functions under this Article XIX to a committee, to the Plan's privacy official, security official, privacy contact, or other officer or employee, or to a group of officers or employees of Portico Benefit Services. Portico Benefit Services or such delegate shall have the authority to establish rules and prescribe forms and procedures for performing its functions hereunder.

Section 19.10 **Consistency with HIPAA and HIPAA Regulations**. In the event any amendment of HIPAA (or of either the Privacy Rule or the Security Rule) is adopted that renders any provision of this Article XIX inconsistent therewith, this Article XIX will be deemed amended to be consistent therewith.

ARTICLE XX. PERSONAL WELLNESS ACCOUNT

Section 20.01 **Personal Wellness Account**. The Personal Wellness Account (“PWA”) is intended to qualify as an employer-provided, self-insured medical reimbursement plan under Code §§ 105 and 106 and regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45. The PWA Expenses reimbursed under the Personal Wellness Account are intended to be eligible for exclusion from PWA Members’ gross income under Code § 105(b). The effective date of the commencement of the Personal Wellness Account portion of the Plan is January 1, 2008.

Section 20.02 **Definitions**. Certain terms are specific to this Article XX and are defined below. Except for the terms defined below, terms that are capitalized throughout the Plan are defined terms, the definitions for which are set forth in various Plan sections.

(a) **Health FSA**. The “Health FSA” is the health flexible spending account as defined in Prop. Treas. Reg. § 1.125-2, Q & A-7(a) offered under the ELCA Flexible Benefit Plan.

(b) **Health Improvement Activity Administrator**. Portico Benefit Services may contract with “Health Improvement Activity Administrators” that will provide health risk assessments, health improvement modules, and/or health improvement support services to PWA Members, Eligible Spouses and Eligible Same Gender Partners. PWA Member, Eligible Spouse and Eligible Same Gender Partner participation in Health Improvement Activities will be recorded by the Health Improvement Activity Administrator and reported to the PWA Administrator so that the PWA Administrator can activate and credit a PWA Member’s Personal Wellness Account in accordance with Section 20.15.

(c) **Health Improvement Activities**. “Health Improvement Activities” are those activities presented by Portico Benefit Services from time to time which must be performed by a PWA Member, Eligible Spouse or Eligible Same Gender Partner before any amounts are credited to a PWA Member’s Personal Wellness Account.

(d) **Maximum Annual Credit Amount**. The “Maximum Annual Credit Amount” for Health Improvement Activities to a Personal Wellness Account for a PWA Member, Eligible Spouse or Eligible Same Gender Partner shall be determined by Portico Benefit Services and specified in the Appendix.

(e) **PWA Administrator**. The “PWA Administrator” is the entity that has contracted with Portico Benefit Services to manage and administer the Personal Wellness Account.

(f) **PWA Dependent.** A “PWA Dependent” is any individual, including an Eligible Spouse, who is a tax dependent of the PWA Member as defined in Code § 105(b), with the following exception: any child to whom Code § 152(e) applies (regarding a child of divorced parents, etc., where one (1) or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) is treated as a dependent of both parents. Notwithstanding the foregoing, the Personal Wellness Account portion of the Plan will provide benefits in accordance with the applicable requirements of any qualified medical child support order, even if the child does not meet the definition of “PWA Dependent.” A PWA Member’s Eligible Same Gender Partner and the partner’s children are PWA Dependents, but only if they are tax dependents of the PWA Member as defined in Code § 105(b).

(g) **PWA Expenses.** Eligible “PWA Expenses” are the expenses described in Section 20.13 incurred by the PWA Member and PWA Dependents. An Eligible Same Gender Partner and her/his children who are not tax dependents of the PWA Member as defined in Code § 105(b) are not eligible to receive reimbursement for medical expenses under the Personal Wellness Account portion of the Plan.

(h) **PWA Member.** A “PWA Member” is a Sponsored Member, Retired Member, Coverage Continuation Member, certain Eligible Spouse, certain Eligible Same Gender Partner if s/he is a tax dependent as defined in Code § 105(b) or eligible Dependent designated as the account holder under the rules and regulations of Portico Benefit Services who

(i) is covered under this Plan in the ELCA-Primary Gold+ Option or ELCA-Primary Platinum+ Option, or

(ii) is covered under this Plan in the ELCA-Primary Bronze+ Option or ELCA-Primary Silver+ Option and is not eligible to participate in the Health Savings Account of the ELCA Flexible Benefits Plan due to Medicare eligibility within the calendar year ; and

(iii) is eligible for and participating in the Personal Wellness Account portion of the Plan in accordance with the provisions of this Article XX.

Notwithstanding the foregoing, an Eligible Same Gender Partner who is not a tax dependent as defined in Code § 105(b) cannot become a PWA Member.

~~(h)~~(i) **Period of Coverage.** A “Period of Coverage” is the Plan Year, with the following exception: for employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences. Portico Benefit Services may, in its sole discretion, establish a different Period of Coverage at any time. Any such change in the Period of Coverage shall be communicated to PWA Members prior to the change becoming effective.

~~(i)~~(j) **Personal Wellness Account.** A “Personal Wellness Account” is the Account described in Section 20.15.

(j)(k) **Plan Year.** The “Plan Year” is the calendar year (i.e., the twelve (12) month period commencing January 1 and ending on December 31).

Section 20.03 **Eligibility.** A Sponsored Member, Retired Member, Coverage Continuation Member or eligible Dependent designated as a “PWA Member” by Portico Benefit Services, and/or the Eligible Spouse or Eligible Same Gender Partner of any such Member who is enrolled in and receiving ELCA-Primary ~~Benefits Coverage~~Gold+ Option or the ELCA-Primary Platinum+ Option, or is receiving ELCA-Primary Bronze+ Option or ELCA-Primary Silver+ Option who is not eligible to participate in the Health Savings Account of the ELCA Flexible Benefits Plan due to Medicare eligibility within the calendar year is eligible to earn Personal Wellness Account credits in accordance with Section 20.15. Notwithstanding the foregoing, an ELCA seminary Sponsored Member in accordance with Sec. 17.20 who elects certain health plan options will not be eligible to earn Personal Wellness Account Credits. Also, an individual who enrolls in the ELCA-Primary Benefits Coverage after September 30 will not be eligible to earn Personal Wellness Account ~~credits~~Credits until January 1 of the following year.

Section 20.04 **Enrollment and Participation.** A PWA Member and her/his Eligible Spouse or Eligible Same Gender Partner may complete certain Health Improvement Activities which will result in credits to the PWA Member’s Personal Wellness Account. A PWA Member’s Personal Wellness Account is automatically activated when the PWA Member or Eligible Spouse or Eligible Same Gender Partner completes the phase one (1) Health Improvement Activity and consents to transmission of the phase one (1) completion information from the Health Improvement Activity Administrator to the PWA Administrator. An individual who terminates ELCA-Primary Benefits ~~Coverage~~and no longer meets the eligibility requirements in Sec. 20.03 may not earn additional Personal Wellness Account credits. However, a PWA Member may continue to be reimbursed for Eligible PWA Expenses until the PWA Member’s Personal Wellness Account balance is depleted.

Notwithstanding the foregoing, in accordance with Section 17.20(g) of the Plan, Sponsored Members employed by an ELCA seminary who are not eligible for a contribution from the ELCA seminary into a Member Health Savings Account as described in the ELCA Flexible Benefits Plan may be enrolled as a PWA member when the ELCA seminary makes an employer contribution for the Sponsored Member into the PWA.

Section 20.05 ~~**PWA Members Electing Continuation Coverage under the ELCA Medical and Dental Benefits Plan.** If a PWA Member elects to continue ELCA Primary Benefits Coverage under the Plan after termination of employment, her/his Eligible Spouse or Eligible Same Gender Partner will remain eligible to receive credits to the Personal Wellness Account up to the Maximum Annual Credit Amount for completing certain Health Improvement Activities during any such continued coverage.~~

Section 20.06 **Section 20.05 Termination of Participation.** A PWA Member will cease to be a Member in the Personal Wellness Account portion of the Plan upon the earlier of:

- (a) the termination of the Personal Wellness Account portion of the Plan; or

- (b) the date on which the PWA Member:
- (i) ~~is no longer a PWA Member enrolled in and receiving ELCA-Primary Benefits Coverage~~meets the PWA Member eligibility requirements in Sec. 20.03; and
 - (ii) has depleted her/his Personal Wellness Account balance.

~~Section 20.07~~Section 20.06 **Reinstatement Following Termination of Employment.** If a PWA Member terminates her/his employment for any reason, including (but not limited to) retirement, layoff or voluntary resignation, and terminates her/his ELCA-Primary Benefits ~~Coverage~~ and the ELCA-Primary ~~Coverage-Benefits~~ for her/his Eligible Spouse or Eligible Same Gender Partner and, if such PWA Member, Eligible Spouse or Eligible Same Gender Partner did not receive the Maximum Annual Credit Amount before the PWA Member terminated such coverage, and the PWA Member is rehired and reinstated under the ELCA-Primary portion of the Plan within the same Plan Year and the PWA Member continues to meet the eligibility requirements of Sec. 20.03, then such PWA Member, Eligible Spouse or Eligible Same Gender Partner shall have the opportunity to receive the Maximum Annual Credit Amount specified in the Appendix by completing designated Health Improvement Activities.

~~Section 20.08~~Section 20.07 **Termination of ELCA-Primary Benefits Coverage under the ELCA Medical and Dental Benefits Plan.** Upon termination of ELCA-Primary Benefits Coverage under the Plan, no further amounts will be credited to the PWA Member's Personal Wellness Account. A PWA Member may continue to be reimbursed for PWA Expenses incurred after such termination until her/his Personal Wellness Account balance is depleted. A PWA Member's Eligible Spouse who receives ELCA-Primary ~~Benefits-Gold+ Option or ELCA-Primary Platinum+ Option Coverage~~ is eligible to become a PWA Member with her/his own PWA Account after such Member has transitioned to ELCA Medicare-Primary Benefits Coverage under this Plan. ~~A PWA Member's Eligible Same Gender Partner who receives ELCA-Primary Benefits Coverage and who is a tax dependent as defined in Code § 105(b) is eligible to become a PWA Member with her/his own PWA Account after the PWA Member has transitioned to Medicare-Primary Benefits Coverage under this Plan.~~ However, a PWA Member's Eligible Same Gender Partner who receives ELCA-Primary Benefits ~~Coverage~~ but who is not a tax dependent as defined in Code § 105(b) is not eligible to become a PWA Member with her/his own PWA Account after the PWA Member has transitioned to Medicare-Primary Benefits Coverage under this Plan.

~~Section 20.09~~Section 20.08 **Death of a PWA Member.** A PWA Member's surviving spouse and/or eligible PWA Dependents may continue to be reimbursed for PWA Expenses incurred after the PWA Member's death until the deceased PWA Member's Personal Wellness Account balance is depleted.

~~Section 20.10~~Section 20.09 **Benefits Offered.** When a Member becomes a PWA Member in accordance with Section 20.04, and the PWA Member or her/his Eligible Spouse or Eligible Same Gender Partner completes the phase one (1) Health Improvement Activity or ~~the a Participating Employer ELCA-seminary~~ contributes to the PWA for a Sponsored Member, the PWA Administrator shall activate a Personal Wellness Account for such PWA Member to

receive reimbursements for PWA Expenses. The amount of and the timing for crediting amounts to each Personal Wellness Account shall be determined by Portico Benefit Services.

Section 20.11~~Section 20.10~~ **Contributions.**

(a) **Member or Participating Employer Contributions.** ~~Neither~~ Members may not make contributions to the Personal Wellness Account. ~~nor~~ Participating Employers may make contributions to the Personal Wellness Accounts for Sponsored Members with ELCA-Primary Bronze+ or Silver+ Options by remitting contributions to Portico. ~~Notwithstanding the foregoing, in accordance with Section 17.20(g) of the Plan, Sponsored Members employed by an ELCA seminary who are not eligible for a contribution from the ELCA seminary into a Member Health Savings Account described in the ELCA Flexible Benefits Plan may receive ELCA Seminary employer contributions to the PWA.~~

(b) **No Funding Under Cafeteria Plan.** Under no circumstances will the Personal Wellness Accounts be funded with salary reduction contributions, ~~employer contributions (e.g., flex credits)~~ or otherwise under a cafeteria plan.

Section 20.12~~Section 20.11~~ **No Benefits Other than Reimbursement Benefits.** In no event shall benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for PWA Expenses. The PWA Administrator will reimburse a PWA Member for PWA Expenses up to the unused amount credited to the PWA Member's Personal Wellness Account, as set forth and adjusted under this Article XX.

Section 20.13~~Section 20.12~~ **Eligible PWA Expenses.** Eligible PWA Expenses are those health care expenses described in Code § 213(d), provided such expenses are:

(a) **Incurred during the Period of Coverage by a PWA Member, her/his Eligible Spouse and PWA Dependents.** A PWA Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. PWA Expenses incurred before a PWA Member or PWA Dependent first becomes covered under the Personal Wellness Account portion of the Plan are not eligible for reimbursement.

(b) **Not Reimbursed or Reimbursable from Another Source.** PWA Expenses can only be reimbursed to the extent that the PWA Member or the PWA Member's Eligible Spouse or PWA Dependent incurring the expense has not been reimbursed for the expense (nor is the expense reimbursable) through the ELCA Medical and Dental Benefits Plan, other insurance, or any other accident or health plan (but see Section 20.18 if the other health plan is the ELCA Health FSA). If only a portion of a PWA Expense has been reimbursed elsewhere (e.g., because the Plan imposes ~~deductible maximums~~ Deductible Amounts), the Personal Wellness Account can reimburse the remaining portion of such PWA Expense if it otherwise meets the requirements of this Article XX.

(c) Eligible PWA Expenses for Members [with ELCA-Primary Bronze+ and Silver+ Options](#) or [ELCA Seminary Members with ~~with~~ ELCA-Primary high deductible health coverage and a Health Savings Account described in the ELCA Flexible Benefits Plan who have a Personal Wellness Account balance from a prior period of coverage](#) are limited to vision, dental and post-deductible eligible medical, mental health and prescription drug expenses.

Notwithstanding the above, PWA Expenses shall not include health insurance premiums for individual policies or for any other group health plan (including a plan sponsored by a Participating Employer) and any other expenses specifically excluded by Portico Benefit Services or PWA Administrator pursuant to the rules, regulations and procedures adopted by Portico Benefit Services for such purpose.

Section 20.14~~Section 20.13~~ **Maximum Benefits.**

(a) **Maximum Benefits [for Health Improvement Activities](#).** The maximum dollar amount that may be credited to a PWA Member's Personal Wellness Account [or for a member with ELCA-Primary Bronze+ and Silver+ Options or ELCA Seminary Members with ELCA-Primary high deductible health coverage and a Health Savings Account](#) for Health Improvement Activities during a twelve (12) month Period of Coverage is specified in the Appendix. Unused amounts may be carried over to the next Period of Coverage, as provided in Section 20.16.

(b) **Changes.** For subsequent Plan Years, the maximum dollar limit may be changed by Portico Benefit Services and shall be communicated to Eligible Employees through the Summary Plan Description or another document.

(c) **Nondiscrimination.** 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 Benefit Services in its sole discretion.

Section 20.15~~Section 20.14~~ **Activation of Account.** The PWA Administrator shall activate and maintain a Personal Wellness Account with respect to each PWA Member who has completed the phase one (1) Health Improvement Activity as reported by the Health Improvement Activity Administrator or a contribution has been received from [a Participating Employer for a Sponsored Member with ELCA-Primary Bronze+, Silver+ or Platinum+ Options](#) or an ELCA seminary for a Sponsored Member described in Section 17.20(g) of the Plan. Each Personal Wellness Account so established will be a bookkeeping account keeping track of credits and available reimbursement amounts, including any unused carryover from a prior Period of Coverage.

(a) **Crediting of Accounts.** A PWA Member's Personal Wellness Account will be credited for Health Improvement Activities, provided that credit will be given for phase two (2) Health Improvement Activities only after credit has been earned for the phase one (1) Health Improvement Activity. Completion of Health Improvement Activities shall be reported by the Health Improvement Activity Administrator to the

PWA Administrator. A Sponsored Member of an ELCA seminary described in Section 17.20(g) of the Plan or a Sponsored Member with ELCA-Primary Bronze+, Silver+ or Platinum+ Options who is enrolled in a Health Savings Account (HSA) under the ELCA Flexible Benefits Plan will be credited for ~~ELCA seminary~~ employer contributions made to the Member's PWAHSA only after such contributions are received.

(b) **Debiting of Accounts.** A PWA Member's Personal Wellness Account will be debited during each Period of Coverage for any reimbursement of PWA Expenses incurred by the PWA Member or by her/his Eligible Spouse or PWA Dependents during the Period of Coverage.

(c) **Available Amount.** The amount available for reimbursement of PWA Expenses is the amount credited to the PWA Member's Personal Wellness Account under subsection (a) reduced by prior reimbursements debited under subsection (b).

(d) **Interest.** No interest shall be credited to a PWA Member's Personal Wellness Account.

Notwithstanding the foregoing, a PWA Member or her/his Eligible Spouse or Eligible Same Gender Partner who is unable to complete Health Improvement Activities due to an illness, injury or mental disorder that is substantiated by medical information from a qualified health care provider shall receive approval from Portico Benefit Services for a Personal Wellness Account credit for the Maximum Annual Credit Amount specified in the Appendix.

~~Section 20.16~~Section 20.15 **Carryover of Accounts.** If any balance remains in the PWA Member's Personal Wellness Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance shall be carried over to reimburse the PWA Member for PWA Expenses incurred during a subsequent Period of Coverage.

~~Section 20.17~~Section 20.16 **PWA Expense Reimbursement Procedure.**

(a) **Timing.** Within thirty (30) days after receipt by the PWA Administrator of a reimbursement claim from a PWA Member, the PWA Administrator will reimburse the PWA Member for the PWA Member's PWA Expenses (if the PWA Administrator approves the claim), or the PWA Administrator will notify the PWA Member that his or her claim has been denied.

A PWA Member must request reimbursement of a PWA Expense within twelve (12) months after the end of the Plan Year in which the expense was incurred.

All information for incomplete claims that have been denied must be submitted to the PWA Administrator within one hundred eighty (180) days from the date of the initial denial letter.

~~(b) **Eligible Medical and Mental Health, Dental and Prescription Drug Expenses.** A Member's Medical and Mental Health, Dental and Prescription Drug Expenses which qualify as PWA Expenses shall be automatically submitted by the Medical and Mental Health Benefits Administrator, Dental Benefits Administrator and~~

~~Prescription Drug Benefits Administrator to the PWA Administrator unless the Member has revoked this “crossover” feature with the Administrators. The PWA Administrator shall reimburse PWA Expenses from the PWA Member’s Personal Wellness Account if there is a sufficient balance in such Account. Notwithstanding the foregoing, if the PWA Member also participates in the ELCA Health FSA, PWA Expenses shall be reimbursed in accordance with Section 20.18. Notwithstanding the foregoing, the PWA Member is responsible for contacting the PWA Administrator and revoking the crossover feature for any ELCA Medical and Dental Benefits Plan dependents who are not PWA Dependents as described in Section 20.02(f).~~

~~(e)(b)~~ **Claims Substantiation Reimbursement** ~~(for claims not automatically submitted for payment to the PWA Administrator)~~. A PWA Member may apply for reimbursement by using the debit card supplied by the PWA administrator or by submitting a reimbursement claim form to the PWA Administrator in such form as the PWA Administrator may prescribe, setting forth:

- (i) the person or persons on whose behalf PWA Expenses have been incurred;
- (ii) the nature and date of the PWA Expenses so incurred;
- (iii) the amount of the requested reimbursement; and
- (iv) a statement that such PWA Expenses have not otherwise been reimbursed and are not reimbursable through any other source and that ELCA Health FSA coverage, if any, for such PWA Expenses has been exhausted.

The claim form shall be accompanied by 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, together with any additional documentation that the PWA Administrator may request.

~~(d)(c)~~ **Claims Denied**. The appeals procedure for reimbursement claims that are denied is set forth in Article XVI.

~~Section 20.18~~Section 20.17 **Coordination of Benefits; ELCA Health FSA to Reimburse First**. Benefits under the Personal Wellness Account portion of the Plan are intended to pay solely for PWA Expenses not previously reimbursed or reimbursable elsewhere. If the PWA Member’s PWA Expenses are covered by both the Personal Wellness Account portion of this Plan and the ELCA Health FSA, then the Personal Wellness Account portion of this Plan is not available for reimbursement of such PWA Expenses until after amounts available for reimbursement under the ELCA Health FSA have been exhausted.

|

APPENDIX

APPENDIX

Certain Annual Amounts Related to Benefits		2014
Sec. 10.04(a)	Deductibles for In-network Eligible Medical and Mental Health Expenses Other Than Preventive Services	
	ELCA-Primary Platinum+ Option	
	• Per Individual	\$500
	• Member and child(ren)	\$750
	• Member/spouse and Member/spouse/child(ren)	\$1,000
	ELCA-Primary Gold+ Option	
	• Per Individual	\$1,000
	• Member and child(ren)	\$1,500
	• Member/spouse and Member/spouse/child(ren)	\$2,000
Sec. 10.04(b)	Deductibles for In-network Eligible Medical, Mental Health and Prescription Drug Expenses Other Than Preventive Services	
	ELCA-Primary Silver+ Option	
	• Single coverage	\$2,000
	• Family coverage	\$4,000
	ELCA-Primary Bronze+ Option	
	• Single coverage	\$4,500
	• Family coverage	\$9,000
Sec. 10.04	Percent Copayments for In-network Eligible Medical and Mental Health Expenses Other Than Preventive Services	
	ELCA-Primary Platinum+ Option	
	• Per Individual	20%
	• Member and child(ren)	20%
	• Member/spouse and Member/spouse/child(ren)	20%
	ELCA-Primary Gold+ Option	
	• Per Individual	20%
	• Member and child(ren)	20%
	• Member/spouse and Member/spouse/child(ren)	20%
	ELCA-Primary Silver+ Option	
	• Single coverage	20%
	• Family coverage	20%
	ELCA-Primary Bronze+ Option	
	• Single coverage	20%
	• Family coverage	20%
Sec. 10.05(a)	Maximum Out-of-Pocket Amount for In-network Eligible Medical, Mental Health and Prescription Drug Expenses	
	ELCA-Primary Platinum+ Option	
	• Per individual	\$3,000
	• Member and child(ren)	\$6,000
	• Member/spouse and Member/spouse/child(ren)	\$6,000
	ELCA-Primary Gold+ Option	
	• Per individual	\$3,600
	• Member and child(ren)	\$7,200
	• Member/spouse and Member/spouse/child(ren)	\$7,200

Sec. 10.05(b)	Maximum Out-of-Pocket Amount for In-network Eligible Medical, Mental Health and Prescription Drug Expenses Other Than Preventive Services	
	ELCA-Primary Silver+ Option	
	• Single coverage	\$3,600
	• Family coverage	\$7,200
	ELCA-Primary Bronze+ Option	
	• Single coverage	\$6,000
	• Family coverage	\$12,000
Sec. 10.06(a)	Deductible for Out-of-network Eligible Medical and Mental Health Expenses Other Than Preventive Services	
	ELCA-Primary Platinum+ Option	
	• Per Individual	\$500
	• Member and child(ren)	\$750
	• Member/spouse and Member/spouse/child(ren)	\$1,000
	ELCA-Primary Gold+ Option	
	• Per Member	\$1,000
	• Member and child(ren)	\$1,500
	• Member/spouse and Member/spouse/child(ren)	\$2,000
Sec. 10.06(b)	Deductibles for Out-of-network Eligible Medical, Mental Health and Prescription Drug Expenses Other Than Preventive Services	
	ELCA-Primary Silver+ Option	
	• Single coverage	\$2,000
	• Family coverage	\$4,000
	ELCA-Primary Bronze+ Option	
	• Single coverage	\$4,500
	• Family coverage	\$9,000
Sec. 10.06	Percent Copayments for Out-of-network Eligible Medical and Mental Health Expenses Other Than Preventive Services	
	ELCA-Primary Platinum+ Option	
	• Per Individual	40%
	• Member and child(ren)	40%
	• Member/spouse and Member/spouse/child(ren)	40%
	ELCA-Primary Gold+ Option	
	• Per Individual	40%
	• Member and child(ren)	40%
	• Member/spouse and Member/spouse/child(ren)	40%
	ELCA-Primary Silver+ Option	
	• Single coverage	40%
	• Family coverage	40%
	ELCA-Primary Bronze+ Option	
	• Single coverage	40%
	• Family coverage	40%
Sec. 10.07(a)	Maximum Out-of-Pocket Amount for Out-of-network Eligible Medical, Mental Health and Prescription Drug Expenses	
	ELCA-Primary Platinum+ Option	
	• Per Individual	\$3,000
	• Member and child(ren)	\$6,000
	• Maximum Member/spouse and member/spouse/child(ren) Maximum	\$6,000
	ELCA-Primary Gold+ Option	
	• Per Individual	\$3,600

	<ul style="list-style-type: none"> Member and child(ren) 	\$7,200	
	<ul style="list-style-type: none"> Member/spouse and Member/spouse/child(ren) 	\$7,200	
Sec. 10.07(b)	Maximum Out-of-Pocket Amount for Out-of-network Eligible Medical, Mental Health and Prescription Drug Expenses Other Than Preventive Services		
	ELCA-Primary Silver+ Option		
	<ul style="list-style-type: none"> Single coverage 	\$3,600	
	<ul style="list-style-type: none"> Family coverage 	\$7,200	
	ELCA-Primary Bronze+ Option		
	<ul style="list-style-type: none"> Single coverage 	\$6,000	
	<ul style="list-style-type: none"> Family coverage 	\$12,000	
Sec. 11.02	Deductible for Eligible Medical Expenses Under Medicare Supplement Coverage		
	<ul style="list-style-type: none"> ELCA Medicare-Primary Premium Option — Per individual 	\$0	
	<ul style="list-style-type: none"> ELCA Medicare-Primary Standard Option — Per individual 	\$180	
	<ul style="list-style-type: none"> ELCA Medicare-Primary Economy Option — Per individual 	*	
	*Member is responsible for Medicare Part B deductible, 25% of Medicare Part A deductible		
Sec. 11.02	Percent Copayments for Eligible Expenses Under Medicare Supplement Coverage		
	<ul style="list-style-type: none"> ELCA Medicare-Primary Premium Option — Per individual 	0%	
	<ul style="list-style-type: none"> ELCA Medicare-Primary Standard Option — Per individual 	20%	
	<ul style="list-style-type: none"> ELCA Medicare-Primary Economy Option — Per individual 	25%	
Sec. 11.03	Maximum Out-of-Pocket Amount for Eligible Medical Expenses Under Medicare Supplement Coverage		
	<ul style="list-style-type: none"> ELCA Medicare-Primary Premium Option — Per individual 	\$0	
	<ul style="list-style-type: none"> ELCA Medicare-Primary Standard Option — Per individual 	\$3,500	
	<ul style="list-style-type: none"> ELCA Medicare-Primary Economy Option — Per individual 	\$2,400	
Sec. 13.02	Deductibles for Eligible Dental Expenses		
	<ul style="list-style-type: none"> Per individual 	\$150	
	<ul style="list-style-type: none"> Family Maximum 	\$300	
Sec. 13.03	Limits on Eligible Dental Benefits Expenses		
	<ul style="list-style-type: none"> Annual Limit Eligible Preventive, Basic and Major Restorative Dental Expenses 	\$2,850	
	<ul style="list-style-type: none"> Lifetime Limit Eligible Orthodontia Expenses 	\$2,850	
Section 15.05(a)	ELCA-Primary Gold+ and Platinum+ Option Prescription Drug Copayments Per Script		
	Generic	Brand Formulary	Brand Non-Formulary
Retail	\$8	\$43	\$69
Mail Order	\$18	\$94	\$152
Specialty Pharmacy (31 day supply)	\$8	\$43	\$69
Sec. 17.20	Special Provisions for Members Employed by an ELCA Seminary—ELCA-Primary Luther Seminary Option		
	Deductible for In-network Eligible Medical, Mental Health Expenses and Prescription Drug Expenses Other Than Preventive Services		
	<ul style="list-style-type: none"> Single coverage 		\$2,000
	<ul style="list-style-type: none"> Family coverage 		\$4,000
	Percent Copayments for In-network Eligible Medical, Mental Health Expenses and Prescription Drug Expenses		
	<ul style="list-style-type: none"> Single coverage 		20%
	<ul style="list-style-type: none"> Family coverage 		20%
	Maximum Out-of-Pocket Amount for In-network Eligible Medical, Mental Health Expenses and Prescription Drug Expenses		
	<ul style="list-style-type: none"> Single coverage 		\$2,500
	<ul style="list-style-type: none"> Family coverage 		\$5,000
	Deductible for Out-of-network Eligible Medical, Mental Health Expenses and Prescription Drug Expenses Other Than Preventive Services		
	<ul style="list-style-type: none"> Single coverage 		\$4,000
	<ul style="list-style-type: none"> Family coverage 		\$8,000
	Percent Copayments for Out-of-network Eligible Medical, Mental Health Expenses and Prescription Drug Expenses		
	<ul style="list-style-type: none"> Single coverage 		40%

	<ul style="list-style-type: none"> • Family coverage 	40%
	Maximum Out-of-Pocket Amount for Out-of-network Eligible Medical, Mental Health Expenses and Prescription Drug Expenses	
	<ul style="list-style-type: none"> ○ Single coverage 	\$5,000
	<ul style="list-style-type: none"> ○ Family coverage 	\$10,000
Sec. 20.14a	Maximum Benefits for Health Improvement Activities	
	<ul style="list-style-type: none"> • Per Member 	\$500
	<ul style="list-style-type: none"> • Per Eligible Spouse 	\$500
	<ul style="list-style-type: none"> • Maximum for Member and Eligible Spouse 	\$1,000

Plan Document

ELCA Survivor Benefits Plan

January 1, ~~2013~~2014

**EVANGELICAL LUTHERAN CHURCH IN AMERICA
SURVIVOR BENEFITS PLAN**

Table of Contents

ARTICLE I. INTRODUCTION	1
Section 1.01 Name of Plan.....	1
Section 1.02 History of the Survivor Benefits Plan.....	1
Section 1.03 “Church Plan” Status	2
Section 1.04 Definitions.....	2
Section 1.05 Administration of the Plan	2
ARTICLE II. ELIGIBLE EMPLOYERS	2
Section 2.01 Eligible Employer	2
Section 2.02 Participating Employer	3
Section 2.03 General Obligations of all Participating Employers	3
Section 2.04 Discontinuance of Status as a Participating Employer	3
ARTICLE III. ELIGIBLE EMPLOYEES	4
Section 3.01 Eligible Employees	4
Section 3.02 Sponsored Member	4
Section 3.03 Duration of Sponsored Member Status.....	5
Section 3.04 Continuation of Coverage While “On Leave from Call	6
Section 3.05 Continuation of Coverage for Disabled Members	6
Section 3.06 Continuation of Coverage for Retired Members	7
Section 3.07 Sponsoring of Eligible Employees as Sponsored Members is Subject to Rules, Regulations and Procedures of Portico Benefit Services	7
Section 3.08 Pre-existing Conditions.....	8
ARTICLE IV. CONTRIBUTIONS FOR SPONSORED MEMBERS.....	9
Section 4.01 Amount of Contributions	9
Section 4.02 Continuation of Contributions by Sponsored Member.....	9
Section 4.03 Continuation of Contributions While “On Leave from Call.....	9
Section 4.04 Continuation of Contributions for Disabled Members	9
Section 4.05 Payment of Contributions Subject to Rules, Regulations and Procedures of Portico Benefit Services.....	10
ARTICLE V. LUMP SUM SURVIVOR BENEFIT	10
Section 5.01 Lump Sum Survivor Benefit.....	10
Section 5.02 Accelerated Payment of Lump Sum Survivor Benefit	11
Section 5.03 Processing Lump Sum Survivor Payments Subject to Rules, Regulations and Procedures of Portico Benefit Services.....	12

ARTICLE VI. BENEFITS FOR SURVIVING SPOUSE OR ELIGIBLE SAME GENDER PARTNER	12
Section 6.01 Entitlement to Surviving Spouse or Eligible Same Gender Partner Benefit.....	12
Section 6.02 Amount of Surviving Spouse or Eligible Same Gender Partner Benefit.....	12
Section 6.03 Payment of Small Amounts	13
Section 6.04 Processing Payments Subject to Rules, Regulations and Procedures of Portico Benefit Services	14
ARTICLE VII. BENEFITS FOR SURVIVING CHILDREN	14
Section 7.01 Monthly Surviving Child Benefit	14
Section 7.02 Payment of Small Amounts	14
Section 7.03 Processing Payments Subject to Rules, Regulations and Procedures of Portico Benefit Services	14
ARTICLE VIII. MISCELLANEOUS DEFINITIONS.....	15
Section 8.01 Church Institution	15
Section 8.02 Churchwide Unit.....	15
Section 8.03 Code	15
Section 8.04 Defined Compensation.....	15
Section 8.05 Designated Beneficiary(ies).....	15
Section 8.06 Disabled Member	16
Section 8.07 ELCA	16
Section 8.08 ELCA Board of Pensions.....	16
Section 8.09 ELCA Ordained Minister.....	16
Section 8.10 ELCA Rostered Layperson.....	16
Section 8.11 Eligible Employee.....	16
Section 8.12 Eligible Employer	17
Section 8.13 Eligible Same Gender Partner.....	17
Section 8.14 ERISA	17
Section 8.15 Inter-Lutheran Agency.....	17
Section 8.16 Member	17
Section 8.17 Monthly Defined Compensation.....	17
Section 8.18 Predecessor Churches	18
Section 8.19 Regular Pension Plan	19
Section 8.20 Retired Member	19
Section 8.21 Separation from Service.....	19
Section 8.22 Sponsored Member	19
Section 8.23 Surviving Child.....	19
Section 8.24 Surviving Spouse	19
ARTICLE IX. MISCELLANEOUS PROVISIONS.....	19
Section 9.01 Administration by Portico Benefit Services	19
Section 9.02 Administrative Fee Paid to Portico Benefit Services.....	20
Section 9.03 Rules of Construction and Applicable Law	20
Section 9.04 Appeals Procedure	20

Section 9.05	Correction of Errors	21
Section 9.06	Fiduciary Standards	21
Section 9.07	Suicide Exclusion.....	22
Section 9.08	No Other Benefits	22
Section 9.09	Source of Benefits.....	22
Section 9.10	Portico Benefit Services is Not a Party to Contract Between an Eligible Employer and an Eligible Employee.....	22
Section 9.11	Limitation of Liability.....	22
Section 9.12	Obligation of Sponsored Members	23
Section 9.13	Amendments	23
Section 9.14	Termination.....	24
Section 9.15	Transfer of Amounts to Medical/Dental Plans	24

**EVANGELICAL LUTHERAN CHURCH IN AMERICA
SURVIVOR BENEFITS PLAN**

**ARTICLE I.
INTRODUCTION**

Section 1.01 **Name of Plan.** The name of the survivor benefits plan set out in this document is the “Evangelical Lutheran Church in America Survivor Benefits Plan.” It is referred to in this document as “Survivor Benefits Plan.”

Section 1.02 **History of the Survivor Benefits Plan.** The Survivor Benefits Plan is designed to replace the survivor benefits plans of the Predecessor Churches. The effective date for commencement of this Survivor Benefits Plan is January 1, 1988. The beneficiaries of Sponsored Members who die on or after January 1, 1988 will be covered by this Survivor Benefits Plan. Survivor benefits for individuals who die prior to January 1, 1988 are subject to the terms of the survivor benefits plans maintained by the Predecessor Churches. In addition, certain individuals who became disabled or retired prior to January 1, 1988 are entitled to benefits from the survivor benefits plans maintained by the Predecessor Churches. These benefits will be provided through the ELCA Survivor Benefits Trust in accordance with the terms of the predecessor plan in effect on the date the individual died, except that effective May 1, 1997, no benefit payments shall be reduced as a result of the remarriage of a surviving spouse.

The Survivor Benefits Plan has been amended effective January 1, ~~1998~~2014. The survivor benefits for any Sponsored Member who died prior to such date will be provided through the ELCA Survivor Benefits Trust in accordance with the terms of this Survivor Benefits Plan in effect on the date the Sponsored Member died, ~~except as described in Section 5.01 and Section 7.01.~~

Effective January 1, 2014, Basic Life and Accidental Death and Dismemberment (AD&D) Insurance benefits under this plan for any Sponsored Member (including foreign missionaries employed by ELCA Global Mission), any enrolled rostered member who is On Leave From Call as defined in Section 3.04, and any Disabled Member as defined in Section 3.05 will be provided by an insurance company qualified and licensed to offer employer-sponsored group life insurance in all 50 states. Appendix A contains a copy of the Group Term Life Insurance Policy currently in effect. Accidental Death and Dismemberment benefits are defined in Appendix A. If a discrepancy exists between this Plan and the policy described in Exhibit A (insured life and A D & D benefits), the terms of the policy document will control.

Effective January 1, 2014, Sponsored Members and Disabled Members may purchase, at their own expense, Supplemental Life and AD&D Insurance on themselves, their Eligible Spouse or Eligible Same Gender Partner, and their Eligible Child(ren) in accordance with the provisions of Appendix A. An eligible Member will pay for this Supplemental Life Insurance by having his/her Participating Employer deduct the required cost from his/her compensation on an after-tax basis and forward such amounts to Portico Benefit Services.

Section 1.03 **“Church Plan” Status.** The Survivor Benefits Plan is exempt from ERISA, because it meets the requirements of a “church plan” within the meaning of Code § 414(e) and ERISA § 3(33).

Section 1.04 **Definitions.** The definitions of capitalized terms that are used throughout this Survivor Benefits Plan are set forth in Article VIII.

Section 1.05 **Administration of the Plan.** This Plan is administered by the Board of Pensions of the Evangelical Lutheran Church in America, doing business as Portico Benefit Services (“Portico Benefit Services” or “Portico”).

ARTICLE II. ELIGIBLE EMPLOYERS

Section 2.01 **Eligible Employer.** An “Eligible Employer” is a legal entity which meets the requirements and conditions Portico Benefit Services imposes, provided it meets one (1) of the following criteria:

(a) The ELCA, or an ELCA synod, seminary or Churchwide Unit that is part of a “church, or a convention or association of churches” within the meaning of Code § 414(e)(3) and ERISA § 3(33)(C).

(b) Church congregations

(i) An ELCA congregation that is part of a “church, or a convention or association of churches” within the meaning of Code § 414(e)(3) and ERISA § 3(33)(C); or

(ii) A former ELCA congregation other than a congregation included in (iv) below that sponsored one (1) or more Eligible Employees in this Plan on or after January 1, 2005; or

(iii) A congregation of a denomination that is in a full communion relationship with the ELCA; or

(iv) A congregation or qualified church-controlled organization described in Code § 3121(w) of a non-ELCA church body that has common religious bonds with the ELCA and has petitioned to and been approved by Portico Benefit Services to be the church body’s sole benefits provider.

(c) An organization that is an ELCA “qualified church-controlled organization” as determined by the ELCA within the meaning of Code § 3121(w).

(d) An organization that is an ELCA “church-controlled organization,” but not a “qualified church-controlled organization” as determined by the ELCA within the meaning of Code § 3121(w).

(e) A 501(c)(3) organization, other than an organization described in (a) through (d) above, that employs an individual who is performing service in the exercise of her/his ministry as an ELCA Ordained Minister or an ELCA Rostered Layperson.

(f) A non-501(c)(3) organization that employs an individual who is performing service in the exercise of her/his ministry as an ELCA Ordained Minister.

(g) An individual who is performing service in the exercise of her/his ministry as an ELCA Ordained Minister who is self-employed or who is employed by an organization described in (e) or (f) above but is not sponsored by her/his employer. Such individual shall be treated as her/his own employer.

Notwithstanding the above, an ELCA elementary or secondary school, day-care center, camp or conference center that is not a separately incorporated legal entity shall be treated as a separate “Eligible Employer” under subsection (c) or (d) above provided the employer otherwise meets the requirements of such subsection.

Section 2.02 **Participating Employer.** An Eligible Employer shall become a Participating Employer by enrolling an individual which it employs as a Sponsored Member under the Survivor Benefits Plan in such manner as Portico Benefits Services shall specify.

Section 2.03 **General Obligations of all Participating Employers.** By enrolling an Eligible Employee in the Survivor Benefits Plan, each Participating Employer shall become obligated as follows:

(a) The Participating Employer shall be bound by the terms of the Survivor Benefits Plan including future amendments and shall comply with any rules, regulations and procedures adopted by Portico Benefit Services; provided, however, that the Participating Employer has the right to discontinue its participation as provided in Section 2.04(a).

(b) The Participating Employer shall be obligated to promptly advise Portico Benefit Services regarding any change that would cause it to cease to be an Eligible Employer, any change in status of the organization under Code § 501(c)(3) or an audit by the Internal Revenue Service that involves an examination of its status under Code § 501(c)(3) or, if such organization is described in Section 2.01(c) or (d), any change in status that could cause it to cease to be “controlled by, or associated with” the ELCA.

(c) The Participating Employer shall provide any information in such form as requested by Portico Benefit Services which is necessary for the administration of the Survivor Benefits Plan. This obligation shall continue after the Participating Employer ceases to be a Participating Employer in the Survivor Benefits Plan.

Section 2.04 **Discontinuance of Status as a Participating Employer.**

(a) A Participating Employer may discontinue its participation in the Survivor Benefits Plan at any time by providing notice in an acceptable manner to Portico Benefit Services and complying with any rules, regulations and procedures adopted by Portico Benefit Services with respect to such discontinuance of participation.

(b) Portico Benefit Services may discontinue the participation of any Participating Employer in the Survivor Benefits Plan if the Portico Benefit Services, in its sole discretion, determines that such Participating Employer is no longer an Eligible Employer as defined in Section 2.01 or that such Participating Employer has failed to comply with any of the provisions of this Survivor Benefits Plan.

ARTICLE III. ELIGIBLE EMPLOYEES

Section 3.01 **Eligible Employees.** The following individuals shall be Eligible Employees for purposes of participation in this Survivor Benefits Plan:

(a) A common-law employee of an Eligible Employer described in Section 2.01(a), (b), (c), (d), (e) or (f) who is an ELCA Ordained Minister serving under a letter of call and who is regularly scheduled to work fifteen (15) or more hours per week for six (6) or more months per year, or

(b) A common-law employee of an Eligible Employer described in Section 2.01(a), (b), (c), (d) or (e) who is an ELCA Rostered Layperson serving under a letter of call and who is regularly scheduled to work fifteen (15) or more hours per week for six (6) or more months per year.

(c) Any other common-law employee of an Eligible Employer described in Section 2.01(a), (b), (c) or (d) who is regularly scheduled to work twenty (20) or more hours per week for six (6) or more months per year and has completed any probationary period specified by the Employer not to exceed ninety (90) days.

(d) An ELCA Ordained Minister who is described in Section 2.01(g).

Section 3.02 **Sponsored Member.** A Participating Employer may sponsor any of its Eligible Employees as a Sponsored Member in this Survivor Benefits Plan. The determination regarding which of its Eligible Employees it shall sponsor shall be solely within the discretion of the Participating Employer, subject to the following:

(a) **Churchwide Unit, Synod or Seminary.** An Eligible Employer described in Section 2.01(a) (other than the ELCA Publishing House), shall sponsor all of its Eligible Employees. Notwithstanding the requirements of this Section 3.02(a), an ELCA Synod, ELCA Seminary or Churchwide Unit shall not be required to sponsor employees who are non-ELCA Ordained Ministers or who are employees deemed to be temporary employees.

(b) **Other Participating Employers.**

(i) A Participating Employer described in Section 2.01(d) may sponsor any of its Eligible Employees who are ELCA Ordained Ministers. In addition, it may elect to sponsor all or none of its other Eligible Employees.

(ii) A Participating Employer described in Section 2.01(e) may sponsor any of its Eligible Employees who are ELCA Ordained Ministers. In addition, it may elect to sponsor all or none of its Eligible Employees who are ELCA Rostered Laypersons.

(iii) A Participating Employer described in Section 2.01(f) may sponsor any of its Eligible Employees who are ELCA Ordained Ministers.

(c) **Participation in Other Plans.** A Participating Employer may sponsor an Eligible Employee as a Sponsored Member of the Survivor Benefits Plan only if it also sponsors such individual in the other three (3) plans of the ELCA Pension and Other Benefits Program:

- (i) The ELCA Retirement Plan,
- (ii) The ELCA Medical and Dental Benefits Plan, and
- (iii) The ELCA Disability Benefits Plan.

Section 3.03 **Duration of Sponsored Member Status.**

Sponsored Member status with respect to a particular individual shall continue until the earliest of the following events:

- (a) The date on which the individual ceases to be an Eligible Employee.
- (b) The date specified in an advance notice provided in an acceptable manner from the individual's Participating Employer that it will no longer sponsor the individual as a Sponsored Member.
- (c) The date of the required contribution if full payment is not received within the time frame specified in Portico Benefit Services' Past-Due Account Management Policy.
- (d) In the case of a Participating Employer that is subject to the requirements of Section 3.02(a), the date determined by Portico Benefit Services to be the date that the Participating Employer was no longer sponsoring all of its Eligible Employees.
- (e) Such date determined by Portico Benefit Services as the date the Participating Employer ceased making contributions on behalf of such Sponsored Member under any of the following plans:

- (i) The ELCA Retirement Plan,

- (ii) The ELCA Medical and Dental Benefits Plan, or
- (iii) The ELCA Disability Benefits Plan.

(f) Such date determined by Portico Benefit Services as the date on which the Participating Employer ceased to provide accurate information needed by Portico Benefit Services for the administration of this Survivor Benefits Plan.

(g) Notwithstanding the above provisions, a Sponsored Member may delay the termination of status as a Sponsored Member for up to ninety (90) days as provided in Section 4.02. Furthermore, if a Sponsored Member terminates employment with a Participating Employer and is employed by another Eligible Employer within thirty-one (31) days, the Sponsored Member's status as a Sponsored Member under this Survivor Benefits Plan shall not terminate during that thirty-one (31) day period. This interim coverage shall be provided without the payment of any contribution, which would otherwise be required under Article IV, by the Sponsored Member or by the Eligible Employer.

Section 3.04 Continuation of Basic Life and AD&D Insurance Coverage While "On Leave from Call." An ELCA Ordained Minister who is "On Leave from Call" or an ELCA Rostered Layperson who is "On Leave from Call" may elect to continue Basic Life and AD&D Insurance coverage of the Lump Sum Survivor Benefit as provided in Article V at her/his own expense under this Survivor Benefits Plan for a period not to exceed three (3) years, or such longer period as determined by Portico Benefits Services, on a case-by-case basis, in its sole discretion; provided, however, that such individual must also continue or waive coverage under the ELCA Medical and Dental Benefits Plan. The amount of contribution required from an ELCA Ordained Minister who is "On Leave from Call" or from an ELCA Rostered Layperson who is "On Leave from Call" is determined in accordance with Section 4.03.

Section 3.05 Continuation of Basic Life and AD&D Insurance Coverage for Disabled Members.

(a) The Participating Employer shall pay the monthly contributions under this Survivor Benefits Plan as provided in Section 4.04 for each of the first two (2) months commencing on the date the Member becomes disabled and entitled to monthly benefits under the ELCA Disability Benefits Plan. If the Participating Employer fails to pay any monthly contribution, the Member can make such contributions on her/his own behalf to prevent a lapse in Basic Life and AD&D Insurance coverage under this Survivor Benefits Plan during the first two (2) months of Disability.

(b) Provided that the contributions have been made to this Survivor Benefits Plan as provided in Section 3.05(a) for two (2) months commencing on the date the Member became disabled, the Member's Basic Life and AD&D Insurance coverage under this Survivor Benefits Plan shall be continued for as long as the Member continues to be eligible for monthly disability benefits from the ELCA Disability Benefits Plan. The contributions for such continued Basic Life and AD&D

Insurance coverage shall be paid to this Survivor Benefits Plan from the ELCA Disability Benefits Trust.

(c) During the period of time the Member's coverage is continued under this Survivor Benefits Plan in accordance with this Section 3.05, such Member shall be referred to as a "Disabled Member."

Section 3.06 **Continuation of Basic Life Insurance Coverage for Retired Members.**

(a) A Sponsored Member shall be entitled to continuation of Basic Life Insurance coverage under this Survivor Benefits Plan as a Retired Member provided that the Sponsored Member satisfies both of the following requirements when the Sponsored Member Separates from Service:

(i) The Sponsored Member has at least ten (10) total years of service with an Eligible Employer or one (1) of the Predecessor Churches, and

(ii) The Sponsored Member has attained the age of sixty (60) or has completed thirty (30) years of service (expressed in whole years) with an Eligible Employer or one (1) of the Predecessor Churches.

(b) A Disabled Member who meets the above requirements upon cessation of disability benefits as described in Section 5.08(b) of the ELCA Disability Benefits Plan also shall be entitled to continuation of Basic Life Insurance coverage under this Survivor Benefits Plan as a Retired Member. The period of time during which the Disabled Member receives coverage under Section 3.05 shall be treated as years of service with an Eligible Employer.

(c) Individuals who are entitled to benefits as a retired employee under a survivor benefits plan maintained by a Predecessor Church as specified in the appropriate Appendix shall be Retired Members under this Survivor Benefits Plan and shall be entitled to the benefits specified in such Appendix.

(d) A Member whose coverage is continued under this Survivor Benefits Plan in accordance with this Section 3.06 shall be referred to as a "Retired Member."

~~(d)~~(e) Accidental Death and Dismemberment benefits are not available to Retired Members.

Section 3.07 **Sponsoring of Eligible Employees as Sponsored Members is Subject to Rules, Regulations and Procedures of Portico Benefit Services.** The sponsoring of Eligible Employees as Sponsored Members shall be subject to such rules, regulations and procedures as Portico Benefit Services may adopt. Such rules, regulations and procedures may be amended at any time without notice to any Eligible Employer, Participating Employer, Eligible Employee or Sponsored Member.

Section 3.08—~~Pre-existing Conditions.~~ A Sponsored Member shall be subject to a pre-existing condition exclusion period as follows:

(a)—~~Any Eligible Employee who becomes a Sponsored Member within sixty (60) days of becoming an Eligible Employee shall not be entitled to receive any benefits under this Survivor Benefits Plan for death within six (6) months after such individual most recently became a Sponsored Member which is due to a condition which was diagnosed or for which the Member received treatment in the six (6) month period prior to the date such Eligible Employee most recently became a Sponsored Member in this Survivor Benefits Plan. Newly ordained ELCA pastors who worked for an Eligible Employer before ordination but who were not sponsored in the ELCA Pension and Other Benefits Program shall be considered to have enrolled on a timely basis if they make application to become a Sponsored Member within sixty (60) days of ordination.~~

(b)—~~Any Eligible Employee who becomes a Sponsored Member more than sixty (60) days after becoming an Eligible Employee shall not be entitled to receive any benefits under this Survivor Benefits Plan for death within eighteen (18) months after such individual most recently became a Sponsored Member which is due to a condition which was diagnosed or for which the Member received treatment in the six (6) month period prior to the date such Eligible Employee most recently became a Sponsored Member in this Survivor Benefits Plan.~~

(c)—The following exceptions apply:

(i)—~~An Eligible Employee described in Section 3.02(a) who is required to be sponsored in this Plan, but who does not enroll within sixty (60) days of becoming an Eligible Employee will not be subject to an eighteen (18) month exclusion period. S/he will be subject to a six (6) month exclusion period beginning on the date that her/his application is received by Portico Benefit Services.~~

(ii)—~~An Eligible Employee described in Section 3.01(a), (b) or (d) who continuously participates in the ELCA Medical and Dental Benefits Plan and the ELCA Survivor Benefits Plan during a period of “On Leave from Call,” and who again becomes a Sponsored Member will be deemed to have continuous sponsorship in this Plan and will not be subject to a new six (6) month or eighteen (18) month exclusion.~~

(iii)—~~An Eligible Employee who continuously participates in the ELCA Medical and Dental Benefits Plan as a Coverage Continuation Member, and who again becomes a Sponsored Member within eighteen (18) months from her/his first day of Coverage Continuation, will be deemed to have continuous sponsorship in this Plan and will not be subject to a new six (6) month or eighteen (18) month exclusion.~~

~~(iv) — An Eligible Employee who enrolls during the annual open enrollment period of the ELCA Medical and Dental Benefits Plan will be subject to a six (6) month exclusion period as described in Section 5.07(a).~~

~~(v) — An Eligible Employee who transfers from another church survivor benefits plan under a reciprocity agreement with the ELCA and becomes a Sponsored Member within ninety (90) days of her/his separation from service with the other church will be given month-for-month credit for the period of time s/he participated in the other church plan.~~

~~(vi) — An Eligible Employee who continuously participates in the ELCA Disability Benefits Plan while between assignments as a called interim pastor under Section 7.04 of that Plan and who again becomes a Sponsored Member in this Plan will be deemed to have continuous sponsorship in this Plan and will not be subject to a new six (6) month or eighteen (18) month exclusion.~~

ARTICLE IV. CONTRIBUTIONS ~~FOR SPONSORED MEMBERS~~

Section 4.01 Amount of Contributions for Basic Life and AD&D Insurance. Each Participating Employer shall make contributions to the Survivor Benefits Plan for each of its Sponsored Members. The amount of the contribution shall be a certain percentage, as determined by Portico Benefit Services, in its sole discretion, of the Defined Compensation paid by the Participating Employer to such Sponsored Member.

Section 4.02 Continuation of Contributions by Sponsored Member. If a Participating Employer fails to make any contribution on behalf of a Sponsored Member who is still an Eligible Employee, the Sponsored Member may make contributions on her/his own behalf for up to ninety (90) days, provided that the Sponsored Member continues to be an Eligible Employee during that ninety (90) day period. The amount of each contribution shall be determined annually by Portico Benefit Services, in its sole discretion. If the Participating Employer has not resumed payment of contributions on behalf of such Sponsored Member by the end of the ninety (90) day period, the Sponsored Member cannot continue to pay the contributions on her/his own behalf, and the Sponsored Member's status as a Sponsored Member will be terminated as provided in Section 3.03.

Section 4.03 Continuation of Contributions While "On Leave from Call." An ELCA Ordained Minister who is "On Leave from Call" or an ELCA Rostered Layperson who is "On Leave from Call" and who elects to continue coverage in accordance with Section 3.04, shall be required to make contributions ~~in an amount equal to the percentage,~~ as determined by Portico Benefit Services, ~~of the average Defined Compensation of all Members on whose behalf contributions are made to the Survivor Benefits Plan as determined by Portico Benefit Services,~~ in its sole discretion.

Section 4.04 Continuation of Contributions for Disabled Members. The amount of contributions required under

Section 3.05 shall be determined in accordance with Section 4.01 assuming the Member's Defined Compensation is the Monthly Defined Compensation multiplied by twelve (12).

Section 4.05 Amount of Contributions for Supplemental Life Insurance. A Sponsoring Participating Employer of Sponsored Members who elect to purchase Supplemental Life Insurance will deduct the cost of such insurance from the Member's compensation on an after-tax basis and remit it monthly to Portico Benefit Services.

Section 4.05 Section 4.06 Payment of Contributions Subject to Rules, Regulations and Procedures of Portico Benefit Services. ~~The ELCA Board of Pensions~~ may impose such rules, regulations and procedures for the payment of contributions by the Participating Employers or any Sponsored Member which Portico Benefit Services, in its sole discretion, considers necessary or convenient for the efficient administration of this Survivor Benefits Plan.

ARTICLE V.
LUMP SUM DEATHSURVIVOR BENEFIT

Section 5.01 Lump Sum DeathSurvivor Benefit.

(a) Upon the death of a Sponsored Member, Disabled Member, or a Member who is On Leave From Call that has continued his/her benefit, or Retired Member, the Member's Designated Beneficiary(ies) will be entitled to a Lump Sum DeathSurvivor Benefit in an amount as specified in Appendix A. If death is due to accidental causes as defined in Appendix A, an additional benefit equal to the Lump Sum Death Benefit will be paid to the Member's Designated Beneficiary(ies). ~~determined based on the age the Member had attained as of the date of death as follows:~~

(a)(b) Upon the death of a Retired Member, the Member's Designated Beneficiary(ies) will be entitled to a Lump Sum Death Benefit based on the age the Member had attained as of the date of death. The factor in the table below is multiplied by the Retired Member's Monthly Defined Compensation as defined in Section 8.17 to determine the amount of the Lump Sum Death Benefit; provided, however, that the amount of any Lump Sum Death Benefit shall not be less than six thousand dollars (\$6,000) nor greater than fifty thousand dollars (\$50,000).

<u>Age at Death</u>	<u>Factor</u>
Under 46	24.0
46-50	21.0
51-55	18.0
56-60	15.0
61-65	12.0
66	9.6
67	7.2
68	4.8
69	2.4

70 and over

0

Furthermore, the Lump Sum ~~DeathSurvivor~~ Benefit for a Member who retired prior to 1998 shall not be less than one (1) times the Member's Monthly Defined Compensation at retirement.

~~(b) The Factor determined according to the table in Section 5.01(a) is multiplied by the Member's Monthly Defined Compensation to determine the amount of the Lump Sum Survivor Benefit; provided, however, that the amount of any Lump Sum Survivor Benefit shall not be less than six thousand dollars (\$6,000) nor greater than fifty thousand dollars (\$50,000).~~

(c) Notwithstanding the provisions of Section 5.01(a) and (b), a Member's Lump Sum ~~DeathSurvivor~~ Benefit shall not be less than the lump sum survivor benefit which would have been paid on behalf of the Sponsored Member under the survivor benefits plan of her/his Predecessor Church in effect on December 31, 1987. Such amount will be based on the Member's level of compensation on December 31, 1987 (where applicable) and actual age at death. Furthermore, the Lump Sum ~~DeathSurvivor~~ Benefit for a Member who retired prior to 1998 shall not be less than one (1) times the Member's Monthly Defined Compensation at retirement.

(d) If any Lump Sum ~~DeathSurvivor~~ Benefit is not paid to the Member's Designated Beneficiary(ies) within thirty (30) days following the Member's death, interest will be added to the amount determined in accordance with Section 5.01(a), (b), and (c), commencing on the thirty-first (31st) day, at an appropriate rate as determined by Portico Benefit Services, in its sole discretion.

Section 5.02 **Accelerated Payment of Lump Sum ~~DeathSurvivor~~ Benefit.** A Member who satisfies the eligibility requirements of Section 5.02(a) may request accelerated payment of all or a portion of her/his Lump Sum ~~DeathSurvivor~~ Benefit in accordance with the provisions of Section 5.02(b).

(a) A Sponsored, Disabled or Retired Member or a Member who is "On Leave from Call" shall be eligible for accelerated payment of her/his Lump Sum ~~DeathSurvivor~~ Benefit if the Member submits a doctor's statement or other evidence acceptable to Portico Benefit Services certifying that the Member is terminally ill and death is expected within twelve (12) months.

(b) The amount of the Lump Sum ~~DeathSurvivor~~ Benefit shall be determined by treating the date the Member's acceptable evidence of eligibility is received by Portico Benefit Services as the date of death. Upon receipt of acceptable evidence, all or a portion of the Lump Sum ~~DeathSurvivor~~ Benefit, as requested by the Member, shall become immediately payable to the Member. Any portion of the Member's Lump Sum ~~DeathSurvivor~~ Benefit remaining to be paid at the Member's death shall become payable to the Member's Designated Beneficiary.

Section 5.03 **Processing Lump Sum ~~DeathSurvivor~~ Payments**
Subject to Rules, Regulations and Procedures of Portico Benefit Services. The processing of Lump Sum ~~DeathSurvivor~~ Payments as provided in this Article V shall be subject to any rules, regulations, and procedures which Portico Benefit Services, in its sole discretion, considers necessary or convenient for the efficient administration of the Survivor Benefits Plan.

ARTICLE VI.
BENEFITS FOR SURVIVING SPOUSE OR ELIGIBLE SAME GENDER PARTNER

Section 6.01 ~~— **Entitlement to Surviving Spouse or Eligible Same Gender Partner Benefit.** Surviving Spouses or Eligible Same Gender Partners of a Sponsored or Disabled Member who died prior to January 1, 2014 are eligible to receive monthly benefits in accordance with the terms of the Plan in effect at the time of the Sponsored or Disabled Member's death. The processing of such payments shall be subject to any rules, regulations, and procedures which Portico Benefit Services, in its sole discretion, considers necessary or convenient for the efficient administration of the Survivor Benefits Plan. Upon the death of a Sponsored Member or a Disabled Member, the Member's Surviving Spouse or Eligible Same Gender Partner will become entitled to a Surviving Spouse or Eligible Same Gender Partner Benefit for any subsequent month determined in accordance with Section 6.02.~~

~~Section 6.02 **Amount of Surviving Spouse or Eligible Same Gender Partner Benefit.**~~

~~(a) — The amount of the Surviving Spouse or Eligible Same Gender Partner Benefit for any particular month shall be a percentage of the Member's Monthly Defined Compensation determined on the basis of (i) the age the Member had attained as of the date of death, (ii) the age of the Member at enrollment in this Survivor Benefits Plan or a survivor benefits plan maintained by a Predecessor Church and (iii) whether the Surviving Spouse is deemed to be eligible for Social Security benefits in the particular month due solely to the Member's earnings record, as follows:~~

~~Surviving Spouse eligible for Social Security benefits (based on Member's earnings record)~~

<u>Member's age at death</u>	<u>Member's age at enrollment in ELCA (or predecessor) plan</u>								
	<u>25</u>	<u>30</u>	<u>35</u>	<u>40</u>	<u>45</u>	<u>50</u>	<u>55</u>	<u>60</u>	<u>65+</u>
25	20%								
30	15	20%							
35	10	15	20%						
40	5	10	15	20%					
45	0	5	10	15	20%				
50	0	0	5	10	15	10%			

55	0	0	0	5	10	5	0%		
60	0	0	0	0	5	0	0	0%	
65	0	0	0	0	0	0	0	0	0%
70	0	0	0	0	0	0	0	0	0

~~Surviving Spouse or Eligible Same Gender Partner not eligible for Social Security benefits (based on Member's earnings record)~~

<u>Member's age at death</u>	<u>Member's age at enrollment in ELCA (or predecessor) plan</u>									
	<u>25</u>	<u>30</u>	<u>35</u>	<u>40</u>	<u>45</u>	<u>50</u>	<u>55</u>	<u>60</u>	<u>65+</u>	
25	40%									
30	35	40%								
35	30	35	40%							
40	25	30	35	40%						
45	20	25	30	35	40%					
50	15	20	25	30	35	30%				
55	10	15	20	25	30	25	20%			
60	5	10	15	20	25	20	15	10%		
65	0	5	10	15	20	15	10	5	0%	
70	0	0	5	10	15	10	5	0	0	

~~Percentages for ages and years not shown in the above tables shall be determined by interpolation. The percentages shall be reduced by one percent (1%) for each year that the Member did not participate in this Survivor Benefits Plan or a survivor benefits plan maintained by a predecessor church after first becoming eligible to enroll.~~

~~For purposes of this Section 6.02(a), a Surviving Spouse is deemed to be eligible for Social Security benefits in a particular month if the Sponsored Member had attained the necessary insured status (or would have attained the necessary insured status if the Member had been subject to Social Security coverage during her/his entire working career determined without regard to any exceptions set forth in Section 210(a) or Section 211(c) of the Social Security Act as in effect on January 1, 1983, including, but not limited to, paragraphs (5), (6), (7), and (8) of Section 210(a), and Section 211(c)(4)) and the Surviving Spouse has not remarried and meets any applicable age, child-care, and/or disability requirements.~~

~~(b) The Surviving Spouse or Eligible Same Gender Partner Benefit shall be increased by three percent (3%) each January 1 and shall continue until death.~~

~~Section 6.03 — Payment of Small Amounts. — Portico Benefit Services, in its sole discretion, may provide for payment annually, semi-annually, quarterly, or in one (1) sum, on an actuarially equivalent basis, of benefits which would~~

~~otherwise be payable in small amounts monthly under this Article VI. Portico Benefit Services, in its sole discretion, may pay such amounts to the ELCA Retirement Plan or to the trust related to such plan to provide for one (1) combined pension payment to a Surviving Spouse or Eligible Same Gender Partner.~~

~~Section 6.04 — Processing Payments Subject to Rules, Regulations and Procedures of Portico Benefit Services. The processing of payments as provided in this Article VI shall be subject to any rules, regulations, and procedures which Portico Benefit Services, in its sole discretion, considers necessary or convenient for the efficient administration of the Survivor Benefits Plan.~~

ARTICLE VII. BENEFITS FOR SURVIVING CHILDREN

~~Section 7.01 — Monthly Surviving Child Benefit. Surviving Children of a Sponsored or Disabled Member who died prior to January 1, 2014 are eligible to receive monthly benefits in accordance with the terms of the Plan in effect at the time of the Sponsored or Disabled Member's death. The processing of such payments shall be subject to any rules, regulations, and procedures which Portico Benefit Services, in its sole discretion, considers necessary or convenient for the efficient administration of the Survivor Benefits Plan. A Monthly Surviving Child Benefit shall be paid to each Surviving Child of a Sponsored Member (other than a Sponsored Member who has continued coverage while "On Leave from Call") or Disabled Member who had not yet attained age twenty-one (21) and was dependent on the Member for more than fifty percent (50%) of her/his support at the time of the Member's death. The amount of the Monthly Surviving Child Benefit to be paid monthly to each eligible Surviving Child will be five percent (5%) of the Member's Monthly Defined Compensation. The amount of the Monthly Surviving Child Benefit shall be increased each January 1 by three percent (3%) of the amount payable for the preceding December. The Monthly Surviving Child Benefit to any eligible Surviving Child will continue until the earlier of the month after the Surviving Child attains age twenty-one (21) or dies.~~

~~Effective January 1, 1998, a Surviving Child Education Benefit that would have been payable to a Surviving Child who had not attained age eighteen (18) by December 31, 1997 will be replaced by extending the Monthly Surviving Child Benefit until the earlier of the month after the Surviving Child attains age twenty-one (21) or dies. Such monthly benefit will be increased, if necessary, commencing January 1, 1998 so that the total of the Monthly Surviving Child Benefits is increased by a minimum of four thousand dollars (\$4,000).~~

~~Section 7.02 — Payment of Small Amounts. Portico Benefit Services, in its sole discretion, may provide for payment annually, semi-annually, quarterly, or in one (1) sum, on an actuarially equivalent basis, of benefits which would otherwise be payable in small amounts monthly under this Article VII. Portico Benefit Services in its sole discretion, may pay such amounts to the ELCA Retirement Plan or to the trust related to such plan to provide for one (1) combined pension payment to a Surviving Child.~~

~~Section 7.03 — Processing Payments Subject to Rules, Regulations and Procedures of Portico Benefit Services. The~~

~~processing of payments as provided in this Article VII shall be subject to any rules, regulations, and procedures which Portico Benefit Services, in its sole discretion, considers necessary or convenient for the efficient administration of the Survivor Benefits Plan.~~

ARTICLE VIII. MISCELLANEOUS DEFINITIONS

Section 8.01 Accidental Death and Dismemberment. “Accidental Death and Dismemberment” occurs when an insured’s death or dismemberment results, directly and independently of all other causes, from an accidental bodily injury which is unintended, unexpected, and unforeseen. The bodily injury must be evidenced by a visible contusion or wound, except in the case of accidental drowning. The bodily injury must be the sole cause of death or dismemberment. Additional information is found in Appendix A.

Section 8.02 Basic Life and AD&D Insurance. “Basic Life and AD&D Insurance” is the amount of Lump Sum Death Benefit provided by a Member’s Participating Employer as defined in Section 2.02.

Section 8.03 Church Institution. A “Church Institution” is an entity that is an Eligible Employer within the meaning of Section 2.01(c) or (d).

Section 8.04 Churchwide Unit. For purposes of this Survivor Benefits Plan, “Churchwide Unit” means each of the following: the ELCA Churchwide Organization, the ELCA Women’s Organization, the ELCA Publishing House, the ELCA Mission Investment Fund, the ELCA Foundation, and Portico Benefit Services.

Section 8.05 Code. “Code” means the Internal Revenue Code of 1986 as from time to time amended.

Section 8.06 Defined Compensation. “Defined Compensation” includes actual gross taxable cash compensation, plus the amount of any contribution made to a tax sheltered annuity plan as defined in Code § 402(g)(3)(C) or for a qualified benefit as provided for in Code § 125 or § 132, pursuant to a salary reduction agreement entered into by the Participating Employer and the Sponsored Member. “Defined Compensation” does not include nontaxable reimbursements or expense allowances. In the case of ELCA Ordained Ministers and certain teachers who are recognized as ministers for purposes of Code § 107, “Defined Compensation” also includes the amount of the individual’s housing allowance as defined in Code § 107, if any, or an additional 30% of cash compensation plus any furnishings or utilities allowance paid directly to the Sponsored Member if housing is furnished by the Participating Employer.

Section 8.07 Designated Beneficiary(ies). A Member’s “Designated Beneficiary(ies)” is the individual(s) designated as beneficiary(ies) by the Member in accordance with any rules, regulations or procedures adopted by Portico Benefit Services. A divorce or Affidavit of Dissolution of Partnership automatically revokes the designation of a spouse or Eligible Same Gender Partner as a Member’s beneficiary. A Member may designate a divorced spouse or former Eligible Same Gender Partner as her/his beneficiary, but the Member must complete a new Designation of Beneficiary Form dated after the date of the divorce decree

or Affidavit of Dissolution of Partnership, naming the former spouse or former Eligible Same Gender Partner as beneficiary. In the event a new form is not filed and a former spouse or former Eligible Same Gender Partner is named as beneficiary, the designation of the former spouse or former Eligible Same Gender Partner as beneficiary is void and the Member's non-spousal beneficiaries become primary. If the Member has not provided Portico Benefit Services with a beneficiary designation in accordance with any rules, regulations or procedures adopted by Portico Benefit Services, the Designated Beneficiary(ies) shall be the person or persons surviving such Member in the first of the following classes in which there is a survivor, share and share alike:

- (a) The Member's Surviving Spouse or Eligible Same Gender Partner.
- (b) The Member's children, except that if any of her/his children predecease her/him but leave issue surviving her/him, such issue shall take by right of representation the share their parent would have taken if living.
- (c) The Member's parents.
- (d) The Member's brothers and sisters.
- (e) The Member's estate.

Determination of the identity of the Designated Beneficiary(ies) in each case shall be made by Portico Benefit Services.

Section 8.08 **Disabled Member**. A "Disabled Member" is an individual described as such in Section 3.05(c).

Section 8.09 **ELCA**. The "ELCA" is The Evangelical Lutheran Church in America, a Minnesota non-profit corporation.

Section 8.10 **ELCA Board of Pensions**. The "ELCA Board of Pensions" is the Board of Pensions of the Evangelical Lutheran Church in America, a Minnesota nonprofit corporation. The ELCA Board of Pensions began doing business as Portico Benefit Services in November 2011.

Section 8.11 **ELCA Ordained Minister**. An "ELCA Ordained Minister" is an individual listed on the roster of ordained ministers of the ELCA.

Section 8.12 **ELCA Rostered Layperson**. An "ELCA Rostered Layperson" is an associate in ministry, deaconess or diaconal minister listed on one (1) of the official rosters of the ELCA.

Section 8.13 **Eligible Child**. For benefits described under Appendix A, a Member's "Eligible Child" includes the insured employee's natural children, stepchild or a child of the eligible same gender partner living in the insured employee's household, legally adopted child, and a child placed in the insured employee's household as a step toward legal adoption by the employee, who are unmarried and dependent on the insured for

more than 50% of financial support. Children are eligible from live birth (stillborn or unborn children are not eligible) to the attainment of age 26.

Eligible Employee. An “Eligible Employee” is an individual described as such in Section 3.01.

Section 8.13 **Eligible Employer.** An “Eligible Employer” is an entity described as such in Section 2.01.

Section 8.14 **Eligible Same Gender Partner.** An “Eligible Same Gender Partner” is a living individual who satisfies the same gender partnership requirements established by Portico Benefit Services and submits a completed Affidavit of Partnership to Portico Benefit Services.

Section 8.15 **Eligible Spouse. A Member’s “Eligible Spouse” is an individual of the opposite sex who is legally married to the member.**

Section 8.15Section 8.17 **ERISA. “ERISA” means the Employee Retirement Income Security Act of 1974 as from time to time amended.**

Section 8.16Section 8.18 **Inter-Lutheran Agency.** For purposes of this Survivor Benefits Plan, “Inter-Lutheran Agency” includes the Lutheran Council in the USA and other inter-Lutheran agencies that function under Lutheran Council in the USA personnel policies. The determination of which inter-Lutheran agencies function under Lutheran Council in the USA personnel policies shall be made by Portico Benefit Services, in its sole discretion.

Section 8.17 **Lump Sum Death Benefit. A “Lump Sum Death Benefit” under Section 5.01(a) is the amount of the insured’s life insurance described in Appendix A paid by the insurer listed in Appendix A. A “Lump Sum Death Benefit” under Section 5.01(b) is the amount described in section 5.01(b) and paid by the ELCA Survivor Benefits Trust.**

Section 8.18Section 8.19 **Member.** “Member” means any Sponsored Member, spouse, ex-spouse, surviving spouse, Eligible Same Gender Partner, or child of any Sponsored Member or any other designated beneficiary, who is entitled to a benefit from this Survivor Benefits Plan.

Section 8.19Section 8.20 **Monthly Defined Compensation.**

(a) A Sponsored Member’s “Monthly Defined Compensation” is one-twelfth (1/12th) of the Member’s Defined Compensation upon which contributions were paid to this Survivor Benefits Plan in the twelve (12) full months immediately preceding the Member’s death.

(b) On the date a Member becomes Totally Disabled, her/his “Monthly Defined Compensation” shall be defined as one-twelfth (1/12th) of the Defined Compensation received by the Member during the twelve (12) full months immediately preceding the Member’s Total Disability and upon which contributions were paid to this Survivor Benefits

Plan or, if the Member received such Defined Compensation for less than twelve (12) full months immediately preceding her/his Total Disability, the Defined Compensation received by the Member for the number of full months immediately preceding her/his Total Disability during which s/he received such Defined Compensation, divided by the number of such months. If the Defined Compensation has decreased during a Member's illness preceding her/his Total Disability, the Member's Monthly Defined Compensation shall be one-twelfth (1/12th) of the Defined Compensation for the twelve (12) full months immediately preceding the decrease in Defined Compensation.

A Totally Disabled Member's Monthly Defined Compensation determined on the date of her/his Total Disability, shall be increased on each January 1 following the Member's date of Total Disability. For each year through January 1, 2003, the annual increase shall be three percent (3.0%). Beginning on January 1, 2004, Portico Benefit Services shall determine the Annual Increase Factor as the annual rate of increase in the average salary of active ELCA clergy sponsored in the ELCA Retirement Plan. Such Annual Increase Factor will be determined on May 31, 2003, and each subsequent May 31 for use on the January 1 following its determination. The Annual Increase Factor will be expressed as a percentage, rounded to one (1) decimal. If the Annual Increase Factor for any year is determined to be less than zero percent (0.0%), the Annual Increase Factor will be established at zero percent (0.0%).

(c) A Retired Member's "Monthly Defined Compensation" is one-twelfth (1/12th) of the Member's Defined Compensation upon which contributions were paid to this Survivor Benefits Plan in the twelve (12) full months immediately preceding the Member's most recent termination of employment.

(d) "Monthly Defined Compensation" for a Member whose coverage has continued while "On Leave from Call" is one-twelfth (1/12th) of the Member's Defined Compensation upon which contributions were paid to this Survivor Benefits Plan in the twelve (12) full months immediately preceding the Member's most recent termination of employment. If a Member received Defined Compensation for less than twelve (12) full months immediately preceding her/his most recent termination of employment, the Monthly Defined Compensation equals the Member's Defined Compensation for the number of full months immediately preceding the Member's most recent termination of employment during which the Member received such Defined Compensation, divided by the number of such months. If a Member is On Leave from Call for more than one (1) year, the Monthly Defined Compensation equals the Member's Defined Compensation for the most recent contiguous twelve (12) month period preceding the Member's most recent termination of employment. If the Member's Defined Compensation decreased during an illness preceding the Member's most recent termination of employment, the Member's Monthly Defined Compensation is one-twelfth (1/12th) of the Defined Compensation for the twelve (12) full months immediately preceding the decrease in Defined Compensation.

Section 8.20 ~~Section 8.21~~ **Predecessor Churches**. Each of the following is a "Predecessor Church": The American Lutheran Church, The Association of Evangelical Lutheran Churches, and Lutheran Church in America, including their antecedent bodies.

Section 8.21 — ~~Regular Pension Plan. For purposes of this Survivor Benefits Plan the term “Regular Pension Plan” refers to the ELCA Regular Pension Plan as from time to time amended.~~

Section 8.22 Retired Member. A “Retired Member” is an individual described as such in Section 3.06(d).

Section 8.23 Separation from Service. The “Separation from Service” of a Sponsored Member for purposes of this Survivor Benefits Plan shall be deemed to occur upon her/his resignation, discharge, retirement, death, failure to return to active service at the end of an authorized leave of absence (including an ELCA Ordained Minister “On Leave from Call” or an ELCA Rostered Layperson “On Leave from Call”), or the authorized extension or extensions thereof, or upon the occurrence of any other event or circumstances which, under the policy of her/his Participating Employer or of Portico Benefit Services, as in effect from time to time, results in a termination of the arrangement for the performance of compensated service; provided, however, that a Separation from Service shall not be deemed to occur upon a transfer between any combination of Participating Employers.

Section 8.24 Sponsored Member. A “Sponsored Member” is an individual described as such in Section 3.02.

Section 8.25 Supplemental Life and AD&D Insurance: Additional life insurance purchased by the Member according to the terms of Appendix A.

Section 8.26 Surviving Child. A “Surviving Child” of a Member includes the following individuals who survive the Member:

- (a) any natural or legally adopted child of the Member,
- (b) a natural or legally adopted child of the Member’s spouse or Eligible Same Gender Partner born or adopted before or during the Member’s marriage or partnership to such spouse or Eligible Same Gender Partner, and who is living in the Member’s household at the time of the Member’s death, and
- (c) a child placed in the Member’s household as a step toward legal adoption by the Member.

Section 8.27 Surviving Spouse. A “Surviving Spouse” is an individual of the opposite sex who is legally married to a Member on the date of the Member’s death and who survives the death of the Member.

ARTICLE IX. MISCELLANEOUS PROVISIONS

Section 9.01 Administration by Portico Benefit Services. Except as expressly otherwise provided herein, Portico Benefit Services shall control and manage the operation and administration of the Survivor Benefits Plan and make all decisions and determinations incident thereto. Except for specified

actions which the Portico Benefit Services determines must be taken by it only in a duly called meeting, action on behalf of Portico Benefit Services may be taken by any of the following:

- (a) Portico Benefit Services in a duly called meeting or by written action.
- (b) The Executive Director who shall be President of Portico Benefit Services or such other corporate officer as is designated by Portico Benefit Services.
- (c) Any person or persons, natural or otherwise, or committee to whom responsibilities for the operation and administration of the Survivor Benefits Plan are allocated by the Bylaws or a resolution of Portico Benefit Services, but action of such person or persons or committees shall be within the scope of said allocation. If allocated by resolution, a copy of each such resolution shall be retained by the Executive Director of Portico Benefit Services and filed with the permanent records of Portico Benefit Services.

Section 9.02 **Administrative Fee Paid to Portico Benefit Services.** Portico Benefit Services shall be paid a reasonable fee by the ELCA Survivor Benefits Trust for the administrative services provided by Portico Benefit Services to the Survivor Benefits Plan and the ELCA Survivor Benefits Trust, including a fee for informing the employees and employers of the availability of the Survivor Benefits Plan. The fee charged to the ELCA Survivor Benefits Trust shall constitute a lien upon the ELCA Survivor Benefits Trust until paid.

Section 9.03 **Rules of Construction and Applicable Law.** The Survivor Benefits Plan shall be construed and administered according to the laws of the State of Minnesota to the extent that such laws are not preempted by the laws of the United States of America. All controversies, disputes, and claims arising hereunder shall be submitted to the Minnesota Fourth Judicial District Court, Hennepin County.

Section 9.04 **Appeals Procedure.** A Member shall apply for her/his benefits from this Survivor Benefits Plan in accordance with the rules, regulations and procedures adopted by Portico Benefit Services. If any Member believes for any reason that her/his benefit under this Survivor Benefits Plan has not been appropriately determined, including, but not limited to, her/his entitlement to a benefit from this Survivor Benefits Plan or the amount of benefit to which such Member is entitled, s/he may proceed as follows:

- (a) **Appeal to the President.** A member may appeal in writing, within one hundred eighty (180) days of the receipt of any adverse 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 which shall consist of at least three (3) staff members who were not involved in the original decision. The President will respond to the appeal within thirty (30) days of receipt, unless the President notifies the Member of the need for an additional thirty (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. All such Plan amendments must be approved by the President, the Board of Trustees and/or the Church Council as described in Section 9.13.

(b) **Appeal to the Appeals Committee of the Board of Trustees.** In the event a Member is dissatisfied with the decision of the President, the Member may appeal to the Appeals Committee of the Board of Trustees of Portico Benefit Services within sixty (60) days of the receipt of the President's written response. The Appeals Committee will consist of not less than five (5) nor more than seven (7) members of the Board of Trustees, at least one (1) of whom must be a participant in the ELCA Pension and Other Benefits Plans. Additionally, the Appeals Committee may include outside independent consultants with special expertise in the area of the appeal who shall serve with voice but without vote. The Appeals Committee shall schedule a meeting to review the appeal within thirty (30) days of receipt. The final written decision of the Appeals Committee shall be forwarded to the Member within sixty (60) days of receipt of the appeal. All decisions of the Appeals Committee are final.

(c) **Court System.** In the event a Member has exhausted the appeals procedure set forth in Section 9.04(a) and (b) and is dissatisfied with the final decision of the Appeals Committee of Portico Benefit Services, the Member may initiate legal action in the Minnesota Fourth Judicial District Court, Hennepin County. Any removal of such action must be to the United States Court for the District of Minnesota.

Section 9.05 **Correction of Errors.** It is recognized that in the operation and administration of the Survivor Benefits Plan certain mathematical and accounting errors may be made or mistakes may arise for several reasons including by reason of factual errors in information supplied to Portico Benefit Services or to the Survivor Benefits Trustee. Portico Benefit Services shall have the power to cause such equitable adjustments to be made to correct such errors as the Portico Benefit Services, in its sole discretion, considers appropriate. Such adjustments shall be final and binding on all persons.

Section 9.06 **Fiduciary Standards.** Each fiduciary shall discharge her/his duties with respect to the Survivor Benefits Plan, solely in the interest of the Members, and in accordance with the following requirements:

(a) For the exclusive purpose of providing benefits to Members and defraying reasonable expenses of administering the Survivor Benefits Plan,

(b) With the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims,

(c) By diversifying the investments of the Survivor Benefits Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so, and

(d) In accordance with the provisions of this Survivor Benefits Plan and the ELCA Survivor Benefits Trust.

Section 9.07 ~~— **Suicide Exclusion.** Notwithstanding any provisions in this Survivor Benefits Plan to the contrary, no benefits will be paid from this Survivor Benefits Plan if the Member's death occurs within the period of time that the Member is subject to the Pre-existing Conditions set forth in Section 3.09, and Portico Benefit Services, in its sole discretion, determines that the Sponsored Member's death was due to suicide.~~

Section 9.08 ~~Section 9.07~~ **No Other Benefits.** No benefits other than those specifically provided for herein are to be provided under the Survivor Benefits Plan.

Section 9.09 ~~Section 9.08~~ **Source of Benefits.** Basic Life Insurance benefits payable upon the death of Retired Members and monthly benefits payable to Surviving Spouses, Surviving Eligible Same Gender Partners, and Surviving Children ~~All benefits to which a person becomes entitled hereunder~~ shall be provided only out of the ELCA Survivor Benefits Trust and only to the extent that such Trust is adequate therefor.

Section 9.10 ~~Section 9.09~~ **Portico Benefit Services is Not a Party to Contract Between an Eligible Employer and an Eligible Employee.** An Eligible Employee may have acquired 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 Survivor Benefits Plan on behalf of the Eligible Employee. Portico Benefit Services is not a party to any such contracts. If the Eligible Employer fails to comply with its obligations under such contract, the Eligible Employee can look only to the Eligible Employer for redress. Portico Benefit Services will not provide coverage under this Survivor Benefits Plan if it has not received contributions.

Section 9.11 ~~Section 9.10~~ **Limitation of Liability.** Portico Benefit Services shall not be liable to any Member for the failure of any Participating Employer to sponsor an individual as a Sponsored Member in accordance with the policies and practices of such Participating Employer, or in accordance with any contract between the Eligible Employee and the Eligible Employer, or in accordance with Section 3.03(a), whether or not Portico Benefit Services or any representative of any part of the ELCA has actual knowledge of such failure to enroll. The sole remedy of Portico Benefit Services is to involuntarily terminate the status of the entity as a Participating Employer pursuant to Section 2.04(b). Furthermore, Portico Benefit Services shall not be liable to any Member for any claim based on its failure to involuntarily discontinue such entity's status as a Participating Employer, whether or not Portico Benefit Services or any other part of the ELCA had actual knowledge of the facts that would justify the involuntary termination of the entity's status as a Participating Employer.

Section 9.12 ~~Section 9.11~~ **Obligation of Sponsored Members.**

A Sponsored Member shall comply with all requirements of Portico Benefit Services regarding enrollment and administration of the Survivor Benefits Plan including, but not limited to, establishing such employee's date of birth, marital status, marital and family support obligations and disabled status. If the employee shall fail to comply with reasonable requirements or knowingly provides false, inaccurate or misleading information to Portico Benefit Services, the employee shall be obligated to reimburse Portico Benefit Services for the reasonable expenses and damages incurred by Portico Benefit Services as the result of such failure including, but not limited to, an amount determined by Portico Benefit Services to be the additional expense of its staff in discovering, correcting, or adjusting for such failure. Portico Benefit Services may charge the Member's future benefit payments under this Survivor Benefits Plan, if any, for such additional expense.

Section 9.13 ~~Section 9.12~~ **Amendments.**

The Survivor Benefits Plan may be amended at any time and from time to time as follows:

(a) **Initiation of Amendments** (in accordance with Section 17.61 of the ELCA Constitution, Bylaws and Continuing Resolutions):

(i) The ELCA Churchwide Assembly may initiate amendments which shall be submitted to Portico Benefit Services for recommendation before final action by the ELCA Church Council,

(ii) The ELCA Church Council may initiate amendments which shall be submitted to Portico Benefit Services for recommendation before final action by the ELCA Church Council, or

(iii) Portico Benefit Services may initiate amendments which shall be submitted to the ELCA Church Council for final action.

(b) **Approval of Amendments**

(i) The President of Portico Benefit Services shall approve amendments involving no change in policy and little or no change in cost or benefits.

(ii) The ELCA Church Council shall approve amendments involving a significant change in policy or a significant change in cost or benefits. When the ELCA Church Council, in its sole discretion, deems it appropriate, proposed amendments shall be submitted to the ELCA Churchwide Assembly for final action.

(iii) The Board of Trustees of Portico Benefit Services shall approve all other amendments.

(c) **Reporting of Amendments**

(i) Amendments approved by the President of Portico Benefit Services shall be reported to the Board of Trustees of Portico Benefit Services.

(ii) Amendments approved by the Board of Trustees of Portico Benefit Services shall be reported to the ELCA Church Council.

(d) No amendment shall reduce the present value of the benefit entitlement under this Survivor Benefits Plan on the effective date of the amendment of a Member who dies prior to the effective date of the amendment.

Section 9.14~~Section 9.13~~ **Termination.** The ELCA Church Council may terminate the Survivor Benefits Plan at any time in accordance with the amendment procedure set forth in Section 9.13. After such termination, no employee shall become a Sponsored Member under the Survivor Benefits Plan and no additional contributions shall be made to the Survivor Benefits Plan. The existing funds may be distributed to, or for the benefit of, the Members in such manner as Portico Benefit Services, in its sole discretion, shall determine is fair and equitable. Any excess funds remaining, after the present value of all benefits with respect to Members who died prior to the effective date of the termination of this Survivor Benefits Plan have been paid, may be returned to the ELCA.

Section 9.15 ~~—~~ **Transfer of Amounts to Medical/Dental Plans.** ~~If a Member fails to remit to Portico Benefit Services any amount to which it is entitled in accordance with the subrogation rules set forth in the ELCA Medical and Dental Benefits Plan, the ELCA Medical Benefits Plan for Seminarians, or the ELCA Continuation of The ALC Major Medical-Dental Plan for Retired Participants, Portico Benefit Services or the Survivor Benefits Trustee may withhold such amounts from the Member's future benefit payments, including appropriate adjustment for interest, in satisfaction of the Member's obligation to remit such amount.~~

APPENDIX A

This page left intentionally blank

**RESTATED
BYLAWS**
of the
BOARD OF PENSIONS
of the
EVANGELICAL LUTHERAN CHURCH IN AMERICA

► **ARTICLE 1** ◀

Purpose

This corporation is established in accordance with the *Constitution, Bylaws and Continuing Resolutions of the Evangelical Lutheran Church in America* (the "ELCA") to carry out the purposes and perform the functions specified in this corporation's Articles of Incorporation. This corporation shall be governed by its Articles of Incorporation and Bylaws, and by the provisions of the *Constitution, Bylaws and Continuing Resolutions of the ELCA* that are expressly made applicable to this corporation.

► **ARTICLE 2** ◀

Location

The principal office of this corporation, at which the general business of this corporation shall be transacted and where the records of this corporation shall be kept, shall be at such place in the State of Minnesota as shall be fixed by duly adopted resolutions of the Board of Trustees. Until otherwise fixed by the Board of Trustees, the principal office shall be at Minneapolis, Minnesota.

► **ARTICLE 3** ◀

Meetings of Members

The Articles of Incorporation of this corporation provide that this corporation has no members with voting rights. Accordingly, there shall be no meetings of the members of this corporation.

► ARTICLE 4 ◀

Board of Trustees

SECTION 4.1 Election and Composition of Board of Trustees. The Board of Trustees shall be elected in the manner and for terms specified by the Constitution, Bylaws and Continuing Resolutions of the ELCA. Members of the Board of Trustees shall include persons with expertise in investments, insurance and pensions, and shall include ~~two to five~~ at least four persons who are members of the plans maintained by the Board of Pensions, at least one of whom shall be a lay plan member or lay recipient of plan benefits and at least one of whom shall be an ordained minister who is a plan member. Up to two trustees may be members of the congregations of church bodies with which the ELCA is in a relationship of full communion, provided that both are not from the same church body.

The Board of Trustees shall be composed of fourteen to eighteen persons elected by the Churchwide Assembly. Approximately one-third of the Board of Trustees shall be elected each ~~biennium-triennium~~ for a ~~six~~three-year term with ~~out~~up to two consecutive re-elections. The terms of the new trustees shall commence at the commencement of the first regular meeting of the Board of Trustees following the close of the Churchwide Assembly at which they are elected and shall expire at the commencement of the first regular meeting of the Board of Trustees in the year in which their successors are elected.

The presiding bishop (or a person designated to serve as the presiding bishop's representative), the bishop elected by the Conference of Bishops, and the treasurer of this Church shall serve as advisory members of the Board of Trustees, with voice but not vote.

SECTION 4.2 Vacancy on Board of Trustees. In the event of an interim vacancy on the Board of Trustees, the Church Council, following consultation with the Board of Trustees, shall elect a trustee to serve the balance of the vacated term. Trustees who are elected to fill a vacancy on the Board of Trustees and who served less than one-half of a term shall be eligible for re-election ~~to one for up to three full terms~~ served consecutively upon the conclusion of the partial term.

SECTION 4.3 Removal of Trustee. A trustee's position shall be deemed vacant following three (3) absences during any rolling two (2) years commencing with the first absence. In accordance with the Constitution, Bylaws and Continuing Resolutions of the Evangelical Lutheran Church in America, upon two successive absences that have not been excused by the Board of Trustees, a trustee's position shall be declared vacant. A trustee may be removed from office, with or without cause, by the affirmative vote of two thirds (2/3) of the trustees present at a duly held meeting; provided that not less than five (5) days and not more than thirty (30) days notice of such meeting, stating that removal of such trustee is to be on the agenda for such meeting, shall be given to each trustee; provided, however, no such removal of a trustee shall be effective without the approval of the Church Council.

► ARTICLE 5 ◀

Meetings of the Board of Trustees

SECTION 5.1 Annual Meeting. The annual meeting of the Board of Trustees shall be held each year at the time and place, within or without the State of Minnesota, as may be designated

by the Board of Trustees. If the Board of Trustees does not fix a time or place, such meeting shall be held at 8:00 o'clock a.m., Central Time, on the first Saturday in November at the registered office of this corporation.

SECTION 5.2 Other Regular Meetings. The Board of Trustees shall establish at least one other regular meeting of the Board and it may establish additional other regular meetings. Notice of such meetings shall be given in the manner described in Section 5.4 hereof.

SECTION 5.3 Special Meetings. Special meetings of the Board of Trustees may be called at any time (a) by the Chairperson, (b) by the President, (c) by the Board of Trustees, or (d) upon the written request of five or more members of the Board of Trustees. Anyone entitled to call a special meeting of the Board of Trustees may make a written request to the Secretary to call the meeting, and the Secretary shall give notice of the meeting, setting forth the time, place and purpose thereof, not less than five nor more than thirty days before the date of the meeting. If the Secretary fails to give notice of the meeting within seven days from the day on which the request was made, the person or persons who requested the meeting may fix the time and place of the meeting and give notice in the manner hereinafter provided.

SECTION 5.4 Notice of Meetings. Notice of each meeting of the Board of Trustees stating the time and place thereof shall be mailed, postage prepaid, or by a form of electronic communication consented to by the trustee to whom the notice is given, not less than five nor more than thirty days before the meeting, excluding the day of the meeting, to each trustee at her or his address, including both mail and electronic address, according to the last available records of this corporation. No business shall be transacted at any special meeting other than the business specified in the notice of special meeting. Any trustee may make written waiver of notice before, at or after a meeting. The waiver shall be filed with the person who has been designated to act as Secretary of the meeting, who shall enter it upon the records of the meeting. Appearance at a meeting is deemed a waiver unless it is solely for the purpose of asserting the illegality of the meeting.

SECTION 5.5 Quorum and Voting. At all meetings of the Board of Trustees, each trustee shall be entitled to cast one vote on any question coming before the meeting. The presence of a majority of the members of the Board of Trustees shall constitute a quorum at any meeting thereof, but the trustees present at any meeting, although less than a quorum, may adjourn the meeting to another time or place. A majority vote of the trustees present at any meeting, if there be a quorum, shall be sufficient to transact any business. A trustee shall not appoint a proxy for her/himself or vote by proxy at a meeting of the Board of Trustees.

SECTION 5.6 Adjourned Meetings. When a meeting of the Board of Trustees is adjourned to another time or place, notice of the adjourned meeting need not be given other than by announcement at the meeting at which adjournment is taken.

SECTION 5.7 Action Without a Meeting. Any action required or permitted to be taken at a meeting of the Board of Trustees may be taken by a signed written action, or consented to by authenticated electronic communication, with two thirds (2/3) or more of the trustees entitled to vote on that action voting in the affirmative. The action is effective when signed or consented to by authenticated electronic communication by the required number of trustees, unless a different effective date is provided in the written action, or the action requires Church Council or Churchwide Assembly of the ELCA approval. When written action or consent is taken by less than all of the trustees, all trustees shall be notified immediately of its text and effective date, except that failure to provide such notice does not invalidate the written action.

SECTION 5.8 Telecommunications. A trustee may participate in a meeting of the Board of Trustees by any means of communication through which the trustee, other persons so participating and all persons physically present at the meeting may simultaneously hear each other during the meeting. Participation in a meeting by that means constitutes personal presence at the meeting. A conference among trustees by any means of communication through which the participants may simultaneously hear each other during the conference, constitutes a meeting of the Board of Trustees if the same notice is given of the conference as would be required for a meeting, and if the number of persons participating in the conference would be sufficient to constitute a quorum at the meeting. Participation in a meeting by that means constitutes personal presence at the meeting.

► ARTICLE 6 ◀

Officers

SECTION 6.1 Classification. The officers of this corporation shall be of three classifications: "Corporate Officers" elected ~~from the trustees of the corporation~~ in the manner described in Section 6.2 hereof, the "Chief Executive Officer" (President) elected in the manner described in Section 6.3 hereof, and "Staff Officers" appointed in the manner described in Section 6.4 hereof.

SECTION 6.2 Corporate Officers. The Corporate Officers of this corporation shall consist of a Chairperson, a Vice Chairperson, a Secretary, a Treasurer and such other Corporate Officers as the Board of Trustees may designate. The Corporate Officers shall be elected by the Board of Trustees from among its own members, ~~except for the Treasurer, which shall be appointed by the Board of Trustees from the Board of Pensions Staff Officers at the last regular meeting of the Trustees before the Churchwide Assembly.~~ The Corporate Officers shall serve terms of two years commencing at the first regular meeting of the Trustees following ~~their election the close of the Churchwide Assembly~~ and until their respective successors are chosen and have been qualified. Any Corporate Officer may be removed from office, at any time, by the Board of Trustees, with or without cause. A Corporate Officer shall not hold more than one corporate office at the same time.

SECTION 6.3 Chief Executive Officer. The Chief Executive Officer of this corporation shall be the President. The President shall be elected by the Board of Trustees to a four-year term in consultation with and upon the approval of the Bishop of the ELCA. Nomination of a candidate for President shall be made jointly by the Bishop of the ELCA and the committee of the Board of Trustees that is from time to time charged with the responsibility of conducting the search for this corporation's President. The President may be terminated at any time, with or without cause, by the Board of Trustees and the Bishop of the ELCA, following recommendation by the Executive Committee of the Board of Trustees.

The Board of Trustees may enter into a contract with the President for a period not extending beyond the expiration of the President's term if, in the Board's judgment, the contract would be in the best interests of this corporation. The removal of the President is without prejudice to any contractual rights of the President.

The Board of Pensions, together with the Bishop of the ELCA, shall arrange for an annual review of the President. The President shall be eligible for re-election.

SECTION 6.4 Staff Officers. The Staff Officers of this corporation shall be one or more Vice Presidents and such other Staff Officers as the Board of Trustees may authorize. The President shall appoint the Vice Presidents and other Staff Officers. The Vice Presidents and other Staff Officers shall be considered, at all times, employees at will and may be removed at any time, with or without cause, by the President, upon consultation with the Executive Committee.

SECTION 6.5 Vacancies. A Vacancy among any of the Corporate Officers, Chief Executive Officer, or Staff Officers because of death, disqualification, resignation, removal or any other cause shall be filled for the unexpired portion of the term in the manner prescribed in these Bylaws for the election or appointment to such office, except that any such election may take place at any meeting of the Board of Trustees.

SECTION 6.6 Chairperson. The Chairperson of this corporation shall preside at all meetings of the Board of Trustees and the Executive Committee, if one is appointed. The Chairperson shall supervise the carrying out of the policies adopted or approved by the Board of Trustees. The Chairperson shall be a member ex officio of all committees. The Chairperson shall also have and may exercise such further powers and duties as may be conferred upon, or assigned to, her or him by the Board of Trustees. The Chairperson may not serve more than two terms.

SECTION 6.7 Vice Chairperson. During the absence or disability of the Chairperson, the Vice Chairperson shall perform the duties of the Chair.

SECTION 6.8 Secretary. The Secretary shall have and may exercise any and all powers and duties pertaining by law, regulation or practice to the office of Secretary, or imposed by these Bylaws. S/he shall also perform such other duties as may be assigned to her or him by the Board of Trustees.

SECTION 6.9 Treasurer. The Treasurer shall exercise such duties and shall make such reports as may be assigned to her or him by the Board of Trustees.

SECTION 6.10 President. The President shall have general supervision, direction and active management of the affairs of this corporation. Subject to the provisions of Section 9.4 hereof, the President may execute on behalf of this corporation all contracts, deeds, conveyances and other instruments in writing which may be required or authorized by the Board of Trustees for the proper and necessary transaction of the business of this corporation.

~~**SECTION 6.11 Senior Vice President.** The President may designate one of the Vice~~

~~Presidents as the Senior Vice President. During the absence or in the event of death or disability of the President, it shall be the duty of the Senior Vice President to perform the duties of the President.~~

SECTION 6.1142 Additional Powers. Any officer of this corporation, in addition to the powers conferred upon her or him by these Bylaws, shall have such powers and perform such additional duties as may be prescribed by the Board of Trustees.

► ARTICLE 7 ◀

Committees

SECTION 7.1 Authority. Subject to the provisions of these Bylaws and the Constitution, Bylaws and Continuing Resolutions of the ELCA, the Board of Trustees may act by and through such committees as may be specified in resolutions adopted by a majority of all of the members of the Board of Trustees. Each such committee shall have such duties and responsibilities as are granted to it by the Board of Trustees. Each committee may nominate and a majority of all of the members of the Board of Trustees may elect persons to act as voting or non-voting members or advisors to the committee. Additional voting members of a committee so elected shall number fewer than the number of elected members of the Board of Trustees on that committee. Each such committee shall at all times be subject to the control and direction of the Board of Trustees.

Each committee designated in Sections 7.2 and 7.3 shall be appointed by a majority of all of the members of the Board of Trustees.

SECTION 7.2 Executive Committee. The Board of Trustees shall designate an Executive Committee composed of the Chairperson, the Vice Chairperson, the Secretary, ~~the Treasurer,~~ and ~~one (1) two (2)~~ other trustees designated by the Board of Trustees. At least one and not more than two (2) members of the Executive Committee shall be plan members. The Executive Committee shall have the authority of the Board of Trustees in the management of the business of this corporation in the interval between meetings of the Board of Trustees, and the Executive Committee shall at all times be subject to the control and direction of the Board of Trustees. The Executive Committee shall also be responsible for reviewing and recommending to the Board of Trustees, compensation and benefits for the chief executive officer.

SECTION 7.3 Audit Committee. The Board of Trustees shall designate an Audit Committee which shall be composed of at least three (3) trustees. The Audit Committee shall be responsible for communications between the Board of Trustees and the corporation's independent auditor, internal auditors (if any) and financial management staff with respect to financial statements, audits, accounting and financial reporting practices, adequacy and effectiveness of the system of internal accounting controls, scope and results of the annual audit and other services performed by independent auditors and for making recommendations as to retention and, where necessary, the termination and replacement of the independent auditors. The Audit Committee shall have authority to investigate and consider any other matters relative to the audit of this corporation's accounts and its financial affairs that the Committee, in its discretion, deems necessary.

SECTION 7.4 Meetings and Voting. Each committee of this corporation may establish the time for its regular meetings and may change that time as it deems advisable. Special meetings of any committee of this corporation may be called by the chairperson of that committee, or by the President. At least five days' notice by mail, telephone or other form of electronic communication, consented to by the committee members, shall be given of any special meeting of a committee. At all meetings of a committee of this corporation each member thereof shall be entitled to cast one vote on any question coming before such meeting. The presence of a majority of the membership of any committee of this corporation shall constitute a quorum at any meeting thereof, but the members of a committee present at any such meeting, although less than a quorum, may adjourn the meeting to another time or place. A majority vote of the members of a committee of this corporation present at any meeting thereof, if there be a quorum, shall be sufficient for the transaction of the business of such committee.

SECTION 7.5 Action Without a Meeting. Any action required or permitted to be taken at a meeting of a committee of the Board of Trustees may be taken by a signed written action or consented to by authenticated electronic communication with two-thirds (2/3) or more of the trustees entitled to vote on that action voting in the affirmative. The written action or consent is effective when signed or consented to by the required number of trustees, unless a different effective date is provided in the written action. When written action or consent is taken by less than all of the trustees entitled to vote, all trustees shall be notified immediately of its text and effective date, except that failure to provide such notice does not invalidate the written action.

SECTION 7.6 Telecommunications. A committee member may participate in a meeting of any committee designated by the Board of Trustees not described above by any means of communication through which the trustee, other persons so participating and all persons physically present at the meeting may simultaneously hear each other during the meeting. Participation in a meeting by that means also constitutes presence in person at the meeting. A conference among members of any committee designated by the Board of Trustees by any means of communication through which the members of the committee may simultaneously hear each other during the conference constitutes a meeting of the committee, if the same notice is given of the conference as would be required for a meeting, and if the number of persons participating in the conference would be sufficient to constitute a quorum at a meeting. Participation in a meeting by that means constitutes presence in person at the meeting.

► **ARTICLE 8** ◀

Fiscal Year

The fiscal year of this corporation shall be January 1 through December 31.

► **ARTICLE 9** ◀

Miscellaneous

SECTION 9.1 Corporate Seal. This corporation shall have no seal.

SECTION 9.2 Amendments. Subject to the provisions of the Constitution, Bylaws and Continuing Resolutions of the ELCA, and the Articles of Incorporation of this corporation, these Bylaws may be amended in the manner prescribed by law.

SECTION 9.3 Indemnification. To the full extent permitted by any applicable law, this corporation shall indemnify each person made or threatened to be made a party to any threatened, pending or completed civil, criminal, administrative, arbitration, or investigative proceeding, including a proceeding by or in the right of this corporation, by reason of the former or present capacity of the person as --

- (a) a trustee, officer, employee or member of a committee of this corporation or,
- (b) a director, officer, partner, trustee, employee or agent of another organization or church pension or other benefit plan ("Plan"), who while a trustee, officer or employee of this corporation, is or was serving the other organization or Plan at the request of this corporation or whose duties as a trustee, officer or employee of this corporation involve or involved such service to the other organization or Plan,

against judgments, penalties, fines (including, without limitation, excise taxes assessed against the person with respect to a Plan), settlements, and reasonable attorneys' fees and disbursements, incurred by the person in connection with the proceeding. This corporation may, with the approval of the affected person, arrange for the provision of legal services at its expense to the extent so doing is not in contravention of any applicable law from time to time in effect.

Indemnification provided by this section shall continue as to a person who has ceased to be a trustee, officer, employee or committee member, shall inure to the benefit of the heirs, executors and administrators of such person and shall apply whether or not the claim against such person arises out of matters occurring before the adoption of this section. Any indemnification realized other than under this section shall apply as a credit against any indemnification provided by this section.

This corporation may, to the full extent permitted by applicable law from time to time in effect, purchase and maintain insurance on behalf of any person who is or was a trustee, officer, employee or a member of a committee of this corporation against any liability asserted against such person and incurred by such person in any such capacity.

SECTION 9.4 Execution of Instruments. All deeds, mortgages, bonds, contracts, checks drawn on the funds of the corporation and other instruments pertaining to the business and affairs of this corporation shall be signed and executed on behalf of this corporation by any two of the corporation's officers or by such other person or persons as may be designated by the Board of Trustees. If a document must be executed by persons holding different offices or functions and one person holds such offices or exercises such functions, that person may execute the document in more than one capacity if the document indicates each such capacity.

SECTION 9.5 Authority to Borrow, Encumber Assets. No officer, agent or employee of this corporation shall have any power or authority to borrow money on its behalf, to pledge its credit or to mortgage or pledge its real or personal property except within the scope and to the extent of the authority delegated by resolutions adopted by the Board of Trustees. Authority may be given by the Board of Trustees for any of the above purposes and may be general or limited to specific instances.

SECTION 9.6 Deposit of Funds. All funds of this corporation shall be deposited to the credit of this corporation in such banks, trust companies or other depositories as the Board of Trustees may approve or designate, and all such funds shall be withdrawn only in the manner or manners authorized by the Board of Trustees.

SECTION 9.7 No Emolument. The Trustees shall serve without emolument.

SECTION 9.8 Independent Auditors, Counsel, Actuary and Consultants. (1) This corporation may employ Independent Auditors, Counsel, Actuaries and Consultants as may be necessary from time to time. (2) The Independent Auditor shall make an annual examination of the accounts of the corporation in accordance with generally accepted auditing procedures. (3) The retention of an Independent Auditor shall be approved annually by the Board of Trustees. (4) No Independent Auditor, Counsel, Actuary, Consultant, or Employee thereof, shall be a member of the Board of Trustees.

SECTION 9.9 Conflict or Duality of Interest. All trustees, officers, agents and employees of this corporation shall disclose all real or apparent conflicts or dualities of interest which they discover or which have been brought to their attention in connection with this corporation's activities. "Disclosure" as used in the Bylaws shall mean providing promptly, to the appropriate persons, a written description of the facts comprising the real or apparent conflict or duality of interest. An annual disclosure statement shall be circulated to trustees, officers and certain identified agents and employees to assist them in considering such disclosures, but disclosure is appropriate and required whenever conflicts or dualities of interest may occur. The written notices of disclosure shall be filed with the President or such other person designated by the President to receive such notifications. All disclosures of real or apparent conflicts or dualities of interest shall be noted for the record in the minutes of a meeting of the Board of Trustees.

An individual trustee, officer, agent or employee who believes that s/he or an immediate member of her/his family might have a real or apparent conflict of interest shall, in addition to filing a notice of disclosure, abstain from: (1) participating in discussions or deliberations with respect to the subject of the conflict (other than to present factual information or answer questions), (2) using their personal influence to affect deliberations, (3) making motions, (4) voting, (5) executing agreements, or (6) taking similar actions on behalf of the corporation where the conflict or duality of interest might pertain by law, agreement or otherwise. At the discretion of the Board of Trustees or a committee thereof, a person with a real or apparent conflict or duality of interest may be excused from all or any portion of discussions or deliberations with respect to the subject of the conflict.

A member of the Board of Trustees or a committee thereof, who, having disclosed a conflict or duality of interest, nevertheless shall be counted in determining the existence of a quorum at any meeting where the subject of the conflict is discussed. The minutes of the meeting shall

reflect the disclosure made, the vote thereon, the abstention from participation and voting by the individual making disclosure.

There shall be no business transactions, whether in the nature of employment, contract, purchase or sale, between the corporation and a trustee during her or his term in office and, except in the case of employment, for a period of one year thereafter. For purposes of this Section 9.9, the payment of any benefit to which the trustee might otherwise be entitled, shall not be deemed a business transaction.

The President shall ensure that all trustees, officers, agents, employees and independent contractors of the corporation are made aware of the corporation's policy with respect to conflicts or dualities of interest.

SECTION 9.10 Confidentiality of Records. Files maintained by the Board of Pensions in respect to the members of its various plans, their dependents or beneficiaries, shall be maintained as confidential records as to non-Board of Pensions' personnel. Release of any information from such files to third persons shall only be made with written consent of the person for whom the file is maintained, the member's personal representative or a duly appointed professional agent.

All Staff Communication

CWO Operational Planning for 2014-16

Why read this?

The ELCA Churchwide Organization (CWO) has begun work on developing a plan for 2014-16. This paper contains information to help all staff understand the nature of the planning underway, the process that will be used to develop and approve the plan and what is expected of staff and others involved with the process. It answers questions that are likely to be asked, so that everyone gets the same message on what will be happening.

What is the CWO Operational Plan?

The CWO has had an Operational Plan in place for the period 2011-13, guiding the joint and separate work of its offices and units. It is now time to plan for the next three years. While some of the existing plan is likely to remain relevant, the process underway provides an opportunity to reassess what is most important for the period ahead. This means thinking about what the CWO wants to achieve, what it needs to get done and how it will measure its effectiveness or success.

The CWO's plan will be in two parts:

Part A The strategic intent - This section covers *Who we are as the ELCA; the vision and values that guide us; the role of the CWO; and, a picture of the CWO's most important work, defined by strategic priorities, goals and cross cutting commitments.*

Part B The detailed operational plan - For each goal, Part B identifies objectives, priority programs and activities, and result indicators. Part B will also capture a picture of key relationships, risks to be managed and the human resource and financial implications of the plan.

The term **operational** is used because the plan is expected to guide decisions and actions at a practical level, not just describe broad intentions. Formulating the plan requires choices about what to focus on and how the CWO can be most effective – getting the best value and impact from the knowledge, assets and resources available.

What has happened so far?

Lyla Rogan, who assisted with the 2011-13 plan, is facilitating the process.

The process commenced in late May with **preliminary meetings** involving the Administrative Team (unit executive directors, Presiding Bishop, Secretary, Treasurer, and the Executive for Administration) and senior leaders (direct reports to unit executive directors) from all offices and units. These meetings explored the achievements and setbacks from the 2011-13 plan, lessons from working with that plan and priorities for the CWO going forward.

A **planning workshop** was held on June 24 involving CWO leaders, Portico, MIF, WELCA, and representatives of the Church Council Planning and Evaluation Committee and the Conference of Bishops. Augsburg Fortress was unable to attend. **A report of this workshop is available through Sonia Hayden in OPB, if you have not already received it.** The consultant met with other people, including staff working on the cross cutting issues, the Research and Evaluation staff and heads of separately incorporated ministries not able to attend the workshop.

One senior leader from each office/unit met as a small group with the consultant to discuss design of the planning process between now and October. Their input has informed the steps set out in this paper.

What was learned last time?

Four themes were evident in preliminary discussions with senior leaders.

- The 2011-13 plan was helpful in providing direction and focus for our efforts.
- But, we were too ambitious in what we hoped to achieve and do.
- The work program for the cross cutting commitments was not made clear enough.
- We need to improve and streamline the result indicators and processes for monitoring, reporting and updating the plan.

These lessons are important this time around, and we will aim to address them through:

- An improved plan template.
- Making the cross cutting commitments a more specific focus for planning.
- Appointing a working group to work with the consultant on developing a smarter approach to reporting and review of the plan.

Who is responsible in the process?

A successful plan is owned by people in the organization at different levels. Staff, especially those in senior leadership positions, have an individual and collective responsibility for the plan. Any plan is only as good as the ideas that shape it and the decisions made during the process. Once the plan is in place, staff with management responsibilities should be held accountable for implementing the plan and for progress made.

- The **Administrative Team** has overall responsibility for the plan. As it is developing they have strategic oversight, resolve divergent views that arise and approve the plan. Once approved they are responsible for driving the plan and holding others to account in its implementation. The Executive for Administration, Wyvetta Bullock, coordinates the development process, including the consultants' work.
- **Senior leaders** are responsible for contributing to development of the plan, shaping and abiding by decisions about what is most important and for monitoring, reporting and active review of the plan during its implementation. They are also responsible for inviting wider staff input during development of the plan and interpreting the implications of the plan to their teams.
- **All staff** will have opportunities to contribute and review drafts of the plan. Staff should be familiar with the priorities for the CWO as a whole and in their areas. Everyone has a part to play, although not every individual staff member's work will be described in the plan.

What is the consultant's role?

Lyla Rogan brings to the process expertise in planning and organizational development. She will advise on planning methods, facilitate discussions and workshops to develop thinking, synthesize the thinking and write drafts of the plan. Her approach to the work is expected to build capacities for planning within a common CWO approach.

What are the steps in the process?

Good progress has been made through the preliminary meetings and the planning workshop. In particular this has shown just **how much agreement there is around the overall priorities**.

The following table sets out in detail the steps and timelines for finalizing the 2014-16 plan. Adjustments will be made as needed, based on the advice of senior leaders and/or the Administrative Team.

Steps	Who and how	Timing
Circulate Report of Workshop Outcomes and Communication on the planning process	<ul style="list-style-type: none"> Written by the consultant on advice of senior leaders. Report circulated to all workshop participants and invitees. Senior leaders share with their teams and provide an opportunity to discuss what is happening. 	Week of July 8
Develop wording of the strategic goals	<ul style="list-style-type: none"> Administrative team decides the approach to updating Part A of the plan based on workshop outcomes. Consultant writes goals in consultation with a writing group (Forrest Meyer MA, Carl Stecker GM, Evelyn Soto CSM, Jonathon Beyer OT/IT, Sue Rothmeyer OS, Wyvetta Bullock OB) 	July 9 (Admin Team meeting) Draft ready by July 24 as a basis for July 29 th workshop
Second planning workshop and getting started with Part B of the plan	<ul style="list-style-type: none"> One day planning workshop involving the Admin Team, senior leaders and some specialist staff, covering: <ul style="list-style-type: none"> Presenting changes to Part A, including draft goals Priority work on cross cutting commitments Development of CWO (internal focus) Cross unit work on objectives for each goal. During the week of July 29 the consultant will hold meetings to develop Part B of the plan, including, senior leaders in offices and units, cross unit groups as needed and the writing group. A draft of Part A of the plan is circulated for feedback from staff and Separately Incorporated Ministries, the Planning and Evaluation Committee and the Conference of Bishops. Consultant reviews the proposed objectives and prepares draft objectives for consideration by the Admin Team. 	July 29 (8.30-4:00) From July 30 (meeting times negotiated) Mid August Draft by end August
Approve content of Part A and draft objectives as a basis for further work	<ul style="list-style-type: none"> The Admin Team will assign time at a meeting after the churchwide assembly to approve Part A content and draft objectives. It is expected the objectives will be refined during September as offices and units work on the detail of the plan. Input will be received from the small group working with the Three Leadership Tables regarding a Narrative for this church toward 2020. 	Decision by September 6 th
Detailed work on the plan	Based on the processes agreed at the July 29 workshop: <ul style="list-style-type: none"> Part A will be shared with the Conference of Bishops and the Planning and Evaluation Committee of the Church Council. The consultant will provide written guidance on working with the plan template. Those with lead responsibility for objectives propose programs/ activities and result indicators. Drafts are circulated to staff for comments and senior 	September to mid-October Draft of Part B of the plan by October 18 Late October

	<p>leaders introduce and discuss the plan with interested staff. At the same time feedback is invited from other entities/groups involved in its development.</p> <ul style="list-style-type: none"> Lyla Rogan reviews and critiques drafts of Part B to ensure it is coherent, well integrated and user friendly. 	Plan finalized mid November.
Distribution of the plan to Church Council and other stakeholders	Part A of the Plan is provided to Church Council for information and affirmation.	November
Deciding processes for monitoring, reporting and updating the plan	A working group will be appointed to work with the consultant to propose how the CWO will monitor report on and update the plan. A goal will be to simplify and streamline these processes and to align them better to other reporting that is required.	November
Approving the operational plan and associated guidelines for use of the plan	Administrative Team	End November

Will all staff have an opportunity to comment on the plan?

Yes. Staff will receive information at key stages from senior leaders engaged in the process. Senior leaders are encouraged to keep their teams informed and to involve key staff during the detailed planning stage. Staff feedback on drafts of Part A and Part B will be sought prior to any approval of the plan. It is anticipated that there will be time for all staff to comment on the plan at the All Staff Convocation on September 3, 2013. There may also be brown bag lunch times for discussion.

How will the plan come together?

Bringing a plan together for the CWO is not an easy task. It demands time and space in a busy calendar and a willingness to look afresh at what is important and doable with available resources. As it plans for 2014-16, the CWO is on a journey to improve the way planning is done. While everyone has a general understanding of what it means to plan, the CWO is being asked by the Administrative Team to plan in a new way. Experience thus far reveals some challenges in this.

- Some teams are used to planning their work independently of other parts of the organization.
- It is hard to stop doing things that are not working or are less important than other priorities.
- It can be hard to move from “good ideas” to decisions.
- Coming up with strategy in some areas is just plain hard.
- Plans need inbuilt flexibility if they are to stay relevant and adapt to new circumstances and learning.
- Leaders and teams must ultimately be accountable for working with agreed priorities and getting results.

Your creativity, expertise and cooperation are needed to make this process deliver a plan that serves the CWO and wider church well.

How do I find out more?

Direct any questions or suggestions you have to your executive director or to Wyvetta Bullock in the Office of the Presiding Bishop. Lyla Rogan can be contacted via email lylarogan@gmail.com .

This page left intentionally blank

**ELCA CHURCHWIDE ORGANIZATION
2013 OPERATING RESULTS SUMMARY
FOR THE FIVE MONTHS ENDING JUNE 30, 2013**

The churchwide organization of the Evangelical Lutheran Church in America had revenue in excess of expenses of \$0.7 million in current operating funds for the five-month period ended June 30, 2013, a favorable variance of \$0.6 million compared to the five months ending June 30, 2012 and favorable to the period budget by \$3.1 million.

Revenue totaled \$27.9 million for the five-month period compared with \$27.1 million the previous year, an increase of \$0.8 million or 2.8 percent. In addition, \$0.8 million in support was released from restriction or designation during the period. Total revenue and support for the five-month period was \$28.7 million, an increase of \$0.7 million or 5.8 percent from the previous year. Expenses related to the current operating fund amounted to \$28.0 million, an increase of \$0.9 million or 3.4 percent from the previous year. Revenue and support in the period was favorable to the budget by \$0.6 million or 2.3 percent. Expenses were below the authorized unit spending plans by \$2.5 million or 8.1 percent.

Income from congregations through synods in the form of Mission Support income for the five months was \$19.3 million, a decrease of \$0.5 million or 2.7 percent compared to same period last year. Mission Support income was unfavorable to the revised budget by \$0.4 million or 2.2 percent. The revised annual Mission Support budget for 2013 of \$49.4 million is \$0.4 million or 0.09 percent lower than the amount received in 2012. With the five month totals behind both budget and prior year, the churchwide organization is actively monitoring mission support trends.

Other temporarily restricted and unrestricted revenue and support funds available for the budgeted operations of the church amounted to \$9.4 million compared with \$7.3 million in the previous year. Income from endowment distributions of \$1.1 million, bequests/trusts of \$3.2 million, and other income of \$1.5 million, resulted in favorable variances to the year-to-date budget, with bequests/trusts and other income also positive compared to the five months ending June 30, 2012. Income from the Mission Investment Fund of \$0.8 million exceeded budget and was favorable to 2012 by \$0.2 million. Income from Vision for Mission of \$0.3 million, investments of \$0.5 million and global church sponsorship (including missionary sponsorship) of \$0.9 million, were behind budget and also behind the same period in 2012. Due to timing differences, other grant revenue is temporarily behind budget.

Total contributions to ELCA World Hunger for the five months were \$5.5 million - favorable to the same five-month period in 2012 by \$0.2 million. Increases were realized in most regular giving categories with the exception of direct individual giving. The ELCA Malaria Campaign received gifts of \$2.2 million in the five months ending June 30 2013 and has raised approximately \$8.8 million campaign-to-date. ELCA members contributed \$2.7 million for the Lutheran Disaster Response in the five-month period, primarily \$1.2 million in support of the ELCA's response to domestic tornadoes. This compares to \$1.6 million in revenue for the same period in 2012, which included \$0.4 million for response to U.S. Severe Spring Storms.

This page left intentionally blank

EVANGELICAL LUTHERAN CHURCH IN AMERICA
CURRENT OPERATING FUNDS
SUMMARY OF REVENUE AND EXPENSES
 (In Thousands)
 For the Period Ending June 30, 2013

	2013	2013	2012	Year-to-Date Variance	
	ACTUAL	BUDGET	ACTUAL	ACTUAL	CURRENT YEAR
				vs BUDGET	vs PRIOR YEAR
				Favorable/(Unfav)	Favorable/(Unfav)
REVENUE					
UNRESTRICTED					
Mission Support	\$ 19,262	\$ 19,692	\$ 19,798	\$ (430)	\$ (536)
Other	<u>5,257</u>	<u>3,714</u>	<u>4,380</u>	<u>1,542</u>	<u>877</u>
Total Unrestricted	<u>24,519</u>	<u>23,407</u>	<u>24,178</u>	<u>1,112</u>	<u>341</u>
TEMPORARILY RESTRICTED					
Designated Gifts	1,894	1,900	1,722	(6)	172
Other	<u>1,443</u>	<u>2,068</u>	<u>1,208</u>	<u>(625)</u>	<u>234</u>
Total Restricted	<u>3,337</u>	<u>3,968</u>	<u>2,930</u>	<u>(631)</u>	<u>406</u>
TOTAL REVENUE	\$ 27,856	\$ 27,375	\$ 27,108	\$ 481	\$ 748
DESIGNATED AND RESTRICTED FUNDS RELEASED	825	666	-	159	825
TOTAL OPERATING REVENUE AND SUPPORT	<u>28,681</u>	<u>28,041</u>	<u>27,108</u>	<u>640</u>	<u>1,573</u>
LESS TOTAL EXPENSES	<u>27,975</u>	<u>30,443</u>	<u>27,050</u>	<u>2,468</u>	<u>(925)</u>
NET REVENUE OVER (UNDER) EXPENSES	<u><u>\$ 706</u></u>	<u><u>\$ (2,402)</u></u>	<u><u>\$ 58</u></u>	<u><u>\$ 3,108</u></u>	<u><u>\$ 648</u></u>

PRELIMINARY AND UNAUDITED

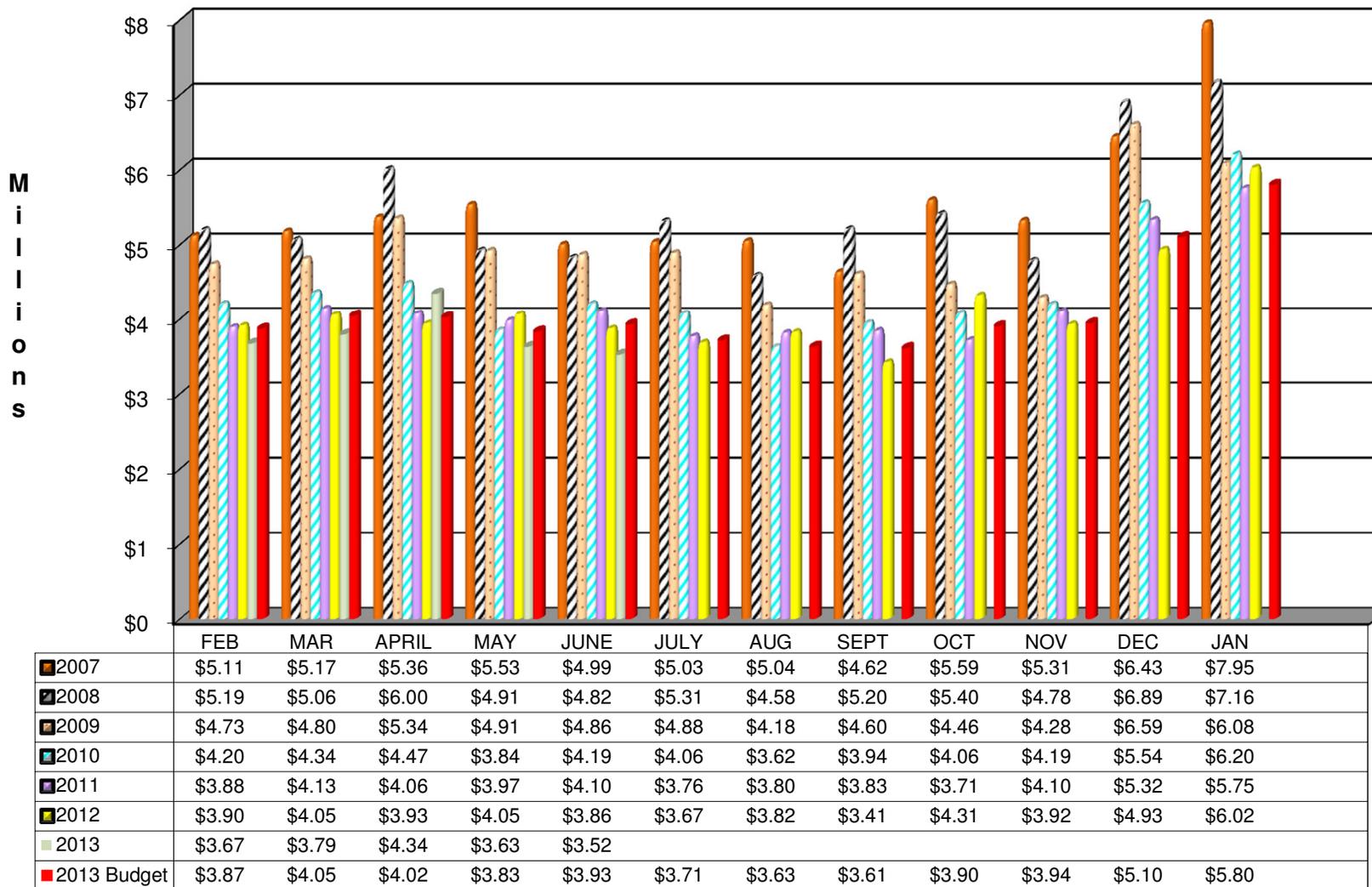
EVANGELICAL LUTHERAN CHURCH IN AMERICA
CURRENT OPERATING FUNDS
REVENUE SUMMARY
For the Period Ending June 30, 2013

	2013	2013	2012	Year-To-Date Variance	
				ACTUAL vs.	CURRENT YEAR
	ACTUAL	BUDGET	ACTUAL	ACTUAL vs.	CURRENT YEAR
UNRESTRICTED					
Mission Support	\$ 19,261,955	\$ 19,692,335	\$ 19,797,524	\$ (430,380)	\$ (535,569)
Vision for Mission	330,611	445,000	487,306	(114,389)	(156,695)
Investment Income	529,439	942,365	1,207,676	(412,926)	(678,237)
Bequests and Trusts	2,479,831	485,000	1,209,480	1,994,831	1,270,351
Endowment	368,711	360,572	371,916	8,139	(3,205)
Rent	695,978	685,216	673,379	10,762	22,599
Other	852,857	796,306	430,366	56,551	422,491
Total Unrestricted	<u>24,519,382</u>	<u>23,406,794</u>	<u>24,177,647</u>	<u>1,112,588</u>	<u>341,735</u>
TEMPORARILY RESTRICTED					
Global Church Sponsorship	892,578	999,480	975,727	(106,902)	(83,149)
Bequests and Trusts	679,664	608,518	433,226	71,146	246,438
Endowment	763,175	747,224	775,119	15,951	(11,944)
Unit-Designated Gifts	176,372	125,250	121,368	51,122	55,004
Mission Investment Fund	825,000	775,000	625,000	50,000	200,000
Grants	-	712,500	-	(712,500)	-
Total Restricted	<u>3,336,789</u>	<u>3,967,972</u>	<u>2,930,440</u>	<u>(631,183)</u>	<u>406,349</u>
TOTAL REVENUE	<u>\$ 27,856,171</u>	<u>\$ 27,374,766</u>	<u>\$ 27,108,087</u>	<u>\$ 481,405</u>	<u>\$ 748,084</u>
Total Designated and Restricted Funds Released	<u>825,148</u>	<u>665,775</u>	<u>-</u>	<u>159,373</u>	<u>825,148</u>
TOTAL OPERATING REVENUE AND SUPPORT	<u>\$ 28,681,319</u>	<u>\$ 28,040,541</u>	<u>\$ 27,108,087</u>	<u>\$ 640,778</u>	<u>\$ 1,573,232</u>

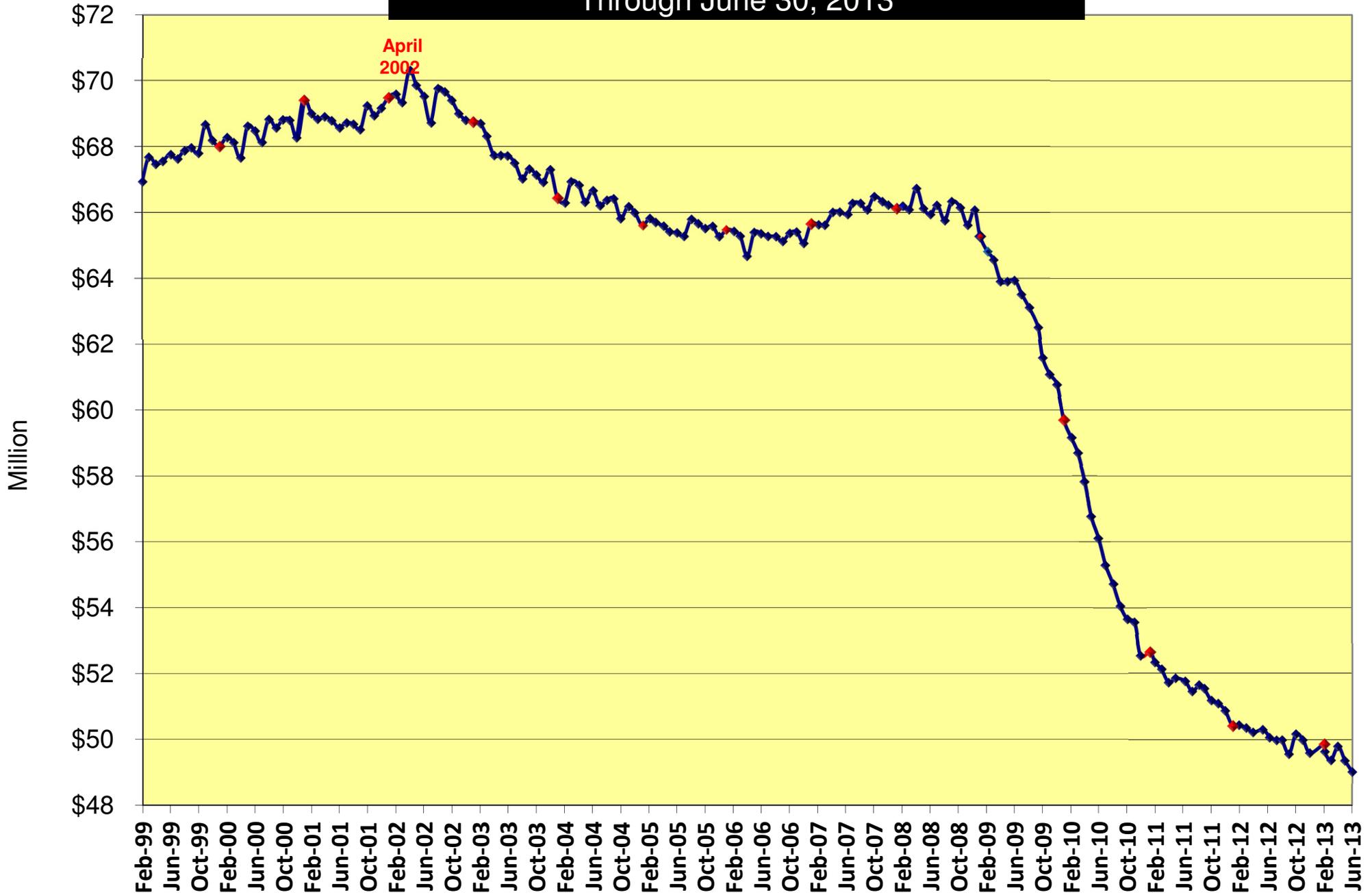
EVANGELICAL LUTHERAN CHURCH IN AMERICA
CURRENT OPERATING FUNDS
ACTUAL EXPENSES VS. SPENDING AUTHORIZATION
For the Period Ending June 30, 2013

	2013 ACTUAL EXPENSES	2013 SPENDING AUTHORIZATION	Variance Favorable (Unfavorable)	Percent of Actual to Budget
UNITS				
Congregational and Synodical Mission	11,587,726	12,484,239	896,513	92.82%
Global Mission	5,434,496	5,661,623	227,127	95.99%
Mission Advancement	1,682,066	2,296,320	614,254	73.25%
OFFICES				
Presiding Bishop	2,088,847	2,239,686	150,839	93.27%
Treasurer	3,351,101	3,612,293	261,192	92.77%
Secretary	1,542,527	1,763,332	220,805	87.48%
OTHER				
General Treasury	78,851	75,500	(3,351)	104.44%
Retiree Minimum Health Obligation	1,041,667	1,041,666	-	100.00%
Depreciation	1,031,029	1,035,192	4,163	99.60%
Strategic Initiatives	136,997	232,827	95,830	58.84%
TOTAL EXPENSES	\$ 27,975,307	\$ 30,442,678	\$ 2,467,371	91.90%

Evangelical Lutheran Church in America Synodical Mission Support By Month 2005 - 2013



Mission Support Received In Preceding 12 Months Through June 30, 2013



**EVANGELICAL LUTHERAN CHURCH IN AMERICA
 ELCA WORLD HUNGER
 SUMMARY OF REVENUE AND EXPENSE
 For the Period Ending June 30, 2013**

	<u>Actual</u>	<u>Budget</u>	<u>Income and Expense Variances Favorable (Unfavorable)</u>	
			<u>Actual Vs. Budget</u>	<u>Current Vs. Previous Year</u>
Beginning Balance	\$ 2,678,583			
Income:				
Through Synods	\$ 2,382,022	\$ 2,450,000	\$ (67,978)	\$ 21,303
Direct Giving - Individual and Others	1,394,961	1,840,000	(445,039)	(396,924)
Direct Giving - Congregations	718,742	530,000	188,742	103,768
Endowments and Donor Requested Payments	236,296	225,000	11,296	8,390
Bequests, Miscellaneous	723,069	235,000	488,069	433,150
Total Income	5,455,090	5,280,000	175,090	169,687
Expense:				
Global Mission	2,710,362	2,660,079	(50,283)	(729,597)
Congregational and Synodical Mission	1,038,380	1,110,002	71,622	(265,831)
Mission Advancement	673,545	1,077,135	403,590	200,628
Total Expense	4,422,287	4,847,216	424,929	(794,800)
Net	\$ 1,032,803	\$ 432,784	\$ 600,019	\$ (625,113)
Ending Balance	\$ 3,711,386			

EVANGELICAL LUTHERAN CHURCH IN AMERICA
 ELCA MALARIA CAMPAIGN
 SUMMARY OF REVENUE AND EXPENSE
 For the Period Ending June 30, 2013

	<u>Actual</u>	<u>Budget</u>	<u>Variance Favorable (Unfavorable)</u>	<u>Campaign To Date</u>
Beginning Balance	\$ 3,207,841			
Income				
Through Synods	416,865	565,000	(148,135)	2,988,078
Direct Giving - Individual and Others	884,668	735,000	149,668	3,945,503
Direct Giving - Congregations	900,777	480,000	420,777	1,830,864
Total Income	\$ 2,202,310	\$ 1,780,000	\$ 422,310	\$ 8,764,445
Expense				
<i>Global Mission</i>				
Program Grants	896,659	946,656	49,997	3,607,112
Capacity Building	57,438	57,508	70	306,738
Program Coordination	170,972	163,196	(7,776)	450,798
<i>Mission Advancement</i>				
Interpretation/Coordination	55,712	38,452	(17,260)	466,220
Fundraising	107,953	153,664	45,711	745,772
Total Expense	\$ 1,288,734	\$ 1,359,475	\$ 70,741	\$ 5,576,640
Net	\$ 913,576	\$ 420,525	\$ 493,051	
Ending Balance	\$ 4,121,417			

This page left intentionally blank

Revised

**2014 Synod Mission Support Plans
With 2012 Actual and 2013 Plans**

SYNOD NAME	#	2012		2013		2014	
		ACTUAL	MS %	SYNOD PLANS		SYNOD PLANS	
ALASKA	1A	155,132	39.50%	152,075	39.50%	161,950	39.50%
N.W. WASH	1B	580,050	45.50%	598,000	46.00%	725,165	46.50%
S.W. WASH	1C	355,530	39.50%	376,000	40.00%	376,000	40.00%
E.WASH/ID	1D	247,631	33.00%	267,960	33.00%	268,600	34.00%
OREGON	1E	362,283	39.50%	360,000	40.00%	356,000	40.00%
MONTANA	1F	405,933	40.00%	394,065	40.50%	434,600	41.00%
SIERRA-PACIFI	2A	889,226	52.00%	984,373	52.50%	1,040,000	52.00%
SW CALIFORNI	2B	542,348	49.00%	530,519	50.00%	541,940	49.00%
PACIFICA	2C	720,385	51.00%	756,193	51.00%	794,003	51.00%
GRAND CANYO	2D	924,549	50.00%	875,000	50.00%	875,000	50.00%
ROCKY MTN	2E	1,183,275	50.00%	1,200,000	50.00%	1,212,500	50.00%
W. NO.DAK	3A	435,305	43.50%	400,400	44.00%	418,500	45.00%
E. NO.DAK	3B	414,239	40.00%	420,000	40.00%	428,823	40.50%
SO. DAK.	3C	701,246	44.50%	742,465	45.00%	773,236	45.50%
NW. MINN.	3D	701,412	51.00%	719,100	51.00%	733,482	51.00%
NE. MINN.	3E	561,577	49.00%	590,450	49.00%	616,420	49.00%
SW. MINN.	3F	1,059,471	52.50%	1,075,215	52.50%	1,085,967	52.50%
MINPLS. AREA	3G	1,551,653	55.00%	1,600,000	50.00%	1,613,500	50.00%
ST PAUL (M)	3H	1,037,511	50.00%	1,000,000	50.00%	950,000	47.50%
SE. MINN.	3I	976,925	52.50%	994,875	52.50%	1,020,250	53.00%
NEBRASKA	4A	1,860,615	54.50%	1,907,500	54.50%	1,900,000	54.50%
CENTRAL STAT	4B	916,718	50.00%	912,567	50.00%	917,500	50.00%
ARK/OK	4C	212,368	40.60%	216,117	40.70%	242,352	40.80%
N.TEX/N.LOU	4D	552,282	47.50%	570,505	48.00%	581,916	48.00%
S.W.TEXAS	4E	737,880	50.00%	714,000	51.00%	746,750	51.50%
GULF COAST	4F	656,818	50.00%	600,000	50.00%	630,000	50.00%
METRO CHGO	5A	1,643,706	53.00%	1,700,504	53.00%	1,676,324	53.25%
NO. ILL	5B	1,291,345	55.00%	1,303,500	55.00%	1,323,575	55.00%
CEN.SO. ILL	5C	800,284	56.00%	798,000	56.00%	840,000	56.00%
SE IOWA	5D	1,397,014	53.50%	1,385,062	53.50%	1,399,025	53.50%
WEST IOWA	5E	366,682	37.10%	338,956	38.10%	353,070	39.10%
NE IOWA	5F	595,103	40.00%	560,000	40.00%	600,000	40.00%
N GRT LKES	5G	413,191	50.00%	416,625	50.50%	425,850	51.00%
NW.SYN (W)	5H	735,761	55.00%	759,000	55.00%	770,000	55.00%
EC WISC	5I	921,406	55.00%	907,500	55.00%	962,500	55.00%
GRTR MILWKEE	5J	1,200,775	55.00%	1,155,000	55.00%	1,155,000	55.00%
SO.-CENT (W)	5K	830,516	55.00%	858,000	55.00%	869,000	55.00%
LACROSSE (W)	5L	428,575	55.00%	451,000	55.00%	455,000	55.00%
SE. MICH	6A	506,692	42.00%	559,000	43.00%	546,000	42.00%
N/W LOWER MI	6B	700,471	50.00%	718,400	50.00%	687,500	50.00%
IND/KY	6C	907,026	52.00%	988,000	52.00%	988,000	52.00%
NW OHIO	6D	856,284	51.00%	858,840	51.00%	867,395	51.00%
NE OHIO	6E	792,745	49.00%	833,000	49.00%	784,000	49.00%
S. OHIO	6F	674,658	37.17% *	737,000	40.00%	705,200	40.00%
				* Est. Average for year			
NEW JERSEY	7A	1,091,138	50.00%	1,100,000	50.00%	1,120,000	50.00%
NEW ENGLAND	7B	1,062,188	54.20%	1,096,425	54.40%	1,100,142	54.00%
METRO NY	7C	590,571	49.00%	618,750	49.50%	625,000	50.00%
UPSTATE NY	7D	491,070	39.90%	523,556	42.03%	513,000	42.00%
NE PENN	7E	1,229,082	46.00%	1,104,000	46.00%	1,104,000	46.00%

Shaded areas reflect notification of plan changes received since the April 2013 Church Council meeting.

Footnote Revised 8-6-13

**2014 Synod Mission Support Plans
With 2012 Actual and 2013 Plans**

SYNOD NAME	#	2012		2013		2014	
		ACTUAL	MS %	SYNOD PLANS		SYNOD PLANS	
SE PENN	7F	1,088,811	48.39%	1,113,000	53.00%	1,050,000	50.00%
SLOVAK ZION	7G	19,162	30.00%	20,000	30.25%	19,200	30.40%
NW PENN	8A	427,873	50.00%	415,987	50.00%	420,124	50.00%
SW PENN	8B	812,055	50.00%	785,650	47.50%	785,650	47.50%
ALLEGHENY	8C	355,064	43.84%	382,500	50.00%	345,000	50.00%
LOW SUSQ	8D	1,344,545	46.50%	1,534,500	46.50%	1,218,000	51.60%
UPP SUSQ	8E	481,333	50.00%	512,500	50.00%	488,500	50.00%
DEL-MRYLND	8F	1,092,029	53.50%	1,090,000	54.50%	1,103,625	54.50%
METRO DC	8G	883,755	50.00%	850,000	50.00%	850,000	50.00%
W. VA/W.MYLD	8H	203,185	45.00%	191,484	37.50%	191,507	37.50%
VIRGINIA	9A	616,070	38.00%	682,500	39.00%	627,064	38.20%
NO. CAROLINA	9B	1,122,047	38.69%	1,000,000	36.82%	1,000,000	36.59%
SO. CAROLINA	9C	1,025,743	41.50%	1,043,750	41.75%	1,071,000	42.00%
SOUTHEASTER	9D	1,086,811	50.00%	1,103,150	50.00%	1,108,650	50.00%
FLORIDA-BAHA	9E	1,009,691	46.00%	1,034,000	47.00%	1,060,800	48.00%
CARIBBEAN	9F	35,000	17.22%	40,000	17.22%	40,000	18.00%
TOTAL REMITTANCES		\$49,871,823	48.51%	\$50,526,518	48.68%	\$50,693,155	49.21%

**Summary of the Questionnaire for the Class of 2013 Church Council Members
Research and Evaluation
Evangelical Lutheran Church in America
Kenneth W. Inskeep
August 6, 2013**

Eleven of the members of the Church Council who will be leaving the Council after 2013 responded to the online questionnaire.

The Constitutional Responsibilities of the Church Council

Of the responsibilities given to the Church Council by the *ELCA Constitution*, the respondents rated the Council's accomplishments above 4 (on a 5 point scale from 1 "not well" to 5 "very well") on the following responsibilities (scores for the 2013 class are in bold with the scores for the 2011 class in italics):

- submitting a budget proposal for approval by the Churchwide Assembly (**4.6**, *5.0*).
- adopting policies for the whole church (**4.4**, *3.7*).
- acting on resolutions from synod councils (**4.3**, *4.3*).
- providing for the installation of churchwide officers (**4.3**, *4.3*).
- adopting the personnel policies for the church (**4.1**, *4.0*).
- determining the appropriate churchwide unit for the fulfillment of the particular program or policy responsibilities identified in the bylaws (**4.1**, *3.9*).
- establishing the criteria and policies for the relationships between this church and independent, cooperative, and related Lutheran organizations (**4.2**, *3.9*).
- exercising the responsibility for the corporate social responsibility of this church (**4.3**, *3.9*).

The following responsibilities were rated below 4:

- establishing ranges for the salaries for the presiding bishop, secretary, and treasurer (3.6, *3.9*).
- reviewing the procedures and programs of the churchwide units to assure that churchwide purposes, policies, and objectives are being fulfilled (**3.6**, *3.6*).
- reviewing and acting on the policies of churchwide units (**3.9**, *3.4*).

How has the work of the Church Council been strengthened?

Respondent #1 – I'm not so sure it has been strengthened.

Respondent #2 - The Council has a stronger voice than when I was first elected, partly because Council members in our class and earlier ones named the concern that the Council was becoming little more than a rubber stamp, asked for information in a timely manner and took more responsibility. Sharing information with Council members has also become much easier since documents can be posted on Net Community.

Respondent #3 - I believe that the Church Council has been weakened when we passed legislation at the 2011 CWA that allowed the executive committee to add Council members that they deem necessary. Many Church Council members did not even realize that they had recommended this action to the CWA. I was not able to attend the April 2011 Church Council meeting that passed this action. I later learned that this action was part of the en bloc and was passed with no discussion. This is another manipulation of the system to move a personal agenda of the executive officers. An action as important as this should never have been placed in en bloc. This action gives more power to the Executive Committee and weakens the CWA by allowing them to hand pick members of the Church Council that think "the right way". The talk of diversity is a joke. It should be called racial diversity. Racially, we as a church are

working in the right direction. When it comes to anyone with a political belief different than the Executive Committee, they are not accepted at all.... Diversity comes in many forms. It appears that the only diversity the churchwide organization is interested in is if it makes them look good. If you look at reality, we have done an extremely poor job of bringing diversity to the congregations of the ELCA.

Respondent #4 - In the last six years, there has been a great trust developed between Council members. The Council also was strengthened as we worked through difficult issues specifically the human sexuality social statements and policies surrounding it. The restructuring and downsizing of the churchwide offices was also a difficult task and provided a prolonged time of transition. There was much anxiety during these years and the open and honest dialogues as well as support shared provided for a stronger Church Council.

Respondent #5 - I believe that at times, the Church Council gives input on decisions.

Respondent #6 - It was working fine when I joined it and it still is.

Respondent #7 - My time on the Council has really been too short to comment on this.

Respondent #8 - By expanding the role of the Advisory Bishops, specifically by including the Chair of the Conference of Bishops as a voting member of the Church Council and as a member of the Executive Committee.

Respondent #9 - Open communication between the Council and the Presiding Bishop and Conference of Bishops has increased. The three leadership tables is an excellent addition and should continue.

Respondent #10 - Board Development Committee has worked hard to "gel" the group. I think each year we learn a little more and get a little better as a board and as a church!

Respondent #11 - Faithful leadership during turbulent times; board development primers; anti-racism training and process observation; intentional listening times in agenda; communal discernment practices.

What suggestions would you offer on how the work of the Church Council could be improved?

Respondent #1 -

- a. I strongly recommend a different seating arrangement or room be found for Council meetings, one in which each council member would be on the same level and have eye contact with every other council member;
- b. I suggest one meeting early in the three year cycle when Conference of Bishops' meeting and Council meeting could overlap. This could enable a time for bishops and council member(s) from assigned synods to meet and discuss how they could effectively work and communicate with each other;
- c. Could Council members be consulted and asked for advice before important decisions are made? d. Re-examine the use of quotas. Is there room for wise and experienced voices? e. Consider moving to three meetings a year.

Respondent #2 - As at large members are added with specific expertise, make sure they are utilized according to their gifts. I'm not sure that was done in my case, but fortunately it worked out. Continue the process of engaging the Council in active, informed decision-making, not just passing off on pre-determined outcomes. Continue examining the ways in which diverse voices are or are not included.

Respondent #3 - Stop pushing political agendas and let's get back to preaching the gospel and doing God's work. The best part of the ELCA is our association with Lutheran World Relief, Lutheran Disaster Relief, Lutheran Services in America. The works that we participate in around the world is what has kept me sane during my 6 years on church Council. Also, stop manipulating the system and let the system work as it is designed. An example of this is when we had a conference call on a Friday before major cuts in the churchwide staff were made. The executive officers pleaded with the Council to pass these cuts so the people affected could be told ASAP and they would be able to move on. We passed the action. On Monday an announcement was made "Church Council makes major cuts to churchwide staff". Another

example is when the Church Council refers an action for consideration to the CWA, it is presented that the Church Council recommends passage of this action when we did not recommend it, but simply referred it to the CWA for consideration.

Respondent #4 - The good work of the Church Council is dependent on the level of trust between Council members, officers and churchwide units. Taking time to develop and nurture those relationships is integral to our work together. More time for group building, sharing and learning about the jobs in the units and how they fit the missional objectives is important.

Respondent #5 - There needs to be clearer communication. Too many decisions come to the Council already signed, sealed and delivered. Council needs to be included earlier in the process.

Respondent #6 - More diversity for more alternative ideas.

Respondent #7 - It is a large group. Any time one can brainstorm in smaller groups it is a good idea because it means everyone is more likely to have voice and make a contribution.

Respondent #8 - Have a Church Council retreat in order to foster better communication and understanding among members of the Church Council (this is already being planned).

Respondent #9 - A retreat to help new members and old get to know each other is needed. Conference calls between meetings is helpful to take care of business so regular meetings are not too jam packed with content.

Respondent #10 - I wish it wasn't so expensive to have us there because if the meeting could be lengthened to have more "free" time for socializing, more breaks for mental renewal, and earlier evenings to get a good night's sleep before each day of meetings, I think everyone would benefit.

Respondent #11 - Prioritize reading - clearly identify background reports and information.

What ways do you see that your leadership as a member of the Church Council has had an impact within the ELCA?

Respondent #1 - I am not sure my leadership has had an impact.

Respondent #2 - I don't know that any particular thing I have done on Council has had an impact on the wider church, but I would hope that I have been a voice of reason and someone who is not afraid to name concerns and potential problems with proposals, rather than tacitly signing off on them.

Respondent #3 - I am extremely disappointed in the time I have spent on the Church Council. I have met many wonderful people and I am very grateful for that opportunity. The Council members are used as a tool of the executive officers to get their agenda passed. I have a real serious problem with a governing church body being so closely tied to one political party. It does not matter which party it is. I believe that we have been spoon fed an agenda that supports the agenda of a political party and it has been wrapped up and called religion.

Respondent #4 - It has been a difficult task but I have felt called to continue to look at ways the Church Council is more involved and accountable to the decisions brought before it. Since my time on the Council, there has been an ongoing concern that we are rubber-stamping what comes forward from the officers or the units of the ELCA without really having much discussion. Also, continually looking at ways that we are becoming a more diverse Council, hearing all voices and lifting up voices that may not be present has been a place where I have given leadership.

Respondent #5 - I feel that a Council member is a steward of that role, and in that way, I feel I was a good steward.

Respondent #6 - Particularly working on Social Statements.

Respondent #7 - I'm not sure what impact that I've had since I was on the Council a short time, but my congregation is better informed. I'm privileged to sit as an advisor on our synod council and I report to them after our Council meetings.

Respondent #8 - I have tried to ensure that the changes to churchwide organization have been properly reflected in the Constitution, Bylaws and Continuing Resolutions of the ELCA in conjunction with the Secretary.

Respondent #9 - I feel that the committee work has had many direct impacts. I believe the work on LIFT has had the most impact on the ELCA and on me. The opportunity to learn about all aspects of the greater ELCA has been incredible.

Respondent #10 - I suppose our legacy was surviving and dealing with the repercussions of the 2009 decisions. I think we worked really well with that. I honestly believe that our group's ability to have retreats our first few years strengthened our group so that when we got into the toughest debates we knew who was on what "side", yet always had the ultimate respect for everyone in the room. After votes were cast, folks from opposite sides of the issue could sit down for dinner together as friends. I have not known the newer classes nearly as well as I feel I knew the former classes with whom we were able to retreat. I know money here is still an issue. But I wish we could figure something out.

Respondent #11 - New programs; discernment of new work and processes; strategic planning and organizational development; intentional listening time; interaction between Conference of Bishops and the Church Council.

What are your thoughts about the way communal discernments practices were used at meetings and what thoughts do you have for communal practices at future meetings?

Respondent #1 - Any attempt to promote more discussion of issues before the Council is good. There still are too many votes taken without discussion.

Respondent #2 - I thought communal discernment worked well, generally, but wish there had been more time for it. This was a high point of the one retreat we had in my term, which, sadly, was not continued. I hope future classes are given this opportunity.

Respondent #3 - A nice try, but no follow up. When issues are identified where we did not do a very good job, we don't seem to make adjustments to correct the problems.

Respondent #4 - Communal discernment has been helpful and is much needed practice in the work we have done and will continue to do.

Respondent #5 - It seems that there needs to be more work in building relationships on the Council, so that we can work together with greater trust, and input from more participants.

Respondent #6 - It seems normal.

Respondent #7 - I think in my short time I have only glimpsed a little of this and have greatly appreciated what I have experienced. Stopping for prayer is important. Identifying prayer concerns of the Council members brings us together as a community to work better together.

Respondent #8 - I think that all members of the Church Council are by nature caring respectful individuals and I think that filling out the communal discernment forms and having the process observation comments at the end of Church Council sessions was largely superfluous.

Respondent #9 - I really appreciate the communal discernment process and would like to see it applied more directly to the specific policy issues we wrestle with. I feel we go deeply into the Bible passages but not always into the social issues we discuss.

Respondent #10 - I never really got it. I probably should have. But, honestly I never really understood what it was, what we were doing, and how it was supposed to help us. I mean, yes, I get the overarching concept and the point of trying to get to a better way of discerning and I think that's noble! But I'm not sure what we were doing was the right way. I may be totally alone here and if so let's just chalk it up as something I didn't get because I'm not as smart as everyone else or don't have as many gifts in that area. Maybe it was just over my head. Let's also be clear I certainly couldn't come up with a better way to do it. It's just one of those things that's just darn hard.

Respondent #11 - Use of prayer during meetings is great; perhaps more time for sharing in small groups around issues that need to be decided, rather than imparting information (Cafe Conversations.) Intentional Dwelling in the Word for faith sharing and ongoing "devotional witness" i.e. the former "Dwelling in the Word" moments by Church Council and Conference of Bishops. I would love to see bishops leading Bible study breaks with small groups much as we have done at CWA...anything to establish and build trust between the members of the three leadership tables.

This page left intentionally blank