Continuing Partners in Ministry

Proposal for Providing Health Benefits to Faculty and Staff of ELCA Seminaries

Submitted by Portico Benefit Services
July 12, 2012
Revised August 13, 2012

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Benefit Services | A Ministry of the ELCA

Introduction

The ELCA seminaries and Portico Benefit Services have enjoyed a 25 year partnership of providing a full spectrum of benefits to seminary faculty and staff. We understand and support the unique role each seminary plays in the ELCA's mission in preparing rostered leaders for ministry.

In response to changing times in health care across our country and the changing needs at ELCA institutions and seminaries, Portico is prepared to create a plan specially designed for ELCA seminaries. The new plan will be available January 1, 2013.

Our proposal is built on meeting your primary goals:

1. Coverage flexibility in the form of alternative plan design choices at the seminary level.
2. A pricing approach that more closely recognizes the actual claims experience of the ELCA seminaries as a group.
3. More flexibility to help manage costs through contribution and benefit eligibility policy.

Each of these goals is addressed in more detail in the following sections. As your decisions become clear for 2013, we will work with you to help communicate changes to your employees.

In addition, we propose a more robust service model, collaboration on joint wellness projects, and enhanced claims reporting—all aimed at better managing claims costs.

Portico's professional expertise, our existing relationship with your employees, our strong relationship with high-quality benefit administrators, our connection to the ELCA's ministry, and our relationships with the wider church health plan community all work to your advantage as we continue to partner in ministry.

Our effective stewardship has been demonstrated through significantly lower growth rate of contribution rates when compared to the national average. From 2007-2011, Portico's rates increased by 21.5% while U.S. employers average increase over the same period was 31.3% according to a Kaiser/Health Research & Educational Trust survey conducted in 2011. In addition to the benefits of lower cost and increased member health we've experienced with our wellness focus, our plan is 15% more efficient than the average of 700 U.S. employers analyzed by Towers Watson and 7% more efficient than the top quartile in their database. We exist to serve you and your employees; we are proud to do so very well.

Proposal

Plan Design Options

Based on our recent conversations with you, Portico is prepared to offer two plan designs from which you can choose to offer your employees. Each plan design will continue to offer a package of medical, pharmacy, and dental benefits, plus existing wellness resources and claims management programs. Based on what you told us, we believe the following designs will meet your needs.

1. The current plan, designed such that employees pay about 20% of allowed claim costs through deductibles, coinsurance, and copayments. Wellness incentives in the form of credits toward our Personal Wellness Account will continue.
2. A high-deductible health plan, designed such that employees pay about 34% of allowed claim costs. The plan will be accompanied by an employer-funded health savings account. Employees and spouses will be able to earn wellness incentives.

Designs: We will offer the following 2013 designs (and pricing) to the Portico trustees at the August 2012 meeting for their approval. Assuming approval is obtained, the designs will be submitted to the ELCA Church Council for final approval. While we believe approval will be obtained, these designs should be considered in that context. The table contains in-network benefits. Separate parameters apply to out-of-network claims.

	Current Plan Design	High Deductible Plan
Deductible	Individual: $1,000 per year Family: $2,000 per year	Individual: $2,000 per year Family: $4,000 per year
Employee share of costs above the deductible	In-network: 15 %	In-network: 20%
Annual out-of-pocket maximum	Individual: $3,600 Family: $7,200	Individual: $2,500 Family: $5,000
Preventive care	100% coverage	100% coverage
Pharmacy benefit	Designed to achieve 25% member share of costs	All pharmacy costs are subject to overall deductible
Wellness incentive	Up to $500 of incentives for completing wellness activities credited to Personal Wellness Account	Up to $500 of incentives for completing wellness activities credited to Health Savings Account
Health savings account	Not available	Employer chooses funding amount
Dental benefits—continuation of current benefit	Initial deductible, coinsurance varies by procedure type, maximum annual benefit.	Initial deductible, coinsurance varies by procedure type, maximum annual benefit.

We estimate the high deductible plan contribution rate will be approximately 84% (including dental) of the current plan design contribution rate.

Since we are considering 2013 as a pilot year, special administrative considerations may apply to seminaries that choose to offer the high deductible plan option. For example, administration of sponsored couples working at different employers and employees who work for more than one ELCA employer may present benefit administration and/or billing issues that require special temporary solutions.

Wellness components: All employees, regardless of plan design chosen, will have continuing access to Portico's wellness benefits—Mayo Clinic's health assessment, website tools and lifestyle coaching, Optum's nurseline, and Blue Cross's Whole Person Health condition management program.

Subject to Portico trustee approval in August, we plan to offer Blue Cross's fitness center discount program in 2013 for all sponsored health plan members.

Seminary choices regarding plan design: Each seminary can choose to offer either or both of these plans to its employees. If a seminary decides to offer both plans to employees, it may want to designate the high-deductible plan as its "base plan" for which the seminary will pay up to 100% of the contribution rate. Employees choosing the current, richer plan design would be required to pay the difference in contribution rates.

As you make this choice, you may want to consider the following:

1. Choosing to offer only the current plan is likely the least disruptive to employees.
    a. Employees are accustomed to how the medical deductibles and pharmacy copayments work.
2. Adding a high deductible plan, either alone or in combination with the current plan, will require much more employee communication.
    a. Employees will need to understand the differences between the current plan and a high deductible plan. Situations could occur where employees are surprised and confused.
    b. Overall, we believe employees will pay about 14 percent more of the allowed costs under the high deductible plan design.
    c. Someone on the seminary staff may need to be prepared to answer some of their questions.
3. Employees may likely be more engaged in making prudent health care choices when covered by a high deductible plan. The purpose in creating these plans was to save health care costs by placing more responsibility on employees.

Pricing: Experience Rating

Portico maintains a risk pool containing more than 25,000 lives (employees and dependents). The seminary pool (excluding Southern) will include about 750-800 lives (employees and dependents). ELCA seminaries are currently combined in a common rate class.

In our conversation with the seminary presidents on June 20, 2012, we outlined three methods for determining future contribution rates. Based on those conversations we recommend a rating approach that preserves the "one rate for all seminaries" concept, but includes experience rating for 2013 and later as described below.

1. Portico will create a seminary-only rate class. The contribution rates will be adjusted up or down from the pooled rates using an experience rating approach.
2. Seminary claims and contributions will be aggregated over successive three-year experience periods. The ratio of aggregate claims to aggregate contributions will be calculated and referred to as the Seminary Loss Ratio (SLR).
3. The same calculation will be made for the entire risk pool using expected claims and contributions estimated as part of the pricing process. Call this the Pricing Loss Ratio (PLR).
4. Portico will calculate a Credibility Loss Ratio (CLR), giving 80% credibility to the experience of the seminary group. The CLR will equal:
    - 80% of the SLR, plus
    - 20% of the PLR.
5. Portico will then determine the rate adjustment for the next plan year as:
    - CLR/PLR
    - This adjustment will be multiplied by the appropriate contribution rate for the net plan year determined for the pool to reflect the combined seminary experience. If CLR/PLR is less than 1.000 the adjustment will be downward, and if CLR/PLR is greater than 1.000 the adjustment will be upward.

Applying this approach to 2013 rate setting, we will use claims and contributions incurred during the three year period 2009-2011. On this basis, the experience of the seminary group compared to our pricing assumptions will lead to a 7% downward adjustment in the 2013 rate. If you have any additional questions about how this might impact your seminary in 2013, please contact us.

Seminary choices regarding pricing: When considering this approach, you should compare it to the current model which combines all seminary claims data with that of the entire risk pool for purposes of establishing contribution rates. The experience rating approach:

1. Responds to the claims experience of the seminary group. It rewards your efforts at engaging employees in healthy behavior by capturing related claim savings.
2. Rate volatility that generally accompanies a smaller risk pool will be moderated by combining all seminaries together, by using a three-year rolling experience, and by assigning 80% credibility to the seminary experience.
3. We require all seminaries to adopt the same rating approach, and have assumed in this proposal that you will agree to use the 3-year experience rating approach.

Cost Sharing

The third goal noted above goes beyond plan design and pricing approaches to one of managing costs through administrative policies such as requiring employees to pay a portion of the contributions or by redefining the pool of benefit-eligible employees. Plan changes of this nature will ultimately go before the ELCA Church Council.

We recommend that each seminary first decide the level at which it expects employees to share in the cost of health coverage. An administrative policy that requires employees to pay a portion of the contribution, separate from (in addition to) their share of out-of-pocket medical costs could be implemented. The contribution policy could be different for employees and dependents.

Portico will work with each seminary as needed to assist in the development and analysis of a strategy that meets its desired cost-sharing target, and help craft messaging for employees.

We understand that some seminaries may choose to raise the minimum number of hours per week at which employees are benefit-eligible. We can accommodate your decisions in this regard.

Seminary choice regarding cost sharing: The choice regarding contribution policy and benefit eligibility will be made at the individual seminary level. When making this choice, consider:

1. Employee satisfaction may decrease if more costs are shifted to them.
2. The seminary's reputation as a desired employer could be affected.
3. A formal, public adoption of these changes will require approval by the ELCA Church Council.

Wellness Focus

Since 2008, Portico has been a leader in offering a health plan that focuses on helping plan members improve and maintain their health, while building member awareness of making prudent financial choices when engaging the health care system. We have partnered with benefit administrators that also subscribe to that approach – Blue Cross Blue Shield of MN (BCBSMN), Mayo Clinic Health Solutions, Express Scripts, and Optum Nurseline.

Risk profile data from our 4-year cohort of health assessment participants, high utilization rates of our preventive service benefits, high utilization of Mayo's lifestyle coaches, high care management programs, our very high generic fill rate, and exceptionally high utilization of the ELCA NurseLine℠ all point to improved health and cost efficiencies since 2008. As a result, our contribution rate increases from 2007 to 2011 have averaged about 3% per year compared to a rate of about 4.6% per year experienced by other self-insured U.S. employers, per a Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2011.

We believe our wellness efforts are having a positive impact on the health and ministry of our members – and so do our members. Visit our website at www.PorticoBenefits.org/livewell to read what our members are telling us. Our wellness voices are a strong testimony to the work we have done.

We are strongly committed to continuing our wellness focus in 2013 and beyond because we believe that healthy leaders enhance lives. To that end, we desire to partner with you to define, implement, and evaluate pilot programs that have a potential impact on employee health.

Claims Management

In combination with our wellness focus, Portico utilizes many of the claim management programs offered by our benefit administrators. BCBSMN has one of the strongest and widest provider networks in the industry. As a result, our in-network penetration is about 99%. This saves all employers money since the BCBSMN provider discounts are among the industry's highest. In addition, BCBSMN's case management capability and their Whole Person Health Care Management program return explicit plan savings.

Express Scripts' pharmacy management programs such as prior authorization and step therapy have been proven to reduce excess drug costs. Portico also participates in a Church Benefit Association pharmacy purchasing coalition which enables us to obtain significantly better administrative fees than we could obtain by ourselves.

Implementation of these and other similar programs on an efficient scale has been possible due to the substantial size of our risk pool.

Administration & Service Model

Portico will create a multi-disciplined service team for each seminary consisting of representatives from our Member Services, Outreach Education, and Products & Services areas. Each team will be dedicated to respond to your environment, your needs, and your desires as a significant ELCA employer.

We will do this through:

1. On-site assistance in conducting open enrollment in November, as needed.
2. Quarterly contact with you, either in person or via conference calls to help you manage the benefits for your employees.
3. Informing you regularly regarding program and service enhancements being worked on at Portico.
4. Annual meetings with representatives from all seminaries as a group to discuss common goals, achievements, and concerns.

Technology enhancements are coming this summer in the form of an "employer link" on our website which will facilitate online bill payment, enrollment changes, and changes reflective of member choices such as pre-tax contributions to the ELCA Retirement Plan. In addition, we will introduce "My Portico" for members – online functionality that enables members to initiate appropriate transactions and verify the accuracy of

compensation and enrollment data. These system enhancements will also enable Portico to communicate more directly and efficiently to employers and employees on a variety of important topics.

Timeline

The following timetable describes how collectively we get to a January 1, 2013 launch of the new approach for seminaries. The schedule is tight, particularly in the next few weeks.

1. Portico delivers its proposal for 2013 health benefits on July 10, 2012.
2. Seminaries confirm agreement to the experience rating approach described above by July 13, 2013.
3. Portico meets with Executive Committee of the Conference of Bishops on July 12, 2012 and with the Lutheran Center Administrative Team on July 13, 2012 to address questions about the new approach.
4. By July 18, 2012 all seminary presidents and Portico president sign off on commitment to recommend the proposed approach to their respective boards.
5. In July and August, seminary and Portico boards approve proposed approach.
6. During the week of September 17, a special Church Council meeting will be conducted to approve the terms of the proposal.
7. Seminaries communicate changes to employees in September/October 2012.
8. Portico develops enrollment materials and plan design information during September and October 2012. Open enrollment in November 2012.
9. January 1, 2013 implementation.

Summary

Portico is committed to continuous and improved service to the ELCA seminaries. This proposal describes a distinct departure from the previous model. Offering multiple plan design options, creating more transparency around cost sharing, and re-defining our service model will only enhance the value you and your employees already receive from Portico.

We believe that value is created through the following:

1. One stop shopping for all of your employee benefits
2. Access to professional expertise in risk taking and pricing
3. Communication, wellness service, and technology
4. Non-profit focus and full risk retention capabilities that provide superior stewardship of health care dollars
5. Relationships with major benefit administrators who bring expertise, innovation, and size to the table
6. Church Benefit Association relationships, which enable the creation of purchasing coalitions containing hundreds of thousands of lives
7. Our collective and shared ministry as part of the ELCA
8. Continuity for your employees—they continue their relationship with their current health care providers

9. A shared commitment to continued innovation to enhance the well-being of the employees and seminaries.

Thank you for your past participation in the ELCA Pension and Other Benefits Program. We look forward to partnering with you in a new way.

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IN BRIEF
For Use by Portico Benefit Services and ELCA Leadership

August 17, 2012 DRAFT

2013 Health Plan Pilot for Seminaries

Background

This year, in response to the changing health care landscape and mounting financial pressures experienced by ELCA organizations, Portico Benefit Services agreed to work with ELCA seminaries to offer them, via a pilot project, a new 2013 health plan option catering to the needs of institutions.

As a group, the seminaries are looking for three things to better manage health costs:

- Alternative plan designs
- Pricing that more closely reflects the claims experience of the seminaries
- Change in policies currently limiting their ability to decide benefit eligibility and level of employee contribution

One of the roles our benefits program plays is to keep benefits from being an issue in the call process. We were open to modifying our benefits program, on a pilot basis, for the seminary group because mobility is less an issue for seminary employee populations (70% lay, 30% clergy) than it is for congregations (30% lay, 70% clergy).

In changing times, Portico Benefit Services embraced this opportunity to identify new creative, cost-effective ways to serve ELCA employers and their employees.

Status

In July, we submitted a proposal describing a new health plan design option and a new pricing strategy. In addition, it identifies steps and consequences related to changing benefit eligibility and contribution policies.

Two ELCA health plan designs

The seminary group will have the option to offer one or both of two plan designs to their employees for the 2013 plan year.

1. The first option is our current ELCA health plan.
2. The second option differs from our current plan in the following ways:
   - Higher deductible
   - Employer-funded Health Savings Account (HSA)
   - Pharmacy costs apply to deductible
   - Lower contribution rate (stemming from high deductible plan design)

Pricing strategy

ELCA seminaries would continue to be combined in a common rate class

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2013 Health Plan Pilot for Seminaries

but their rate would be adjusted up or down using an experience rating approach. This approach creates a 7% downward adjustment in the 2013 rate.

Because the seminary group rate would be based on seminary claims experience, seminaries would realize a financial return for encouraging healthy behavior and engaging employees successfully around health and wellness.

Changing benefit eligibility and contribution policies

Seminaries are also looking for administrative plan changes to help them manage health costs.

- Cost-sharing — requiring employees to pay a portion of the contribution
- Changing eligibility — redefining the pool of benefit-eligible employees

Plan changes of this nature can be accommodated by this pilot. They have been approved by Portico Benefit Services' Board of Trustees and will be subject to final approval by the ELCA Church Council.

Implications for the ELCA

Via this pilot, seminaries would be able to:

- Pay lower costs for benefits based on their own claims experience
- Offer plan design options not yet available to other ELCA employers
- Limit eligibility of their employees
- Require employees to pay a greater share of the cost of coverage

Clearly, cost savings associated with this pilot can have a positive effect on the cost of tuition for seminarians. Graduating students with less debt is good for the ELCA — for our future leaders and the congregations they serve.

However, this pilot also raises important questions for the ELCA about alignment, whole-person health, equity and mobility.

Alignment

Q: How does this seminary pilot affect the whole church?

A: This proposal provides the seminaries with flexibility and options to help them remain in the ELCA plan. Currently, they have varying opinions about how best to reduce costs. This pilot offers flexibility so that each seminary can make its own choices about plan offerings, benefit eligibility and cost-sharing. We have consistently made the point that it is in the best interests of this whole church that we remain in the plan, together.

Whole-person health

Q: Will this pilot compromise our collective emphasis on health and wellness?

2013 Health Plan Pilot for Seminaries

A: No, it will support it. In fact, it could become a model for other ELCA employers.
- Seminaries prepare leaders to lead effective lives in ministry, and it's essential that seminaries train and model behaviors that help future leaders learn to be healthy leaders. The proposed plan designs and our continued partnership support that wellness training.
- Seminaries have consistently put a high emphasis on wellness, and their efforts are having a positive impact. New pricing that more closely reflects the seminaries' loss experience as a group would allow them to lower their cost for 2013.

Equity

Q: Will a lower seminary rate increase costs for congregations sponsoring employees in the ELCA health plan?

A: No. Several years ago, the seminaries agreed to a common rate, and their loss experience (claims cost/contributions) has been better than the ELCA overall. That means they have been contributing a surplus into the Medical Trust. With new pricing, seminary rates will more closely reflect their loss experience as a group, and they'll most likely pay contributions closer to their claims. The impact of this surplus, however, has not been great enough to create price increases going forward for our larger population.

Mobility

Q: If seminaries can charge employees for health care coverage, why can't congregations opt to, as well?

A:
- This pilot is only a first step. It is giving us an opportunity to work with Church leadership and gain experience prior to updating the ELCA health plan in 2014 to coordinate with changes stemming from health care reform.
- We are piloting these changes in the seminary context where mobility is less of an issue than for congregations, and change is less likely to impact to the call process. Unlike our larger population which is predominately clergy, the majority of seminary employees are lay employees.

Seminaries compete in the market for employees and need to offer competitive compensation and benefit packages.

Role of ELCA social statements

- We have read the social statements on economic life and health, and they are informing our thinking. The social statements give us valuable evidence of how the church has informed the benefit program for the sake of ministry.
- The social statements are being used to review and potentially revise the ELCA Philosophy of Benefits — a collection of benefit statements and principles established in ELCA documents and historic practices that have guided the ELCA benefit program. That work has been applied

directly to the creation of this pilot.

- It is fair to ask the seminary leadership how they are applying the social statements to their decision-making regarding benefits. Example: Changing eligibility places an employee at risk of having no health insurance coverage.

This pilot project supports key parts of the ELCA's health and economic life social statements — that health care is a shared endeavor, and that stewardship and openness to change are expressions of God's promise to provide.

> From *A social statement on health, healing, and health care … Caring for Health: Our Shared Endeavor:*
>
> "Caring for one's own health is a matter of human necessity and good stewardship. Caring for the health of others expresses both love for our neighbor and responsibility for a just society. As a personal and social responsibility, health care is a shared endeavor."

The ELCA benefit program is a "shared endeavor," a collaboration involving Church, synods, congregations, other employers, and the individuals supporting them. While this pilot allows some tinkering with the ELCA Philosophy of Benefits, it is, in fact, providing flexibility in changing times to enable this shared endeavor to continue.

> From *A social statement on economic life … Sufficient, Sustainable Livelihood for All:*
>
> "While economic reasoning assumes that resources are scarce relative to people's wants, we affirm that God promises a world where there is enough for everyone, if only we would learn how to use and share what God has given for the sake of all."

Working individually and collectively to better steward our resources — our physical health, our finances, our communities — is an expression of God's promise. To best steward limited resources, we need to "learn how to use and share what God has given us," be open to new opportunities, be willing to change our assumptions, be disciplined about maintaining one's health, be ready to use benefits more cost-effectively, and be willing to pay a little more so that others may benefit.

This seminary pilot is an exercise in stewardship. By modifying assumptions, we are testing a new way to deliver benefits in a more cost-effective manner. This new approach could reinforce our collective

2013 Health Plan Pilot for Seminaries

	attention to health and wellness time — in time for us, collectively, to adapt to the fast-changing national health care landscape.
Current health plan is competitive	• Significantly lower growth in contribution rates when compared to the national average. From 2007 – 2011, our rates increased by 21.5% while U.S. employers' average increase over the same period was 31.3%, and averaged about 3% per year compared to a rate of about 4.6% per year experienced by other self-insured U.S. employers. • Early wellness leader — Since 2008, our innovative plan design has helped plan members: - Improve and maintain their health - Make prudent financial choices when using their health benefits and the health care system • Partner with wellness-oriented benefit administrators — Blue Cross Blue Shield of MN, Mayo Clinic Health Solutions, Express Scripts and Optum Nurseline • Contracting with Express Scripts to administer our prescription drug benefit together with other denominations via the Church Benefit Association • Improved health and cost efficiencies since 2008: - Positive change to risk profile data for 4-year cohort of health assessment participants - High use of preventive benefits, Mayo Clinic lifestyle coaches and care management - Very high generic fill rate - Exceptionally high use of the ELCA NurseLine℠

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Plan Document

ELCA Medical and Dental Benefits Plan

EVANGELICAL LUTHERAN CHURCH IN AMERICA
MEDICAL AND DENTAL BENEFITS PLAN

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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.

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 of the following criteria:

(a) The ELCA, or an ELCA synod, seminary or Churchwide Entity 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 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 Entity, 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 Entity 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 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-month 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 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 November 1-30 of each calendar year, with coverage becoming effective the following January 1. Eligible Employees enrolling during this period shall have no Applicable Waiting Period.

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.

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-month 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 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 of the following age or disability requirements to be considered an Eligible Child:

(a) is under age 26 and is not eligible to enroll in an eligible employer-sponsored health plan; 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 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 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.

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-month 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 on any subsequent date, provided that such coverage is requested in an acceptable manner form 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-month 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 Participating Employer of a Sponsored Member is responsible for the payment of all contributions associated with membership of the Sponsored Member. The Participating Employer is also responsible for remitting to Portico Benefit Services the contributions 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 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 extent to which a Sponsored Member's Eligible Dependents are enrolled.

(b) Variations in the level of medical and dental costs by geographic area.

(c) The availability to such Member of primary medical coverage under Medicare.

Section 7.03 Special Rules Where Two 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 or More Participating Employers.

(a) If both are employed by Participating Employers, the Members shall designate which one is to be enrolled as the Sponsored Member and which one 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 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 by Participating Employers. The total contribution shall be based on the couple's total Defined Compensation and allocated between the respective Participating Employers in a manner determined by Portico Benefit Services.

(b) When a Sponsored Member is employed concurrently by two or more Participating Employers, each employer shall contribute based on 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 to each Employer in proportion to the Defined Compensation paid by that Employer.

Notwithstanding the above, an ELCA seminary will make contributions for such Sponsored Members as described in Section 17.20 (e).

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 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 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 of the following requirements on December 31, 1987:

(1) The individual had attained age sixty-two (62);

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

(3) 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 Option described in Article XI 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-year period immediately preceding her/his Separation from Service. Only a four-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 or 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 Medicare Supplement Benefit Option 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, as determined by Portico Benefit Services, in its sole discretion:

Year Individual Attained Age 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 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 (up to a maximum of $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. The reimbursement shall be equal to the SMI premium paid by the Member (up to a maximum of $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 Medicare Supplement Benefit 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 .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 Eligible Spouse of a Retired Member.

(iii) For a Surviving Eligible Spouse, the percentage calculated in subparagraph (i) multiplied by .75.

For purposes of calculating the above percentages, a “year” shall be expressed by omitting the first two digits (e.g., the “year of birth” of an individual born in 1950 is 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. 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. An ELCA-Primary Member 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 Medicare-Primary Benefits Coverage. A Member is a 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.

A 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 a Medicare-Primary Member who 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 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 Medicare-Primary Members. The Plan will reimburse certain Medicare-Primary 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. If a Member has a mid-year change of benefit 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:

(a) From ELCA-Primary Benefits Coverage to ELCA-Primary Benefits Coverage for (i), (ii) and (iii) above:

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

Medical and Mental Health Expenses.

(ii) 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.

(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.

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 a 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 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):

(1) 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.

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

(3) 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:

(1) 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.

(2) If the divorce decree or other court-approved custody document

does not establish responsibility for the child's medical expenses, then where there are two or more plans:

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

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

(cc) 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 percent (35%) 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 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 percent (15%) of such expenses in excess of the In-network Deductible Amount until the Maximum In-network Out-of-Pocket Amount has been reached.

The applicable per-Member In-network Medical and Mental Health Deductible Amount for which the Member is responsible is shown in the Appendix. 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 the maximum Deductible Amount for the type of family coverage elected by the Member. See Appendix for applicable amount.

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 Expenses. The Maximum In-network Out-of-Pocket Amount the Member must pay pursuant to Section 10.04 for Deductibles and Percent Copayments for In-network Eligible Medical and Mental Health Expenses incurred in a calendar year is shown 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. 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 percent (35%) 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 applicable per-Member Out-of-network Medical and Mental Health Deductible Amount for which the Member is responsible is shown in the Appendix. The sum of the Out-of-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 the maximum Deductible 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 Expenses. The maximum Out-of-network Out-of-Pocket Amount the Member must pay pursuant to Section 10.06 for Deductibles and Percent Copayments for Out-of-network Eligible Medical and Mental Health Expenses incurred in the calendar year 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.

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 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; and

(iii) Administer precertification and Medical Necessity requirements with respect to Medical and Mental Health Benefits.

(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 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 percent (15%) 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-five percent (35%) 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 $10,000 for travel and lodging expenses for the Member and companion if approved in advance by the Medical and Mental Health Benefits Administrator.

ARTICLE XI: MEDICARE SUPPLEMENT BENEFITS

Section 11.01 Medicare Supplement Benefits. Medicare Supplement Benefits provide reimbursement for Eligible Medical Expenses under Medicare as defined in Section 11.05. 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 Supplement Benefits. No reimbursement of Eligible Medical Expenses under 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 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 Medicare Supplement Benefits. The maximum 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 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 Medicare Supplement Benefits Administrator. Medicare Supplement Benefits Administrator means the entity that has contracted with Portico Benefit Services to manage and administer Medicare Supplement Coverage. The Medicare Supplement Benefits Administrator shall administer Medicare Supplement Benefits, including the reimbursement of Eligible Medical Expenses.

Section 11.05 Eligible Medical Expenses Under 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) 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.

(c) 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) Other services shown in the Appendix for specific Medicare Supplement Benefits 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 Medicare Supplement Benefits.

Section 11.06 Medicare Supplement Benefit Options. The Plan shall provide the Medicare Supplement Benefit Options for Members as shown in the Appendix. A Retired Member or Coverage Continuation Member may choose from 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 a Medicare 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 standard Medicare Supplement Benefit only.

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

(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.

(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 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 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 $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 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 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 Master's-prepared therapist, provided the therapist possesses:

(i) A Master's 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 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, 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, 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 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 20% of Eligible Basic Dental Expenses and 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 100% of Eligible Expenses. The Member will pay no Copayment for Eligible Preventive Expenses and 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:

Type of Eligible Dental Expense	Reimbursement Limit
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 Section18.27.

(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 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 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 18 or younger.

(h) Space maintainers for extracted posterior primary teeth and the installation and fitting thereof, at age 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 relining or re-basing 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 ELCA Prescription Drug Coverage and ELCA Part D Drug Benefit Coverage. Members who have ELCA-Primary Benefits Coverage and Sponsored Members and their family members who have ELCA Medicare-Primary Benefits Coverage shall have ELCA Prescription Drug Coverage. 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 ELCA Part D Drug Benefit Coverage.

Section 15.02 Eligible Prescription Drug Expenses. Prescription Drug Benefits provide 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 ELCA Prescription Drug 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. 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 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 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.

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 ELCA Part D Drug Benefit Coverage. Notwithstanding the foregoing, certain additional drugs may be deemed Eligible Prescription Drugs by the Plan for 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 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 that are deemed investigational or experimental by the Prescription Drug Benefits Administrator because FDA approval for marketing has not been granted;

(c) Over-the counter medications, except insulin;

(d) Drugs for cosmetic treatment of hair loss or other cosmetic treatment;

(e) Herbal, mineral and nutritional supplements;

(f) Vitamins for preventive purposes;

(g) Drugs taken in preparation of, or in conjunction with, artificial insemination;

(h) Drugs taken for the purpose of terminating pregnancy;

(i) 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 ELCA Part D Drug Benefit Coverage;

(j) Expenses for Specialty Drugs not purchased from the Specialty Drug Pharmacy operated by the Prescription Drug Benefits Administrator for Members with ELCA Prescription Drug Coverage. However, Members with ELCA Part D Drug Benefit Coverage may purchase eligible Specialty Drugs from a Medicare-approved pharmacy;

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

(l) Drugs determined ineligible by Medicare for 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 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.

(b) 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.

(c) 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).

(d) 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.

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 Prescription Drug Coverage. The Prescription Drug Benefits Administrator shall:

(a) Contract with Participating Network Pharmacies to provide Prescription Drugs to Members who have Prescription Drug Coverage 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 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 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) 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 ELCA-Primary Medical and Mental Health Benefits shall be applied to the Member who changes mid-year to ELCA-Primary Benefits Coverage 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 7.03, where two Members are married to each other or are in an Eligible Same Gender Partnership and one is employed by an ELCA seminary; or where a Sponsored Member is employed by two or more Participating Employers including an ELCA seminary, the ELCA seminary shall pay the full contribution rate based on the Sponsored Member's Defined Compensation.

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

(g) 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.

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 Entity. For purposes of this Medical and Dental Benefits Plan, "Churchwide Entity" means each of the following: ELCA Churchwide Organization, Women of the ELCA, Publishing House of the ELCA, Mission Investment Fund of the ELCA, 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 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); or

(b) "Eligible Child" as set forth at Section 4.05 (also meeting the "Age or Disability Requirements" set forth at Sec. 4.06).

(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 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 or more Coverage Continuation Members who are Eligible Children of the same deceased Sponsored, Coverage Continuation or Retired Member shall be considered one 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 function under Lutheran Council in the USA 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 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 Entity; (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; or (j) a Medicare Health Plan Option under a Medicare Advantage plan or Medicare Cost Plus 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 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; and

(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;
(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 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.

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" 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 Appendix A.

(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 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 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.

(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.

(j) Personal Wellness Account. A "Personal Wellness Account" is the Account described in Section 20.15.

(k) Plan Year. The "Plan Year" is the calendar year (i.e., the 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, is eligible to earn Personal Wellness Account credits in accordance with Section 20.15. Notwithstanding the foregoing, an ELCA seminary Sponsored Member 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 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 Health Improvement Activity and consents to transmission of the phase one completion information from the Health Improvement Activity Administrator to the PWA Administrator. An individual who terminates ELCA-Primary Benefits Coverage 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.

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 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; and

(ii) has depleted her/his Personal Wellness Account balance.

Section 20.07 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 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, then such PWA Member, Eligible Spouse or Eligible Same Gender Partner shall have the opportunity to receive the Maximum Annual Credit Amount specified in Appendix A by completing designated Health Improvement Activities.

Section 20.08 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 Coverage is eligible to become a PWA Member with her/his own PWA Account after such Member has transitioned to 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 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 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 Health Improvement Activity, 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 Contributions.

(a) Member or Participating Employer contributions. Neither Members nor Participating Employers may make contributions to the Personal Wellness Accounts.

(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 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 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), the Personal Wellness Account can reimburse the remaining portion of such PWA Expense if it otherwise meets the requirements of this Article XX.

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 Maximum Benefits.

(a) Maximum Benefits. The maximum dollar amount that may be credited to a PWA Member's Personal Wellness Account during a 12-month Period of Coverage is specified in Appendix A. 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 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 Health Improvement Activity as reported by the Health Improvement Activity Administrator. 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 Health Improvement Activities only after credit has been earned for the phase one Health Improvement Activity. Completion of Health Improvement Activities shall be reported by the Health Improvement Activity Administrator to the PWA Administrator.

(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 Appendix A.

Section 20.16 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 PWA Expense Reimbursement Procedure.

(a) Timing. Within 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).

(c) Claims Substantiation (for claims not automatically submitted for payment to the PWA Administrator). A PWA Member may apply for reimbursement 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) Claims Denied. The appeals procedure for reimbursement claims that are denied is set forth in Article XVI.

Section 20.18 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.

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APPENDIX		
Certain Amounts Related to Benefits		**2013**
Section 10.04	**Deductibles for In-network Eligible Medical and Mental Health Expenses Other Than Preventive Services, Retail Clinic Visits**	
	• Per Member	$1,000
	• Member/spouse and member/spouse/child(ren) Maximum	$1,500
	• Member and child(ren) Maximum	$2,000
Section 10.05	**Maximum Out-of-Pocket Amount for In-network Eligible Medical and Mental Health Expenses**	
	• Per Member	$3,600
	• Member/spouse and member/spouse/child(ren) Maximum	$7,200
	• Member and child(ren) Maximum	$7,200
Section 10.06	**Deductible for Out-of-network Eligible Medical and Mental Health Expenses Other Than Preventive Services**	
	• Per Member	$1,000
	• Member/spouse and member/spouse/child(ren) Maximum	$1,500
	• Member and child(ren) Maximum	$2,000
Section 10.07	**Maximum Out-of-Pocket Amount for Out-of-network Eligible Medical and Mental Health Expenses**	
	• Per Member	$3,600
	• Member/spouse and member/spouse/child(ren) Maximum	$7,200
	• Member and child(ren) Maximum	$7,200
Section 11.02	**Deductible for Eligible Medical Expenses Under Medicare Supplement Coverage**	
	• **Option 1—Per Member**	**$0**
	• **Option 2—Per Member**	**$180**
	• **Option 3—Per Member *Member is responsible for Medicare Part B deductible and 25% of Medicare Part A deductible**	*****
Section 11.02	**Percent Copayments for Eligible Expenses Under Medicare Supplement Coverage**	
	• **Option 1—Per Member**	**0%**
	• **Option 2—Per Member**	**20%**
	• **Option 3—Per Member**	**25%**
Section 11.03	**Maximum Out-of-Pocket Amount for Eligible Medical Expenses Under Medicare Supplement Coverage**	
	• **Option 1—Per Member**	**$0**
	• **Option 2—Per Member**	**$3,500**
	• **Option 3—Per Member**	**$2,330**
Section 13.02	**Deductibles for Eligible Dental Expenses**	
	• Per Member	$150
	• Family Maximum	$300
Section 13.03	**Limits on Eligible Dental Benefits Expenses**	
	• Annual Limit Eligible Preventive, Basic and Major Restorative Dental Expenses	$2,850
	• Lifetime Limit Eligible Orthodontia Expenses	$2,850

Section 15.05	2012 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

Section 17.20	**Special Provisions for Members Employed by an ELCA seminary—High Deductible Health Plan Option**	
	• **Deductible for In-network Eligible Medical and Mental Health Expenses and Prescription Drug Expenses Other Than Preventive Services**	
	○ **Per Member**	**$2,000**
	○ **Family Maximum**	**$4,000**
	• **Percent Copayments for In-network Eligible Medical and Mental Health Expenses and Prescription Drug Expenses**	
	○ **Member percent copayment for applicable in-network medical and prescription drugs in excess of the deductible**	**20%**
	• **Maximum Out-of-Pocket Amount for In-network Eligible Medical and Mental Health Expenses and Prescription Drug Expenses**	
	○ **Per Member**	**$2,500**
	○ **Family Maximum**	**$5,000**
	• **Deductible for Out-of-network Eligible Medical and Mental Health Expenses and Prescription Drug Expenses Other Than Preventive Services**	
	○ **Per Member**	**$4,000**
	○ **Family Maximum**	**$8,000**
	• **Percent Copayments for Out-of-network Eligible Medical and Mental Health Expenses and Prescription Drug Expenses**	
	○ **Member percent copayment for applicable out-of-network medical and prescription drugs in excess of the deductible**	**40%**
	• **Maximum Out-of-Pocket Amount for Out-of-network Eligible Medical and Mental Health Expenses and Prescription Drug Expenses**	
	○ **Per Member**	**$5,000**
	○ **Family Maximum**	**$10,000**
Section 20.14	**Section 20.14 Personal Wellness Account Maximum Annual Credit Amounts**	
	• Per Member	$500
	• Per Eligible Spouse	$500
	• Maximum for Member and Eligible Spouse	$1,000

PORTICO
Benefit Services
A ministry of the ELCA

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Memo

Date: August 14, 2012

To: ELCA Legal and Constitutional Review Committee
ELCA Church Council

Cc: Rev Jeffrey D. Thiemann, President & CEO, Portico Benefit Services
David D. Swartling, Secretary, ELCA

From: Jewelie Grape, General Counsel

Subject: Description of Amendments

The ELCA benefit plans require ELCA Church Council approval of amendments involving a change in policy or a significant change in cost or benefits.

We are asking the Church Council to approve two amendments to the ELCA Medical and Dental Benefits Plan, and amendments to the ELCA Medical and Dental Benefits Trust. These amendments are described below.

New Health Plan Design Option for ELCA Seminaries
Section 17.20 of the ELCA Medical and Dental Benefits Plan is being added, along with related changes to the Appendix, to provide the seminaries more flexibility in defining eligibility, pricing/financing and a high deductible option with higher deductibles, copayments and out-of-pocket amounts described in the Appendix. This pilot project for 2013 is in response to the changing health care landscape and mounting financial pressures faced by ELCA organizations. Seminaries can choose to offer the current plan design, the high deductible plan design, or both.

The Board of Trustees of Portico Benefit Services approved the ELCA seminary plan design option, including the information specified in the Appendix, at its meeting the first week of August. After that meeting the seminary deductibles, copayments and out-of-pocket amounts in the Appendix were revised because of a request by the ELCA seminaries. The Appendix you see is pending approval by the Portico Board of Trustees via electronic vote.

New Health Plan Design Options for Members with Medicare Supplement Coverage
Section 11.06 of the Plan is being added to provide two additional Medicare supplement benefit options for retirees (right now members have only one option). Members will be allowed to choose from a range of deductibles, copayments and out-of-pocket amounts described in the Appendix. Option 1 has generally lower benefits than the current coverage at a lower cost, Option 2 is the current coverage, and Option 3 has generally higher benefits than the current coverage at a higher cost.

Changes to the ELCA Medical and Dental Benefits Trust
The terms of the Trust are being amended to clarify that it can pay for wellness-related programs and activities for members of the ELCA Pension and Other Benefits Program. We feel the clarification is important because of our continued commitment to the wellness of our members.

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Restated
ELCA Medical and Dental Benefits Trust

RESTATED EVANGELICAL LUTHERAN CHURCH IN AMERICA MEDICAL AND DENTAL BENEFITS TRUST

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RESTATED EVANGELICAL LUTHERAN CHURCH IN AMERICA
MEDICAL AND DENTAL BENEFITS TRUST

PREAMBLE

This Amendment and Restatement of this ELCA Medical and Dental Benefits Trust ("Trust"), is made and entered into effective August 1, 2012, by and between the BOARD OF PENSIONS OF THE EVANGELICAL LUTHERAN CHURCH IN AMERICA, doing business as Portico Benefit Services ("Portico Benefit Services" or "Portico"), a Minnesota nonprofit corporation, in its capacity as the administrator of a church medical and dental benefits plan, and Portico Benefit Services in its capacity as the corporate trustee of this Trust (the "Medical Benefits Trustee" or "Trustee");

WITNESSETH:

WHEREAS, the ELCA Board of Pensions has established and maintained a medical and dental benefits plan since January 1, 1988, known as the "Evangelical Lutheran Church in America Medical and Dental Benefits Plan" (the "Medical Benefits Plan"); and

WHEREAS, historically, the individuals elected by the ELCA Churchwide Assembly to serve as trustees of the ELCA Board of Pensions have also served as individual trustees of the benefits trusts maintained by the ELCA Board of Pensions, including the ELCA Medical and Dental Benefits Trust; and

WHEREAS, during the 2009 legislative session, Section 317A.909 of the Minnesota Statutes was amended to clarify that a church benefits board such as the ELCA Board of Pensions may act as corporate trustee of its trusts; and

WHEREAS, it has been determined that having a corporate trustee and naming the ELCA Board of Pensions, a Minnesota non-profit corporation, as a corporate trustee of this Trust provides a better trust structure; and

WHEREAS, to accomplish this goal, the individual trustees of this Trust appointed the ELCA Board of Pensions as corporate trustee of this Trust, transferred and delivered this Trust assets to the ELCA Board of Pensions as corporate trustee in accordance with the provisions of Section 5.06 herein, and then resigned their positions as individual trustees; and

WHEREAS, provisions of this Trust must be amended to reflect the new trustee structure; and

WHEREAS, in November 2011 the Board of Pensions of the Evangelical Lutheran Church in America began doing business as Portico Benefit Services; and

WHEREAS, Portico Benefit Services desires to amend the trust to reflect this name change.

WHEREAS, this Trust provides that it may be amended as set forth in Article VII.

NOW, THEREFORE, in consideration of the premises and the mutual covenants and agreements herein contained, this Trust is amended and restated as follows:

ARTICLE I: GENERAL

Section 1.01 Name of Medical Benefits Trust. This trust shall be known as the "Restated Evangelical Lutheran Church in America Medical and Dental Benefits Trust" (the "Medical Benefits Trust" or "Trust").

Section 1.02 Acceptance of Trust Responsibilities. The Medical Benefits Trustee accepts its appointment as such, and agrees to hold, manage and disburse all the property received by it, pursuant to this Medical Benefits Trust and applicable law.

Section 1.03 Purpose. This Medical Benefits Trust is formed exclusively for religious and charitable purposes and in connection therewith exclusively for the benefit of, and to assist in carrying out the purposes of, the Evangelical Lutheran Church in America (the "ELCA"), an organization described in Section 501(c)(3) of the Internal Revenue Code of 1986, by providing medical and dental benefits and wellness-related programs and activates to employees of the ELCA and other organizations described in Section 501(c)(3) of the Internal Revenue Code of 1986, that are affiliated with the ELCA (including its member congregations, colleges, schools, and social service organizations), ordained ministers on the ELCA roster, ELCA rostered laypersons, other eligible employees, and to other 501(c)(3) organizations operated exclusively for religious purposes.

This Medical Benefits Trust shall not afford pecuniary gain, incidentally or otherwise, to the Medical Benefits Trustee and no part of the net income or net earnings of this Medical Benefits Trust shall inure to the benefit of the Medical Benefits Trustee or any other individual and no substantial part of its activities shall consist of carrying on propaganda or otherwise attempting to influence legislation; provided, however, that nothing in this Section 1.03 shall preclude any individual, including the Medical Benefits Trustee, from receiving any benefit to which he or she may be entitled as a member of, or beneficiary in, the Medical Benefits Plan, so long as the benefit is computed and paid on a basis which is consistent with the terms of the Medical Benefits Plan as applied to all other members and beneficiaries. This Medical Benefits Trust shall not participate in or intervene in (including the publishing or distributing of statements) any political campaign on behalf of any candidate for public office.

Section 1.04 Part of Medical Benefits Plan. This Medical Benefits Trust will form a part of the ELCA Medical Benefits Plan ("Medical Benefits Plan") and will be used to fund benefits thereunder. The Medical Benefits Plan provides that Portico Benefit Services has certain duties, authorities, and responsibilities in connection with the Medical Benefits Plan, including the responsibility to direct the Trustee as to disbursement of Trust assets for purposes of the Medical Benefits Plan. To the extent that this Trust conflicts with any provision in the Medical Benefits Plan, the Medical Benefits Plan document shall control.

Portico Benefit Services agrees that promptly upon the adoption of any amendment to the Medical Benefits Plan it will furnish the Medical Benefits Trustee with a copy of the amendment and with an appropriate certificate evidencing its due adoption. Portico Benefit Services further agrees that no amendment of the Medical Benefits Plan shall have the effect of changing the rights, duties, and liabilities of the Medical Benefits Trustee without its written consent. The Medical Benefits Trustee may rely on the latest Medical Benefits Plan documents furnished as above provided without further inquiry or verification.

Section 1.05 Church Plan Trust. Portico Benefit Services intends by this document to have created a trust forming part of the Medical Benefits Plan which shall be exempt from federal income tax pursuant to Code Section 501(a). This Medical Benefits Trust and the Medical

Benefits Plan are intended to qualify as a church plan as defined in Section 414(e) of the Internal Revenue Code of 1986 and Section 3(33) of the Employee Retirement Income Security Act of 1974. In the event of any ambiguity or uncertainty as to any provision of this Trust or the Medical Benefits Plan, they shall be interpreted and administered in such fashion as to meet the requirements applicable to a church plan.

Section 1.06 Certifications. The Secretary of Portico Benefit Services or such other corporate officer as is designated by the Board of Trustees of Portico Benefit Services shall certify to the Medical Benefits Trustee the name of the person or persons who have authority on behalf of Portico Benefit Services to direct the Medical Benefits Trustee as to disbursements from this Medical Benefits Trust for purposes of the Medical Benefits Plan and the name of the person or persons who have authority on behalf of Portico Benefit Services to communicate with the Medical Benefits Trustee with respect to any other matter or matters relating to this Medical Benefits Trust, and shall provide the Medical Benefits Trustee with a specimen signature of each of the persons referred to above. Action by the Church Council or by the ELCA Churchwide Assembly will be certified by the Secretary of the ELCA. The Medical Benefits Trustee may rely on the latest relevant certificate without further inquiry or verification.

ARTICLE II: MEDICAL AND DENTAL BENEFITS TRUST

Section 2.01 Composition. This Trust shall consist of such sums of money, property or other assets as shall from time to time be paid or delivered to the Trustee or which otherwise represent this Trust's interest in the Medical Benefits Plan, plus all income and gains, less losses, distributions and expenses credited or chargeable thereto. This Trust shall be administered in accordance with the provisions of this Trust document and the Medical Benefits Plan. The assets with respect to this Trust shall be held by a custodian designated by the Trustee.

Section 2.02 Contributions. The Medical Benefits Trustee shall have no duty to require any contributions to be made to it, to determine that the contributions received comply with the provisions of the Medical Benefits Plan, or to collect any contributions payable pursuant to the Medical Benefits Plan. The responsibility of the Medical Benefits Trustee shall be limited to the sums of money, securities, and other property actually received.

Section 2.03 Benefits May Not Be Assigned or Alienated. Except as otherwise expressly permitted by the Medical Benefits Plan, or required by law, the interests of members and their beneficiaries under the Medical Benefits Plan or this Trust may not in any manner whatsoever be assigned or alienated, whether voluntarily or involuntarily, directly or indirectly.

Section 2.04 No Diversion. This Medical Benefits Trust shall be for the exclusive purpose of providing benefits to members under the Medical Benefits Plan and their beneficiaries, for providing wellness-related programs and activities for members of the ELCA Pension and Other Benefits Program and defraying reasonable expenses of administering or operating the Medical Benefits Plan. For purposes of this Medical Benefits Trust, the expenses of administering or operating the Medical Benefits Plan shall be paid from contributions made to the Medical Benefits Plan or from assets held in this Trust under the Medical Benefits Plan. Such expenses shall include, without in any way limiting the generality of the foregoing, any and all expenses relating to the preparation of Medical Benefits Plan amendments (whether required by law or otherwise), and any costs relating to the design, maintenance or termination of the Medical Benefits Plan (including the costs associated with a change in the persons or organizations from time to time providing services to the Medical Benefits Plan). Such expenses may also include premiums for the bonding of officials of the Medical Benefits Plan as required by any applicable law. No part of the corpus or income of this Medical Benefits Trust may be used for, or diverted to, purposes other than for the exclusive benefit of members or their beneficiaries and for providing wellness-related programs and activities for members of the ELCA Pension and Other Benefits Program.~~.~~

Notwithstanding the foregoing, if any contribution or portion thereof is made by a Participating Employer by a mistake of fact, the Medical Benefits Trustee shall, upon written request of Portico Benefit Services, return such contribution to the Participating Employer.

ARTICLE III: TRUSTEE

Section 3.01 General Responsibility. Except as expressly otherwise provided, the general responsibilities of the Medical Benefits Trustee shall be as follows:

(a) The Medical Benefits Trustee shall have exclusive authority and discretion to manage and control the assets of the Medical Benefits Plan held in this Medical Benefits Trust subject to the provisions of Article IV.

(b) The Medical Benefits Trustee shall hold, administer, invest and reinvest the principal and income of this Medical Benefits Trust in accordance with the powers and subject to the restrictions stated herein.

(c) The Medical Benefits Trustee shall disburse monies and other properties from this Medical Benefits Trust on direction of Portico Benefit Services pursuant to the provisions of the Medical Benefits Plan and for wellness-related programs and activities established by Portico Benefit Services~~,~~ to the payee or payees specified by Portico Benefit Services in directions to the Medical Benefits Trustee, in such form as the Medical Benefits Trustee may reasonably require. The Medical Benefits Trustee shall be under no liability for any distribution made by it pursuant to such directions and shall be under no duty to make inquiry as to whether any distribution made by it pursuant to any such direction is made pursuant to the provisions of the Medical Benefits Plan. The payee's receipt of the distributions shall constitute a full acquittance to the Medical Benefits Trustee.

(d) The Medical Benefits Trustee shall have the responsibilities, if any, expressly allocated to it by the Medical Benefits Plan and this Trust. Except as responsibilities may be expressly so allocated, the Medical Benefits Trustee in its capacity as such shall have no responsibility or authority with respect to the operation and administration of the Medical Benefits Plan, and the rights, powers and duties of the Medical Benefits Trustee shall be governed solely by the terms of this Trust, provided, however, that to the extent this Trust conflicts with a provision in the Medical Benefits Plan, the provisions of the Medical Benefits Plan shall control.

(e) The Trustee may commingle for investment purposes the assets of this Trust with any other assets devoted exclusively to church purposes; provided, however, that at all times such commingling occurs, the Trustee shall maintain separate accounts to reflect the interests of this Trust in the commingled assets.

Section 3.02 Powers of the Medical Benefits Trustee. As provided in Section 4.01(b) hereof, it is the intention of Portico Benefit Services in establishing this Trust that the Trustee be, at all times, a directed trustee of this Trust, so that the Trustee shall not be deemed to exercise any discretion with respect to the investment or distribution of the Trust assets unless such discretion is delegated by Portico Benefit Services. The Medical Benefits Trustee shall have the right, power, and authority to take any action and to enter into and carry out every agreement with respect to this Medical Benefits Trust that may be necessary or advisable to discharge its responsibilities hereunder. Without limiting the generality of the foregoing and in addition to all other powers and authorities herein elsewhere specifically granted to the Medical Benefits Trustee, the Medical Benefits Trustee shall have the following powers and authorities to be exercised in its absolute discretion, except as otherwise expressly provided herein:

(a) To hold securities and other properties in bearer form or in the name of a nominee or nominees without disclosing any fiduciary relationship; provided, however, that on the books and records of the Medical Benefits Trustee such securities and properties shall constantly be shown to be a part of this Medical Benefits Trust, and no such registration or holding by the Medical Benefits Trustee shall relieve it from liability for the safe custody and proper disposition of such securities and properties in accordance with the terms and provisions hereof.

(b) To sell, grant options to buy, transfer, assign, convey, exchange, mortgage, pledge, lease or otherwise dispose of any of the properties comprising this Medical Benefits Trust at such prices and on such terms and in such manner as it may deem proper, and for terms within or extending beyond the duration of this Medical Benefits Trust.

(c) To manage, administer, operate, lease for any number of years, regardless of any restrictions on leases made by fiduciaries, develop, improve, repair, alter, demolish, mortgage, pledge, grant options with respect to, or otherwise deal with any real property or interest therein at any time held by it; and to cause to be formed a corporation or trust to hold title to any such real property with the aforesaid powers, all upon such terms and conditions as the Medical Benefits Trustee may deem advisable.

(d) To renew or extend or participate in the renewal or extension of any note, bond or other evidence of indebtedness, or any other contract or lease, or to exchange the same, or to agree to a change in the rate of interest or rent thereon or to any other modification or change in the terms thereof, or of the security therefor, or any guaranty thereof, in any manner and to any extent that it may deem advisable in its absolute discretion; to waive any default, whether in the performance of any covenant or condition of any such note, bond or other evidence of indebtedness, or any other contract or lease, or of the security therefor, and to carry the same past due or to enforce any such default as it may in its absolute discretion deem advisable; to exercise and enforce any and all rights to foreclose, to bid in property on foreclosure; to exercise and enforce in any action, suit, or proceeding at law or in equity any rights or remedies in respect to any such note, bond or other evidence of indebtedness, or any other contract or lease, or the security therefor; to pay, compromise, and discharge with the funds of this Medical Benefits Trust any and all liens, charges, or encumbrances upon the same, in its absolute discretion, and to make, execute, and deliver any and all instruments, contracts, or agreements necessary or proper for the accomplishment of any of the foregoing powers.

(e) To borrow such sums of money for the benefit of this Medical Benefits Trust from any lender upon such terms, for such period of time, at such rates of interest, and upon giving such collateral as it may determine; to secure any loan so made by pledge or mortgage of the trust property; and to renew existing loans.

(f) To use the assets of this Medical Benefits Trust, whether principal or income, for the purpose of improving, maintaining, or protecting property acquired by this Medical Benefits Trust, and to pay, compromise, and discharge with the assets of this Medical Benefits Trust any and all liens, charges, or encumbrances at any time upon the same.

(g) To hold uninvested such cash funds as may appear reasonably necessary to meet the anticipated cash requirements of the Medical Benefits Plan from time to time and to deposit the same in its name as Medical Benefits Trustee in such depositories as it may select.

(h) To receive, collect, and give receipts for every item of income or principal of this Medical Benefits Trust.

(i) To institute, prosecute, maintain, or defend any proceeding at law or in equity concerning this Medical Benefits Trust or the assets thereof, at the sole cost and expense of this Medical Benefits Trust, and to compromise, settle, and adjust any claims and liabilities asserted against or in favor of this Medical Benefits Trust or of Medical Benefits Trustee; but the Medical Benefits Trustee shall be under no duty or obligation to institute, maintain, or defend any action, suit, or other legal proceeding unless it shall have been indemnified to its satisfaction against any and all loss, cost, expense, and liability it may sustain or anticipate by reason thereof.

(j) To vote all stocks and to exercise all rights incident to the ownership of stocks, bonds, or other securities or properties held in this Medical Benefits Trust, to issue proxies to vote such stocks, and to give general or special proxies or powers of attorney, with or without substitution; provided, however, that the Medical Benefits Trustee cannot delegate its right to vote any stocks pursuant to a proxy or a power of attorney without limiting such right to specific instructions; to enter into voting trusts for such period and upon such terms as it may determine; to sell or exercise any and all subscription rights and conversion privileges; to sell or retain any and all stock dividends; to oppose, consent to, or join in any plan of reorganization, readjustment, merger, or consolidation in respect to any corporation whose stocks, bonds, or other securities are a part of this Medical Benefits Trust, including becoming a member of any stockholders' or bondholders' committee; to accept and hold any new securities issued pursuant to any plan of reorganization, readjustment, merger, consolidation, or liquidation; to pay any assessments on stocks or securities or to relinquish the same; and to otherwise exercise any and all rights and powers to deal in and with the securities and properties held in this Medical Benefits Trust in the same manner and to the same extent as any individual owner and holder thereof might do.

(k) To make application for any contract issued by an insurance company to be purchased under the Medical Benefits Plan, to accept and hold any such contract, and to assign and deliver any such contract.

(l) To employ such agents, experts, counsel, and other persons (any of whom may also be employed by or represent a Participating Employer or Portico Benefit Services) deemed by the Medical Benefits Trustee to be necessary or proper for the administration of this Medical Benefits Trust; to rely and act on information and advice furnished by such agents, experts, counsel, and other persons; to delegate to agents, experts, counsel or other persons any or all of the discretionary powers granted to the Trustee under the terms of this Medical Benefits Trust; and to pay its reasonable expenses and compensation for services to this Medical Benefits Trust from this Medical Benefits Trust. The Trustee shall not be liable for any act or omission of any such agent, expert, counsel or other persons, including an agent, expert, counsel or other person having delegated authority to exercise discretionary powers, provided that the

Trustee has exercised due care in the selection of such agent, expert, counsel or other person.

(m) To pay out of this Medical Benefits Trust all real and personal property taxes, income taxes, and other taxes of any and all kinds levied or assessed under existing or future laws against this Medical Benefits Trust, without the need to seek any approval or direction of Portico Benefit Services.

(n) To pay any estate, inheritance, income, or other tax, charge, or assessment attributable to any benefit which, in the Medical Benefits Trustee's opinion, it shall be or may be required to pay out of such benefit; and to require, before making any payment, such release or other document from any taxing authority and such indemnity from the intended payee as the Medical Benefits Trustee shall deem necessary for its protection.

(o) To retain any funds or property subject to any dispute without liability for the payment of interest, and to decline to make payment or delivery thereof until final adjudication is made by a court of competent jurisdiction.

(p) To serve not only as Medical Benefits Trustee but also in any other fiduciary capacity with respect to the Medical Benefits Plan pursuant to such agreements or practices as the Medical Benefits Trustee considers necessary or appropriate under the circumstances.

(q) To make, execute, acknowledge, and deliver any and all documents of transfer and conveyance and any and all other instruments that may be necessary or appropriate to carry out the powers herein granted to the Medical Benefits Trustee.

(r) To bring action before any court of competent jurisdiction for instructions with respect to any matter pertaining to the interpretation or administration of this Medical Benefits Trust.

(s) To take into account the investment objectives, policies, fiduciary responsibilities, and restrictions of Portico Benefit Services in a manner consistent with the ELCA social statements, and the religious, moral and ethical posture of the ELCA and Portico Benefit Services with respect to the investments of the Trust assets.

All of the powers of this Medical Benefits Trust shall be exercised only so that its operations shall be exclusively within the contemplation of Section 501(c)(3) of the Internal Revenue Code of 1986.

Section 3.03 Appointment of Ancillary Trustee. In the event that any property which is or may become a part of this Medical Benefits Trust is situated in a state or states in which the Medical Benefits Trustee acting hereunder is prohibited from holding real estate as trustee, or in a foreign country, the Medical Benefits Trustee is hereby empowered to name an individual or corporate trustee qualified to act in any such state or foreign country in connection with the property situated therein as ancillary trustee of such property and require such security as may be designated by the Medical Benefits Trustee. Any ancillary trustee so appointed shall have such rights, powers, discretions, responsibilities, and duties as are delegated to it by the Medical Benefits Trustee, but shall exercise and discharge the same subject to such limitations or directions of the Medical Benefits Trustee as shall be specified in the instrument evidencing the appointment. Any such ancillary trustee shall be answerable to the Medical Benefits Trustee for all monies, assets, or other property

entrusted to it or received by it in connection with the administration of this Medical Benefits Trust. The Medical Benefits Trustee may remove any such ancillary trustee and may appoint a successor at any time or from time to time as to any or all of the assets. Any instrument designating an ancillary trustee may contain such provisions with respect to payment of income and principal to this Medical Benefits Trust, payment of expenses with respect to ancillary trust property, termination of the ancillary trust, and administrative powers of the ancillary trustee as the Medical Benefits Trustee hereunder, in the exercise of its discretion, may deem appropriate and consistent with the provisions of this Trust.

Section 3.04 Expenses. The Medical Benefits Trustee shall be entitled to reimbursement for all reasonable and necessary costs, expenses, and disbursements incurred by it in the performance of its services as Medical Benefits Trustee or in any other capacity in connection with the Medical Benefits Plan or wellness-related programs and activities established by Portico Benefit Services as may be agreed upon with Portico Benefit Services. Such reimbursements shall be paid from this Medical Benefits Trust if not paid directly by Portico Benefit Services or Participating Employers in such proportions as Portico Benefit Services shall determine, and shall constitute a lien upon this Medical Benefits Trust until paid.

Section 3.05 Records and Accountings. The Medical Benefits Trustee shall keep accurate and detailed records and accounts of all investments, receipts, and disbursements, and other transactions hereunder, and all records, books, and accounts relating thereto shall be open to inspection by any person designated by Portico Benefit Services at all reasonable times.

As soon as reasonably practicable following the close of each annual accounting period of this Medical Benefits Trust, and as soon as reasonably practicable after the resignation or removal of the Medical Benefits Trustee has become effective, the Medical Benefits Trustee shall file with Portico Benefit Services a written accounting setting forth all investments, receipts, disbursements, and other transactions effected by it during such year, or during the part of the year to the date the resignation or removal is effective, as the case may be, and containing a description of all securities purchased and sold, the cost or net proceeds of sale, the securities and investments held at market value at the end of such period, and the cost of each item thereof as carried on the books of the Medical Benefits Trustee. The accounting shall also furnish Portico Benefit Services such other information as the Medical Benefits Trustee may possess and as may be necessary for Portico Benefit Services to comply with the reporting requirements of applicable law. If the fair market value of an asset in this Medical Benefits Trust is not available, when necessary for accounting or reporting purposes the fair value of the asset shall be determined in good faith by the Medical Benefits Trustee, assuming an orderly liquidation at the time of such determination. If there is a disagreement between the Medical Benefits Trustee and anyone as to any act or transaction reported in an accounting, the Medical Benefits Trustee shall have the right to have its account settled by a court of competent jurisdiction.

Section 3.06 Record Retention. The Medical Benefits Trustee shall retain the records relating to this Medical Benefits Trust as long as necessary for the proper administration thereof and at least for any period required by any applicable law.

ARTICLE IV: INVESTMENTS

Section 4.01 General.

(a) The Trustee is vested with title to all assets of this Trust and shall have full power and authority to do all acts necessary to carry out the duties hereunder. Members and beneficiaries shall not have any right or interest in this Trust except as provided in the Medical Benefits Plan. No member or beneficiary (or legal representative of a member or beneficiary) shall have any right to assign, encumber, or in any manner dispose of any interest in this Trust except as permitted under the Medical Benefits Plan or as required by law or directed by a court of competent jurisdiction.

(b) Portico Benefit Services shall direct the Trustee as to the investment of the assets of this Trust. Except for those Trust assets that are under the investment control of an investment manager, the Trustee shall exercise exclusive investment direction and control of Trust assets subject to the direction of Portico Benefit Services. Accordingly, Portico Benefit Services shall have the full power and authority to direct the Trustee as to the investment, acquisition, management, or disposition of assets of this Trust, and the Trustee shall not have any duty to question any direction, to review any acquisition or disposition of securities or other property, or to make any suggestions in connection therewith. Consistent with applicable law, the Trustee shall promptly comply with any direction given by Portico Benefit Services. The Trustee will not be liable in any manner or for any reason for any loss or other unfavorable investment results arising from compliance with such direction, and will not be liable for failing to invest any of the assets of this Trust under the management and control of Portico Benefit Services in the absence of investment directions regarding such assets.

(c) Portico Benefit Services may delegate responsibility for the investment of Trust assets in accordance with the Investment Committee Charter, consistent with the Constitution, Bylaws and Continuing Resolutions of the ELCA and the Articles of Incorporation and Bylaws of Portico Benefit Services of the ELCA.

(d) Except as otherwise expressly provided herein, the Medical Benefits Trustee shall have exclusive authority and discretion to invest and reinvest the principal and income of this Medical Benefits Trust in real or personal property of any kind and shall do so 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. Consistent with the objectives of Portico Benefit Services' Investment Policy for the Medical Benefits Plan, the Medical Benefits Trustee shall diversify the investments of this Medical Benefits Trust so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so. The Medical Benefits Trustee shall not be limited by the laws of any state proscribing or limiting the investment of trust funds by corporate or individual trustees in or to certain kinds, types, or classes of investments or limiting the value or proportion of Trust assets that may be invested in any one property or kind, type, or class of investment. Investments and reinvestments shall be subject to the above standard, and without limiting the generality of the foregoing, shall also be subject to the following:

(i) The Medical Benefits Trustee may invest and reinvest principal and income of this Medical Benefits Trust in common, preferred, and other stocks of any corporation; private equity; voting trust certificates; interests in investment trusts; bonds, notes, and debentures, secured or unsecured; mortgages on real or personal property; conditional sales contracts; real estate leases and real estate partnerships; and other asset classes approved by Portico Benefit Services in accordance with this Article IV.

(ii) The Medical Benefits Trustee may invest and reinvest the principal and income of this Medical Benefits Trust by investing in an annuity contract or contracts (including any agreement or agreements supplemental thereto) issued by an insurance company.

(iii) The Medical Benefits Trustee may utilize financial futures, forwards and options to assist in controlling risk and enhancing portfolio values in a manner that is prudent and intended to further the purposes of this Medical Benefits Trust. Specifically, financial futures and options may be used to help maintain market exposure, targeted duration exposure and targeted currency exposure. The Medical Benefits Trustee may not sell uncovered call options or sell put options nor invest so as to leverage the size of this Trust.

Section 4.02 Investment Managers.

(a) Portico Benefit Services has the power and authority to appoint one or more investment managers. Each investment manager so appointed will have the power and authority to invest, acquire, manage or dispose of the assets of this Trust under its management in accordance with the provisions of the Medical Benefits Plan and Trust and to direct the Trustee with respect to the investment, reinvestment and sale of such assets.

(b) If Portico Benefit Services elects to delegate investment authority for all or any portion of the assets of this Trust to an investment manager pursuant to Section 4.02(a), Portico Benefit Services will inform the Trustee in writing of such designation and such written notice shall describe the portion of this Trust affected. Upon receipt of such notice, the Trustee will be obligated to follow the investment directions of the investment manager with respect to the assets of the specified portion of this Trust until the Trustee receives written notice that such investment manager has resigned or has been removed or replaced by Portico Benefit Services.

(c) The Trustee shall have no duty to supervise any investment manager to whom investment authority has been delegated, and the Trustee shall not be subject to or otherwise manage any assets of the Medical Benefits Plan which is subject to management of such investment manager. The Trustee will not be liable for any acts or omissions of such investment manager or for acting or failing to act at the direction or absence of direction from the investment manager, unless the Trustee knows that acting or failing to act constitutes participation in a breach of fiduciary duty by such investment manager. The fees and expenses of an investment manager shall be paid by this Trust, except to the extent paid by any Participating Employer or by Portico Benefit Services.

ARTICLE V: APPOINTMENT AND CHANGE IN TRUSTEE

Section 5.01 Appointment of Trustee. The ELCA Church Council or Portico Benefit Services may initiate an amendment appointing the Trustee of this Trust which shall be submitted to the ELCA Church Council for final action in accordance with Section 7.01. If necessary, the ELCA Church Council Executive Committee may agree to such amendment subject to ratification by the ELCA Church Council.

Section 5.02 Resignation. The Trustee may resign at any time by delivering to the ELCA Church Council and Portico Benefit Services (or if Portico Benefit Services is resigning as Trustee, to the ELCA Church Council) a written notice of resignation, to take effect not less than sixty (60) days after delivery, unless such time period is waived by Portico Benefit Services (or by the ELCA Church Council if Portico Benefit Services is resigning as Trustee).

Section 5.03 Removal. A Trustee may be removed by amendment of this Trust appointing a new Trustee as set forth above. If there is an immediate need for removal, the ELCA Church Council or Portico Benefit Services may remove the Trustee at any time by delivering to the Trustee a written notice of removal and initiating an amendment appointing a new Trustee of this Trust in accordance with Section 5.01 above. Before removing a Trustee, Portico Benefit Services shall consult with the ELCA Church Council or ELCA Church Council Executive Committee. Similarly, if there is removal by the ELCA Church Council or the ELCA Church Council Executive Committee, it shall first consult with Portico Benefit Services. Such removal will take effect no less than thirty (30) days after delivery of such notice to the Trustee, unless such time period is waived by the Trustee.

Section 5.04 Successor. Upon the resignation or removal of the Trustee, one or more successor Trustees may be appointed in accordance with Section 5.01 above, and subject to each successor Trustee's acceptance of such appointment and execution of this Trust.

Section 5.05 Failure to Appoint Successor Trustee. If no appointment of a successor is made by Portico Benefit Services or the ELCA Church Council in accordance with Section 5.01 above within a reasonable time after resignation or removal of the Trustee, any court of competent jurisdiction may appoint successor Trustee, after notice, to Portico Benefit Services and the ELCA Church Council and to the retiring Trustee, as such court may deem proper and suitable. The retiring Trustee shall be furnished with written notice from Portico Benefit Services or the court, as the case may be, of the appointment of the successor, and shall also be furnished with written evidence of the successor's acceptance of the trusteeship. Only then shall the retiring Trustee cease to be Trustee.

Section 5.06 Duties on Succession. No predecessor Trustee shall have any right, title, or interest in this Trust except as hereinafter provided in the case of the replacement of the Trustee. Upon the appointment and acceptance of successor Trustee, the predecessor Trustee shall transfer and deliver the assets of this Trust to the successor, after reserving such reasonable amount as such Trustee shall deem necessary to provide for fees and expenses and any sums chargeable against this Trust for which such Trustee may be liable. Any predecessor Trustee shall do all acts necessary to vest title of record in the successor Trustee.

Every successor Trustee accepting a trusteeship under this Trust shall have all the rights, titles, powers, duties, exemptions, and limitations of the predecessor Trustee(s) hereunder, subject to the right of amendment of this Trust. No person or entity becoming a Trustee hereunder shall be in any way liable or responsible for anything done or omitted to be done by any Trustee prior to acceptance of the trusteeship, nor shall such

person or entity have any duty to examine the administration of this Trust prior to such acceptance.

ARTICLE VI: MISCELLANEOUS

Section 6.01 Incompetent Payee. If, in the opinion of Portico Benefit Services, a person to whom the Trustee is directed to make one or more payments is disabled from caring for her/his affairs because of mental or physical condition, payment due such person may be made to such person's guardian, conservator, or other legal personal representative upon furnishing Portico Benefit Services with evidence satisfactory to Portico Benefit Services of such status. Prior to the furnishing of such evidence, Portico Benefit Services may cause payments for the person under disability to be made, for such person's use and benefit, to any person or institution then in the opinion of Portico Benefit Services caring for or maintaining the person who is under the disability. The Medical Benefits Trustee shall have no liability with respect to payments made to an individual designated by Portico Benefit Services. The Trustee shall have no duty to make inquiry as to the competence of any person to whom it is directed to make payment.

Section 6.02 Evidence. Evidence required of anyone under this Trust may be by certificate, affidavit, document, or other instrument which the person acting in reliance thereon considers to be pertinent and reliable, and to be signed, made, or presented by the proper party.

Section 6.03 Dealings of Others With Trustee. No person (corporate or individual) dealing with the Trustee shall be required to see to the application of any money paid or property delivered to the Trustee or to determine whether the Trustee is acting pursuant to any authority granted to it under this Trust.

Section 6.04 Fiduciary Standards. Each fiduciary shall discharge her/his duties with respect to this Medical Benefits Trust, 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 their beneficiaries in the Medical Benefits Plan, for providing wellness-related programs and activities for members of the ELCA Pensions and Other Benefits Program, and defraying reasonable expenses of administering this Medical Benefits Trust,

(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 this Medical Benefits Trust 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 Benefits Trust and the ELCA Medical and Dental Benefits Plan and any wellness-related programs and activities established by Portico Benefit Services.~~,~~

Nothing herein shall be construed or applied to restrict or prohibit the fiduciaries from administering this Medical Benefits Trust, in accordance with the investment objectives and policies from time to time established for such Trust, and the fiduciaries shall not be liable to any member or other person solely by reason of their adherence to such investment objectives and policies as set forth in the Investment Policy for this Medical Benefits Trust.

Section 6.05 Administrative Fee Paid to Portico Benefit Services. The Portico Benefit Services shall be paid a reasonable fee by this Medical Benefits Trust for the administrative services provided by Portico Benefit Services to the Medical Benefits Plan, wellness-related programs and activities established by Portico Benefit Services and this Medical Benefits Trust, including a fee for informing the employees and employers of the availability of the Medical Benefits Plan. The fee charged to this Medical Benefits Trust shall constitute a lien upon this Medical Benefits Trust until paid.

Section 6.06 Audits. Portico Benefit Services shall have the right to cause the books, records, and accounts of the Medical Benefits Trustee that relate to the Medical Benefits Plan to be examined and audited by independent auditors designated by Portico Benefit Services at such times as Portico Benefit Services may determine, and the Medical Benefits Trustee shall make such books, records, and accounts available for such purposes at all reasonable times. The expense of such audit shall be paid from this Medical Benefits Trust, if not paid by the Participating Employers in such proportion as Portico Benefit Services shall determine, and shall constitute a lien upon this Medical Benefits Trust until paid.

Section 6.07 Successors. The provisions of this Trust shall be binding on each Participating Employer and its successors. If a successor to a Participating Employer or a purchaser of all or substantially all of a Participating Employer's assets is eligible to, and elects to, continue the Medical Benefits Plan, such successor or purchaser shall be substituted for the Participating Employer under this Trust.

Section 6.08 Waiver of Notice. Any notice required under this Trust may be waived by the person entitled thereto.

Section 6.09 Headings. Headings at the beginning of articles and sections are for convenience of reference, shall not be considered a part of this Trust, and shall not influence its construction.

Section 6.10 Use of Compounds of Word "Here". Use of the words "hereof", "herein", "hereunder", or similar compounds of the word "here" shall mean and refer to the entire Trust unless the context clearly indicates otherwise.

Section 6.11 Construed as a Whole. The provisions of this Trust shall be construed as a whole in such manner as to carry out the provisions thereof and shall not be construed separately without relation to the context.

Section 6.12 Severability. In the event any provision of this Medical Benefits Trust shall be held illegal or invalid for any reason, said illegality or invalidity shall not affect the remaining provisions of this Medical Benefits Trust, but shall be fully severable, and this Medical Benefits Trust shall be construed and enforced as if said illegal or invalid provisions had never been inserted therein.

Section 6.13 Counterparts. This Trust may be executed in any number of counterparts, each of which shall be deemed an original. Such counterparts shall constitute but one and the same instrument, which may be sufficiently evidenced by any one counterpart.

Section 6.14 Indemnification of Medical Benefits Trustee. The Participating Employers jointly and severally agree, to the fullest extent permitted by law, to indemnify the Medical Benefits Trustee for and to hold it harmless against any and all liabilities, losses, costs, or expenses (including legal fees and expenses) of whatsoever kind and nature which may be imposed on, incurred by, or asserted against the Medical Benefits Trustee at any time

by reason of the Medical Benefits Trustee's service under this Trust if the Medical Benefits Trustee did not have reasonable grounds to believe the conduct was unlawful or act in willful violation of the law or regulations under which such liability, loss, cost, or expense arises.

Section 6.15 Internal Revenue Code of 1986. All references in this Trust to sections of the Internal Revenue Code of 1986 include any provisions thereof adopted by future amendments thereto and any cognate provisions in future internal revenue codes to the extent such provisions are applicable to this Trust.

Section 6.16 Applicable Law. This Medical Benefits Trust shall be deemed a Minnesota trust and shall be controlled and construed in accordance with the laws of the State of Minnesota.

Section 6.17 Deemed Compliance With Terms of Trust. If, at any time, Portico Benefit Services serves as the Trustee hereunder, then any requirement in this Trust that either Portico Benefit Services or the Trustee must provide the other party with a notification, certification, report, accounting, written direction, waiver or other similar document or communication shall be deemed to be satisfied without the actual provision of the same.

Section 6.18 Parties to this Trust. Any Participating Employer that contributes to the Medical Benefits Plan in accordance with the terms thereof shall become a party to this Trust and shall be bound by all terms and conditions of the Medical Benefits Plan and this Trust, as then in effect and as may thereafter be amended.

Any corporation or other participating entity, other than Portico Benefit Services, shall cease to be a party to this Trust upon delivering to the Trustee or to Portico Benefit Services a certified copy of a resolution terminating its participation in the Retirement Plan. In such event, or in the event of the merger, consolidation, sale of property or stock, separation, reorganization or liquidation of any corporation that is a party to this Trust, the Trustee, until directed otherwise by Portico Benefit Services, shall continue to hold, in accordance with the provisions of this Trust, that portion of this Trust which, pursuant to the determination of Portico Benefit Services, is attributable to the participation in the Medical Benefits Plan of the employees and their beneficiaries affected by such termination or by such transaction.

Section 6.19 Necessary Parties to Legal Actions. Only Portico Benefit Services and the Trustee will be considered necessary parties in any legal action or proceeding with respect to this Trust, and no member, beneficiary or other person having an interest in this Trust will be entitled to notice. Any judgment entered on any such action or proceeding will be binding on all persons making a claim against the Trustee. Nothing in this Section 6.19 is intended to preclude a member or beneficiary from enforcing his or her legal rights.

ARTICLE VII: AMENDMENTS AND TERMINATION

Section 7.01 Amendments. This Medical Benefits Trust may be amended at any time and from time to time as follows; provided, however, that no such amendment shall cause any part of the corpus or income of this Medical Benefits Trust to be diverted to purposes other than the payment of benefits to members under the Medical Benefits Plan and their beneficiaries, for providing wellness-related programs and activities for members of the ELCA Pension and Other Benefits Program, or reasonable expenses of administration of the Medical Benefits Plan:

(a) 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, or

(b) 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.

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

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.

This Trust shall be amended in accordance with the final action taken by the ELCA Church Council or the ELCA Churchwide Assembly by written agreement executed by at least two corporate officers of Portico Benefit Services who are authorized by the Board of Trustees of Portico Benefit Services to take such action and the Medical Benefits Trustee.

Section 7.02 Termination. This Medical Benefits Trust may be terminated at any time in accordance with the amendment procedure set forth in Section 7.01. Upon termination of this Trust, any surplus property remaining after the payment of all benefits of this Trust attributable to the Medical Benefits Plan, and all of the debts of the Medical Benefits Plan and Trust, shall be disposed of by transfer to the ELCA, to be held and used for exclusively religious and charitable purposes; provided that the ELCA is at that time an organization described in Section 501(c)(3) of the Internal Revenue Code of 1986 and, if not, the surplus property shall be distributed to such other entity that is at that time an organization described in said Section 501(c)(3) as the Trustee shall determine. Notwithstanding any provision herein to the contrary, nothing herein shall be construed to affect the disposition of property and assets held by this Trust upon specific trust or other condition, or subject to an executorial or special limitation, and such other property, upon dissolution of this Trust, shall be transferred in accordance with the specific trust, condition, or limitation imposed with respect to it.

(Signature page follows on next page)

IN WITNESS WHEREOF, Portico Benefit Services has caused this Restated Trust to be executed as of the day and year written below.

PORTICO BENEFIT SERVICES

Dated: _____, 2012 By _____
Jeffrey Thiemann, President and Chief Executive Officer

Dated: _____, 2012 By _____
Stacy Kruse, Vice President, Chief Administrative and Chief Financial Officer

(Notary page follows on next page)

STATE OF MINNESOTA)
) ss.
COUNTY OF HENNEPIN)

On this ____ day of August 2012, before me personally appeared JEFF THIEMANN, to me personally known, who, being by me duly sworn, did say that he is PRESIDENT AND CHIEF EXECUTIVE OFFICER of PORTICO BENEFIT SERVICES, the Minnesota nonprofit corporation named in the foregoing instrument, and that said instrument was signed in behalf of said corporation by authority of its Board of Trustees, and he acknowledged said instrument to be the free act and deed of said corporation.

_____

Notary Public _____ County, _____

My commission expires _____, 20 ___

STATE OF MINNESOTA)
) ss.
COUNTY OF HENNEPIN)

On this ____ day of August 2012, before me personally appeared STACY KRUSE, to me personally known, who, being by me duly sworn, did say that she is VICE PRESIDENT, CHIEF ADMINISTRATIVE AND CHIEF FINANCIAL OFFICER of the PORTICO BENEFIT SERVICES, the Minnesota nonprofit corporation named in the foregoing instrument, and that said instrument was signed in behalf of said corporation by authority of its Board of Trustees, and she acknowledged said instrument to be the free act and deed of said corporation.

_____

Notary Public _____ County, _____

My commission expires _____, 20 ___

Summary of ELCA Philosophy of Benefits

July 2012

Current Discussion on Philosophy of Benefits

The mission of Portico Benefit Services has always been to provide pension, health and other benefits and related services that will enhance the lives of pastors, rostered laypersons, lay employees, and their families while supporting the well-being of congregations and institutions of the ELCA. 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 Benefit Services. Current realities, however, call for a review of the philosophy of benefits and the principles used to implement the philosophy, keeping in mind the historic and continuing ELCA intentions of fairness and protection and the very real disparities between clergy compensation relative to the corporate world.

To that end, a task force was created in early 2012 to review the philosophy of benefits. The task force members are the following:

Bp. Jon Anderson, Conference of Bishops
Pr. Bob Berg, Portico Benefit Services
Bp. Elizabeth Eaton, Conference of Bishops
Ms. Marjorie Ellis, Church Council
Mr. John Emery, Church Council
Mr. Brad Joern, Portico Benefit Services
Bp. Jim Justman, Conference of Bishops
Pr. Linda Norman, ELCA Treasurer
Bp. Robert Rimbo, Conference of Bishops
Mr. David Swartling, ELCA Secretary
Pr. Jeffrey Thiemann, Portico Benefit Services

The intent is to bring a final draft of the revised philosophy to the Portico trustees, Conference of Bishops and Church Council in the fall of 2012. What follows is a summary of the most recent ELCA Philosophy of Benefits, written in 2004.

Guiding Principles

Plan participation	All church workers should be sponsored in the ELCA benefits program.
Level of benefits	The benefits program should provide adequate financial protection in the event of illness, injury, disability, retirement or death.
Bundled program	The Board of Pensions should bundle the four plans – health, retirement, disability and survivor – and offer them as a package.
Contribution policy	The monthly cost of the program should be affordable and paid entirely by congregations and other sponsoring employers.
Sharing of health costs	The cost of the 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.

Application of Philosophy to Eligibility and Plan Participation

Sponsorship is required	Sponsorship is mandatory for pastors, rostered laypersons and lay employees of the churchwide organization, churchwide units (except for Augsburg Fortress Publishers), synods and seminaries.
Sponsorship is encouraged	Sponsorship is encouraged but not required for rostered leaders serving congregations. Synod compensation guidelines call on congregations to provide ELCA benefits. Individual letters of call generally require sponsorship in the ELCA benefits program.
Sponsorship is discretionary	Sponsorship is at the discretion of each employer for employees of the ELCA publishing house, for nonrostered lay employees in congregations and for church workers serving ELCA institutions.

Application of Philosophy to ELCA Health Benefits Plan

The health plan is intended to "protect employees from suffering a financial disaster because of health problems by keeping the out-of-pocket costs at manageable levels."[1] The reimbursement schedule has changed in the last 25 years as health care costs have escalated faster than salaries (maximum out-of-pocket limits have increased in dollars and in relation to salaries).

Application of Philosophy to ELCA Retirement Plan

The goal of the retirement plan is "to provide retired church workers with a replacement income including Social Security at a level to assist them to maintain their pre-retirement standard of living."[2] The minimum contribution was raised from 9 percent to 10 percent in the early 1990s. Even though 10% represents a pension contribution rate that meets the ELCA's adequacy principle, the retirement plan has always allowed a lower minimum contribution (6%) for ELCA institutions that participate in the bundled program. The Board of Pensions' 2003 pension equity report supports this view. "The issue of pension equity would be best addressed by ensuring compensation for rostered leaders that at least meets minimum synod compensation guidelines. Additional efforts would be best spent on growing the Special Needs Retirement Fund to meet the needs of those who served at low compensation and now have low pensions and those currently serving at low salaries."[3] For second-career pastors, most leaders support the view that ELCA employers should provide retirement plan contributions for an individual's years of church service, but should not be expected to ensure the adequacy of retirement accumulations for prior years.

[1] The 1986 Report and Recommendations of the Commission for a New Lutheran Church, (Page 177).
[2] *Ibid*, (Page 178).
[3] ELCA Board of Pensions, Pension Equity Report, Feb. 25, 2003 (Page 16).

Summary of Comments from Synod Bishops and Other Church Leaders (2004)[4]

Plan Participation

- Difficulty in achieving sponsorship for all church workers
- Only 20% of non-rostered lay employees sponsored in the benefits program (as of 2004)
- Most bishops are open to lower-cost options for non-sponsored employees
- Most letters of call require benefits program sponsorship
- Financially unrealistic to require ELCA institutions (SMOs) to sponsor employees

Level of Benefits

Against offering employers a choice in level of benefits because:

- poorer congregations would provide less benefits
- benefits would become an issue in the call process

Bundled Program

Strong support because:

- waiving coverage if covered by spouse is an option
- discourages congregations from seeking lower-priced/lower-value health or disability coverage
- maintains high participation thereby ensuring financial integrity of the plans

Contribution Policy

- Seminary presidents and finance directors strongly support more flexibility because they must pay market-competitive salaries but also pay above-average benefit costs.
- Synod bishops strongly support employers paying the full monthly cost of benefits.
- Synod bishops unanimously support the sharing principle.
- Many congregations are questioning the current policy.
- 20% of bishops are open to considering employee contributions to benefits.

Overall

Bishops and other leaders support the current benefits program, but there is concern about growing costs and placing the full cost of benefits on congregations and other employers.

Proposals for Greater Flexibility (2004)

- Emphasize that the contribution principle sets a standard for employers while acknowledging the final decision to sponsor employees rests with the employer.
- Encourage employers to pay the entire cost but allow seminaries and other large employers flexibility.
- Create an extension that allows employers to make a 6% minimum pension contribution for nonrostered lay employees instead of 10%.

[4] In 2003 and 2004, Portico (Board of Pensions) arranged discussions among synod bishops and other church leaders on the principles underlying the ELCA plan.

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Caring for Our Health: Our Shared Endeavor
Social Statement Adopted (935-34) by 2003 Churchwide Assembly

Introduction

- Caring for one's own health is a matter of human necessity and good stewardship. Caring for the health of others expresses both love for our neighbor and responsibility for a just society.

The Crisis in Health Care

- Community investment in public health and prevention adds to the length and quality of life for many.
- Health care resources often are rationed based on ability to pay rather than need.

The Church and the Health Care Crisis

- The Christian Church is called to be an active participant in fashioning a just and effective health care system.
- We of the Evangelical Lutheran Church in America have an enduring commitment to work for and support health care for all people as a shared endeavor.

Biblical and Theological Perspectives

Health

- Health is good for living abundantly in relationship with God and in loving service to our neighbor in the vocations to which God has called us.
- We see sin at work in the environmental damage, poverty, social isolation, discrimination, oppression, and violence that degrade health and the relationships necessary to support it.

Healing

- Human healing activities in all their variety—medicine and other biomedical technologies, cultural and religious practices, governmental and social organizations, human behavior and decisions—can be avenues of healing blessed and empowered by God. Because human beings are finite, none of these activities will produce perfect health; because of sin, each of them can be abused.
- The healing work of the triune God is the basis for the Church's commitment to good health, healing, and health care.

Health Care

- Regardless of the means used to provide health care and ensure access to it, we must diligently preserve the nature of health care as a shared endeavor. This means that we recognize our mutual responsibilities and guard against the ways in which motivation to maximize profit and to market health care like a commodity jeopardizes health and the quality of health care for all.

A Vision of Health Care and Healing as a Shared Endeavor

Personal Responsibilities

- Each of us has responsibility to be a good steward of his or her own health out of thankfulness for the gift of life and in order to serve God and the neighbor. This means taking effective steps to promote health and prevent illness and disease (for example, eating well, getting adequate exercise and sleep, avoiding use of tobacco and abuse of drugs, limiting alcohol, and using car seat restraints).

- As citizens, we ought to support those disease-preventing and health-promoting public health measures that can be taken only at community, state, and national levels. We also have responsibility to support similar efforts that address disease prevention, health promotion, and treatment on a global scale. (e.g., the ELCA Malaria Campaign)

Congregations

- Congregations can pay particular attention to the health of all staff, providing a working environment that is physically and emotionally safe and supportive, as well as a work schedule that allows for adequate recreation and stress reduction.[1]

Toward a Better System of Health Care Services

- No one group – public or private – can design the structure or financing of such a system alone; representatives of all groups that provide services and financing must together seek a solution that enhances interdependence.
- At a minimum, each person should have ready access to basic health care services that include preventive, acute, and chronic physical and mental health care at an affordable cost.[2]

Public Health Services

- We urge renewed political and financial support for services undertaken on behalf of the entire community to prevent epidemics, limit threats to health, promote healthy behavior, reduce injuries, assist in recovery from disasters, and ensure that people have access to needed services. Governments have an obligation to provide or organize many of these services, but all services depend on active collaboration with the entire community.

Equitable Access to Health Care for All

- One major challenge is achieving equitable access to basic health care for all people. We of the Evangelical Lutheran Church in America commit ourselves to work with others to attain this goal.
- We call upon our society to give priority to people and groups who are not benefitting from access to health care services and research: people who are uninsured and underinsured, people living in poverty, those in rural areas, immigrants, residents of U. S. Territories and Puerto Rico, marginalized groups, and those suffering the consequences of our failure to implement adequate public health protection.

Moving toward Just Access

- Our obligation could be met through any one of several combinations of personal, market, and governmental means, although none of these means alone can provide equitable access to health care.
- Governments are shaped by political pressures and often function with inefficiencies; yet as representatives of all citizens they have a particular responsibility to ensure society's obligations to promote the general welfare. This includes such areas as security, education, and health care.

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[1] Division for Ministry and Board of Pensions, *Ministerial Health and Wellness 2002* (Chicago: Evangelical Lutheran Church in America, 2002).

[2] More specifically, such a set of basic services likely will include: primary care services (including a relationship with a provider, routine well-child and well-adult examinations and prevention, age-appropriate screening for disease, treatment for acute problems, coordinated referral for more complex levels of care); dental care; in- and out-patient care for acute and chronic physical and mental illness; emergency care; treatment for substance abuse; and appropriate complementary and supportive services.

Meeting Our Obligations

- Achieving these obligations of love and justice requires sacrifice, goodwill, fairness, and an abiding commitment to place personal and social responsibilities of love and justice above narrower individual, institutional, and political self-interests.
- Alongside the pursuit of justice, we in the Evangelical Lutheran Church in America recognize the biblical obligation that each person in society is responsible for the neighbor. No one of us is free to pass by "on the other side" (Luke 10:31-32) and assume that governments and other parties will take care of all obligations for health care. We therefore seek to participate in and supplement health care services out of love for all people who are in need (Matthew 25:36).

Ethical Guidance for Individuals and Families

Health and Finitude

- Finding ethical guidance begins with being mindful of how we as a people of faith understand health and health care and what it means to be healthy. We must accept the limits imposed by human finitude and have realistic expectations of health care because our resources also are finite.

Stewardship

- The obligation to be good stewards of what God has given us should inform our use of health care resources. This means using health and health care wisely, judiciously, and in service toward God and God's purposes.

Justice

- In addition, people should consider their individual health care decisions within the context of the just distribution of health care resources.

Conclusion

- Accepting health care as a shared endeavor requires commitment of all people to the well-being of their neighbor and themselves.
- The Gospel offers the world the hope of abundant and everlasting life that liberates us from idolatry of health and fear of death. Out of this freedom, Christians can accept the limits of this life and seek to realize a vision of health care for all people as a shared endeavor.

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Sufficient, Sustainable Livelihood for All
Social Statement on Economic Life
Adopted (872-124) by 1999 Churchwide Assembly

The Church Confesses

- We are called to love the neighbor and be stewards in economic life, which, distorted by sin, is still God's good creation.

Our Obligation and Ongoing Tensions

- While a market economy assumes people will act to maximize their own interests, we acknowledge that what is in our interest must be placed in the context of what is good for the neighbor.
- While competitiveness is key to economic success, we recognize that intense competitiveness can destroy relationships and work against the reconciliation and cooperation God desires among people.

Livelihood: Vocation, Work, and Human Dignity

- We call for addressing the barriers individuals face in preparing for and sustaining a livelihood (such as lack of education, transportation, child care, and health care).
- We commit ourselves as a church to provide adequate pension and health benefits, safe and healthy work conditions, sufficient periods of rest, vacation, and sabbatical, and family-friendly work schedules.

Sufficiency: Enough, but not too much

- "Sufficiency" means adequate access to income and other resources that enable people to meet their basic needs, including nutrition, clothing, housing, health care, personal development, and participation in community with dignity.
- Justice seeks fairness in how goods, services, income, and wealth are allocated among people so that they can acquire what they need to live.

Sustainability: of the Environment, Agriculture, and Low-Income Communities

Sustainable development of low-income communities

- Government and the private sector also must invest in health, education, and infrastructures necessary for sustainable development. When people and resources are connected in ways that multiply their power and effectiveness, this will help bring about productive results and meaningful participation in community and economic life.

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Affordable Care Act Timeline

Affordable Care Act, March 23, 2010

On March 23, 2010, President Obama signed the Affordable Care Act. The health care law extends insurance to more than 30 million people, primarily by expanding Medicaid and providing federal subsidies to help lower- and middle-income Americans buy private coverage. The law puts in place comprehensive health insurance reforms that will roll out over four years and beyond, with most changes taking place by 2014. Some changes had already been in effect prior to the signing.
http://www.healthcare.gov/law/timeline/

Supreme Court Ruling, June 28, 2012

The Supreme Court ruled that the Affordable Care Act was constitutional. The court ruled that the mandate at the heart of the act, which requires Americans to obtain minimum health insurance coverage or pay a penalty, falls within Congress' power under the Constitution to "lay and collect taxes." However, the Supreme Court also ruled that states have the option of declining a planned expansion of Medicaid for their state's residents. National Federation of Independent Business vs. Sebelius
http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf

Update from Portico Benefits Services, July 10, 2012

Health care reform will likely bring significant change to the ELCA health plan in 2014. A Portico webinar recording from July 10, 2012 on the Supreme Court's ruling on health care is available here: https://vimeo.com/45843615 . Portico intends to create more webinars to address the health care reform questions.

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