

The Benefits Plan 2019

of the Presbyterian Church (U.S.A.)



THE BOARD OF PENSIONS
OF THE PRESBYTERIAN CHURCH (U.S.A.)

The Benefits Plan of the
Presbyterian Church (U.S.A.)

2019

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The Benefits Plan of the Presbyterian Church (U.S.A.)

GENERAL PROVISIONS

ARTICLE I

INTRODUCTION

Sec. 1.1 Name of Benefits Program. The name of the integrated benefits program of the Presbyterian Church (U.S.A.) is “The Benefits Plan of the Presbyterian Church (U.S.A.)” and is hereinafter referred to as the “Benefits Plan.” The Benefits Plan consists of the Pension Plan, Retirement Savings Plan, Death and Disability Plan, Medical Plan and the Optional Benefits programs. Subject to the Plan’s eligibility, participation, and enrollment requirements, an employer may elect to provide its employees with the coverage options under the Plan as described in Article IV.

Sec. 1.2 Purpose. The Board of Pensions and the Benefits Plan were established by the Presbyterian Church (U.S.A.) to provide retirement, disability, death, medical, and optional benefits coverage for its churches and associated employers to offer to their Ministers and other employees and their eligible dependents and beneficiaries.

Sec. 1.3 History of Benefits Plan. The Benefits Plan is a continuation of The United Presbyterian Pension and Benefits Plan adopted by the General Assembly of the United Presbyterian Church in the United States of America in 1958, as the same has been amended, and the Ministers’ Annuity Fund and Employees’ Annuity Fund adopted by the General Assembly of the Presbyterian Church in the United States in 1926 and 1942, and the Group Life and Medical Plan and Group Dental Program, as the same have been amended, and as all of the foregoing are amended and restated herein.

Sec. 1.4 Construction and Applicable Law. The Benefits Plan is intended to be a “church plan” as defined in Section 414(e) of the Internal Revenue Code of 1986 (the “Code”) and in Title I of the Employee Retirement Income Security Act, as the same may be amended from time to time. The Plan shall be construed and administered in accordance with the laws of the Commonwealth of Pennsylvania. With respect to Puerto Rico Members enrolled in the Pension Plan, the Pension Plan also shall be governed and construed in accordance with the applicable provisions of the Puerto Rico Tax Code as set forth in Appendix E hereto.

ARTICLE II

DEFINITIONS

Sec. 2.1 Definitions. When used in this Plan, the following capitalized terms shall have the meanings set forth below. Additional defined terms specific to certain benefits are set forth elsewhere in the Plan (e.g., Sec. 12.1).

(a) **ACTIVE MEMBER.** A Minister or other employee who is eligible and currently enrolled for coverage in the Plan under Sec. 4.2 or enrolled in Transitional Participation Coverage under Sec. 5.1(e) and whose dues are not delinquent.

(b) **ACTUARIAL (OR ACTUARIALLY) EQUIVALENT.** Equality in value of the aggregate amounts expected to be received under different forms of pension and survivor's pension benefit distribution options based upon generally accepted actuarial methods and such mortality, interest, and other assumptions as may, from time to time, be adopted by the Board and set forth in Appendix A, as it may be amended from time to time.

(c) **ACTUARY OR ACTUARIES OF THE PLAN.** The individually enrolled actuary or actuaries, or firm or firms including one or more actuaries, selected by the Board to provide actuarial services in connection with the administration of the Plan.

(d) **BENEFIT COMMENCEMENT DATE.** The date as of which the first benefit is due to a Member under the terms of the Plan's benefits coverage. The Benefit Commencement Date for disability benefits (the "Disability Benefits Commencement Date") is the 91st day of the period during which the Member is Disabled or the day following the last day of any employer severance pay.

(e) **BOARD.** The Board of Pensions of the Presbyterian Church (U.S.A.), a Pennsylvania nonprofit corporation.

(f) **CHILDREN (OR CHILD).** A Member's Children (natural children, legally adopted children, or stepchildren) for each of whom the Member is providing at least fifty percent (50%) support. For purposes of eligibility for coverage as a Dependent under the Medical Plan, the support requirement is not applicable, except in the case of extended coverage for an adult child age 26 or older who is Totally Disabled.

(g) **CHURCH.** The Presbyterian Church (U.S.A.).

(h) **CONGREGATIONAL MINISTERS' MEDIAN.** The annual churchwide median Effective Salary of Ministers serving congregations of the Church and enrolled for Benefits Plan coverage for the immediately preceding Plan Year as the same may be determined by the Board from time to time.

(i) **COVERED PERSON.** A Member, Spouse, and their eligible Children and a Surviving Spouse, provided that each individual is enrolled for benefits coverage under the Plan and the dues required for their coverage, if any, are not delinquent.

(j) **DEATH AND DISABILITY PLAN.** Articles I through VI, X, XI, XVIII, and XIX of the Benefits Plan constitute the Death and Disability Plan.

(k) **DEATH BENEFIT BASIS.** The greater of (i) the Member's Pension Participation Basis or (ii) the Employment Classification Median.

(l) **DEPENDENT.** When used in the Plan, it means any individual other than a Spouse for whom the Member is, or was immediately prior to the Member's death, providing at

least fifty percent (50%) support. For purposes of eligibility for coverage as a Dependent under the Medical Plan, the support requirement is not applicable, except in the case of extended coverage for an adult child age 26 or older who is Totally Disabled.

(m) **DISABILITY (OR DISABLED).** The inability of a Member due to sickness or bodily injury to perform substantially all of the material duties of his or her regular work and, after a period of twenty-four (24) consecutive months of such disability, the inability of a Member due to sickness or bodily injury to perform any type of work for which he or she is fitted by education, training, or experience, all of which conditions must be certified by the Board.

(n) **DISABLED MEMBER.** A Member who has been certified as Disabled under Sec. 11.2 and is receiving benefits under Article XI.

(o) **EFFECTIVE DATE.** The Benefits Plan became effective on January 1, 1987. The Effective Date of this restatement of the Plan is January 1, 2019.

(p) **EFFECTIVE SALARY.** Any compensation received during a Plan Year by a Plan Member from an employer, including but not limited to any sums paid as a housing (including utilities and furnishings) allowance. Effective Salary shall also include (1) any deferred compensation (funded or unfunded) credited to or contributed on account of a Member by an employer during a Plan Year, with the exception of any amounts contributed as an employer contribution to the Retirement Savings Plan under a matching contribution program that is available to at least all employees of the employer in the same employment classification, and (2) any salary reduction contributions to a plan or other arrangement providing a tax-favored benefit. Effective Salary does not include amounts received for reimbursement of professional expenses through an accountable reimbursement plan or Social Security amounts up to fifty percent (50%) of a minister's Self-Employment Contributions Act obligations. With respect to a Member eligible for a housing allowance, the amount for housing is calculated as follows: If a Manse is provided, the amount shall be at least thirty percent (30%) of all other compensation described above; if no Manse is provided, the amount shall be the actual housing allowance.

(q) **ELIGIBLE FAMILY.** A Spouse (including a Surviving Spouse and former Spouse where applicable) and all Children enrolled for Plan benefits coverage.

(r) **ELIGIBLE SERVICE.** Employment by the Church or any board, agency, or local church under the jurisdiction of the Church; any employment approved by the General Assembly or a presbytery of the Church; employment by an organization eligible for participation in the Plan under Sec. 3.1; or any validated service of a Minister, regardless of whether the employer is participating in the Plan.

(s) **EMPLOYER AGREEMENT.** The form that an eligible employer completes and submits to the Board to enroll Ministers and other employees for coverage in the Benefits Plan. In the Employer Agreement, the employer designates its eligible employment classifications, coverage elections for each class, contribution requirements for employees (where permitted), and other participation terms elected by the employer and agrees to remit the requisite dues.

(t) **EMPLOYMENT CLASSIFICATION MEDIAN.** The annual churchwide median Effective Salary for employees enrolled for Plan benefits coverage that is determined by the Board for each employment classification designated for this purpose by the Board. When applicable, benefits for a Member based on an Employment Classification Median shall be reduced proportionally using the following ratio: the number of hours of employment of the Member during such Plan Year that are fewer than one thousand eight hundred twenty (1,820) hours compared to one thousand eight hundred twenty (1,820) hours.

(u) **EPO BENEFITS.** The exclusive provider organization Medical Plan coverage option described in Secs. 13.1 and 13.3 that reimburses for Medical Costs of Network Providers only.

(v) **FORMER PLANS.** The former United Presbyterian Pension and Benefits Plan, and Ministers' Annuity Fund and Employees' Annuity Fund of the Presbyterian Church in the United States.

(w) **HDHP BENEFITS.** The Medical Plan's high deductible health plan coverage option described in Secs. 13.1 and 13.4. HDHP Benefits have a higher deductible than the PPO and EPO Benefits options and are qualified to be offered with a health savings account.

(x) **INSTALLED PASTOR.** A Minister who is serving in a called and installed pastoral relationship with a local church as defined in Section G-2.0504a of the *Book of Order of the Presbyterian Church (U.S.A.)*.

(y) **MANSE.** Housing, which may include rental or other living accommodation that is furnished to a Minister Member by an employer without charge to the Member.

(z) **MAXIMUM DISABILITY BENEFITS BASIS.** The maximum Effective Salary established by the Board, in its sole discretion, upon which benefits under Secs. 7.2 and 11.3(c) are based, is one hundred thousand dollars (\$100,000) effective January 1, 2015.

(aa) **MEDICAL PLAN.** Articles I through VI, XII, XIII, XIV, XVIII, and XIX of the Benefits Plan, which collectively describe the benefits terms and options available for Active Medical, Medical Continuation, and Medicare Supplement coverage.

(bb) **MEMBER.** An individual (i) whose enrollment as an Active Member has been received and accepted by the Board, (ii) who is a Terminated Vested Member, (iii) who is a Disabled Member, or (iv) who is a Retired Pensioner.

(cc) **MINISTER.** A Minister of the Word and Sacrament (sometimes referred to as a teaching elder) is an ordained minister of the Church committed to teaching the faith and may serve in a variety of ministries, as authorized by the presbytery, as defined in G-2.0501 of the *Book of Order of the Presbyterian Church (U.S.A.)*.

(dd) **MINISTER MEMBER.** A Minister employed by an eligible employer, as defined in Sec. 3.1, and enrolled for Benefits Plan coverage under Sec. 4.1.

(ee) **NORMAL RETIREMENT AGE.** Attainment of sixty-five (65) years of age.

(ff) NORMAL RETIREMENT DATE. First day of the month beginning on or after the date of Member's sixty-fifth (65th) birthday.

(gg) OPTIONAL BENEFITS. The optional benefits programs that an eligible employer may elect to offer to all or a classification of its eligible employees, including the dental benefits and vision materials programs described in Articles XV and XVI, and such other benefits programs as the Board may offer in the future.

(hh) PASTOR'S PARTICIPATION. Pastor's Participation consists of enrollment of a Minister Member under Sec. 4.1(a) for non-contributory coverage for retirement pension and survivor's pension (Article VIII), death (Article X), disability (Article XI), and family medical PPO Benefits described in Sec. 13.2 and the offer of elective contribution participation in the Retirement Savings Plan (Article IX).

(ii) PENSION COVERAGE. Enrollment of a Member who has satisfied the applicable requirements of Articles IV and V for coverage in the Pension Plan.

(jj) PENSION CREDITS. The total amount of (i) all credits accrued by a Member under Article VII of the Pension Plan as of any given point in time for years of Pension Coverage, including credits from Experience Apportionments, and/or credits accrued while receiving benefits as a Disabled Member, and (ii) all credits from whatever source that have accrued to a Member prior to the Effective Date of the Benefits Plan from such Member's membership in the former United Presbyterian Pension and Benefits Plan (or, if applicable, the Actuarial Equivalent expressed in credits of the amount of the alternate pension as of December 31, 1986), under Article I, Section A(1) of such plan; the former Ministers' Annuity Fund of the Presbyterian Church in the United States; or the former Employees' Annuity Fund of the Presbyterian Church in the United States.

(kk) PENSION PARTICIPATION BASIS. The greater of (i) Effective Salary or (ii) twenty-five percent (25%) of the Congregational Ministers' Median, but no more than the maximum compensation amount permitted for consideration to a qualified plan under Section 401(a)(17) of the Internal Revenue Code.

(ll) PENSION PLAN. Articles I through VIII, XVIII, and XIX of the Benefits Plan constitute the Pension Plan.

(mm) PLAN. The official terms and conditions of the Benefits Plan of the Presbyterian Church (U.S.A.) as set forth herein, as it may be amended from time to time.

(nn) PLAN YEAR. A consecutive twelve (12)-month period commencing January 1 and terminating December 31.

(oo) POST-NORMAL RETIREMENT. The retirement of a Member on a date subsequent to the Normal Retirement Date.

(pp) POST-RETIREMENT SERVICE. Employment in Eligible Service by a Member after the Member has initiated retirement benefits under the Pension Plan, which Eligible Service

has been approved by the Board, in its sole discretion, pursuant to Secs. 8.9 and 8.10 as not causing a temporary suspension of retirement benefits for such Member.

(qq) PPO BENEFITS. The preferred provider organization Medical Plan coverage option described in Secs. 13.1 and 13.2 that reimburses for Medical Costs of Network and Non-Network Providers.

(rr) QUALIFIED DOMESTIC PARTNER. An individual who is in a legally sanctioned same-gender union other than a marriage (such as a state-licensed civil union or state-licensed domestic partnership) with a Member affording rights of inheritance under the laws of the jurisdiction where the union occurred. A Qualified Domestic Partner enrolled by a Member for benefits coverage during the period January 1, 2013, through December 31, 2016, based on a state-licensed civil union or state-licensed domestic partnership with the Member (and not a marriage under state law) shall be deemed a “Spouse” under this Plan and may continue to be enrolled for benefits coverage as a Spouse of the Member on and after January 1, 2017, for the duration of that relationship.

(ss) REQUIRED BEGINNING DATE. The date by which a Member with accrued vested Pension Credits must begin to receive retirement pension benefits under Article VIII. The Required Beginning Date is no later than April 1 of the calendar year following the later of (i) the calendar year in which the Member attains age 70½ or (ii) the calendar year in which the Member retires from Eligible Service.

(tt) RETIRED PENSIONER. A Member who has initiated his or her retirement benefits under the Pension Plan.

(uu) RETIREMENT SAVINGS PLAN. The Section 403(b)(9) of the Code retirement income account plan described in Article IX, permitting elective deferrals, employer and matching contributions and providing defined contribution retirement benefits.

(vv) RULE OF 70. The minimum age and participation a Member must satisfy to be eligible for designated benefits under the Plan. To satisfy the Rule of 70, the Member must have: (1) participated as an Active Member of the Plan for at least five years; (2) attained at least age fifty-five (55) at the time he or she ceased being an Active Member; and (3) a combined result of seventy (70) when the individual’s age and years of participation as an Active Member of the Plan at the time of termination of service are added together.

(ww) SPOUSE. An individual who is legally married to a Member and in a marriage that conforms to the definition of marriage in the *Book of Order* of the Presbyterian Church (U.S.A.). A Qualified Domestic Partner enrolled by a Member for benefits as a covered partner during the period January 1, 2013, through December 31, 2016, based on a state-licensed civil union or state-licensed domestic partnership with the Member shall be deemed to be a Spouse under this Plan and may continue to be enrolled for benefits coverage and qualify for spousal benefits on and after January 1, 2017.

(xx) SURVIVING SPOUSE. The Spouse of a Member on the date of a Member’s death who survives the death of the Member.

(yy) **TERMINATED VESTED MEMBER.** An individual with accrued vested Pension Credits who is not an Active Member, a Disabled Member, or a Retired Pensioner.

(zz) **TOTALLY DISABLED.** A physical, emotional, or mental condition which, in the sole opinion of the Board or its designated medical counsel, so seriously impairs an individual that the individual is unable to live independently, even in a supportive environment.

(aaa) **TRANSITIONAL PARTICIPATION COVERAGE.** The coverage available to a Member who was enrolled for Pastor's Participation in the Plan as an active employee under Sec. 3.2 and who has been approved for coverage following a change in employment status in accordance with Sec. 5.1(e).

(bbb) **YEAR OF PLAN PARTICIPATION.** A period of twelve (12) months, which need not be consecutive, during which a person employed in Eligible Service is also enrolled for participation in the Plan.

(ccc) **YEAR OF SERVICE.** A period of service of twelve (12) months, which need not be consecutive, during which a person is employed in Eligible Service. For purposes of vesting under Sec. 6.4 of the Pension Plan, a Year of Service shall also include any period of qualified military service deemed to constitute service of a deceased Member under Section 401(a)(37) of the Code and applicable regulations.

EMPLOYER PROVISIONS

ARTICLE III

ELIGIBILITY

Sec. 3.1 Eligible Employers. Churches and employers controlled by or associated with the Presbyterian Church (U.S.A.) and employers of Ministers engaged in the exercise of ministry validated by the Church, regardless of the source of the Minister's compensation for such ministry, may participate in the Plan by entering into an Employer Agreement with the Board. Employers of Ministers engaged in the exercise of ministry validated by the Church that are not controlled by or associated with the Church are eligible only to enroll their Ministers for coverage.

Sec. 3.2 Eligibility. The Employer Agreement shall specify the Ministers and other employees whom the employer determines are eligible for enrollment for benefits coverage under the Plan, subject to the following eligibility requirements of the Plan:

(a) **MINISTERS.**

- (1) Installed Pastors shall be enrolled by their employers for Pastor's Participation upon commencement of employment in accordance with Section G-2.0804 of the *Book of Order* of the Presbyterian Church (U.S.A.).
- (2) All other Ministers normally scheduled to work at least twenty (20) hours per week in active service may be enrolled by their employer
 - (A) for Pastor's Participation, or
 - (B) for such other benefits as the employer offers to its other employees under Sec. 4.1(b) and (c).
- (3) A Minister working in the exercise of ministry in self-employed service validated under Section G-2.0503a of the *Book of Order* of the Presbyterian Church (U.S.A.) shall be considered the employer for purposes of enrolling the Minister for coverage under Sec. 3.2(a)(2) and shall enter into an Employer Agreement as the employer with the Board under Sec. 3.1. Notwithstanding Sec. 3.2(a)(2), there is no minimum weekly hours of active service requirement for a Minister serving in self-employed validated service to enroll for Medical Plan coverage.

(b) **OTHER EMPLOYEES.** Subject to the requirements of Sec. 4.2, an eligible employer may enroll an employee for coverage under the Plan if such employee (1) has commenced employment and (2) is normally scheduled to work at least twenty (20) hours per week in active service. Notwithstanding the foregoing sentence, an eligible employer may offer

all employees the opportunity to enroll for participation in the Retirement Savings Plan; there is no minimum-hour employment requirement to participate in the Retirement Savings Plan.

(c) SEMINARIANS. Subject to the Medical Plan's enrollment and subscription requirements for seminarians, a seminary student who is an inquirer or candidate for ordination and in a covenant relationship with a presbytery may subscribe for Medical Plan coverage while enrolled in full-time study and upon payment of the applicable dues.

(d) The Board, in its sole discretion, may establish minimum hour employment requirements for enrollment for certain benefits coverage offered under the Plan.

ARTICLE IV

PARTICIPATION

Sec. 4.1 Employer Election of Participation Options. Subject to the following requirements, an employer may elect to offer all of its employees, or classifications of its employees, the opportunity to enroll for all or some of the benefits coverage options of the Plan and designate the eligibility requirements, coverage options, and contribution requirements for their enrollment in the Employer Agreement.

(a) A local church is required by the *Book of Order* of the Presbyterian Church (U.S.A.) to enroll all Installed Pastors in the Plan's Pastor's Participation, consisting of enrollment in the Pension Plan, Retirement Savings Plan (elective contribution), Death and Disability Plan, and Medical Plan PPO Benefits upon the commencement of employment. An employer may elect to enroll its other Ministers in Pastor's Participation or may elect to offer its other Ministers coverage under the participation options described in subsection (b).

(b) An employer may offer its employees (other than Installed Pastors) benefits coverage under one or any combination of the Pension, Retirement Savings, Death and Disability, Medical, and optional benefits programs. Coverage for the benefits will be effective as of the later of (i) the date the employee commences eligible employment, (ii) the expiration of any employer waiting period after the employee becomes eligible for the coverage, or (iii) January 1 of the year for which the employer first elected to offer the coverage to the employee's employment classification. An initial benefits eligibility waiting period established by an employer may not exceed any limit established by applicable law.

(c) Except for Board-approved grandfathered coverage for enrolled Plan members, an employer must offer each eligible member of a designated employment classification enrollment on the same terms and conditions as each other member of that employment classification. Any employment classification established by an employer for purposes of Plan participation should be based on reasonable job classifications and be non-discriminatory under applicable law.

Sec. 4.2 Enrollment Responsibilities.

(a) To participate in Benefits Plan, an employer must:

- (1) Complete an Employer Agreement (as required under Sec. 4.1) selecting the benefits coverage options and designating the employee classifications eligible for enrollment in such options and any required employee contributions for the dues if the employee enrolls for such coverage, which Agreement must be accepted by the Board as being complete and submitted within the time period specified;
- (2) Cause its eligible employees to enroll for coverage within the time periods specified under Sec. 4.2(b), and
- (3) Pay all dues required by Article V.

(b) Employees may enroll for the coverage options selected by their employer: (1) within sixty (60) days of commencement of employment upon initial employment or reemployment with the employer, or the initial benefit eligibility date established by the employer (if later), and the coverage shall be effective as of the later of the first date of employment, reemployment, or eligibility; (2) during any annual enrollment period offered by the Board and the coverage shall be effective as of January 1 of the next Plan Year, or (3) within sixty (60) days of becoming eligible for any special enrollment period as a result of an eligible life change in which event the coverage shall commence as of the date of the life change. An initial benefit eligibility waiting period established by an employer may not exceed any limit established by applicable law.

(c) An employer may establish, modify, or terminate the Plan benefits options it has selected for its employees, or classifications thereof, annually by completing a new Employer Agreement, and such changes shall be effective as of January 1 of the next calendar year.

(d) Employees may change their Plan enrollment elections (including termination of coverage) during any annual enrollment period offered by the Board and such change will be effective as of January 1, or within sixty (60) days of becoming eligible for a special enrollment period as a result of an eligible life change and such enrollment election change will be effective as of the date of the life change.

Sec. 4.3 Optional Benefits. An employer must offer Minister Members enrolled in Pastor's Participation the opportunity to enroll in any dental benefits program offered by the Board. An eligible employer is not required to but may offer optional benefits to any other classification of eligible employees.

Sec. 4.4 Termination of Enrollment. Unless coverage is terminated at an earlier date by an employer or by the Board on account of a dues delinquency, an employee's enrollment as a Minister in Pastor's Participation coverage, and the employer's obligation to pay dues for such Member, shall terminate on the Member's last day of employment in Eligible Service for that employer, and an employee's enrollment as a Minister or other employee for coverage under Sec. 4.1(b), and the employer's obligation to remit dues for such Member, shall terminate on the last date of the month following the Member's termination of Eligible Service for that employer.

ARTICLE V

DUES

Sec. 5.1 Required Dues.

(a) For Minister Members enrolled for Pastor's Participation, the employer shall remit the following dues, on a non-contributory basis:

- (1) Dues for Pension Coverage and death and disability coverage under Sec. 10.1(a) shall be a total of twelve percent (12%) of the Member's Pension Participation Basis.
- (2) Dues required to provide Member and Eligible Family Medical Plan PPO Benefits shall be the greater of (1) the lesser of a percentage established annually by the Board multiplied by the Member's Effective Salary or the PPO Benefits maximum dues rate for Family coverage, or (2) the minimum dues rate for PPO Benefits Family coverage established by the Board.

(b) For Minister Members and all other employees enrolled for benefits on other than the Pastor's Participation basis, the employer shall remit the following dues:

- (1) Dues for Pension Coverage shall be eleven percent (11%) of the Member's Pension Participation Basis and shall be paid by the employer on a non-contributory basis.
- (2) Dues for death and disability coverage under Sec. 10.1(a) shall be a rate or percentage of Effective Salary (with minimums and maximums) established annually by the Board. Dues for Group Term Life Coverage under Sec. 10.1(b) shall be at rates authorized by the Board. Death and disability dues for coverage under Secs. 10.1(a) and (b) shall be paid by the employer on a non-contributory basis.
- (3) Dues required for Member and Eligible Family medical coverage shall be established annually by the Board on the basis of pricing parameters approved by the Board's Healthcare Committee for the Medical Plan benefits options and coverage levels. An employer may not require a Member to contribute more than fifty percent (50%) of the dues for Member-only coverage in the lowest cost benefits option offered by the employer. An employer may require a Member to contribute up to one hundred percent (100%) of the dues for medical coverage elected for Eligible Family member(s).

(c) Notwithstanding the provisions in Sec. 5.1(a) and (b) above, the Board, in its sole discretion, may offer targeted reductions or waivers of dues for the purpose of encouraging

employers to offer coverage under the Benefits Plan to employees or classifications of employees.

(d) ***Other Benefits Options.*** The Board shall establish the dues required for Supplemental Death, Supplemental Disability, Medicare Supplement, Medical Continuation, and optional benefits.

(e) ***Transitional Participation Coverage.*** A Minister Member enrolled for Pastor's Participation who is, in the sole determination of the Board, temporarily unemployed or on an approved leave of absence, may enroll to continue coverage for all or some of the Plan benefits, at his or her own cost, but only to the extent the Member was enrolled for such coverage prior to the change in employment status. The Minister Member may enroll for such period as may be determined by the Board.

- (1) A Minister Member enrolled for Transitional Participation Coverage may elect to pay dues for pension, death and disability, and/or medical coverage and receive benefits on the basis of either the Member's most recent Effective Salary or the Congregational Ministers' Median.
- (2) A Minister Member must apply for Transitional Participation Coverage within sixty (60) days of the termination of Eligible Service.

(f) ***Extension of Medical Plan Coverage on Member's Death.*** If an Active Member dies while enrolled for full coverage in Pension, Death and Disability, and Medical Plan benefits under Sec. 4.1(a) or Sec. 4.1(b), the Medical Plan coverage then in effect shall continue for the Member's Eligible Family member(s) who were enrolled in the Active Medical Plan on the date of such Member's death for a period of one (1) year from the date that the Member died. No payment of dues or other subscription charges shall be required during this coverage period but the Eligible Family member(s) shall be responsible for any deductible and copayment obligations required under the Medical Plan coverage. Thereafter, the Member's Eligible Family member(s) who were enrolled in the Medical Plan may subscribe for Medical Continuation coverage under Sec. 12.11 or Secs. 14.1 and 14.2 of the Medicare Supplement coverage, as appropriate.

(g) ***Continuation of Death Benefits for Member upon Termination of Eligible Service.*** Upon disenrollment of coverage under Sec. 4.1(a) due to a termination of Eligible Service, a Minister Member who has not elected to enroll for continuation of coverage under Transitional Participation shall continue to have coverage for death benefits under Article X at no additional cost to the Member or his or her employer for an additional ninety (90) days.

Sec. 5.2 Payment of Dues. The required dues shall be remitted to the Board by the employer of the Member or by the Minister Member, if personally remitting dues or enrolled for Transitional Participation Coverage, or the Member or Covered Person for Medical Continuation and Medicare Supplement in installments on a monthly basis in advance or at such other time or times as may be specified by the Board. The Board reserves the right to terminate or suspend the benefits entitlement of any Covered Person for whom dues payments are delinquent. Dues are delinquent if on a monthly billing basis, they are not paid in full by the first day of the next month.

Sec. 5.3 **Late Charge.** A dues payment shall be considered delinquent if it is not made by the last day of the period designated by the Board for payment of dues. An additional fee or charge for loss of interest earnings and additional administrative costs of collection shall be made in such amount as may be set by the Board from time to time with such charge commencing to run on the first day the dues payment is considered delinquent.

PENSION PLAN

ARTICLE VI

SERVICE AND VESTING

Sec. 6.1 Period of Service. In determining a Member's vested status under the Pension Plan, all Years of Service shall be considered.

Sec. 6.2 Commencement of Period of Service. A period of service for purposes of calculating a person's Years of Service shall commence on the date a person who satisfies the applicable eligibility requirements of Sec. 3.2.

Sec. 6.3 Termination of Period of Service. Except for a Disabled Member or a Minister Member enrolled in Transitional Participation Coverage, a period of service for purposes of calculating a person's Years of Service shall end upon termination of enrollment as an Active Member in the Pension Plan.

Sec. 6.4 Vesting of Pension Benefits. Benefits provided by the Pension Plan shall become vested in an Active Member or Disabled Member of the Pension Plan at the earliest of (a) the Member's completion of three (3) Years of Service, (b) the Member's attainment of Normal Retirement Age, (c) termination of the Pension Plan, or (d) discontinuance of his or her employer's participation in the Pension Plan for such Member's employment classification. After completing three (3) Years of Service, a Member shall be fully vested and eligible to receive all benefits to which he or she may be entitled by the terms of the Pension Plan, to the extent of his or her accrued Pension Credits. For purposes of this Sec. 6.4, the term "Years of Service" shall include (a) all employment in Eligible Service, (b) Eligible Service while a Member of one of the Former Plans during which time all requisite dues had been paid, and (c) years in seminary under the care of a presbytery, provided that the seminarian becomes a Minister and commences service in a validated ministry of the Church.

Sec. 6.5 Vested Benefits from Membership in Former Plans. Any vested benefits or options to which a Member of one of the Former Plans was entitled pursuant to Article II, Sec. 3 of The United Presbyterian Pension and Benefits Plan, Sec. 2.4 of the Ministers' Annuity Fund, or Sec. 2.5 of the Employees' Annuity Fund shall be available to such Member who is a Member of this Plan.

ARTICLE VII

PENSION CREDITS

Sec. 7.1 Accrual of Pension Credits. For each Plan Year, or part thereof, during which a Member is enrolled as an Active Member in the Pension Plan, such Member shall accrue Pension Credits equal to the greater of one and one-quarter percent (1¼%) of

- (a) the Member's Pension Participation Basis for that year; or

- (b) the annual Employment Classification Median. Pension credits accrued under this Sec. 7.1(b) shall be reduced proportionally to the same ratio that the number of hours of employment of the Member during the Plan Year, which are fewer than one thousand eight hundred twenty (1,820) hours bears to one thousand eight hundred twenty (1,820) hours.

Members participating in the Pension Plan under the Transitional Participation Coverage option of Sec. 5.1(e) shall accrue credits on the same basis on which they are paying dues for Pension Coverage. No credits shall accrue to a Member for whom dues are not paid in full or who is not enrolled for Pension Coverage.

Sec. 7.2 Accrual of Credits during Disability. Notwithstanding Sec. 7.1 to the contrary, for any period during which a Disabled Member is entitled to Pension Coverage under Sec. 11.5, such Member shall accrue Pension Credits equal to the greater of one and one-quarter percent (1¼%) of

- (a) the Member's Pension Participation Basis, but not more than the Maximum Disability Benefits Basis applicable on the Disability Benefits Commencement Date, as determined by the Board; or

- (b) the Employment Classification Median Pension Credits accrued under this Sec. 7.2(b) shall be reduced proportionally to the same ratio that the number of hours of employment of the Disabled Member during the Plan Year immediately preceding the commencement of the Disability which were fewer than one thousand eight hundred twenty (1,820) hours bears to one thousand eight hundred twenty (1,820) hours.

Members who become eligible for Disability benefits while participating in the Pension Plan under the Transitional Participation Coverage option of Sec. 5.1(e) shall accrue credits on the basis of their Transitional Participation Coverage. No credits shall accrue to a Disabled Member for whom dues are not paid in full or who was not enrolled for Pension Coverage at the commencement of the Disability.

Sec. 7.3 Experience Apportionments. Should Pension Plan assets, due to favorable investment and actuarial experience, be accumulated over and above those required for actuarial reserves, general contingency reserves, and other special reserves, as determined by the Board, such funds may, in the sole discretion of the Board, be apportioned among the Members of the Pension Plan and their eligible survivors in the form of increased benefits or Pension Credits or both in such manner as to equitably distribute such apportionment among those persons who on the date of such apportionment are receiving retirement or survivor's benefits and those persons with accrued Pension Credits who are not then Retired Pensioners. No person shall have a right to any such apportionment unless and until it has been authorized, and such authorization, availability of funds, determination of eligibility, and manner of distribution shall be solely within the discretion of the Board. Experience Apportionments granted by the Board since the adoption of the Benefits Plan in 1987 are listed in Appendix B.

ARTICLE VIII

RETIREMENT PENSION BENEFITS

Sec. 8.1 Normal Pension. A Member of the Pension Plan shall be entitled to initiate annual retirement benefits, payable monthly, in an amount equal to 1/12 of such Member's accrued Pension Credits provided that such Member has

- (a) attained age sixty-five (65);
 - (b) terminated employment with his or her most recent Eligible Service employer;
- and
- (c) completed the Board's application for retirement benefits, which application has been accepted by the Board as being complete and evidencing entitlement to retirement pension benefits.

Sec. 8.2 Early Retirement Options. A vested Member who satisfies Sec. 8.1(b) and (c) above may elect to initiate early retirement benefits, payable monthly, at any time after attaining age fifty-five (55). Early retirement benefits are payable in one of the following forms:

(a) **STANDARD EARLY RETIREMENT.** Under this option, the amount of the annual pension beginning as of the Benefit Commencement Date shall be adjusted as of the Member's early retirement Benefit Commencement Date on the basis of the Early Retirement Option Factors listed in Appendix A or on such other basis as may have been applicable to Pension Credits accrued prior to December 31, 1986.

(b) **LEVEL INCOME BASIS EARLY RETIREMENT.** A vested Member in the Pension Plan who has not attained age sixty-two (62) as of the date of early retirement and has not elected Joint and Survivor Options II or III under Sec. 8.6, may elect to initiate early retirement benefits on a level income basis, payable monthly.

Under this option, the amount of the annual early retirement benefit (calculated in accordance with Sec. 8.2(a), above) payable beginning as of the Member's Benefit Commencement Date until the Member attains age sixty-two (62) shall be increased, and the amount of the annual early retirement benefit payable from age sixty-two (62) to the date of the Member's death shall be decreased on the basis of the Social Security Leveling Option Factors listed in Appendix A. The adjusted early retirement benefit initially payable under this Sec. 8.2(b) will be approximately equal to the aggregate of: (i) the Member's estimated Social Security primary insurance amount if commenced at age sixty-two (62), calculated on the basis of the provisions of the federal Social Security Act in effect at the date of early retirement (the "Estimated Social Security Benefit"), and (ii) the Member's adjusted early retirement benefit payable at age sixty-two (62) under the benefit option selected by the Member under Secs. 8.2 and 8.4 of the Pension Plan.

Upon attaining age sixty-two (62), the Member's annual early retirement benefit shall be reduced by the amount of the Estimated Social Security Benefit. The survivor's pension payable under

Sec. 8.4 shall not be affected by electing early retirement benefits on a level income basis under this Sec. 8.2(b). This option is not available to a Member if the adjusted retirement benefit that would be payable from the date of early retirement until attainment of age sixty-two (62) is less than the Estimated Social Security Benefit.

Sec. 8.3 Post-Normal Retirement Age Option. Under this option, a vested Member may defer commencement of his or her retirement pension benefits beyond the Normal Retirement Date but no later than the Required Beginning Date. The amount of the annual pension payable beginning on the Post-Normal Retirement Benefit Commencement Date shall be adjusted as of the Member's Post-Normal Retirement Benefit Commencement Date for the deferred Benefit Commencement Date based on the Post-Normal Retirement Option Factors listed in Appendix A.

Upon the death of a Member who has elected to commence his or her retirement pension under this Sec. 8.3, except to the extent an optional joint and survivor option was elected under Sec. 8.6, the annual survivor's pension payable monthly under Sec. 8.4 shall be equal to one-half (1/2) of the benefit being paid to the Member as of the date of death. If a Member elects to defer pension benefits under this Sec. 8.3 and dies prior to commencing benefits, the survivor's pension payable under Sec. 8.4 shall be equal to one-half (1/2) of the Pension Credits accrued by the Member as of the date of death and adjusted for the deferred Benefit Commencement Date (the date of death) based on the Post-Normal Retirement Option Factors set forth in Appendix A.

Sec. 8.4 Survivor's Pension.

(a) Upon the death of a Retired Pensioner, except to the extent an optional form of benefit was elected under Sec. 8.6 in lieu of the survivor's pension payable under this Sec. 8.4, an annual survivor's pension shall be payable monthly in the amount of one-half (1/2) of the annual Pension Credits accrued to such Member at the time of his or her death (or such other amount as appropriate under Sec. 8.3) to the survivors of such Member in one, and only one, of the classes set forth in Sec. 8.5, below, in the order of numerical priority set forth therein.

(b) Upon the death of a vested Member who dies prior to his or her Benefit Commencement Date who is survived by an eligible Surviving Spouse, an annual survivor's pension shall be payable monthly to the Surviving Spouse in an amount equal to the larger of (a) the adjusted pension the Surviving Spouse would be entitled to receive under Option I of Sec. 8.6(b) based on the date of death as the Benefit Commencement Date or (b) one-half (1/2) of the annual Pension Credits accrued to such Member at the time of his or her death.

(c) Upon the death of a vested Member who dies prior to his or her Benefit Commencement Date who is not survived by an eligible Surviving Spouse, an annual survivor's pension shall be payable monthly in the amount of one-half (1/2) of the annual Pension Credits accrued to such Member at the time of his or her death (or such other amount as appropriate under Sec. 8.3) to the survivors of such Member in one, and only one, of the classes set forth in Sec. 8.5, below, in the order of numerical priority set forth therein.

(d) Notwithstanding any provision of the Pension Plan to the contrary, effective as of January 1, 2007, in the case of a Member who leaves Eligible Service for qualified military

service and dies while in such service, the survivors of the Member shall be entitled to any additional benefits under the Pension Plan (other than the accrual of Pension Credits relating to the period of qualified military service) that would have been payable if the Member had died while an Active Member of the Pension Plan.

Sec. 8.5 Classes of Survivors. For purposes of Sec. 8.4, above, unless otherwise assigned by court order pursuant to Sec. 18.2, the survivor's pension shall be divided equally only among all of those eligible survivors in the first class listed below in which there are eligible survivors. Upon termination of payments to the last survivor in such class, the survivor's pension benefits shall be paid to the Dependent(s) in the next subsequent class, provided that the beneficiary was a Dependent on the date of the Member's death.

Class I. To the Member's Surviving Spouse for life provided the marriage took place either (i) before the Member first received any retirement or disability benefits, or (ii) at least one (1) year prior to the Member's death.

Class II. To such of the Member's Dependent Children under age twenty-one (21) who are not in a marriage (including Totally Disabled Children age twenty-one (21) or over who are not in a marriage) who were Dependent during the twelve (12) months immediately preceding and on the date of the Member's death, until age twenty-one (21) or earlier marriage; or in the case of a Totally Disabled Child who is not in a marriage, until marriage or the Board in its sole discretion determines that such individual is no longer Totally Disabled.

Class III. To the Member's Dependent parents for life.

Class IV. To such of the Member's Dependent siblings under age twenty-one (21) who are not in a marriage (including Totally Disabled siblings age twenty-one (21) or over who are not in a marriage) who were Dependent during the twelve (12) months immediately preceding and on the date of the Member's death, until age twenty-one (21) or earlier marriage; or in the case of a Totally Disabled sibling who is not in a marriage, until marriage or the Board in its sole discretion determines that such individual is no longer Totally Disabled.

Sec. 8.6 Joint and Survivor Options (Combined Retirement Pension and Survivor's Pension Benefits Options).

(a) **ELECTION OF JOINT AND SURVIVOR COVERAGE.** A Member with a Spouse who has attained age fifty-five (55) and whose marriage occurred at least one (1) year prior to his or her retirement pension Benefit Commencement Date may elect one of the options set forth below, in substitution for both the retirement benefits described in Secs. 8.1, 8.2, or 8.3 and the survivor's pension benefits described in Sec. 8.4. An election is valid and effective when submitted to the Board and received and accepted as complete by the Board prior to the Member's Benefit Commencement Date.

(b) **JOINT AND SURVIVOR BENEFIT OPTIONS.** Based on the option elected, the combined retirement pension payable to a Member pursuant to Secs. 8.1, 8.2, or 8.3, above, and survivor's pension payable to the Member's Surviving Spouse pursuant to Sec. 8.4 shall be

adjusted based on the Joint and Survivor Option Factors listed in Appendix A. If a Member's Spouse predeceases the Member after the Benefit Commencement Date and the Member remarries and is in the marriage with the new Spouse for at least a year prior to the Member's death, the Spouse surviving the Member shall be entitled to a survivor's pension benefit based on fifty percent (50%) of the pension credits accrued as of the date of the Member's death.

Option I. An adjusted retirement pension shall be payable beginning upon the Benefit Commencement Date of a Member; and upon the death of the Member, a pension equal to seventy-five percent (75%) of such adjusted retirement pension shall be payable to such Member's Surviving Spouse for life.

Option II. An adjusted retirement pension shall be payable beginning upon the Benefit Commencement Date of a Member; and after the death of the Member or the Member's Spouse, whichever first occurs, a pension equal to seventy-five percent (75%) of such adjusted retirement pension shall be payable to the survivor of them for life.

Option III. An adjusted retirement pension shall be payable beginning upon the Benefit Commencement Date of a Member; and after the death of the Member or the Member's Spouse, whichever first occurs, a pension equal to sixty-six and two-thirds percent (66 2/3%) of such adjusted retirement pension shall be payable to the survivor of them for life.

Option IV. An adjusted retirement pension shall be payable beginning upon the Benefit Commencement Date of a Member; and after the death of the Member or the Member's Spouse, whichever first occurs, a pension equal to one hundred percent (100%) of such adjusted retirement pension shall be payable to the survivor of them for life.

(c) **EFFECTIVE DATE OF ELECTION.** A Member's joint and survivor option election is effective as of his or her Benefit Commencement Date.

(d) **CANCELLATION OF ELECTION.** A Member may cancel a joint and survivor option election at any time prior to the Member's Benefit Commencement Date. Any cancellation must be made in writing on a form supplied by the Board, which cancellation must be complete and accepted by the Board on or before the last date allowable for cancellation. A Member's joint and survivor option election shall be canceled automatically upon the death of the Member's Spouse prior to the Member's Benefit Commencement Date.

Sec. 8.7 Small Benefit Distribution.

(a) **MANDATORY CASHOUT.** Notwithstanding any other provision of the Pension Plan, if the single-sum present value determined using the actuarial basis for single-sum factors described in Appendix A (the "Single-Sum Present Value") of a Terminated Vested Member's accrued Pension Credits is not greater than one thousand dollars (\$1,000) and the Member has terminated service with his or her most recent Eligible Service employer, the Board shall distribute the Single-Sum Present Value of the accrued Pension Credits in a single lump-sum.

(b) **VOLUNTARY CASHOUT.** With the irrevocable consent of the Member, the Board may distribute the Single-Sum Present Value of a Terminated Vested Member's accrued

Pension Credits in a lump-sum distribution if such value is not more than five thousand dollars (\$5,000) and the Member has terminated service with his or her most recent Eligible Service employer.

(c) **LUMP-SUM DISTRIBUTION.** Any lump-sum distribution paid under Sec. 8.7(a) and (b) shall be made as soon as practicable after termination of service with the Member's most recent Eligible Service employer. Upon payment of a Single-Sum Present Value lump-sum under this Sec. 8.7, neither the Member nor his or her eligible survivor(s) shall be entitled to any further benefits under the Pension Plan and Sec. 10.1(a) of the Death and Disability Plan for Eligible Service prior to the date of the termination of service.

(d) **SMALL PENSION OR SURVIVOR'S PENSION SETTLEMENT.**

(1) Where the amount of a given monthly pension payment to a person under this Article is less than an amount which the Board may fix from time to time as being large enough to administer effectively, the Board may, with the consent of the Member, pay such Member the Single-Sum Present Value in a lump-sum in lieu of the continuing monthly retirement pension and survivor's pension benefits payments, and neither the pensioner nor a survivor of any class shall be entitled to any further benefits under the Pension Plan.

(2) Where the amount of the monthly survivor's pension payment is less than an amount which the Board may fix from time to time as being large enough to administer effectively, the Board may, with the consent of the Member, pay the Single-Sum Present Value of all future survivor's pension benefits due to such survivor in a lump-sum in lieu of continuing monthly survivor's pension benefits.

(e) Upon receipt of a lump-sum distribution under Sec. 8.7(c), no pensioner or survivor of any class shall be entitled to any further benefits under the Pension Plan.

Sec. 8.8 Maximum Annual Benefit. Notwithstanding anything in this Plan to the contrary, in no event shall benefits under the Pension Plan violate the limitations set forth in Section 415 of the Code or the regulations thereunder, which limits are incorporated by reference herein.

Sec. 8.9 Temporary Suspension of Retirement Pension. In the event a Retired Pensioner returns to Eligible Service with an employer providing Pension Coverage to employees in the Member's employment classification, except in the case of approved Post-Retirement Service under Sec. 8.10, further pension benefits payments shall be suspended until such Member again meets the eligibility requirements for the payment of a retirement pension. During such a period of Eligible Service, such Member shall be enrolled as an Active Member of the Pension Plan and accrue additional Pension Credits. The annual pension beginning as of the Member's subsequent initiation of retirement benefits from the Pension Plan will be actuarially adjusted to reflect the pension payments previously made to the Member using the interest and mortality basis for the single-sum factors defined in Appendix A.

Sec. 8.10 Post-Retirement Service. In certain limited special situations in which it would be beneficial to both the Church and a Retired Pensioner for the Retired Pensioner to return to Eligible Service, the Board may, pursuant to special rules which may from time to time be adopted by the Board and approved by the General Assembly, approve a return to certain designated Eligible Service by the Retired Pensioner without causing a temporary suspension of the Retired Pensioner's retirement pension under Sec. 8.9 for the period of time during which such Retired Pensioner is engaged in the approved designated Eligible Service. Such Member shall not accrue Pension Credits during such approved Post-Retirement Service.

Sec. 8.11 Payment of Benefits. All benefits payable under the Pension Plan, other than lump-sum distributions pursuant to Sec. 8.7, shall be paid monthly at the beginning of each month. Payment of Pension Plan benefits shall commence as of the first day of the month consecutive with or next following the satisfaction of the applicable requirements of Secs. 8.1, 8.2, or 8.3 by a Member, an eligible survivor as defined in Sec. 8.5, or an Alternate Payee as defined in Sec. 18.2.

ARTICLE IX

RETIREMENT SAVINGS PLAN

Sec. 9.1 Eligible Employees. An eligible employer may offer participation in the Retirement Savings Plan to all employees employed in Eligible Service (other than an employee located in Puerto Rico); there is no minimum hours of service requirement for participation in the Retirement Savings Plan.

Sec. 9.2 Employer Options. Enrollment of a Minister in Pastor's Participation automatically includes enrollment in the Retirement Savings Plan for employee elective deferrals. On the Employer Agreement (described in Sec. 4.1), an employer may select the Retirement Savings Plan for other Ministers and employees, or a classification of its employees, which selection provides each eligible employee with the opportunity to enroll in the Retirement Savings Plan and to designate an annual elective deferral contribution amount. An employer may select additional contribution provisions, including employer contributions and/or matching contributions.

Sec. 9.3 Plan Document. The Board maintains supplemental plan documents for churches and qualified church-controlled organizations and non-qualified church-controlled organizations (as defined in Section 3121(w) of the Code) that describe the benefits available and the employer and participant requirements for the Retirement Savings Plan. The terms of the applicable plan document are incorporated herein by reference. In the event of inconsistencies in terms and definitions, the terms and definitions in the Retirement Savings Plan document shall govern for these benefits.

Sec. 9.4 Administration. The Board shall, from time to time, adopt such provisions and rules and regulations applicable thereto as it, in its sole discretion, deems necessary or appropriate for the administration of the Retirement Savings Plan. The Board may, in its sole discretion, designate agents to provide the record keeping, investment management, and other plan administration activities required for the Retirement Savings Plan and allocate the cost of those third-party services and its plan administration to the participants' accounts.

DEATH AND DISABILITY PLAN

ARTICLE X

DEATH BENEFITS

Sec. 10.1 Death Benefits Coverage Options.

(a) DEATH BENEFITS INCLUDED UNDER DEATH AND DISABILITY PLAN. Members enrolled by their employer for Death and Disability Plan coverage under Sec. 4.1(a) or Sec. 4.1(b) are eligible for the death benefits described in Secs. 10.2 (Salary Continuation Benefit), 10.3 (Lump-Sum Death Benefit), 10.4 (Children's Education Benefit) and 10.5 (Living Needs Benefit).

(b) GROUP TERM LIFE BENEFITS. An employer may elect to provide Group Term Life coverage (described in Sec. 10.6) to all of its employees, or classifications of its employees, other than members enrolled for Death and Disability Plan coverage under Sec. 10.1(a), by electing such coverage in one of the available coverage amounts in its Employer Agreement.

(c) SUPPLEMENTAL DEATH BENEFITS. An employer electing Death and Disability Plan coverage may also elect to offer employees enrolled for coverage under Sec 10.1(a) or 10.1(b), the Supplemental Death Benefits described in Sec. 10.7.

(d) A Member may only be enrolled for benefits coverage under Sec. 10.1(a) or 10.1(b) but not both options. With the exception of the dues for any Supplemental Death Benefits elected by a Member under Sec. 10.7, an employer is responsible for payment of all dues for coverage under Article X on a non-contributory basis and may not require a contribution from a Member for the dues.

Sec. 10.2 Salary Continuation Benefit.

(a) DEATH OF AN ACTIVE OR DISABLED MEMBER. Upon the death of an Active Member enrolled in the Death and Disability Plan, a monthly payment equal to one-twelfth (1/12) of the Member's Death Benefit Basis shall be paid to the beneficiary or beneficiaries of such Active Member for a period of twelve (12) months.

(b) DEATH OF A RETIRED PENSIONER.

(1) Upon the death of a Retired Pensioner who initiated retirement benefits under the Pension Plan immediately upon termination of Pension Coverage and was not paid a lump-sum pension benefit under Sec. 8.7, the beneficiary or beneficiaries of such Retired Pensioner shall be entitled to the same Salary Continuation Benefit set forth above on the date preceding such retirement, except that the amount of the monthly benefit shall be reduced by one-twelfth (1/12) of the amount of the monthly benefit calculated in accordance with the preceding paragraph for each

successive three (3)-month period by which the date of death follows the first date of retirement from Eligible Service. In no event, however, shall the total of twelve (12) monthly payments hereunder be less than nine thousand dollars (\$9,000). If the death occurs at or after the end of the twelfth three (3)-month period, in lieu of the periodic payments described above, the benefit shall be one single lump-sum payment of nine thousand dollars (\$9,000).

- (2) Upon the death of a Retired Pensioner who did not initiate retirement benefits under the Pension Plan immediately upon termination of Pension Coverage but (i) was receiving retirement pension benefits on January 1, 2007, or (ii) whose participation in the Plan satisfied the Rule of 70, the beneficiary or beneficiaries of such Retired Pensioner shall be entitled to one single, lump-sum payment of nine thousand dollars (\$9,000).

(c) **DEATH OF A TERMINATED VESTED MEMBER.** Upon the death of a Terminated Vested Member whose participation in the Plan satisfied the Rule of 70, the beneficiary or beneficiaries of such Terminated Vested Member shall be entitled to one single, lump-sum payment of nine thousand dollars (\$9,000).

(d) A Member shall be entitled to only one Salary Continuation Benefit under this Sec. 10.2, which shall be the greatest of the Salary Continuation Benefit calculated under Secs. 10.2(a), (b), or (c). The Salary Continuation Benefit under this Sec. 10.2 shall be paid in equal shares to such beneficiary or beneficiaries as may be named by the Member in writing on a form provided by the Board. A Member may change a beneficiary designation at any time by completing the form required by the Board which designation shall be effective only as of the date accepted by the Board. In the event that more than one beneficiary is named as a primary beneficiary, payment will be made in equal shares to all beneficiaries designated as primary who survive the Member unless otherwise designated in writing on the beneficiary form by the Member.

(e) In the event that a Member fails to properly designate a beneficiary, or no named beneficiary survives the Member, the Salary Continuation Benefit shall be paid in equal shares to the Member's survivors in the first class in which there are eligible survivors of those classes of survivors set forth below, or in default thereof to the Member's estate.

Class I. To the Member's Surviving Spouse provided the marriage took place at least one (1) year prior to the Member's death.

Class II. To such of the Member's Dependent Children under age twenty-one (21) who are not in a marriage (including Totally Disabled Children age twenty-one (21) or over who are not in a marriage) who were Dependent during the twelve (12) months immediately preceding and on the date of the Member's death.

Class III. To the Member's Children (regardless of dependency or age).

Sec. 10.3 Lump-Sum Death Benefit.

(a) **MEMBER WITH DEPENDENT COVERAGE.** Upon the death of an Active Member enrolled in the Death and Disability Plan who is survived by an eligible survivor as set forth in Sec. 8.5, a Lump-Sum Death Benefit, in an amount equal to the applicable percentage from the following schedule multiplied by the lesser of the Member's Death Benefit Basis at the time of the Member's death or one hundred thousand dollars (\$100,000), shall be paid in equal shares to the Member's survivors in the first class in which there are eligible survivors of those classes of survivors set forth in Sec. 8.5:

Member's Age at Death	Benefits as a Percentage of Death Benefit Basis
Under age 31	400%
31 but under 32	380%
32 but under 33	360%
33 but under 34	340%
34 but under 35	320%
35 but under 36	300%
36 but under 37	280%
37 but under 38	260%
38 but under 39	240%
39 but under 40	220%
40 but under 41	200%
41 but under 42	190%
42 but under 43	180%
43 but under 44	170%
44 but under 45	160%
45 but under 46	150%
46 but under 47	140%
47 but under 48	130%
48 but under 49	120%
49 but under 50	110%
50 and over	100%

(b) **MEMBER WITHOUT DEPENDENT COVERAGE.** Upon the death of an Active Member enrolled in the Death and Disability Plan who is not survived by an eligible survivor as set forth in Sec. 8.5, a Lump-Sum Death Benefit in an amount equal to one hundred percent (100%) of the lesser of the Member's Death Benefit Basis, on which dues were being paid at the time of the Member's death, or one hundred thousand dollars (\$100,000) shall be paid to the Member's estate.

Sec. 10.4 Children's Education Benefit. Upon the death of an Active Member enrolled in the Death and Disability Plan or a Retired Pensioner who initiated retirement benefits under the Pension Plan immediately upon termination of Pension Coverage, there shall be paid to each of

such Member's Children who are under the age of twenty-five (25) years an amount of ten thousand dollars (\$10,000) a year for each of the first four (4) years of study beyond high school during which such Child is in full-time attendance at an accredited school, college, university, or other institution of higher learning. The maximum aggregate lifetime benefit for any one Child is forty thousand dollars (\$40,000).

Sec. 10.5 Living Needs Benefit. An Active Member with Death and Disability Plan coverage who is certified by a physician as having an illness or physical condition that can reasonably be expected to result in death in twenty-four (24) months or less after the date of certification may apply to the Board for the early payment of the present values of the Salary Continuation Benefit and/or seventy-five percent (75%) of the Lump-Sum Death Benefit that would be payable to any Member under Sec. 10.3(b) (Member without Dependent Coverage) upon a Member's death (the "Living Needs Benefit"). The Board reserves the right, in its sole discretion and at its expense, to obtain verification from independent medical counsel of the medical condition of any Member who applies for a Living Needs Benefit.

Any amount paid to a Member as a Living Needs Benefit under this Sec. 10.5 will be offset from the amount of death benefits payable under the Death and Disability Plan at the death of the Member.

Living Needs Benefits will not be available if any one or more of the following circumstances exist: (a) the Member's illness or physical condition is due to an intentionally self-inflicted injury; (b) the Member's Death and Disability Plan coverage has been in effect for less than two (2) years; (c) the Member has made a prior assignment of the benefit; (d) the Member is required by law to use the benefit to meet claims of creditors, whether in bankruptcy or otherwise; or (e) the Member is required by a government agency to use the benefit to apply for, get, or keep a government benefit or entitlement. Living Needs Benefits will not be paid to any person or entity other than the Member.

Sec. 10.6 Group Term Life Benefits. Upon the death of a Member enrolled by an employer for Group Term Life Benefits under Sec. 10.1(b), the designated beneficiary or beneficiaries of such Member shall be paid the coverage amount in effect for the Member. Upon enrollment for the Group Term Life benefits, the Member shall designate the beneficiaries for this benefit in the enrollment forms provided by the Board. A Member may change a beneficiary designation at any time in such manner as provided by the Board, which designation shall only be effective as of the date approved and accepted by the Board. In the event that more than one beneficiary is named as a primary beneficiary, payment will be made in equal shares to all beneficiaries designated as primary who survive the Member unless otherwise designated by the Member. In the event that a Member does not have a valid beneficiary designation on record with the Board for these benefits, or no designated beneficiary survives the Member, the Group Term Life benefits shall be paid in equal shares to the Member's survivors in the order set forth in Section 10.2(e).

Sec. 10.7 Supplemental Death Benefits. Any Member enrolled for Death and Disability coverage under Secs. 10.1(a) or (b) whose employer selects Supplemental Death Benefits coverage is eligible to enroll for the Supplemental Death Benefits described in this section.

(a) **ELIGIBILITY.** A Member may enroll for Supplemental Death Benefits coverage for the Member, a Spouse, and/or their Children until attainment of age 26.

- (1) A Member may continue to enroll for coverage for a Dependent Child who is not in a marriage who is Totally Disabled beyond age 26.
- (2) A Member enrolled for Supplemental Death Benefits coverage as of the date of the Member's retirement shall have the option of continuing to subscribe for the same or lesser Supplemental Death Benefits coverage as was in effect for the Member and Spouse on the date of such retirement until a termination event under Sec. 10.7(h) by paying to the Board monthly in advance, or at such other time or times as may be specified by the Board, such amount as the Board may establish from time to time for the applicable coverage.

(b) **COVERAGE AMOUNTS AND MEDICAL INSURABILITY.** The Board shall designate the amounts of coverage for which Members may enroll to cover the Member and/or the Member's Spouse, Children under the age of 26 and Dependent Children who are not in a marriage and Totally Disabled beyond age 26 and establish the medical insurability requirements for such coverage. The Board shall provide for one or more minimum levels of coverage for which a Member may apply within sixty (60) days of initial eligibility for enrollment for Supplemental Death Benefits, which minimum levels of coverage shall not be subject to the Plan's medical insurability requirements.

(c) **ENROLLING FOR COVERAGE.** Subject to the satisfaction of any insurability requirements described in Sec. 10.7(d), a Member may within sixty (60) days of first becoming eligible under Secs. 10.1(a) or (b) elect to enroll for one, but not more than one, of the Supplemental Death Benefits coverage levels authorized by the Board. After such sixty (60) days initial period a Member may elect or change from one or more of the Supplemental Death Benefits coverage levels to another only during an annual enrollment period specified by the Board and subject to the Member or Spouse providing evidence of insurability satisfactory to the Board if the new coverage election is for a higher level of benefit. A Member may be enrolled for Supplemental Death Benefits coverage only as either a Member or a Spouse at any one time. If both parents are Members of the Plan, only one may subscribe for coverage of an eligible Child.

(d) **EVIDENCE OF INSURABILITY.** All coverage levels for Supplemental Death Benefits under this Sec. 10.7, other than minimum coverage levels for Members described in Sec. 10.7(b), shall be subject to satisfaction of the Board's medical insurability requirements.

- (1) Application by a Member for coverage of a Spouse shall be subject to satisfaction of the Board's evidence of insurability requirements.
- (2) Enrollment of Children shall not be subject to insurability requirements.

- (3) Coverage for a Member who is not actively at work due to health-related reasons at the time the coverage would otherwise commence, and/or for a Spouse who is currently confined in a healthcare facility for treatment or unable due to sickness or injury to perform substantially all of the material duties of his or her regular work or daily responsibilities, shall be delayed, in the case of the Member, until such time as the Member is certified to return to work and, in the case of the Spouse, until the Board receives official notification that the confinement and/or the medical disability has ended.

(e) **DUES.** Dues for Supplemental Death Benefits shall be in amounts set by the Board for the specified coverage levels. The Board may, in its sole discretion, elect to establish different dues rates for persons who have used tobacco products during the previous twelve (12)-month period. Dues shall be remitted to the Board by the employer. An employer may require a Member to pay up to one hundred percent (100%) of the Dues for Supplemental Death Benefits through a payroll deduction from the Member or other arrangement with the employee. Dues shall be paid to the Board in installments on a monthly basis in advance or at such other time or times as may be specified by the Board.

(f) **PAYMENT OF SUPPLEMENTAL DEATH BENEFITS.**

- (1) Upon the death of a Member covered for benefits under Sec. 10.7, the amount set forth in the applicable coverage level in effect shall be paid in one lump-sum to such beneficiary or beneficiaries as may be designated by the Member in the enrollment records at the Board. A Member may change a beneficiary designation at any time in such manner as provided by the Board, which designation shall only be effective as of the date approved and accepted by the Board. In the event that more than one beneficiary is named as a primary beneficiary, payment will be made in equal shares to all beneficiaries designated as primary who survive the Member unless otherwise designated by the Member. In the event that a Member does not have a valid beneficiary designation on record with the Board for these benefits, or no designated beneficiary survives the Member, the Supplemental Death Benefits shall be paid in equal shares to the Member's survivors in the order set forth in Section 10.2(e).
- (2) Upon the death of a Spouse or Child covered for benefits under Sec. 10.7, the amount set forth in the applicable coverage election in effect shall be paid in one lump-sum to the Member. In the event that the Member fails to survive the Spouse or Child, the Supplemental Death Benefits shall be paid to the estate of the Member.

(g) **COVERAGE DURING DISABILITY.** If a Member who is covered for benefits under Sec. 10.1(a) becomes Disabled in accordance with the provisions of Article XI of the Plan, no further dues shall be required to continue coverage for the Member, including the Spouse's and/or Children's coverage, under Sec. 10.7 during the period of Disability, or until the first receipt of any applicable retirement benefit under Article VIII, if earlier.

(h) **TERMINATION OF COVERAGE.** Coverage under Sec. 10.7 of a Member, a Spouse, or Dependent Child shall terminate (1) on the first dues payment date next following the termination of a period of service as set forth in Sec. 6.3 of the Plan; (2) on the last day of the period for which a dues payment for coverage under Article 10.7 has been made if the subsequent dues payment is not made on the date required; (3) at the end of the month in which the Member or a Spouse attains the age of seventy (70) years; or (4) at the end of the month in which a Member died.

(i) **DENIAL OF PAYMENT OF SUPPLEMENTAL DEATH BENEFITS.** The Board reserves the right to deny payment of Supplemental Death Benefits where it is determined by the Board that fraudulent statements were made in the evidence of insurability presented to the Board upon enrollment of the Member or in connection with a request for a change in the Supplemental Death Benefits coverage option.

ARTICLE XI

DISABILITY BENEFITS

Sec. 11.1 Eligibility for Disability Benefits. A Member shall be entitled to disability benefits under this Article XI following certification by the Board or its medical counsel that such Member became Disabled while an Active Member enrolled in the Death and Disability Plan and approval by the Board of the Member's disability application as timely filed and complete.

Sec. 11.2 Certification of Disability. The Board may, in its sole discretion, require an independent medical or psychiatric examination or case review to determine whether a disability should be certified or continued to be certified as a Disability. In applying for disability benefits, the Member shall furnish such evidence of Disability as the Board shall deem necessary. The Board shall have the right to require evidence of continuing Disability from time to time.

Sec. 11.3 Amount and Duration of Disability Benefits.

(a) **BEGINNING DATE.** Disability benefits under this Article XI are intended to provide for a long-term disability and are payable only for a Disability that continues for more than ninety (90) consecutive days. Disability benefits shall be payable to the Member beginning on the Disability Benefits Commencement Date.

(b) **PRE-EXISTING CONDITIONS.** No disability benefit shall be paid to a Member for any disability arising during the first twelve (12) months of a Member's coverage under the Death and Disability Plan from a condition (physical or mental) for which a Member received a diagnosis, medical advice, treatment, or medication within the twelve (12)-month period immediately preceding the date of the Member's enrollment for Death and Disability Plan coverage.

(c) **AMOUNT.** The initial annual amount, payable monthly, of the disability benefit shall equal sixty percent (60%) of the Member's Effective Salary (excluding the portion of such salary in excess of the Maximum Disability Benefits Basis on the date the Disability began, as

determined by the Board), less any payments received on account of the Disability, as such phrase is defined in Sec. 11.3(d). The total annual amount of the disability benefit paid under the Death and Disability Plan, including all payments on account of the Disability from all other sources, shall not be less than sixty percent (60%) of the Employment Classification Median, except that in no event shall such initial total annual amount of the disability benefit exceed the Member's Effective Salary on the date the Disability began.

(d) **OFFSETS FOR PAYMENTS RECEIVED FROM THE PENSION PLAN AND OTHER SOURCES ON ACCOUNT OF THE DISABILITY.** The total annual amount of the disability benefit paid under the Death and Disability Plan shall be offset by any amount received by the Member from other sources on account of the Disability, including but not limited to the following: monthly retirement pension benefit payments under Article VIII hereof; individual benefits under the Social Security disability income program and Social Security retirement income program; individual benefits under workers' compensation; veterans' and other governmental programs for which the Member becomes eligible on account of the Disability; any disability benefit (group or individual) provided by the Member's employer on a noncontributory basis, unless it is to cover the portion of Effective Salary in excess of the Maximum Disability Benefits Basis; any compensation, judgment, or settlement paid by any motor vehicle insurance coverage, including but not limited to uninsured/under-insured coverage carried by the Member; or any payments made to the Member by a third party as a result of the Disability other than a disability benefit payment made to a Member under other disability coverage purchased by a Member.

(e) **COST-OF-LIVING INCREASE IN PAYMENTS RECEIVED FROM OTHER SOURCES.** In the event a Member receiving a disability benefit becomes eligible to receive a cost of living increase in benefits from Social Security, workers' compensation, veterans', or any other governmental benefit program after the commencement of disability benefits hereunder, such increase shall not reduce the sum the Member is receiving as a disability benefit from the Death and Disability Plan.

(f) **DISABLED MEMBER IS NOT PARTICIPATING IN SOCIAL SECURITY OR ELECTS TO DEFER INITIATION OF RETIREMENT BENEFITS.** If the Disabled Member is not participating in Social Security and is therefore ineligible to receive Social Security disability or retirement income benefits, the amount of the disability benefits shall be reduced by the benefit which the Board determines would have been payable under the Social Security disability or retirement income program had the Member participated thereunder based on the record of Effective Salaries on which FICA or SECA taxes would have been paid on behalf of the Member. If the Disabled Member elects to defer initiation of payment of the retirement pension under Article VIII or Social Security retirement income benefits beyond the attainment of the Plan's Normal Retirement Age, the amount of the disability benefit shall be reduced beginning the first month after the Member attains the Plan's Normal Retirement Age by an amount equal to the sum of the monthly retirement benefit the Member would have received as a Normal Pension Benefit payment and the Social Security retirement income benefit if the Member had initiated the benefits upon attaining the Plan's Normal Retirement Age.

(g) **PAYMENTS FROM EMPLOYERS AND EARNED INCOME DURING THE DISABILITY.** Notwithstanding the provisions in Sec. 11.3(c), a Disabled Member may receive

income, in the form of salary payments and/or a Manse or housing allowance from an employer or any form of earned income from an employer or other source (such as self-employment) while receiving disability benefits provided that the work is approved by the Board, as required under Sec. 11.7, and the earnings are reported to the Board annually or more frequently upon request from the Board. If the total annual payments received by the Member from these sources exceed forty percent (40%) of the Member's Effective Salary on the date the Disability began, the Board may reduce the Member's disability benefits by the amount that the payments exceed the forty percent (40%).

If the employer of a Disabled Member makes a salary payment to the Member and/or provides a Manse or housing allowance during the Disability, the amount of the disability benefit shall be reduced only by the amount in excess of any such employer compensation over forty percent (40%) of the Member's Effective Salary on the date the Disability began. If the Disabled Member has other earned income which, together with any such employer compensation, exceeds forty percent (40%) of the Member's Effective Salary on the date the Disability began, the Board may reduce the disability benefit by all or part of such excess.

(h) **DURATION OF DISABILITY BENEFIT.** Disability benefits shall continue as long as a Member remains Disabled but not beyond the dates or durations specified below:

- (1) The first day of the month following the date on which the Disabled Member attains age sixty-five (65), if the disability benefit commenced prior to the Member's attainment of age sixty-two (62).
- (2) If the disability benefit commenced on or after the Member's attainment of age sixty-two (62), the benefit shall be payable as follows:
 - Disabled at 62: benefits for 3.5 years
 - Disabled at 63: benefits for 3 years
 - Disabled at 64: benefits for 2.5 years
 - Disabled at 65: benefits for 2 years
 - Disabled at 66: benefits for 1.75 years
 - Disabled at 67: benefits for 1.5 years
 - Disabled at 68: benefits for 1.25 years
 - Disabled at 69 or above: benefits for 1 year
- (3) The death of the Member.
- (4) The return to work of a Member unless the work is approved pursuant to the provisions of Sec. 11.7, relating to rehabilitation, at which point the Member's benefits may be reduced but not terminated.

(i) **DISABILITY BENEFIT INCREASES.** Should Death and Disability Plan assets, due to favorable investment and actuarial experience, be accumulated over and above those required for actuarial reserves, general contingency reserves and other special reserves, as determined by the Board, such funds may, in the sole discretion of the Board, be allocated among the Members of the Death and Disability Plan in the form of increased benefits in such manner as to equitably distribute such increases among those persons who on the date of such

increases are receiving disability benefits (a “Disability Benefit Increase”). No person shall have a right to any such increase unless and until it has been authorized, and such authorization, availability of funds, determination of eligibility and manner of distribution shall be solely within the discretion of the Board. Disability Benefit Increases granted by the Board since the adoption of the Benefits Plan in 1987 are listed in Appendix C.

Sec. 11.4 Minimum Annual Disability Benefit. Regardless of any payments on account of the Disability from sources other than the Death and Disability Plan, the annual disability benefit payable pursuant to Sec. 11.3 shall not be less than six hundred dollars (\$600).

Sec. 11.5 Continued Benefits Coverage while Disabled. An employer’s enrollment of a Disabled Member for Benefits Plan coverage shall terminate on the Member’s Disability Benefits Commencement Date and the employer’s obligation to pay dues shall end as of that date. A Disabled Member’s continued enrollment for pension, death benefits, and medical benefits coverage, to the extent that such coverage was in effect on the Disability Benefits Commencement Date, shall be funded by the Death and Disability Plan thereafter. Only death benefits under Article X, and not disability benefits under Article XI, shall continue after the Member’s Disability Benefits Commencement Date. Pension coverage under this Sec. 11.5 shall continue only until the Member’s Normal Retirement Date, and no additional Pension Credits shall accrue to such Disabled Member thereafter, subject to the following qualifications. Medical benefits coverage for the Disabled Member shall continue until Member’s Normal Retirement Date and for the Eligible Family shall continue for a period of three years from the Disability Benefits Commencement Date or the Member’s Normal Retirement Date, whichever is the earlier, subject to the Disabled Member’s payment of any contribution requirements imposed by the Member’s last employer for such Medical Plan coverage. Disabled Members approved for and commencing Disability benefits prior to January 1, 2017, shall continue to be eligible for the benefits coverage in effect as of December 31, 2016 and the dues for such coverage shall be waived.

Sec. 11.6 Protection for Survivors. In the event of the death of a Member who is receiving benefits under this Death and Disability Plan, the benefits provided in Article X shall be paid as if such Member had not been Disabled, using where applicable the greater of the Member’s annual Effective Salary on the date the Disability commenced or the Employment Classification Median of the Disabled Member’s last employment.

Sec. 11.7 Rehabilitation and Return-to-Work Provisions.

(a) The Board in its sole discretion may consider reimbursement of costs for rehabilitation programs for Disabled Members when funds are not available from any other source.

(b) The Board in its sole discretion may continue to pay all or a portion of the disability benefits, or continue eligibility for coverage for medical benefits only, during a period of limited rehabilitation, trial work, or a partial return to work provided the Disabled Member continues under the regular care of his or her duly licensed physician. Any reduction in disability benefits will be made in accordance with Sec. 11.3(f).

Sec. 11.8 Time Limit for Application for Disability Benefits. A disability benefits application must be received by the Board within twelve (12) calendar months after the date the Disability initially occurred unless it can be shown that an earlier filing was not reasonably possible and that the disability application was furnished as soon as it was reasonably possible.

Sec. 11.9 Reservation of Right To Suspend or Terminate Benefits. The Board reserves the right to suspend or terminate the payment of disability benefits to any Member who fails to

(a) apply for Social Security Disability Insurance benefits recommended by the Board and, if denied, pursue any appeal to the fullest extent possible, unless the Board approves otherwise;

(b) remain under the appropriate available treatment (as defined herein) under the care of a duly licensed physician or psychologist in accordance with a treatment plan recommended by the Member's treating healthcare provider that the Board's medical counsel or medical case management representatives consider consistent with generally accepted medical standards of practice for the Member's diagnosis;

- (1) Appropriate available treatment for medical illness means care or services which are
 - (A) generally acknowledged by physicians to cure, correct, limit, treat, or manage the disabling condition;
 - (B) accessible within the Member's geographical region;
 - (C) provided by a physician who is licensed and certified by the American Board of Medical Specialties or the American Board of Physician Specialties qualified in a discipline suitable to treat the disabling injury or sickness, and
 - (D) in accordance with generally accepted medical standards of practice.
- (2) Appropriate available treatment for behavioral illness means care or services which are
 - (A) generally acknowledged by psychiatrists and psychologists to cure, correct, limit, treat, or manage the disabling condition; utilizing both psychotherapy and psychopharmacology modalities when indicated, occurring with a regular frequency, as defined by accepted guidelines, as long as the condition is significantly decreasing capacity, resulting in second opinions when there is little clinical improvement after six months;
 - (B) accessible within the Member's geographical region;

- (C) provided by a professionally licensed mental health care practitioner, and
 - (D) in accordance with American Psychological and American Psychiatric Associations' standards of practice.
- (c) participate in vocational rehabilitative services as recommended by the Board;
 - (d) notify the Board immediately in the event of a return to active Eligible Service or other employment;
 - (e) cooperate with the Board in its exercise of its rights to examinations and to receive evidence of continued Disability of the Disabled Member, as described in Sec. 11.2; or
 - (f) provide the Board with documentation requested by the Board or its designee to substantiate earned income (or lack thereof), Social Security Disability Income retroactive payments, or any other information that the Board reasonably requires to administer the terms of the Disability provisions.

Sec. 11.10 Reservation of Right To Suspend or Terminate Benefits upon Member's Incarceration. The Board in its sole discretion reserves the right to suspend payment of all or part of the disability benefits of a Disabled Member who is incarcerated upon conviction for a felony.

Sec. 11.11 Supplemental Disability Coverage. An Active Member of the Death and Disability Plan who has an Effective Salary in excess of the Maximum Disability Benefits Basis shall be eligible to subscribe for optional supplemental disability coverage in such amounts and at such time or times as may be specified by the Board subject to the following terms:

(a) Coverage for supplemental disability benefits shall commence upon an eligible Member (i) executing and filing with the Board an application on a form supplied by the Board, which application is accepted by the Board as being complete and evidencing entitlement to the coverage provided in Sec. 11.11, and (ii) paying all dues required by Sec. 11.11.

(b) An eligible Member may elect supplemental disability coverage in increments of ten thousand dollars (\$10,000) of that Member's Pension Participation Basis in excess of the Maximum Disability Benefits Basis. An application for enrollment for or a request for increased supplemental disability benefits after the initial eligibility period established by the Board shall be subject to the Member providing evidence of insurability satisfactory to the Board.

(c) In the event a Member covered for benefits under this Sec. 11.11 becomes eligible to receive a disability benefit under Sec. 11.3, the Member shall receive as a supplemental disability benefit, an annual amount, payable monthly beginning on the 91st day of the period during which the Member is Disabled, of sixty percent (60%) of the Member's elected supplemental disability coverage amount under Sec. 11.11(b) for the same duration that disability benefits are payable to the Member under Sec. 11.3(g).

(d) Supplemental disability benefits payable to a Member under Sec. 11.11(c) shall not be increased by any Disability Benefit Increase provided under Sec. 11.3(i).

(e) Supplemental disability benefits payable under Sec. 11.11(c) shall not be offset or reduced for salary payments, Manse or housing allowance, or other earned compensation, provided that any employment is reported to and approved by the Board, the earnings are reported to the Board annually or more frequently upon request from the Board, and the total annual payments received by the Member from the Board under this Article XI and from approved earnings under this subsection do not exceed eighty (80%) percent of the Member's Pension Participation Basis.

(f) Dues for supplemental disability coverage shall be paid to the Board in installments on a monthly basis or at such other time or times as may be specified by the Board. Dues shall be in amounts established by the Board from time to time. The employer may offer supplemental disability coverage under Sec. 11.11 on a fully or partially contributory basis.

(g) No Pension Credits shall accrue to a Disabled Member under Sec. 7.2 for Effective Salary increments covered under Sec. 11.11.

(h) No dues shall be required for the continuation of coverage under Sec. 11.11 to the extent coverage was in effect on the date the Disability began.

(i) If the Member becomes Disabled during the first twelve (12) months of coverage under Sec. 11.11 as a result of a condition (physical or mental) for which the Member received a diagnosis, medical advice, treatment, or medication within the twelve (12)-month period immediately preceding the initial date of enrollment for supplemental disability benefits, no benefit shall be payable under Sec. 11.11(c) and the Board shall return to the employer (or Member in the case of dues paid in accordance with Sec. 5.2) any dues paid on account of the Member's enrollment for supplemental disability coverage.

(j) The terms and conditions set forth in Secs. 11.1, 11.2, 11.3(a), 11.3(g), 11.7(b), 11.8, 11.9, and 11.10 shall apply to the supplemental disability coverage.

MEDICAL PLAN

ARTICLE XII

MEDICAL BENEFITS — GENERAL PROVISIONS

Sec. 12.1 Medical Benefits Definitions. When used in the Plan, the following terms shall have the meanings set forth below:

(a) **ACTIVE MEDICAL PLAN.** Medical benefits coverage under Articles XII and XIII available for Active Members, Disabled Members under Sec. 11.5, and Minister Members eligible for Transitional Participation Coverage under Sec. 5.1(e). A Covered Person enrolled for Medical Continuation coverage is also eligible for Active Medical Plan benefits as specified in Sec. 12.11.

(b) **ALLOWABLE CHARGES.** The rates or allowances (“Plan Allowances”) established by the Plan, upon the recommendation of its claim administrator(s), as the reasonable charges to be reimbursed for Medically Necessary Covered Medical Services provided by a licensed health care practitioner or facility based on the network contract rates or other fee schedules that medical providers are willing to accept for the same type of service or facility in the same or neighboring community, taking into consideration any special skill or experience or special facility required to provide the necessary treatment.

(c) **CUSTODIAL CARE.** Care rendered to a patient who:

- (1) is mentally or physically Disabled and such Disability is expected to continue and be prolonged;
- (2) requires a protected, monitored, and controlled environment, whether in an institution or in the home;
- (3) requires assistance to support the essentials of daily living; and
- (4) is not under active and specific rehabilitative medical/surgical or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored, or controlled environment as determined by the Board.

Charges for Custodial Care are not covered Covered Medical Services. See Sec. 12.3(b)(10).

(d) **EMERGENCY SERVICES.** Services received for a medical condition manifesting itself by acute symptoms of sufficient severity so that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to place his or her health in serious jeopardy or result in serious impairment of bodily functions or serious dysfunction of any bodily organ or part. Emergency Services include emergency screening and treatment sufficient to stabilize the patient.

(e) **MEDICAL BENEFITS COVERAGE OPTIONS.** The medical benefits options available for an employer to offer to its eligible employees as described in Article XIII.

(f) **MEDICAL CONTINUATION.** Medical benefits coverage available on a subscription basis under Articles XIII and XIV to certain Members and their Eligible Family under Secs. 12.11 and 14.1 upon termination of eligibility.

(g) **MEDICALLY NECESSARY.** Except as more specifically defined in 12.2(u) for Habilitative Services for Children, services or supplies provided or prescribed by a hospital, physician, or other healthcare practitioner licensed to diagnose, treat, or prevent a sickness or bodily injury that the Plan, in its sole discretion, determines are

- (1) appropriate to the symptom and diagnosis or treatment of the sickness or injury;
- (2) not custodial or for the convenience of the patient, physician, or other healthcare practitioner;
- (3) not educational, experimental, or investigational in nature;
- (4) of demonstrated medical value; and
- (5) the most appropriate standard or level of services which accord with sound medical practice and can be safely provided to the patient. When applied to hospitalization, this further means that acute care as an inpatient is required and appropriate to the nature of services or condition of the patient and that the care cannot be rendered safely or adequately in another treatment setting.

(h) **MEDICARE SUPPLEMENT.** The medical benefits coverage that provides supplemental benefits coverage to Medicare Parts A, B and D prescription drug coverage on a subscription basis, as described in Sec. 14.3(g), to retired Members and other persons eligible to subscribe for such coverage under Sec. 14.2.

(i) **NETWORK AREA.** A geographical area designated by the Plan as an area where the Plan has entered into one or more agreements with preferred providers or other managed care organizations relating to the costs to be charged by Network Providers for services rendered to Members and their Eligible Families.

(j) **NETWORK MEDICAL COSTS.** Charges for Covered Medical Services furnished by a Network Provider as of the date the services are rendered.

(k) **NETWORK PROVIDER.** A provider that as of the date the services are rendered has an agreement with a preferred provider or other managed care organization with which the Plan has contracted to provide services to Members and their Eligible Families for prescribed charges.

(l) **NON-NETWORK AREA.** A geographical area designated by the Plan, in its sole discretion, as an area where the Plan, as of the date the services are rendered, has not established sufficient relationships with preferred providers or other managed care organizations to provide reasonable access to Network Providers to Members and their Eligible Families.

(m) **NON-NETWORK MEDICAL COSTS.** Charges for Covered Medical Services provided by a Non-Network Provider.

(n) **NON-NETWORK PROVIDER.** A provider who provides services or supplies in a Non-Network Area to a Member or an Eligible Family member and has not agreed to participate in a network with which the Plan has a contractual relationship.

(o) **OUT-OF-NETWORK MEDICAL COSTS.** Charges for Covered Medical Services provided in a Network Area by an Out-of-Network Provider.

(p) **OUT-OF-NETWORK PROVIDER.** A provider who provides services or supplies to a Member or an Eligible Family member in a Network Area and who, as of the date the services are rendered, is not party to an agreement with a preferred provider or other managed care organization with which the Plan has contracted in the Network Area.

(q) **PRESCRIPTION DRUG BENEFITS.** The Plan's managed Prescription Drug Benefits coverage for outpatient prescription drugs administered by a pharmaceutical benefits manager designated by the Plan. The Plan may, from time to time, establish separate rules for the Prescription Drug Benefits, relating to reimbursement based upon the types of pharmacy provider, formulary design and benefits, the coverage and uses of specific drugs, quantity of orders, copay limits, deductibles or copayment maximums, and other related requirements, as it, in its sole discretion, deems necessary and appropriate to administer the Prescription Drug Benefits.

Sec. 12.2 Covered Medical Services. Subject to the Member's responsibility for applicable deductibles and copayments and the managed care and exclusions and limitations provisions of the medical benefits option in which the Covered Person is enrolled, the Plan reimburses the Allowable Charges for the following Medically Necessary healthcare services and treatment for sickness or bodily injury:

(a) Hospital charges for semiprivate accommodations or services in an intensive care unit. If private accommodations are used, the rate shall be the average cost of semiprivate accommodations for that hospital or, if that hospital has no semiprivate accommodations, then the average cost of semiprivate accommodations of Network Provider hospitals in the same locale or region. Charges for services reimbursed under this subparagraph are subject to the managed care provisions set forth in Sec. 12.4.

(b) Diagnosis, treatment and surgery by a physician or certified healthcare practitioner duly licensed in the state to provide such services.

(c) Administration of anesthetics by a physician or professional anesthetist duly licensed in the state to provide such services.

- (d) Diagnosis or treatment by a radiologist, physiotherapist or licensed laboratory.
- (e) Registered or licensed practical nurse for private duty nursing in an in-patient facility or elsewhere if an intensive care unit is not available at the facility. Custodial care is not a Covered Medical Service. See Sec. 12.3(b)(10), relating to exclusions and limitations.
- (f) Local ambulance service or transportation by professional ambulance service to a local hospital or for transportation by professional ambulance, railroad or regularly scheduled flights of a commercial aircraft from the place where the illness is contracted or injury sustained to the nearest hospital equipped to furnish treatment not available in the local hospital.
- (g) Drugs, medicines or medical supplies requiring a written prescription by a physician and reimbursable as a Prescription Drug Benefit of the applicable Medical Plan coverage option. Charges for outpatient prescription drugs are subject to the reimbursement limits and exclusions of the Prescription Drug Benefits. See Sec. 12.1(q).
- (h) Use of imaging technology, such as X-rays, radium or radioactive isotopes, for diagnosis or therapy; blood or blood plasma; anesthesia and fluids needed for surgery; artificial limbs or eyes, casts, splints, surgical dressings, trusses, braces or crutches; oxygen and the rental of equipment for its use; rental of wheelchair or hospital-type bed; rental of an iron lung or other mechanical equipment required for treatment of respiratory paralysis. In appropriate circumstances, the Plan, in its discretion, may authorize the purchase of certain medical equipment. Charges for the routine maintenance of rented or purchased medical equipment may be subject to restrictions under the medical policy followed by the Plan, or by such organizations(s) as may be designated by the Plan to advise it on such matters.
- (i) Pregnancy and childbirth care, including a hospital stay of no less than forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a delivery by cesarean section.
- (j) Behavioral health treatment of nervous, mental and substance abuse disorders in a hospital, treatment facility for substance abuse and dependencies, or residential treatment center, or for outpatient treatment provided by a psychiatrist, clinical psychologist Ph.D., Diplomate or Fellow Member of the American Association of Pastoral Counselors, clinical marriage counselor or family therapist who is either state-licensed or a clinical member of the American Association for Marriage and Family Therapy, licensed clinical social worker or psychiatric nurse specialist, provided that a written diagnosis of a nervous or mental disorder is furnished to the Plan. In addition to the providers designated in this paragraph, the Plan may, from time to time, in its sole discretion, authorize reimbursement of charges for outpatient services rendered by a professional counselor who has satisfied the licensing requirements of a state and has been pre-approved by the Plan. Charges for services reimbursed under this subparagraph are subject to the managed care provisions set forth in Sec. 12.4 and the exclusions and limitations set forth in Sec. 12.3.
- (k) Dental care for
 - (1) treatment of an injury to the jaw or sound natural teeth resulting from an accident provided that written notice of the injury to the jaw or teeth is

received by the Board within ninety (90) days after the accident and treatment is completed within one (1) year after the accident;

- (2) removal of up to four (4) bony impacted wisdom teeth; and
- (3) treatment of temporomandibular joint dysfunction, by whatever name called. Charges for these services are subject to the reimbursement limits set forth in Sec. 12.3(a)(1).

(l) The adjustment and manipulation of the spinal column and associated nervous system in restoration of health.

(m) Diagnosis or treatment by a licensed podiatrist. Charges for these services are subject to the exclusions and limitations set forth in Sec. 12.3(b)(17).

(n) Home healthcare in the Member's home furnished by a home healthcare agency certified by Medicare up to a maximum of one hundred (100) visits (a "visit" is up to an eight (8)-hour continuous session) in a calendar year for the following Medically Necessary services and supplies:

- (1) part-time or intermittent nursing care by or under the supervision of a registered nurse;
- (2) part-time or intermittent home health aide services; for the care of a person covered under Article XIII; and
- (3) services for physical and occupational and speech therapy by a licensed or certified therapist.

(o) Diagnosis or treatment of a disease of or injury to the eye by a licensed ophthalmologist or optometrist, but only in those states where optometrists are licensed to diagnose and treat diseases and injuries to the eye, and Allowable Charges for an annual vision examination under the Plan's preventive services benefits.

(p) Speech therapy when services are prescribed by a physician for correction of a speech impairment resulting from disease or trauma. Except for services described in Sec. 12.2(u), relating to Habilitative Services for Children with Developmental Disabilities, charges for services that are determined to be primarily developmental are not Covered Medical Services. See Sec. 12.3(b) relating to Medical Costs Not Covered for exclusions and limitations on Covered Medical Services.

(q) Acupuncture treatment but only if provided by a physician (or an acupuncturist duly licensed in the state to provide such services).

(r) Reconstructive surgery of a breast on which a mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

(s) Foot orthotics prescribed by a physician for treatment of metabolic, peripheral-vascular disease or other medical condition except (i) foot orthotics prescribed for nonsurgical treatment of fractures, (ii) replacement foot orthotics unless the orthotic is irreparably damaged due to normal wear and tear or a change in the patient's condition or size necessitates the replacement, and (iii) foot orthotics prescribed for the conditions listed in this Sec. 12.2(s). Orthotic shoes are covered only when they are prescribed as an integral part of a brace.

(t) Charges for advanced reproductive technology, including in vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), and ovum microsurgery, and for the supplies and prescription drugs related to such therapies. See Sec. 12.3(a)(2) relating to treatment reimbursement limits and Sec. 13.3(e)(2) relating to exclusions and limitations in the EPO Benefits option.

(u) Habilitative Services for Children with Developmental Disabilities, subject to the following terms:

(1) Covered Developmental Disabilities:

(A) **Autism Spectrum Disorder**

- ICD-10 Diagnosis codes
 - F84.0 Autistic disorder
 - F84.3 Childhood disintegrative disorder
 - F84.8 Other specified pervasive development disorders current
 - F84.9 Pervasive development disorder, unspecified

(B) **Cerebral Palsy**

- ICD-10 Diagnosis code G80.0

(C) **Down Syndrome**

- ICD-10 Diagnosis code Q90.9

(D) **Intellectual Disability**

- ICD-10 Diagnosis codes F70.0 – F79.0

(E) **Spina Bifida**

- ICD-10 Diagnosis codes Q05.4 – Q07.01

(2) **Definitions.** The following definitions apply for the Covered Medical Services provided under this subsection:

- (A) “Applied Behavior Analysis” means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.
- (B) “Autism” means a pervasive, neurologically based developmental disability of extended duration that causes severe learning, communication and/or behavior disorders, with age of onset during infancy or childhood. Individuals with autism exhibit impairment in reciprocal social interaction, impairment in verbal and nonverbal communication and imaginative ability, and a markedly restricted repertoire of activities and interests.
- (C) “Case Management” means the planning and coordination of medical, educational and other services appropriate to the goal of habilitation. It may include, but is not limited to, care assessment and assistance in developing, implementing and coordinating a treatment plan with providers as well as with the family of the Child who has a developmental disability. Case management is not the provision of medical care. The goal of case management is to coordinate the use of all available resources, including those provided by the medical community, as well as the local school district, county and other community agencies, to ensure the optimal delivery of services for the Child who has a developmental disability.
- (D) “Cerebral Palsy” means a group of disabling symptoms of extended duration which results from damage to the developing brain that may occur before, during, or after birth and which results in the loss or impairment of control over voluntary muscles. For the purposes of this definition, cerebral palsy does not include those symptoms or impairments resulting solely from a stroke.
- (E) “Developmental Disability” means a disorder or syndrome that is attributable to a mental or physical impairment or a combination of mental and physical impairments which may be identified as autism spectrum disorders, intellectual disability (including but not limited to Down syndrome), cerebral palsy, and spina bifida that manifests before the age of 18 and that constitutes a substantial disability that can reasonably be expected to continue indefinitely.
- (F) “Habilitation” means the process by which an individual is assisted to acquire and maintain those life skills which enable the individual to cope more effectively with the demands of his or her

condition and environment and to raise the level of his or her physical, mental and social efficiency.

(G) “Intellectual Disability” is characterized by significant limitations both in intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. This disability originates before the age of 18 and can reasonably be expected to continue indefinitely. “Significant limitations in intellectual functioning,” for the purpose of this definition, means performance which is two or more standard deviations from the mean score on a standardized intelligence test. “Adaptive behavior,” for the purpose of this definition, means the effectiveness or degree with which an individual meets the standards of personal independence and social responsibility expected of his or her age, cultural group and community.

(H) “Medically Necessary” means a covered service described in (3) below that will or is reasonably expected to accomplish one or more of the following:

(i) Arrive at a correct medical diagnosis.

(ii) Prevent the onset of an illness, condition, injury or disability.

(iii) Reduce, correct, or ameliorate the physical, mental, developmental, or behavioral effects of an illness, condition, injury, or disability.

(iv) Assist in the achievement or maintenance of sufficient functional capacity to perform age-appropriate or developmentally appropriate daily activities.

(I) “Specialized Therapies” means those treatments or activities prescribed by and provided by an appropriately trained and licensed or certified professional or staff person, pursuant to Evidence-based Standards of Care guidelines, and may include, but are not limited to, physical therapy, speech therapy, respiratory therapy, occupational therapy and behavior therapy.

(J) “Spina bifida” means a medical diagnosis of spina bifida cystica or myelomeningocele.

(3) **Covered Habilitative Services.** Using Evidence-based Standards of Care guidelines, and subject to any limitations set forth herein, the Allowable Charges incurred for:

- (A) Behavioral Therapy (Applied Behavioral Analysis or “ABA”). ABA therapy services provided by healthcare practitioners trained to provide ABA therapy, with state licensure or credentialing (as required) and subject to approval by the Board or its delegate.
- (B) Specialized Therapies, including Speech, Occupational and Vocational Therapies. Medically Necessary services (as defined in subsection (u)(2)(H) above) are limited to an annual maximum of up to fifty (50) visits per Child. The first ten (10) visits prescribed by a physician shall be covered in full without review for Medical Necessity. Subsequent visits must be prescribed by a physician, satisfy the definition of Medically Necessary in subsection (u)(2)(H), and be subject to Case Management (as defined in subsection (u)(2)(C) above).

Sec. 12.3 Exclusions and Limitations. The following exclusions and limitations shall apply to the reimbursement of medical benefits claims:

(a) TREATMENT REIMBURSEMENT LIMITS. Certain Covered Medical Services are subject to the following additional limitations:

- (1) ***Reimbursement for Charges Relating to the Treatment of Temporomandibular Joint Dysfunction, by Whatever Name Called.*** Such benefits shall be limited to a dollar maximum described in Appendix F for each Covered Person’s lifetime.
- (2) ***Reimbursement for Medically Necessary Use of Advanced Reproductive Technology.*** A Covered Person enrolled for PPO Benefits under Sec. 13.2 shall be reimbursed for Covered Medical Services for advanced reproductive technology defined in Sec. 12.2(t), subject to a maximum of three (3) procedures in the aggregate for each Member as a lifetime limit. This limitation shall apply also to the supplies and infertility drugs prescribed to support these procedures. A Member enrolled for EPO medical benefits under Sec. 13.3 shall not be reimbursed for a Member’s, Spouse’s or Dependent’s advanced reproductive technology as defined in Sec. 12.2(t). See Sec. 13.3(e)(2).
- (3) ***Reimbursement for Treatment in an Extended Care Facility.*** If within fourteen (14) days of discharge from a Medically Necessary hospital confinement for an illness or injury, a Member or an Eligible Family member, pursuant to a written certification by a supervising physician, requires skilled nursing care in an extended care facility for the same or a related condition, then and in that event the Member shall be reimbursed for Covered Medical Services actually paid for each day up to an annual maximum limit of one hundred eighty (180) days of treatment in such a facility up to a maximum of fifty percent (50%) of the hospital daily room

rate for semiprivate accommodations for the hospital from which discharged.

- (4) ***Reimbursement for Charges Relating to the Loss of Hearing.*** Hearing aids or the fitting thereof are covered subject to reimbursement limits described in Appendix F.

(b) **MEDICAL COSTS NOT COVERED.** Charges for the following medical services and supplies are not covered under the Medical Plan:

- (1) 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 country or agency thereof, or received elsewhere for which the Member is not, in the absence of this Medical Plan, legally obligated to pay.
- (2) Dentures, dental services (including orthodontic services that are ancillary to a covered Medical Cost), or dental X-rays, except as set forth in Sec. 12.2(k).
- (3) Except for the annual eye examination coverage described in 12.2(o), eye refractions, eyeglasses, or examinations for eyeglasses, except for temporary and/or initial permanent corrective lenses needed following a cataract operation, or for orthoptic treatment.
- (4) Cosmetic surgery or treatment procedures, except (i) in connection with treatment for a bodily injury resulting from an accident occurring while covered under the Medical Plan, provided such treatment is commenced within ninety (90) days of such accident, (ii) to correct a congenital disease or congenital anomaly which congenital condition results in an appearance that is not within the range of normal human variation, or (iii) for breast reconstructive surgery covered under Sec. 12.2(r). For purposes of this Sec. 12.3, a “cosmetic” procedure means a procedure or course of treatment that is performed or undertaken primarily to improve or alter the appearance of any portion of the body and that does not significantly improve the function of that body part.
- (5) Any injury or sickness for which benefits are paid or are payable under any workers’ compensation law or similar legislation.
- (6) Covered Medical Services where the Member or other Covered Person hereunder is not actually required to pay for such services.
- (7) Covered Medical Services incurred while the Member’s benefits are suspended because the dues have not been paid in accordance with Sec. 5.2 and are not guaranteed by a presbytery.

- (8) Covered Medical Services incurred for any person who is not or is no longer eligible for coverage pursuant to Secs. 3.2, 5.1(d), 12.10, 12.11, 13.1, 14.1 or 14.2.
- (9) Diagnostic and treatment procedures which in the sole determination of the Board are deemed to be experimental, investigative, unproven, for purposes of research, not Medically Necessary, or not generally accepted by the medical profession.
- (10) Custodial Care (as defined in Sec. 12.1(c)) rendered to a Covered Person. (A Custodial Care determination is not precluded by the fact that a patient is under the care of a supervising or attending physician and that services are being ordered and prescribed to support and generally maintain the patient's condition, or provide for the patient's comfort, or ensure the manageability of the patient. Further, a Custodial Care determination is not precluded because the ordered and prescribed services and supplies are being provided by an R.N., L.P.N., or L.V.N.)
- (11) Reversal of a previous sterilization procedure for either sex, unless the initial sterilization was required because of an accident or disease.
- (12) Radial keratotomy.
- (13) Services which are primarily for the Covered Person's education, training, or development of skills needed to cope with an injury or sickness unless such services are approved in advance by the Board as Medically Necessary (as defined in Sec. 12.1(g)).
- (14) Services or supplies provided primarily for personal hygiene, comfort, or convenience.
- (15) Services other than Medically Necessary diagnosis, treatment, or surgery, including but not limited to charges for failing to keep an appointment, completion of claim forms, preparation of medical reports (other than reasonable costs related to reports requested by the Board), or telephone consultations with medical personnel, marriage counselors, or home studies (other than as provided in Sec. 12.4(g)).
- (16) Services rendered by a person who ordinarily resides in a Covered Person's home or who is related to the patient, including parents, Children, siblings, or Spouses, whether the relationship is by blood or exists by law.
- (17) Treatment or supplies for (a) weak, strained, flat, unstable or unbalanced feet, metatarsalgia, or bunions, except open cutting operations, or (b) corns, calluses, or toenails, except foot orthotics prescribed for the treatment of metabolic, peripheral-vascular disease or other medical condition under Sec. 12.2(s). Orthopedic shoes or orthopedic prescription

devices to be attached to or placed in shoes are not covered except as provided in Sec. 12.2(s).

- (18) Outpatient prescription drugs that were not purchased in accordance with the Prescription Drug Benefits requirements or are excluded from benefits coverage under the medical benefits option.

Sec. 12.4 Managed Care Provisions. Reimbursement for Covered Medical Services is subject to the following additional provisions:

(a) **PRE-ADMISSION TESTING.** Subject to the applicable deductibles, the Plan shall reimburse one hundred percent (100%) of the eligible Covered Medical Services incurred by a Covered Person for pre-admission testing on an outpatient basis for an illness or injury requiring hospital confinement.

(b) **CERTIFICATION FOR INPATIENT CONFINEMENT FOLLOWING EMERGENCY TREATMENT.** When a Covered Person is admitted to a hospital or other residential inpatient treatment facility following emergency treatment, within 48 hours following the first treatment for any emergency illness or injury, the Member, or someone on behalf of the Member, must apply to and receive from the Board, or such other organization as may be designated by the Plan, a certification authorizing such inpatient confinement. If a Member, or someone on behalf of the Member, fails to obtain from the Plan, or its designee, timely certification of the emergency treatment admission and length of stay, the Plan may request an independent review of the Medical Necessity of the admission and stay prior to adjudicating the claim and such Member's reimbursement for care found to be Medically Necessary shall be reduced by an amount designated by the Board to cover the cost of the review.

(c) **PRECERTIFICATION FOR NON-EMERGENCY INPATIENT ADMISSION AT A HOSPITAL OR OTHER TREATMENT FACILITY.** A Member, or someone on behalf of the Member, must apply to and receive from the Plan, or such other organization as may be designated by the Plan, precertification of any non-emergency inpatient admission to a hospital or other residential healthcare facility of a Covered Person. If a Member, or someone on behalf of the Member, fails to obtain precertification of a non-emergency admission to a hospital or other residential healthcare facility from the Plan, or its designee, the Plan may request an independent review of the Medical Necessity of the admission and duration of the inpatient stay prior to adjudicating the claim and such Member's reimbursement for care found to be Medically Necessary shall be reduced by an amount designated by the Plan to cover the cost of the review.

(d) **PRAUTHORIZATION OF NON-EMERGENCY DIAGNOSTIC, SURGICAL, AND OUTPATIENT SERVICES AND PROCEDURES.** The Plan may specify that certain non-emergency diagnostic, surgical, and outpatient services and procedures shall be subject to prospective review and approval by the Plan or such other organization as may be designated by the Plan, including a second opinion from another non-affiliated physician when required. If a Member, or someone on behalf of the Member, fails to obtain pre-certification required by the Plan for a specified non-emergency diagnostic, surgical, or outpatient service or procedure from the Plan, or its designee, the Plan may request an independent review of the Medical Necessity of the service or procedure prior to adjudicating the claim and such Member's reimbursement for

care found to be Medically Necessary may be reduced by an amount designated by the Plan to cover the cost of the review. Any Member may obtain a second opinion prior to a non-emergency diagnostic, surgical procedure and the cost of the second opinion (physician fees only) shall be reimbursed to the Member on the basis of one hundred percent (100%) of the Plan Allowances for Covered Medical Services without regard to the deductible.

(e) **PRIMARY PREVENTIVE SERVICES.** The Plan shall designate, in its sole discretion and consistent with federal Patient Protection and Affordable Care Act requirements, certain primary preventive health services that shall be reimbursed without being subject to the applicable office visit, deductible, and/or annual copayment provisions.

(f) **PREVENTIVE PRESCRIPTION DRUG SERVICES.** The Plan may designate, in its sole discretion, certain preventive prescription drugs that may be reimbursed without being subject to the applicable deductible and/or annual copayment provisions of the PPO, EPO or HDHP Benefits provisions. Prescription drugs or medications are considered preventive care when taken by a person who has developed risk factors for a disease that has not yet manifested itself or not yet become clinically apparent (*i.e.*, asymptomatic), or to prevent the reoccurrence of a disease from which a person has recovered.

(g) **MEDICAL CASE MANAGEMENT.** A Member shall be reimbursed only for fifty percent (50%) of the Covered Medical Services incurred where the Member or other Covered Person has refused case management when required by the Plan, or by such organization as may be designated by the Plan for such services.

(h) **PRESCRIPTION DRUG BENEFITS.** A Member shall be reimbursed only for outpatient prescription drug costs incurred by the Member or other Covered Person if (1) the drug is prescribed for Medically Necessary uses approved by the Prescription Drug Benefits administrator in accordance with general medical practices; (2) the prescription is written in accordance with FDA-approved usages; and (3) the order is filled in the quantity specified by the Board or its designated Prescription Drug Benefits administrator. Reimbursement for prescriptions filled at non-participating pharmacies shall be based on the Allowable Charges established for participating pharmacies.

(i) **OFFICE VISITS BY TELEMEDICINE.** Subject to the satisfaction of all requirements of state law, a medical policy adopted by the Plan or by such organization(s) as may be designated by the Plan to advise it on such matters, and any credentialing requirements of the Plan's claims administrator, visits with physicians and other eligible healthcare practitioners via telemedicine services may be reimbursed by the Medical Plan as an office visit.

(j) **CENTERS OF EXCELLENCE.** A Member may be reimbursed for Covered Medical Services with reduced copayments and for reasonable travel expenses incurred for the Covered Person and a travel companion for specified procedures provided by facilities designated by the Board's designated claims administrator as preferred centers of excellence.

Sec. 12.5 Annual and Lifetime Limits.

(a) Essential health benefits, as defined in Section 1302(b)(1) of the federal Patient Protection and Affordable Care Act, shall not be subject to Plan annual or lifetime medical benefits limits.

(b) In no event shall the annual copayment maximum for Covered Medical Services for essential health benefits exceed the annual limitation on out-of-pocket maximums described in Section 1302(c) of the federal Patient Protection and Affordable Care Act.

Sec. 12.6 Time Limit for Submission of Claims for Reimbursement. In order to be eligible for reimbursement, all medical benefits claims must be received by the Plan within twelve (12) calendar months after the date the charges were incurred, unless it can be shown that an earlier filing was not reasonably possible and that proof of the claim was furnished as soon as it was reasonably possible.

Sec. 12.7 Dual Coverage. Reimbursement of Covered Medical Services under the Plan shall be limited to the extent that other coverage is available to the Member or his or her Eligible Family. The Plan shall take into account any coverage such person has under any other group and nongroup insurance contract, health maintenance organization contracts, closed panel plans, or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, medical benefits under group or individual automobile contracts, and Medicare or any other federal governmental plan, as permitted by law. The benefits under the Plan shall be coordinated as provided in Sec. 12.7(a), below. For purposes of this Sec. 12.7, benefits provided in the form of services rather than cash payments shall be assigned a reasonable cash value, and benefits which may be payable but for which no claim has been made shall be taken into account.

(a) **ORDER AND PRIORITY OF BENEFITS.** The primary plan shall pay its benefits according to its terms of coverage and without regard to the benefits under any other plan. If coverage under this Plan is secondary, the Plan shall coordinate benefits on a maintenance of benefits basis. In such event, the Plan shall pay an amount equal to the reimbursable amount under the Plan (as if the Plan were primary) less any amount actually paid by the primary plan. If the Plan is both the primary and secondary plan by reason of Member coverage by multiple Members in an Eligible Family, the Plan shall pay on a coordination of benefits basis. In such event, the Plan shall pay an amount equal to the reimbursable amount under each plan as if each were primary but in no event shall the total of all benefits paid or payable under all plans exceed the total Allowable Charges for the Covered Services actually incurred.

The following rules in the order listed below shall apply to the paying of benefits:

- (1) A plan which does not have a coordination of benefits provision shall be primary.
- (2) The benefits of a plan which covers the person as an active employee shall be considered primary; however, in the event the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the

plan covering the person as a Spouse or Child and primary to the plan covering the person as an active employee (under an exception to the Medicare Secondary Payer rules), then the plan covering the person as an active employee is the secondary plan and the other plan is the primary plan.

- (3) The benefits of a plan which covers the person other than as a Spouse or Child shall be considered primary; however, in the event the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a Spouse or Child and primary to the plan covering the person as other than a Spouse or Child (under an exception to the Medicare Secondary Payer rules), then the plan covering the person as other than a Spouse or Child is the secondary plan and the other plan is the primary plan.
- (4) The benefits of a plan which covers a Child of the Member or the Spouse whose birthday falls earlier in the calendar year shall be considered primary or, if both parents have the same birthday, the plan that has covered a parent the longest is the primary plan.
- (5) The benefits of a plan which covers the person as a Child whose parents are divorced/dissolved, separated, or not living together, whether or not they have ever been married, shall be paid in the following order:
 - (A) If a court decree has established financial responsibility for the healthcare expenses of a Child and the plan of that parent has actual knowledge of those terms, the plan of the parent responsible shall be primary for those plan years commencing after the plan is given notice of the court decree.
 - (B) If a court decree states that both parents are responsible for the Child's healthcare expenses or healthcare coverage, or if a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the Child, the provisions of Sec. 12.7(a)(4) shall determine the order of benefits.
 - (C) If there is no court decree allocating responsibility for the Child's healthcare expenses or healthcare coverage, the order of benefits for the Child is as follows:
 - (i) The plan of the parent with custody shall be primary.
 - (ii) The plan of the stepparent married to the parent with custody shall be primary.
 - (iii) The plan of the parent not having custody shall be primary.

- (iv) The plan covering the Spouse of the parent not having custody shall be primary.
- (6) For a Child covered under more than one plan of individuals who are not the parents of the child, the provisions of Sec. 12.7(a)(4) or (5) shall determine the order of benefits as if those individuals were the parents of the Child.
- (7) When rules (1) through (6) above do not establish an order of benefit determination, the benefits of a plan which has covered the person for the longer period of time shall be primary.
- (8) When rules (1) through (7) above do not establish an order of benefit determination, the Allowable Charges shall be shared equally between the plans; however, the Plan will not pay more than it would have paid had it been primary.
- (9) In the case of Disabled Members and Dependent Totally Disabled Children who are eligible for Medicare under the Social Security Disability Insurance benefits program, the Plan shall be secondary to Medicare coverage.
- (10) In the case of a health maintenance organization-type plan or other form of plan with fixed maximum fees for providers, this Plan shall not cover any charges in excess of what that participating provider has agreed to accept as payment.
- (11) When the Plan is secondary, it shall not recognize a reduction of the allowable expense by the primary plan if the reduction is taken because the Covered Person does not comply with the primary plan's provisions concerning second surgical opinions or precertification of admissions or services or because the Covered Person has a lower or no benefit because the Covered Person did not use a preferred provider.
- (12) When the Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a Plan Year are not more than the total Allowable Charges. The Plan shall credit to its deductible any amounts it would have credited to its deductible in the absence of any other healthcare coverage.

(b) **FACILITY OF PAYMENT.** The Board in its sole determination shall have the right to repay any party for a benefit payment made by that party when the payment should have been made by the Board. Amounts so paid shall be deemed benefits paid under this Plan.

(c) **RIGHT OF RECOVERY.** The Board shall have the right to recover from the Member any sum paid by the Board which should have been paid by another plan.

Sec. 12.8 Rights of Recoupment, Subrogation, and Reimbursement.

(a) Covered Medical Services otherwise reimbursable by the Plan shall not be payable to or for a Member or an Eligible Family member or anyone acting on behalf of a Covered Person when such Covered Medical Services are subject to recovery from another source, including, but not limited to, reimbursement for damages caused from the act or omission of a third party or reimbursement from other insurance coverage (other than another group health plan subject to the dual coverage provision set forth in Sec. 12.7) maintained by or on behalf of the Covered Person.

(b) The Board may, in its sole discretion, advance sums from the Plan to a Covered Person or anyone acting on his or her behalf for eligible Covered Medical Services that are excluded under subsection (a) of this Sec. 12.8 until such time as the Member or the Eligible Family member or person acting on behalf of the Covered Person recovers the reimbursement from the other source. The Covered Person or person acting on behalf of the Covered Person shall be required

- (1) to repay the Plan in full all sums advanced by the Plan for Covered Medical Services relating to the injury or illness from any judgment, settlement, or reimbursement he or she receives, regardless of how the proceeds of the judgment or settlement are characterized and without deduction for any costs or fees of any nature therefrom;
- (2) to subrogate any right of recovery he or she may have against the other source; and
- (3) to cooperate fully with the Plan in assisting it to protect its legal rights under the agreement and this Sec. 12.8.

(c) The rights of reimbursement, recoupment, and subrogation granted under this Sec. 12.8 shall constitute a lien and first priority claim against any person or entity, to be paid before any other claims are repaid, whether or not the Member or an Eligible Family member has been made whole or has recovered the total amount of damages incurred. The entire amount of any damages recovered, notably the part specifically allocated to Covered Medical Services, shall be made available by the Covered Person for the repayment of the reimbursement and subrogation obligation under this Sec. 12.8.

Sec. 12.9 Exchange of Medical Plan Information. Subject to 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 individually identifiable health information (“Protected Health Information”) and the security of electronic Protected Health Information as set forth in 45 C.F.R. Subtitle A, Part 164, Subpart E, as it may be amended from time to time (the “HIPAA Rules”), and any more stringent state law applicable to the Plan, the Board shall have the right to give and receive such information as it, in its sole discretion, deems necessary to administer the Medical Plan and any other benefits plan or program administered or sponsored by the Board without notice to or

obtaining the consent of any person. The Member shall be required to furnish to the Board such information as the Board or the Plan's agents may require in connection with any medical or dental benefit claim. The Board's use of the information shall be subject to the provisions of Sec. 12.12. All other uses and disclosures of information by the Plan shall be as set forth in the Plan's privacy notice provided to Members under the HIPAA Rules.

Sec. 12.10 Termination of Coverage. Active Medical Plan coverage shall terminate for Members and/or Eligible Family members enrolled for Pastor's Participation coverage under Sec. 4.1(a) on the date the event described in (a) below occurs and for Members and/or their Eligible Family members enrolled for coverage under Sec. 4.1(b) (menu options) on the last day of the month in which any one of the events described in (a) below occurs.

- (a) Active Medical Plan coverage shall terminate upon:
- (1) The retirement of a Member.
 - (2) The termination of the Member's employment in Eligible Service or reduction in hours that results in loss of eligibility, except that a Member and his or her Eligible Family who have been enrolled for Pastor's Participation coverage shall continue to be covered for Medical Plan PPO Benefits (or Medicare Supplement coverage if Medicare-eligible) for an additional thirty (30) days, at no additional dues obligation to the employer or Member.
 - (3) The date of death of a Member.
 - (4) For a Spouse, the date of divorce from the Member.
 - (5) For a Dependent Child, the date of the Child's 26th birthday.
 - (6) The last day of the period for which a dues payment for Active Medical Plan coverage has been made if the next subsequent dues payment is not received by the Plan by the date required.
 - (7) The last day of continued medical benefits coverage of a Disabled Member or an Eligible Family member under Sec. 11.5.
 - (8) The date the employer terminates Active Medical Plan coverage and withdraws its employees or a class of its employees from Medical Plan participation.

(b) Upon termination of Active Medical Plan coverage under this Sec. 12.10, an affected Member and/or his or her Eligible Family member(s) may be eligible for Medical Continuation or the Medicare Supplement benefits as set forth in Secs. 12.11, 14.1, and 14.2.

Sec. 12.11 Medical Continuation Coverage. On or within sixty (60) days of the termination date for Active Medical Plan coverage, those persons for whom coverage was in

effect on the date prior to the occurrence of an event described in Sec. 12.10(a)(1) through (7) shall have the option of subscribing for Medical Continuation coverage.

(a) Except as otherwise provided herein or as otherwise may be required by law, a Covered Person may subscribe for continued medical benefits for the following durations:

- (1) Upon termination of coverage under subsections 12.10(a)(1), (2) or (6), Members and their Eligible Family may subscribe for a period of eighteen (18) months.
 - (A) If a Covered Person is or becomes Totally Disabled (as defined by the Social Security Act) at any time during the first sixty (60) days of Medical Continuation coverage, the subscription period shall be extended from eighteen (18) months to twenty-nine (29) months.
 - (B) Notwithstanding subsection (a)(1) above, if the Member, on the date the Active Medical Plan coverage under subsections 12.10(a)(1) or (2) terminates, satisfies the Rule of 70, the Member and/or his or her Eligible Family member(s) (as long as they continue to remain Eligible Family members) may subscribe until the Covered Person becomes eligible for Medicare.
- (2) Upon termination of coverage under subsection 12.10(a)(3), surviving Eligible Family members may subscribe for Medical Continuation benefits for thirty-six (36) months from the date of the Member's death. Medical Continuation dues shall be waived for any period that the Covered Person may be entitled to coverage under Sec. 5.1(e).
- (3) Upon termination of coverage under Sec. 12.10(a)(4) or (7), a Spouse may subscribe for a period of thirty-six (36) months.
- (4) Upon termination of coverage under Sec. 12.10(a)(5) (or (7), a Child may subscribe for a period of thirty-six (36) months.

(b) To be eligible for Medical Continuation coverage, a Covered Person must complete and submit the appropriate application form for Medical Continuation benefits to the Board within sixty (60) days of the triggering event under Sec. 12.10, and pay to the Board monthly in advance, or at such other time or times as may be specified by the Board, such amount as the Board may establish from time to time for Medical Continuation coverage. Any Children born to, adopted by, or placed for adoption with a Member, Spouse, Surviving Spouse, or former Spouse subscribing for Medical Continuation coverage shall also be eligible for coverage for the duration of the parent's subscription period.

(c) Medical Continuation coverage is not available to a Member and his or her Eligible Family member(s) if the termination of Active Medical Plan coverage is due to an event described in Sec. 12.10(a)(8) (relating to termination of participation by employer).

(d) Failure to pay any subscription dues established by the Board for Medical Continuation coverage may result in immediate and permanent termination of Medical Continuation benefits.

(e) If a Surviving Spouse, former Spouse, or a Terminated Vested Member who meets the requirements of the Rule of 70 maintains Medical Continuation coverage through the date of eligibility for Medicare, or obtains a waiver of the continuous coverage requirement from the Board as set forth in Sec. 14.1 below, such Surviving Spouse, former Spouse, or Terminated Vested Member is eligible to subscribe for Medicare Supplement coverage under Sec. 14.2.

Sec. 12.12 Use of Protected Health Information by Board. The provisions of this Sec. 12.12 are intended to comply with the HIPAA Rules relating to use by and disclosure of Protected Health Information (as defined in the HIPAA Rules) to plan sponsors. The Medical Plan, including without limitation the Active Medical, Medical Continuation, Medicare Supplement, and any other health plan subject to HIPAA sponsored by the Plan, constitute an organized health care arrangement.

(a) **Definitions.** Each capitalized term used in this Sec. 12.12 that is not otherwise defined in the Plan shall have the meaning ascribed to it under HIPAA.

(b) **Required Uses and Disclosures of Protected Health Information.** Except as otherwise set forth herein, the medical benefits, and any other health plan that is part of the Plan's organized health care arrangement (individually and collectively referred to herein as the "Health Plan") or any Health Insurance Issuer may disclose Protected Health Information of the Health Plan to the Board in its capacity as plan sponsor for the following uses and disclosures:

- (1) for disclosure to the Secretary of the U.S. Department of Health and Human Services when required by the Secretary for HHS investigation or determination of the compliance of the Health Plan with the HIPAA Rules;
- (2) for disclosure to a Covered Person of that individual's Protected Health Information upon the individual's written request or in appropriate response to an exercise by the Covered Person of any other of his or her individual rights with respect to Protected Health Information, all in accordance with the requirements of the HIPAA Rules; and
- (3) for use or disclosure to other persons, as required by applicable law other than HIPAA, provided that nothing in this Sec. 12.12 shall permit or require the use by or disclosure of Protected Health Information to the Board to the extent such disclosure is prohibited by HIPAA.

(c) **Permitted Uses and Disclosures of Protected Health Information.** Except as otherwise set forth herein, the Protected Health Information created or received by the Health Plan or any Health Insurance Issuer providing benefits under the Health Plan shall be permitted to be disclosed to the Board (upon receipt from the Board 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 Sec. 12.12) for purposes of the Health Plan's administration functions that the Board

performs on behalf of the Health Plan, or as otherwise required by HIPAA, including without limitation

- (1) for Treatment, Payment, or Health Care Operations;
- (2) for other wellness, prevention, and disease management programs;
- (3) for benefit appeals and complaints;
- (4) for purposes relating to subpoenas and other court orders; and
- (5) pursuant to and in accordance with a valid authorization under the HIPAA Rules.

Nothing in this subsection shall permit or require the disclosure of Protected Health Information to the Board to the extent such disclosure is prohibited by HIPAA.

(d) **Requirements of Board.** The Board shall:

- (1) not use or disclose Protected Health Information received from the Health Plan, or any Health Insurance Issuer providing benefits under the Health Plan, other than as permitted by the Health Plan document, for Health Plan administration, or as otherwise required by law;
- (2) ensure that any agent (including a subcontractor) to whom the Board provides Protected Health Information received from the Health Plan, or any Health Insurance Issuer providing benefits thereunder, agrees to the same restrictions and conditions with respect to Protected Health Information as they apply or applied to the Board under this Sec. 12.12;
- (3) not use or disclose Protected Health Information received from the Health Plan, or any Health Insurance Issuer providing benefits under the Health Plan, for employment-related actions or decisions or in connection with any employee benefit plan or benefit provided by the Board other than the Health Plan or a health benefit provided under the Health Plan without the written authorization of the individual;
- (4) report to the Health Plan or Health Insurance Issuer providing benefits thereunder, as applicable, in accordance with the interim final rules issued by the Department of Health and Human Services on August 24, 2009, and any final rules that arise from such interim rules, any use or disclosure of Protected Health Information received from the Health Plan, or Health Insurance Issuer providing benefits under the Health Plan, that is inconsistent with the uses or disclosures required or permitted under this Sec. 12.12 and of which the Board becomes aware;
- (5) make the Protected Health Information of a Covered Person available to that individual, upon the individual's written request, in accordance with

the requirements of the HIPAA Rules as modified by the Health Information Technology for Economic and Clinical Health Act;

- (6) incorporate amendments of Protected Health Information of a Covered Person as, and to the extent, required by the HIPAA Rules;
- (7) make available to a Covered Person 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 HIPAA Rules as modified by the Health Information Technology for Economic and Clinical Health Act;
- (8) make the Board's internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Health Plan, or any Health Insurance Issuer providing benefits under the Health Plan, available to the Secretary of Health and Human Services for determinations as to the compliance of the Health Plan with HIPAA;
- (9) if feasible, return or destroy all Protected Health Information received from the Health Plan, or any Health Insurance Issuer providing benefits under the Health Plan, that the Board maintains 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;
- (10) ensure that the requirements set forth in subsections (e)(1) and (2) are satisfied with respect to Protected Health Information; and
- (11) grant a restriction, if requested, on Protected Health Information disclosure to a health plan for payment or healthcare operations purposes (not treatment purposes), if the Protected Health Information pertains solely to a healthcare item or service for which the healthcare provider has been paid out of pocket in full.

(e) **Access to Protected Health Information.**

- (1) Access. Access to and use of Protected Health Information shall be limited to employees or agents of the Board who perform the functions relating to Health Plan administration on behalf of or in connection with the Health Plan, as described in subsections (b) and (c), in order to perform such activities.
- (2) Minimum Necessary. Except as to a use or disclosure of information related to the treatment of an individual, when using or disclosing Protected Health Information or when requesting Protected Health Information from another entity, the Health Plan or any individual acting on behalf of the Health Plan, including the Board, must make reasonable efforts to limit the use or disclosure of Protected Health Information to the

minimum necessary to accomplish the intended purpose of the use, disclosure, or request. Adherence to policies established by the Health Plan with respect to the use, disclosure, or request of Protected Health Information shall be deemed to constitute such an effort. Employee(s) of the Board responsible for such Health Plan administration activities include employees from the following:

Healthcare Benefits
Plan Operations
Information Technology
Mailroom/Fax Delivery
Finance/Treasury
Appeals Board
Legal
Accounting
Internal Audit

(f) **Security of Electronic Protected Health Information.** With respect to electronic Protected Health Information, the Board shall

- (1) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic Protected Health Information that it creates, maintains, or transmits on behalf of the Plan;
- (2) ensure that the adequate separation of the members of its Workforce who have access to electronic Protected Health Information pursuant to Sec. (e)(2) above is supported by reasonable and appropriate security measures;
- (3) report to the Plan any security incidents of which it becomes aware; and
- (4) ensure that any agent, including a subcontractor, to whom it provides electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect the information.

(g) **Noncompliance.** If the Health Plan becomes aware of any issues relating to noncompliance with the requirements of this Sec. 12.12, the Health Plan's privacy or security official shall undertake an investigation to determine the extent, if any, of such noncompliance; the individuals, policies, or practices responsible for the noncompliance; whether the affected individual(s) should be notified of any unauthorized disclosure of unsecured Protected Health Information; and the appropriate means for curing or mitigating the effects of noncompliance and preventing such noncompliance in the future. Any individual or entity who is determined by the Health Plan to be responsible for such noncompliance shall be subject to disciplinary action, as determined by the Health Plan and Board, in their sole discretion, including, but not limited to, one or more of the following: termination of Health Plan-related responsibilities, required additional training and education with respect to the use or disclosure of or request for Protected

Health Information, limitations on or revocation of access to Protected Health Information, reprimand, diminution of duties, suspension, disqualification for bonus or other pay or promotion, demotion in pay or status, removal from position, or discharge.

(h) **Authorized Representative.** The Health Plan shall recognize an individual who is the personal representative or an authorized representative of a Covered Person as if the individual were the Covered Person himself or herself, provided that the individual has designated the personal representative in accordance with state law or an authorized representative in accordance with the procedures established by the Health Plan.

(i) **Action by the Board.** The Board may act as prescribed in this Sec. 12.12 or may delegate, in writing and in its sole discretion, any and all of its functions under this Sec. 12.12 to a committee, to the Health Plan's privacy and security officials, privacy contact person responsible for receiving complaints, or other officer or employee, or to a group of officers or employees of the Board. The Board or such delegate shall have the authority to establish rules and prescribe forms and procedures for performing its functions hereunder.

(j) **Inconsistent Provisions.** This Sec. 12.12 shall supersede any provisions of the Health Plan to the extent those provisions are inconsistent with this Sec. 12.12.

ARTICLE XIII

MEDICAL PLAN COVERAGE OPTIONS

Sec. 13.1 Eligibility for Active Medical Benefits Coverage.

(a) **PPO BENEFITS.**

- (1) All Members who are enrolled by their employer for Pastor's Participation are covered for the PPO Benefits described in Sec. 13.2.
- (2) Employers may offer to enroll their other Ministers, and other employees normally scheduled to work for 20 hours or more per week, and their Eligible Family for PPO Benefits.

(b) **EPO BENEFITS.** Employers may offer EPO Benefits for other Ministers and other employees and their Eligible Family. The EPO Benefits are described in Sec. 13.3.

(c) **HDHP BENEFITS.** Employers may offer qualified HDHP Benefits for other Ministers and other employees and their Eligible Family members, subject to the applicable legal requirements for participation by individuals in such a plan. The HDHP Benefits are described in Sec. 13.4.

(d) **ENROLLMENT PERIODS.** Members and Eligible Family members are eligible for enrollment in accordance with the eligibility and enrollment rules of the employer and any requirements of applicable law, the Plan, and the Board's administrative rules. A Member may elect to enroll Eligible Family member(s) during any enrollment period established by the Board

and such coverage shall be effective as of the initial date of enrollment, January 1 of the new Plan Year, or within sixty (60) days of a triggering event qualifying for a special enrollment period under the Board's administrative rules. Special enrollment coverage shall be effective as of the day of the eligible life change.

(e) **COVERAGE FOR CHILDREN.** Children shall be eligible for enrollment for the same benefits coverage as the Member until the earlier of the Member's termination of coverage or a Child's attainment of age twenty-six (26). A Dependent Totally Disabled Child shall continue to be covered under the Member's medical benefits coverage beyond the attainment of age twenty-six (26), for such period of time as such Child remains a Dependent and is not in a marriage and the Member is enrolled for Plan medical benefits coverage.

(f) **COVERAGE FOR DISABLED MEMBERS AND DEPENDENT TOTALLY DISABLED CHILDREN.** Continued coverage for Plan medical benefits is only available to a Medicare-eligible Disabled Member or a Dependent Totally Disabled Child of a Member who is not enrolled for Active Medical Plan coverage as an active employee for continued coverage after the attainment of age twenty-six (26) for such period of time during which such Disabled Member or Disabled Child is enrolled in both Part A and Part B of Medicare.

(g) The Plan may, from time to time, offer regional medical plans or provider network options and pilot programs and offer employer dues concessions and other incentives to encourage the use of such programs.

(h) The Plan may adopt health and wellness programs to include in the medical benefits options, including the *Call to Health* program, and encourage participation by offering incentives, in the form of enhanced benefits, reduced or varying deductibles, copayments and/or copayment maximums, or cash payments, to all or some Members, their Eligible Family members, and other persons covered by the Medical Plan, as it, in its sole discretion, deems necessary and reasonable to encourage the appropriate use of healthcare services, contain costs, and promote good health habits.

Sec. 13.2 PPO Benefits. PPO Benefits consist of reimbursement to the Member or his or her assignee for Medically Necessary Covered Medical Services provided to the Member and his or her Eligible Family, subject to the Member's payment responsibilities for copayments and deductibles as described in this Sec. 13.2 and Appendix F, the provisions of Article XII, and other applicable provisions of the Plan.

(a) **MEMBER COPAYMENTS FOR COVERED MEDICAL SERVICES OTHER THAN PRESCRIPTION DRUGS.**

(1) ***Physician Office Visits.***

(A) **Network and Non-Network.** The Member shall pay the copayment amount specified in Appendix F per visit with a Network or Non-Network primary care practitioner, specialist physician or urgent care center.

- (B) Out-of-Network. The Member shall pay fifty percent (50%) of the Plan Allowance for an office visit to an Out-of-Network primary care or specialist physician.
 - (C) No Deductible for Office Visits. Office visits reimbursed under this Sec. 13.2(a)(1) shall not be subject to the annual deductible requirements in Sec. 13.2(c).
 - (D) Preventive Health Screenings. Notwithstanding the foregoing, the Member shall not have a copayment obligation and the Medical Plan shall reimburse one hundred percent (100%) of the eligible Covered Medical Services for an office visit for prevention screenings covered by the Plan's preventive health benefits.
- (2) ***Other Medical Services.***
- (A) Reimbursement after Satisfaction of Deductibles. Upon satisfaction by the Member and Eligible Family member(s) of the applicable annual deductible amount set forth in Sec. 13.2(c) and Appendix F, the Medical Plan shall reimburse a Member:
 - (i) *Network and Non-Network Providers*: Eighty percent (80%) of the Plan Allowance for Covered Medical Services incurred by the Member and the Eligible Family member(s). The remaining twenty percent (20%) is the Member's copayment responsibility.
 - (ii) *Out-of-Network Providers*: Sixty percent (60%) of the Plan Allowance for Covered Medical Services incurred by the Member and the Eligible Family member(s). The remaining forty percent (40%) is the Member's copayment responsibility.
 - (B) Reimbursement after Satisfaction of Annual Copayment Maximums in Sec. 13.2(d). Upon satisfaction by the Member and Eligible Family member(s) of any applicable Annual Copayment Maximum amount set forth in Sec. 13.2(d) and Appendix F, the Medical Plan shall reimburse a Member:
 - (i) *Network and Non-Network Providers*: One hundred percent (100%) of the Plan Allowance for Covered Medical Services incurred by the Member and Eligible Family member(s).
 - (ii) *Out-of-Network Providers*: The lesser of one hundred percent (100%) of the charges for Covered Medical Services incurred by the Member and Eligible Family

member(s) or one hundred percent (100%) of the Plan Allowance.

(b) MEMBER COPAYMENTS FOR PRESCRIPTION DRUG BENEFITS COSTS.

For outpatient prescription drug costs reimbursable under the Prescription Drug Benefits, the Member shall be responsible for the copayment amounts specified in Appendix F for generic, brand, and specialty drugs based on the type of pharmacy (retail or mail-order), the amount supplied (up to 30 or 90 days), and whether the drug is on the applicable formulary.

(c) ANNUAL DEDUCTIBLES. Reimbursement for Covered Medical Services under this Sec. 13.2 is subject to the Member's satisfaction of the annual deductibles specified in Appendix F. For purposes of determining annual deductible amounts, the Board may, in its sole discretion, establish minimum, maximum, and graduated bands of Effective Salary ("Compensation Bands") on which to apply the applicable percentage stated below, provided that the Member shall not be placed in a Compensation Band that exceeds the Member's Effective Salary.

(1) For Covered Medical Services Other than Prescription Drug Benefits Costs.

(A) Physician Office Visits. There are no annual deductibles for physician office visits.

(B) Other Medical Services. The annual deductibles for Covered Medical Services other than costs incurred for office visits and for Prescription Drug Benefits shall be:

(i) *For Network and Non-Network Covered Medical Services*. One and one-half percent (1.5%) of the Member's Compensation Band and an additional one and one-half percent (1.5%) of the Member's Compensation Band for the Member's Eligible Family, in the aggregate.

(ii) *For Out-of-Network Covered Medical Services*. Two and one-half percent (2.5%) of the Member's Compensation Band and an additional two and one-half percent (2.5%) of the Member's Compensation Band for the Member's Eligible Family, in the aggregate.

(iii) Out-of-Network Covered Medical Services are applied to satisfy the Network and Non-Network Covered Medical Services Deductibles.

(iv) Network and Non-Network Covered Medical Services are applied to satisfy the Out-of-Network Covered Medical Services Deductibles.

- (2) ***For Prescription Drug Benefits Costs.*** There are no annual deductibles for Covered Medical Services incurred under the Prescription Drug Benefits.
- (3) ***Annual Caps on Deductibles.*** Notwithstanding subparagraph (c)(1) above:
 - (A) The aggregate annual deductibles for Covered Medical Services (Network, Non-Network, and Out-of-Network) shall not exceed two and one-half percent (2.5%) of the Member's Compensation Band for Covered Medical Services for a Member and an additional two and one-half percent (2.5%) of the Member's Compensation Band for Covered Medical Services for the Member's Eligible Family.
 - (B) No more than two (2) annual deductibles shall be applicable to a Member and such Member's Eligible Family in any one (1) calendar year.
 - (C) A Member's aggregate maximum annual deductible responsibility shall not exceed the sum of two (2) annual deductibles for Covered Medical Services.
- (4) ***Annual Deductible for Disabled Members.*** The annual deductibles for a Disabled Member and Eligible Family's medical benefits coverage under Sec. 11.5 shall be as specified in Appendix F.
- (5) ***Annual Deductible for Medical Continuation Coverage.*** The annual deductibles for individuals enrolled for Medical Continuation benefits under Sec. 12.11 shall be as specified in Appendix F.
- (6) Reimbursable Covered Medical Services credited toward satisfaction of the annual deductibles for Covered Medical Services are not credited toward satisfaction of the Annual Copayment Maximum Amounts.
- (7) For Out-of-Network Covered Medical Services, only charges up to the Plan Allowance for Covered Medical Services shall be credited toward the satisfaction of the annual deductibles.

(d) **COPAYMENT MAXIMUM AMOUNTS.** Reimbursement for Covered Medical Services under this Sec. 13.2 is subject to the Annual Copayment Maximums specified in Appendix F. For purposes of determining the Annual Copayment Maximum amounts, the Board may, in its sole discretion, use Compensation Bands on which to apply the applicable percentage stated below.

- (1) For Covered Medical Services Other than Prescription Drug Benefits Costs ("Annual Copayment Maximum").

- (A) For Network and Non-Network Covered Medical Services. A Member's Annual Copayment Maximum is five percent (5%) of the Member's Compensation Band.
 - (B) For Out-of-Network Covered Medical Services. A Member's Annual Copayment Maximum is fifteen percent (15%) of the Member's Compensation Band.
 - (C) Disabled Member. For Disabled Members and their Eligible Family enrolled for medical benefits under Sec. 11.5, the Compensation Band for purposes of determining the Annual Copayment Maximum in Sec. 13.2(d)(1)(A) and (B) above shall be the Compensation Band applicable to the greater of the Disabled Member's Effective Salary on the date the Disability began or the current Congregational Ministers' Median.
 - (D) Individuals Enrolled for Medical Continuation Benefits. For individuals enrolled for Medical Continuation benefits under Sec. 12.11, the amount of the Annual Copayment Maximum in Sec. 13.2(d)(1)(A) and (B) above shall be established on the basis of the Congregational Ministers' Median.
 - (E) Notwithstanding subparagraphs (1)(A) and (B) above, the aggregate Annual Copayment Maximum shall not exceed fifteen percent (15%) of all reimbursable Covered Medical Services.
 - (F) For Out-of-Network Covered Medical Services, only charges for Covered Medical Services up to the Plan Allowance shall be credited toward satisfaction of the Annual Copayment Maximum Amounts.
- (2) ***For Prescription Drug Benefits Costs ("Prescription Drug Annual Copayment Maximum").*** In the event that during a given calendar year, the Prescription Drug Benefits copayment charges paid by a Member and a Member's Eligible Family, exclusive of copayment charges for non-formulary brand-name drugs, exceed the Annual Copayment Maximum for Prescription Drug Costs on Appendix F, no further copayments under Sec. 13.2(b) shall be required for the balance of that calendar year and all reimbursable Prescription Drug Benefits charges (other than copayments for non-formulary brand-name drug charges) in excess thereof shall be reimbursed on the basis of one hundred percent (100%) of Allowable Charges, subject to the managed care provisions of Sec. 12.4(g).

Sec. 13.3 EPO Benefits. EPO Benefits consist of reimbursement by the Medical Plan to the Member or his or her assignee for Medically Necessary Covered Medical Services provided by Network and Non-Network Providers to a Member and his or her covered Eligible Family, subject to the Member's payment responsibilities for copayments and deductibles as described in

this Sec. 13.3 and Appendix F, the provisions of Article XII, and other applicable provisions of the Plan.

(a) MEMBER COPAYMENTS FOR COVERED MEDICAL SERVICES OTHER THAN PRESCRIPTION DRUGS.

(1) ***Physician Office Visits.***

- (A) Network and Non-Network. The Member shall pay the copayment amount specified in Appendix F per visit with a Network or Non-Network primary care practitioner, specialist physician or urgent care center.
- (B) Out-of-Network. No reimbursement shall be made for Out-of-Network office visits.
- (C) Preventive Health Screenings. Notwithstanding the foregoing, the Member shall not have a copayment obligation and the Medical Plan shall reimburse one hundred percent (100%) of the eligible Covered Medical Services for an office visit for prevention screenings covered by the Medical Plan's preventive health benefits.

(2) ***Other Medical Services.***

- (A) Reimbursement after Satisfaction of Deductibles. Upon satisfaction by the Member and Eligible Family member(s) of the applicable annual deductible amounts set forth in Sec. 13.3(c) and Appendix F, the Medical Plan shall reimburse a Member:
 - (i) *Network and Non-Network Providers:* Eighty percent (80%) of the Plan Allowance for the Covered Medical Services incurred by the Member and the Eligible Family member(s). The remaining twenty percent (20%) is the Member's copayment responsibility.
 - (ii) *Out-of-Network Providers:* No reimbursement shall be made for Out-of-Network Covered Medical Services, except Emergency Services.
- (B) Reimbursement after Satisfaction of Annual Copayment Maximum Amounts. Upon satisfaction by the Member and Eligible Family member(s) of the Annual Copayment Maximum set forth in Appendix F, the Medical Plan shall reimburse a Member:
 - (i) *Network and Non-Network Providers:* One hundred percent (100%) of the Plan Allowance for Covered Medical

Services incurred by the Member and the Eligible Family member(s).

- (ii) *Out-of-Network Providers*: No reimbursement will be made for Out-of-Network services, except Emergency Services.

(b) MEMBER COPAYMENTS FOR PRESCRIPTION DRUG BENEFITS COSTS.

For outpatient prescription drug costs reimbursable under the Prescription Drug Benefits, the Member shall be responsible for the copayment amounts specified in Appendix F for generic, brand, and specialty drugs based on the type of pharmacy (retail or mail-order), the amount supplied (up to 30 or 90 days), and whether the drug is on the applicable formulary.

(c) ANNUAL DEDUCTIBLES. Reimbursement for Covered Medical Services under this Sec. 13.3 is subject to the Member's satisfaction of the annual deductibles specified in Appendix F.

- (1) There are no annual deductibles for Covered Medical Services incurred for office visits subject to Sec. 13.3(a)(1)(A).
- (2) There are no annual deductibles for Covered Medical Services incurred under the Prescription Drug Benefits.

(d) COPAYMENT MAXIMUM AMOUNTS. Reimbursement for Covered Medical Services under this Sec. 13.3 is subject to the Annual Copayment Maximums specified in Appendix F.

(e) EXCLUSIONS AND LIMITATIONS APPLICABLE TO EPO BENEFITS.

In addition to the exclusions and limitations generally applicable to the Medical Plan as described in Article XII, EPO Benefits also exclude from reimbursement the following Covered Medical Services:

- (1) Services and supplies provided by Out-of-Network Providers, except Emergency Services,
- (2) Advanced reproductive services described in Sec. 12.3(a)(2), and
- (3) Hearing aids and fittings as described in Sec. 12.3(a)(4).

Sec. 13.4 HDHP Benefits. HDHP Benefits consist of reimbursement by the Medical Plan to the Member or his or her assignee for Medically Necessary Covered Medical Services provided by Network or Non-Network Providers to a Member and his or her covered Eligible Family member(s), subject to the Member's payment responsibilities for copayments and deductibles as described in Sec. 13.4 and Appendix F, the provisions of Article XII, and other applicable provisions of the Plan.

(a) **ANNUAL DEDUCTIBLE.** Except for Covered Medical Services incurred for preventive office visits under Sec. 13.4(b)(1)(C) or for Preventive Prescription Drug Services under Sec. 13.4(b)(3), reimbursement for Covered Medical Services under this Sec. 13.4 is subject to the Member's satisfaction of the annual deductibles specified in Appendix F.

(b) **COPAYMENTS FOR COVERED MEDICAL SERVICES OTHER THAN PRESCRIPTION DRUGS.** Upon satisfaction by the Member and Eligible Family member(s) of the applicable annual deductible amounts specified in 13.4(a) and Appendix F, the Member shall be responsible for the following copayments for the Covered Medical Services.

(1) ***Physician Office Visits.***

(A) Network and Non-Network. The Member shall pay the copayment amount specified in Appendix F per visit with a Network or Non-Network primary care practitioner, specialist physician or urgent care center.

(B) Out-of-Network. No HDHP Benefits are payable for Out-of-Network office visits. The Member shall be solely responsible for any charges incurred for Covered Medical Services.

(C) Preventive Health Screenings. Notwithstanding the foregoing, the Member shall not have a deductible or copayment obligation and the Medical Plan shall reimburse one hundred percent (100%) of the eligible Covered Medical Services for an office visit with a Network or Non-Network provider for prevention screenings covered by the Medical Plan's preventive health benefits.

(2) ***Other Medical Services.***

(A) *Network and Non-Network Providers:* The Medical Plan shall reimburse eighty percent (80%) of the Plan Allowance for the Covered Medical Services incurred by a Member and Eligible Family member(s). The remaining twenty percent (20%) is the Member's copayment responsibility.

(B) *Out-of-Network Providers.* No HDHP Benefits are payable for Out-of-Network Covered Medical Services except Emergency Services. The Member shall be solely responsible for any charges incurred for Covered Medical Services except Emergency Services. Emergency Services shall be reimbursed as described in Sec. 13.4(2)(A).

(3) ***Prescription Drug Benefit.*** For covered outpatient prescription drugs other than prescription drugs covered under the Preventive Prescription Drug Services benefit, until the Member has satisfied the annual deductible for HDHP Benefits specified in Appendix F, the Member shall be responsible for the Plan Allowance for generic, brand, and specialty

drugs based on the type of pharmacy (retail or mail-order), the amount supplied (up to 30 or 90 days) and whether the drug is on the applicable formulary. After satisfaction of the annual deductible, the Member shall be responsible for a copayment of thirty percent (30%) of the Plan Allowance for covered Prescription Drugs.

(c) **ANNUAL COPAYMENT MAXIMUM AMOUNTS.** Upon satisfaction of the Member or Family Annual Copayment Maximum specified in Appendix F, and any other requirements of the Plan, the Member shall be reimbursed for one hundred percent (100%) of Covered Medical Services.

- (1) *Network and Non-Network Providers:* One hundred percent (100%) of the Plan Allowance for Covered Medical Services incurred by the Member and the Eligible Family member(s).
- (2) *Out-of-Network Providers:* No reimbursement will be made for Out-of-Network services, except Emergency Services. Emergency Services shall be reimbursed as described in Sec. 13.4(2)(A).

(d) **EXCLUSIONS AND LIMITATIONS APPLICABLE TO HDHP BENEFITS.** In addition to the exclusions and limitations generally applicable to the Medical Plan as described in Article XII, HDHP Benefits also exclude from reimbursement the following Covered Medical Services:

- (1) Services and supplies provided by Out-of-Network Providers, except Emergency Services.

ARTICLE XIV

POST-RETIREMENT MEDICAL BENEFITS

Sec. 14.1 Medical Benefits Coverage Prior to Eligibility for Medicare.

(a) **MEDICAL CONTINUATION COVERAGE.** Medical benefits coverage for Members who have terminated or retired from Eligible Service prior to eligibility for Medicare coverage is available under and subject to the provisions of Sec. 12.11 (Medical Continuation Coverage).

(b) **CONTINUOUS MEDICAL COVERAGE REQUIREMENT.** Except as otherwise provided herein, Members and/or Eligible Family members must maintain continuous coverage in a qualified health plan (as defined in Section 1301(a) of the federal Patient Protection and Affordable Care Act) up to the date of Medicare eligibility to be eligible to enroll for Medicare Supplement benefits under Sec. 14.3.

Sec. 14.2 Post-Retirement Medicare Supplement Coverage Following Eligibility for Medicare. Members who satisfy the Rule of 70 and/or their Eligible Family members shall each have the option to subscribe for Medicare Supplement benefits as set forth in Sec. 14.3.

Coverage will commence as of the latest of the date of termination of Active Medical Plan coverage, termination of qualified health plan coverage, or the first day of the month during which such person becomes eligible for Medicare, provided that the person is enrolled in both Part A and Part B of Medicare and:

(a) The Member and Eligible Family were participants in the Group Medical Plan for Retired Personnel and their Families administered by the Board of Annuities and Relief of the Church on December 31, 1986;

(b) The Member and Eligible Family were participants in the Supplement to Medicare administered by the Board of Pensions of the United Presbyterian Church in the U.S.A. on December 31, 1986; or

(c) The Member has terminated from Eligible Service or is not normally scheduled to work for twenty (20) or more hours per week in Eligible Service and

(1) has maintained continuous Plan Medical benefits or qualified health plan coverage until the date of eligibility for Medicare Supplement coverage; and

(2) had a minimum of five (5) Years of Medical Plan participation.

(d) Medicare Supplement coverage shall not be available to any person enrolled in a Medicare Advantage program.

(e) Medicare Supplement coverage may also be offered to a Terminated Vested Member, retired Member, Spouse of a Terminated Vested Member or retired Member, and Dependent Totally Disabled Child who is eligible for and participating in Part A and Part B of Medicare and who does not otherwise qualify under this Sec. 14.2 upon payment of such subscription charge and under such administrative rules and regulations as the Board may establish from time to time.

Sec. 14.3 Medicare Supplement Plan Benefits. Medicare Supplement coverage for those subscribing persons eligible under Sec. 14.2 shall be a supplement to the benefits provided by Medicare. Medicare Supplement coverage shall not be available to a subscribing person for any period of time during which such subscribing person is not enrolled in both Part A and Part B of Medicare.

(a) **MEDICARE SUPPLEMENT REIMBURSEMENT.** With the exception of certain managed care provisions of Sec. 12.7, the exclusions and limitations in Sec. 12.3, the provisions of Sec. 14.3(b), and the Medicare Supplement deductible and copayment maximum provisions of Sec. 14.3(c) and (d), the Medical Plan shall reimburse a person covered hereunder for eighty percent (80%) of the Covered Medical Services allowable under Medicare other than Prescription Drug Benefits charges, as defined in Sec. 12.2(g), less any amount reimbursable by Medicare for such Covered Medical Services regardless of whether or not such allowable amount is reimbursed by Medicare. Prescription Drug Benefits charges shall be reimbursed as set forth in Sec. 14.3, subsections (d) and (g).

(b) **MEDICARE SUPPLEMENT REIMBURSEMENT EXCLUSIONS AND LIMITATIONS.** The Covered Medical Services reimbursed under Sec. 14.3(a) shall not include charges:

- (1) exceeding one hundred dollars (\$100) in any one day made by a registered nurse or by a licensed practical nurse if prescribed by a physician;
- (2) of a provider that has elected not to participate in the Medicare program;
- (3) for outpatient prescription drugs incurred when the Medicare Supplement subscriber is enrolled in a Medicare Part D Plan;
- (4) incurred when the Medicare Supplement subscriber is enrolled in a Medicare Advantage program.

(c) **ANNUAL MEDICARE SUPPLEMENT DEDUCTIBLES.** No benefits under this Sec. 14.3 shall be paid until the reimbursable Covered Medical Services of an individual exceed the Annual Deductible. The Annual Deductible for reimbursement of Covered Medical Services other than those eligible for payment under the Prescription Drug Benefits shall be one-half of one percent (0.5%) of the Congregational Ministers' Median.

(d) **ANNUAL MEDICARE SUPPLEMENT COPAYMENT MAXIMUM LIMITS.** In the event that during a given calendar year the twenty percent (20%) copayments of reimbursable Covered Medical Services incurred by an individual under Sec. 14.3(a), when combined with the applicable deductible under Sec. 14.3(c), exceed four percent (4%) of the Congregational Ministers' Median, such excess of Covered Medical Services for the balance of the calendar year shall be reimbursed at one hundred percent (100%). In the event that during a given calendar year the Prescription Drug Benefits copayment charges paid by an individual, exclusive of copayment charges for non-formulary brand-name drugs, exceed two thousand five hundred dollars (\$2,500), no further copayment shall be required for the balance of that calendar year and all reimbursable Prescription Drug Benefits charges (other than copayments for non-formulary brand-name drug charges) in excess thereof shall be paid to the Member on the basis of one hundred percent (100%) reimbursement, subject to the managed care provisions of Sec. 12.4.

(e) **SUBSCRIPTION CHARGE FOR MEDICARE SUPPLEMENT.** The charges to provide coverage under this Sec. 14.3 shall be payable monthly in advance or at such other time or times as may be established by the Board and shall be in such amounts as the Board, in its sole discretion, deems necessary to provide such coverage. The subscription charge for a person who becomes eligible under Sec. 14.2 for coverage provided by this Sec. 14.3 shall be waived for the remainder of the month in which the Member retires provided the subscription charge for Medical Plan coverage for such person has not been previously waived under Sec. 14.2. The determination of the amount of the subscription charge shall take into account any funds received by the Board from special church offerings, and voluntary church contributions allocated by the Board for this purpose as well as whether the Member qualifies as a low-income subscriber as described in Sec. 14.3(g)(4). The Board may, in its sole discretion, allocate all or a portion of any funds received by the Board to cover the plan sponsor's share of the cost of Prescription Drug

Benefits for qualified retirees enrolled for Medicare Supplement benefits to the extent necessary to qualify the Medicare Supplement for the subsidy under Part D of Title XVIII of the Social Security Act (42 U.S.C. Section 1302 and Section 1395w-101 et seq.).

(f) **TERMINATION OF MEDICARE SUPPLEMENT COVERAGE.** Coverage under this Sec. 14.3 shall terminate upon the earlier of the death of the subscribing person or the last day of the period for which a subscription payment has been received if the next subsequent payment is not made on the date required.

(g) **MEDICARE SUPPLEMENT PRESCRIPTION DRUG BENEFITS.**

- (1) Except as otherwise provided in this Sec. 14.3(g), the Medicare Supplement Prescription Drug Benefits coverage shall consist of Medicare Part D plan benefits through a Part D plan sponsored and administered by a designated vendor of the Plan and such other wraparound benefits as the Board, in its sole discretion, may determine, so as to provide coverage comparable to the benefits provided in the Active Medical Plan Prescription Drug Benefits.
- (2) The Board may establish from time to time Prescription Drug Benefits for Medicare-eligible beneficiaries, as part of the Medicare Supplement benefits or as a carve-out, stand-alone plan or program, including, without limitation, pilot programs, provider networks, and incentive programs for all Medicare-eligible Members or reasonably classified Medicare-eligible Member groups nationally or regionally and adopt administrative rules and regulations as it, in its sole discretion, deems necessary and appropriate to comply with the Medicare laws and regulations, contain Plan and enrollee costs, and encourage the appropriate use of prescription drug products and services.
- (3) Medicare Supplement reimbursement for Members and Eligible Family member(s) enrolled in a Medicare Part D plan other than the Medicare Supplement Part D Prescription Drug Benefits shall be limited to medical and behavioral health benefits under this Sec. 14.3 only. The other Medicare Part D plan shall be the primary and only outpatient prescription drug coverage for such enrollees. Medicare Supplement coverage does not coordinate benefits with the Part D plan. The Member shall pay the Board the requisite dues established by the Board under Sec. 14.3(e) for regular Medicare Supplement coverage.
- (4) Commencing January 1, 2006, any Medicare Supplement subscriber eligible for a subsidy under Section 1860D-15 of the Social Security Act and regulations (Subpart P of 42 C.F.R. Part 423) and enrolled in a Medicare Part D plan as an individual with low income and limited assets may enroll for alternate Medicare Supplement benefits under this Sec. 14.3(g). Medicare Supplement reimbursement for any Medicare Supplement subscriber enrolled in a Medicare Part D plan as a low-

income individual shall be limited to all medical and behavioral health benefits under Sec. 14.3 other than Prescription Drug Benefits and such enrollees shall pay the Board the requisite dues established by the Board under Sec. 14.3(e) for such limited Medicare Supplement coverage.

OPTIONAL BENEFITS

ARTICLE XV

DENTAL BENEFITS

Sec. 15.1 Dental Benefits . The Board shall, from time to time, adopt such provisions, rules, and regulations applicable thereto and designate a claims administrator as it, in its sole discretion, deems necessary or appropriate for the administration of a Dental Benefits program to be offered to the Members of this Plan as an optional benefit. The Board may select an insurance company to underwrite and administer the group coverage provided in Article XV, in which event the terms of the Dental Benefits program shall be as set forth in the certificate of coverage or equivalent document provided by the Carrier.

Sec. 15.2 Dental Benefits Definitions. When used in Article XV, the following words shall have the respective meanings set forth below unless the context clearly indicates otherwise:

(a) DENTIST. An individual legally licensed to practice dental medicine.

(b) CARRIER. The insurance company which the Board may select from time to time to underwrite and administer the coverage provided in Article XV.

Sec. 15.3 Eligibility. All Members whose employers select dental benefits on their Employer Agreement and their Eligible Family members shall be eligible for enrollment in the Dental Benefits program.

Sec. 15.4 Commencement of Coverage. Coverage for dental benefits shall commence upon an eligible Member (a) enrolling for the benefits as provided in Sec. 4.2. A Member may also be required to complete a supplemental application or other forms supplied by the Board, which application is accepted by the Board, its claim administrator or the Carrier as being complete and evidencing entitlement to the coverage provided by Article XV, and (b) paying all dues required by Article XV.

Sec. 15.5 Reimbursement of Dental Expenses. Subject to the deductible and maximum benefit provisions established by the Board, a Member enrolled for Dental Benefits shall be reimbursed the amount listed on the schedule of eligible benefits published by the Board, its designated claims administrator or the Carrier for the Dental Benefits.

Sec. 15.6 Deductible. No benefits shall be paid to or for any individual until the charges for covered dental services for such individual in any one calendar year exceed such deductible as may be established by the Board from time to time.

Sec. 15.7 Dental Services. The dental services covered under this program shall include only those dental services described in a schedule published by the Board, its claims administrator or, if the Board has selected a Carrier to underwrite the coverage provided in Article XV, as defined in the group insurance policy of the Carrier underwriting the coverage contained in Article XV.

Sec. 15.8 Predetermination of Benefits. Any person covered under Article XV may submit to the claims administrator or Carrier in advance of treatment a treatment plan which will permit the claims administrator or Carrier to issue to such person a predetermination of benefits as to the approved course of treatment and an estimate of benefits payable.

Sec. 15.9 Dues for Dental Benefits. Dues shall be paid to the Board in installments on a monthly basis in advance or at such other time or times as may be specified by the Board. Dues shall be in an amount as established by the Board from time to time.

Sec. 15.10 Termination of Coverage. Coverage for a Member and his or her Eligible Family member(s) under Article XV shall terminate upon the occurrence of any one of the following events:

- (a) The date of retirement of a Member.
- (b) The date of termination of Eligible Service of a Member other than a Disabled Member (unless the Member enrolls to continue coverage under Transitional Participation Coverage (described in Sec. 5.1(e)).
- (c) The date of death of a Member.
- (d) The last day of the period for which a dues payment for coverage under Article XV has been made if the next subsequent dues payment is not made on the date required.

ARTICLE XVI

VISION MATERIALS BENEFITS

Sec. 16.1 Eligibility. An employer may elect to offer Vision Materials Benefits coverage to its employees, or classifications of employees, and their Eligible Family members by making an election in its Employer Agreement. An employer may offer the coverage on a fully or partially employee contributory basis.

Sec. 16.2 Vision Materials Benefits. Subject to any maximum benefit provisions established by the Board, the Vision Benefits program shall reimburse an individual enrolled for Vision Material Benefits the amount listed on the schedule of eligible benefits published by the Board or its designated claims administrator of the Vision Materials Benefits. If the Board has selected a Carrier to underwrite the Vision Materials Benefits, the reimbursement shall be as stated in the group insurance policy of the Carrier underwriting the coverage.

Sec. 16.3 Dues for Vision Materials Benefits. Dues shall be in an amount established by the Board from time to time. An employer may require a Member to pay up to one hundred percent (100%) of the Dues for Vision Materials Benefits through a payroll deduction from the Member or other arrangement with the employee. Dues shall be remitted to the Board by the employer in installments on a monthly basis in advance or at such other time or times as may be specified by the Board.

Sec. 16.4 Termination of Coverage. Coverage for a Member and his or her Eligible Family member(s) under Article XVI shall terminate upon the occurrence of one of the following events:

- (a) The date of retirement of a Member.
- (b) The date of termination of Eligible Service of a Member other than a Disabled Member (unless the Member enrolls to continue coverage under Transitional Participation Coverage (described in Sec. 5.1(e)).
- (c) The date of death of a Member.
- (d) The last day of the period for which a dues payment for coverage under Article XVI has been made if the next subsequent dues payment is not made on the date required.

ARTICLE XVII (RESERVED)

ADMINISTRATIVE PROVISIONS

ARTICLE XVIII

ADMINISTRATION

Sec. 18.1 Administration of Benefits Plan. The Board shall administer the Plan and have the sole and exclusive discretion and authority to interpret its provisions. It shall be the fundamental obligation of the Board to maintain the financial and actuarial soundness of the Plan at all times and to administer the Plan and the Plan assets solely in the interest of the Members and their Eligible Family in accordance with its terms. In the event that the Board, based on the advice of its actuarial and legal counsel, determines that the current assets held from dues and earnings on reserves for Plan coverage, other than the dues and earnings held on account of the Pension and Retirement Savings Plans, exceed the existing and future benefits liabilities and obligations, the Board may, in its sole discretion, allocate such excess assets for other benefits of the Plan, for the Board's Assistance Program, or for such other purposes that are consistent with the mission of the Board of Pensions.

Sec. 18.2 Assignment of Benefits.

(a) The interest of Members and all other persons entitled to receive any benefit or payment under the Plan shall not be subject to anticipation, assignment, attachment, or to voluntary or involuntary alienation except as provided in Sec. 18.2(b).

(b) A Spouse, former Spouse, or Child or other Dependent of a Member ("Alternate Payee") may, in the event of a divorce, dissolution of marriage, or legal separation (in states where recognized) between a Member and such Member's Spouse, become entitled to receive a portion of the Member's retirement, survivor's pension, or disability benefits. Such a benefit, or portion thereof, shall be payable to an Alternate Payee pursuant only to a domestic relations order issued by a court of competent jurisdiction and accepted by the Board, provided however that no such order shall be valid and binding upon the Board if such order entitles an Alternate Payee to receive a benefit which (a) requires any type or form of benefit, payment, or option not permitted by the Plan; (b) requires the acceleration of any benefit payment hereunder except that an Alternate Payee shall be permitted to initiate payment of his or her retirement pension benefits at the earliest retirement date of the Member permitted by the Pension Plan; (c) requires the Plan to provide increased benefits (determined on the basis of an actuarial valuation of the Actuary of the Plan); or (d) requires the payment of benefits which are being paid to another Alternate Payee pursuant to a previous domestic relations order issued by a court of competent jurisdiction. Any such entitlement paid to an Alternate Payee shall reduce the amount of any benefit that would otherwise, absent the entitlement paid to the Alternate Payee, have been payable to the Member or any succeeding Spouse or Dependent of the Member, as the case may be, to the extent of the entitlement paid to the Alternate Payee. Determinations of the Plan's Appeals Board as to the interpretation of an Order or the reduction in Member benefits as a result of such Order shall be conclusive and binding.

Sec. 18.3 Payments to Incapacitated Payee. If any payee hereunder is, in the judgment of the Board, legally, physically, or mentally incapable of personally receiving and receipting for any payments due hereunder, or is deceased, the Board may make payments thereof to such other person, persons, or institution as, in the Board's sole opinion, is then maintaining or has custody of such payee, until a guardian, committee, or other legal representative of such payee shall be duly appointed and claim made by such appointee, or in the case of a deceased Member or payee, to any person or persons appearing to the Board to be equitably entitled to the same. Such payment shall constitute a full discharge of the liability of the Board to the extent thereof.

Sec. 18.4 Payees Who Cannot Be Located. In the event that any person who is entitled to a benefit or payment under the Plan cannot, after a reasonable search, be located within two years after becoming eligible for such benefit or payment, the full commuted value or amount of said benefit or payment shall be paid into the reserve funds of the Plan and no person shall have a further right or claim to the same. Further, any benefit or payment paid to any person but not cashed or deposited within two years shall be paid into the reserve funds of the Plan and no person shall have a further right or claim to the same. In no event shall a Plan benefit or payment escheat to, or otherwise be paid to, any governmental unit under any escheat or unclaimed property law.

Sec. 18.5 Proof of Loss. To be eligible for benefits or claims' reimbursement, all benefits applications and claims must be received by the Plan within twelve (12) calendar months of the date the benefit became due or the charges to be reimbursed were incurred, unless the Board determines that an earlier filing was not reasonably possible and that proof of the claim was furnished as soon as it was reasonably possible.

Sec. 18.6 Comity Agreements. Comity agreements between the Church and other denominations may be made by the Board and will become effective only when approved by the General Assembly. The purpose of such comity agreements will be to establish an equitable basis for the maintenance of accrued Pension Credits for those Ministers who leave the Church while in good standing to become ministers of another denomination and for the maintenance of similar Pension Credits by another denomination for those of its ministers who transfer to the Church.

Sec. 18.7 Notices. Any notice required by the terms of the Plan shall be in writing and delivered to a Member or other Covered Person by email, with delivery receipt, U.S. Mail or nationally recognized and reputable express delivery service, postage pre-paid to a Member or other Covered Person to his or her last known address as shown on the records of the Board. Unless the Board has established an electronic communication or notification option for a required benefit application or notice requirement, notice to the Board by an employer or Member shall be made in writing, delivered at its registered office and directed to Plan Operations.

Sec. 18.8 Rules Applicable to Specialized Ministries and Other Church Groups. The Board shall, from time to time, adopt such rules and regulations as it, in its sole discretion, deems necessary or appropriate to administer the Plan with regard to seminary students, children, Members engaged in a validated ministry beyond the jurisdiction of the Church, and other groups within the Church.

Sec. 18.9 Administrative Rules. The Plan shall, from time to time, adopt such rules and regulations as it, in its sole discretion, deems necessary or appropriate to administer the Plan or any part thereof. The determination by the Plan of any amount due or eligibility for any benefits pursuant to the Plan shall be conclusive and binding.

Sec. 18.10 Appeals. The Board shall establish a process by which a Member or a Member's duly authorized representative may obtain a review of any denial of all or a portion of a claim for benefits by a Member or a Member's beneficiary, or an adverse eligibility determination. The initial request for a review of a claim denial or adverse eligibility determination must be made by the Member or the Member's authorized representative in writing within one hundred eighty (180) days of the date of the Plan's notice of denial of the claim or adverse eligibility determination.

The appeals process shall provide that prior to any final denial of a claim for benefits or adverse eligibility determination, the Plan shall furnish notice to the Member setting forth

- (a) the specific reasons for the denial;
- (b) the specific reference to the Plan provision on which the denial is based;
- (c) a description of any additional information necessary for the Member to perfect the claim and an explanation of why such information is necessary; and
- (d) appropriate information as to the steps to be taken if the Member wishes to submit the claim for further review.

The appeals procedure adopted by the Board pursuant to this Sec. 18.10 shall be the exclusive means for contesting a decision denying benefits or eligibility under the Plan. Determinations of the Plan's Appeals Board shall be conclusive and binding.

Sec. 18.11 Recoupment of Benefit Overpayments. The Plan shall have the right to repayment of any payment to the Member or the Member's beneficiary, or on the Member's or the Member's beneficiary's behalf, which was made by the Plan or its designee in error, after the Member or the Member's beneficiary benefits entitlement had expired, based on a mistake of fact, or a fraudulent misrepresentation by the Member, the Member's beneficiary, or on the Member's or Member's beneficiary's behalf. At its option, the Plan may deduct the payment from future benefits payments to which the Member or the Member's beneficiary may be entitled or which might otherwise be payable on the Member's or the Member's beneficiary's behalf. If the Member fails to repay the money upon demand from the Plan, the Member and the Member's beneficiary will be ineligible for all future benefits under the Plan until the money is repaid in full, or until the Plan receives the initial repayment in accordance with the terms of a voluntary repayment plan agreed to between the Member or the Member's beneficiary and the Board. Such repayment plan shall contain such terms and conditions as the Plan may require. In the event the Member or the Member's beneficiary should fail to make a timely payment under the repayment plan, the Plan may suspend coverage, effective as of the paid-through date, for the Member and Member's Dependents, and the Member (and the Member's Dependents) shall thereafter be ineligible for all future benefits until the entire amount owed to the Plan is repaid in full.

In the event that legal action is required to recover Plan funds paid to a Member or the Member's beneficiary, the Member or the Member's beneficiary shall be liable for all costs of collection, including reasonable attorneys' fees and costs.

Sec. 18.12 Limitation of Liability. The Board shall not be liable to any person or entity for any acts carried out hereunder in good faith and based upon the information available to the Board or its designated agents at the time. Neither the Board nor the Plan shall be liable to any Member, Spouse, former Spouse, Dependent, or the personal representative, heir, successor, or assign of any Member, Spouse, former Spouse, or Dependent for

(a) the failure of any church or employer to enroll an eligible employee, Spouse, or Dependent of the employee for coverage under the Plan in accordance with the policies and practices of such employer or the *Book of Order* of the Presbyterian Church (U.S.A.) or in accordance with any contract between the employee and the employer, whether or not the Plan or any representative of the Plan has actual knowledge of such failure to enroll;

(b) the failure of any church or employer to pay the dues for such person's coverage under the Plan, whether or not the Plan or any representative of the Plan has actual knowledge of such failure to pay; and

(c) the failure of a Member, Spouse, former Spouse, Dependent, or the personal representative, heir, successor, or assign of any Member, Spouse, former Spouse, or Dependent, to apply for benefits within twelve (12) calendar months after the date that the individual became eligible for such benefits, unless the Board, in its sole discretion, determines that an earlier filing was not reasonably possible and that the claim was filed as soon as it was reasonably possible.

ARTICLE XIX

ALTERATIONS OR AMENDMENTS

Sec. 19.1 Right To Alter or Amend Plans. The right to alter or amend the Plan is reserved solely to the Board. Notice of any amendment to the Plan shall be provided by the Board to the General Assembly, Members, local churches, and presbyteries in such manner as the Board deems reasonable and appropriate based on the nature of the amendment.

Sec. 19.2 Amendment of Pension Plan. The Board, in its sole discretion, shall have the right, from time to time, to amend the Pension Plan, except that any alteration or amendment that is in the nature of a benefits reduction to the Members shall be effective only with the approval of the General Assembly of the Church. Any amendment to the Pension Plan, other than a benefits reduction or a dues increase (which amendments require the approval in advance of the General Assembly of the Church), shall require an affirmative two-thirds majority vote of the Directors of the Board present at a duly constituted meeting. Notice of any proposed alteration or amendment to the Pension Plan requiring the approval of General Assembly of the Church shall be given by the Board to Members, local churches, and presbyteries at least sixty (60) days prior to the date of the meeting of the General Assembly of the Church at which such alteration or amendment will be considered.

Sec. 19.3 Amendment of Medical Benefits. The Board, in its sole discretion, taking into consideration claims experience, administrative expenses, changes in the healthcare industry, and other relevant factors, shall have the right, from time to time, to amend the medical benefits and report any such amendment to the next succeeding General Assembly of the Church.

Sec. 19.4 Amendment of Death and Disability Benefits. The Board, in its sole discretion, shall have the right, from time to time, to amend the Death and Disability benefits and report any such amendment to the next succeeding General Assembly of the Church.

Sec. 19.5 Amendment of Optional Benefits. The Board, in its sole discretion, shall have the right from time to time to amend the Optional Benefits or adopt such other additional optional benefits plans or programs as it deems in the best interest of the Members of the Plan. Any such amendment or additional optional benefits provision shall be reported to the next succeeding General Assembly of the Church.

Sec. 19.6 Right To Terminate Plans. The Board, in its sole discretion, shall have the right from time to time to terminate the Plan in its entirety or to terminate one or more of the benefits coverage options. Such termination shall be reported to the next succeeding General Assembly of the Church. The Board, in its sole discretion, shall have the right from time to time to terminate the Pension Plan with the approval of the General Assembly of the Church and subject to the terms of the Pension Plan Trust. Notwithstanding anything to the contrary in this Plan, in the event that the Death and Disability, the Medical benefits, or an Optional Benefit is terminated, after all existing benefits obligations are satisfied, any remaining assets shall revert to the Board for use, in its sole discretion, for other plans or programs of the Plan, for the Board's Assistance Program, or for such other purposes that are consistent with the mission of the Board of Pensions.

**APPENDIX A
ACTUARIAL ASSUMPTIONS**

Single-Sum Factors

Benefits payable on a single-sum basis will be actuarially determined using the following assumptions and procedure:

Interest: 4.5%

Mortality: RP-2014 Healthy Annuitant Mortality Table (no collar) Male and Female Tables, with future mortality improvement in accordance with Scale MP-2015 from 2006 (sex distinct).

Form of Benefits:

Retirement: Joint and 50% Survivor

Survivor: Life Annuity

Spouse Age:

Active: For a Member in a marriage, the factors are based on the Member's age and Spouse's age on their birthdays nearest to the Determination Date. For a Member not in a marriage, the factors are based on the Member's age on the birthday nearest to the Determination Date and a Spouse the same age as the Member.

Inactive: For inactive Members, the Spouse is assumed to have the same birth date as the Member.

Unisex Procedure: To determine the single-sum factors on a unisex basis, two factors are calculated:

Factor based on the male RP-2014 Healthy Annuitant Mortality Table (no collar) with future mortality improvement in accordance with Scale MP-2015 from 2006 (sex distinct) for a Member and the female RP-2014 Healthy Annuitant Mortality Table (no collar) with future mortality improvement in accordance with Scale MP-2015 from 2006 (sex distinct) for a survivor.

Factor based on the female RP-2014 Healthy Annuitant Mortality Table (no collar) with future mortality improvement in accordance with Scale MP-2015 from 2006 (sex distinct) for a Member and the male RP-2014 Healthy Annuitant Mortality Table (no collar) with future mortality improvement in accordance with Scale MP-2015 from 2006 (sex distinct) for a survivor.

The two factors are averaged.

Joint and Survivor Option Factors

Benefits payable under the joint and survivor option will be actuarially adjusted based on the following factors and procedures:

1. Determine the age of Member on his or her retirement pension commencement date based on the birthday nearest to the Benefit Commencement Date. Determine the number of full years between the birthdays of the Member and Spouse.
2. Determine the basic factor in Table A (below) using the age of the Member from Step 1.
3. Multiply the full years between the birthdays of the Member and Spouse by the factor from Table B.
4. Determine the joint and survivor option factor using the figures from Steps 2 and 3:
 - a. If the Member is older than the Spouse, subtract the result of Step 3 from the result of Step 2.
 - b. If the Member is younger than the Spouse, add the result of Step 3 to the result of Step 2.

TABLE A

Age	Option I (75% to Spouse)	Option II (75% to Survivor)		Option III (66 2/3% to Survivor)		Option IV (100% to Survivor)
		Spouse Older than Member or Spouse Younger than Member by less than 9 Years	Spouse Younger than Member by 9 or More Years	Spouse Older than Member or Spouse Younger than Member by less than 9 Years	Spouse Younger than Member by 9 or More Years	
55	0.990	1.058	1.034	1.078	1.054	0.980
56	0.990	1.053	1.029	1.074	1.050	0.980
57	0.990	1.048	1.024	1.070	1.046	0.980
58	0.990	1.044	1.020	1.067	1.043	0.980
59	0.990	1.040	1.016	1.063	1.039	0.976
60	0.990	1.036	1.012	1.060	1.036	0.971
61	0.990	1.028	1.004	1.053	1.029	0.961
62	0.986	1.021	0.997	1.047	1.023	0.953
63	0.978	1.014	0.990	1.040	1.016	0.944
64	0.969	1.007	0.983	1.033	1.009	0.935
65	0.962	1.000	0.976	1.027	1.003	0.927
66	0.961	1.000	0.976	1.028	1.004	0.924
67	0.959	1.000	0.976	1.029	1.005	0.922
68	0.958	1.000	0.976	1.030	1.006	0.920
69	0.957	1.000	0.976	1.031	1.007	0.917
70 or older	0.956	1.000	0.976	1.032	1.008	0.915

TABLE B

Age	Option I (75% to Spouse)	Option II (75% to Survivor)		Option III (66 2/3% to Survivor)		Option IV (100% to Survivor)
		Spouse Older than Member or Spouse Younger than Member by 8 or Fewer Years	Spouse Younger than Member by 9 or More Years	Spouse Older than Member or Spouse Younger than Member by 8 or Fewer Years	Spouse Younger than Member by 9 or More Years	
	0.003*	0.006	0.003	0.006	0.003	0.005**

* Use 0.99 if the result of Step 2 is higher than .99.

** Use 0.98 if the result of Step 2 is higher than .98.

Early Retirement Option Factors

Benefits payable on an early retirement Benefit Commencement Date will be determined based on the following table and procedures:

Age	Board of Pensions Factors	Board of Annuity & Relief Factors
55	50%	64%
56	53%	67%
57	56%	70%
58	59%	73%
59	62%	76%
60	65%	82%
61	71%	88%
62	77%	94%
63	84%	100%
64	92%	100%
65	100%	100%

1. The Member's age in years and completed months will be determined as of the early retirement date.
2. The factor will be determined by interpolation using the Board of Pensions' factor in the preceding table.
3. The factor from Step 2 will be multiplied by the Member's Pension Credits.
4. For pension credits accrued under the former Ministers' Annuity Fund of the Presbyterian Church in the United States or the former Employees' Annuity Fund of the Presbyterian Church in the United States, the factor will be determined using the Board of Annuity and Relief's factors from the table.

Social Security Leveling Option Factors

Benefits payable under the Social Security Leveling Option will be actuarially adjusted based on the following table and procedures:

Age	Factor
55	61.90%
56	66.04%
57	70.55%
58	75.44%
59	80.78%
60	86.61%
61	92.99%
62	100.00%

1. The Member's age in years and completed months will be determined as of the early retirement date.
2. The factor will be determined by interpolation in the table.
3. The factor from Step 2 will be multiplied by the Member's estimated Social Security Primary Insurance Amount at age 62.
4. The Member's early retirement benefit will be increased by the result of Step 3 to determine the benefit beginning at initiation of retirement benefits.
5. The result of Step 4 will be reduced by the Member's estimated Social Security Primary Insurance Amount to determine the benefit at age 62.
6. If the result of Step 5 is negative, this option is not available.

Post-Normal Retirement Option Factors

Benefits payable on a Post-Normal Retirement age Benefit Commencement Date will be actuarially adjusted to reflect later commencement by the applicable factors listed below, based on the following factors and procedures:

Age	Factor
65	1.0
66	1.065
67	1.130
68	1.195
69	1.260
70	1.325

1. The Member's age in years and completed months will be determined as of the Post-Normal Retirement date.
2. The factor will be determined by interpolation using the Board of Pensions' factor in the preceding table.
3. The factor from Step 2 will be multiplied by the Member's Pension Credits.

**APPENDIX B
HISTORY OF EXPERIENCE APPORTIONMENTS**

The Pension Plan in Sec. 7.3 grants to the Board discretion to determine periodic Experience Apportionments. The following table provides a history of those Experience Apportionments for the Pension Plan.

Plan Operational Year	Amendment Year	Experience Apportionment
1987	1988	5.0%
1988	1989	7.0%
1989	1990	8.0%
1990	1991	*
1991	1992	8.0%
1992	1993	4.0%
1993	1994	8.0%
1994	1995	3.0%
1995	1996	8.0%
1996	1997	6.0%
1997	1998	11.0%
1998	1999	10.0%
1999	2000	9.0%
2000	2001	3.0%
2001	2002	*
2002	2003	*
2003	2004	2.0%
2004	2005	3.0%
2005	2006	3.6%
2006	2007	3.7%
2007	2008	3.8%
2008	2009	*
2009	2010	*
2010	2011	*
2011	2012	*
2012	2013	1.0%
2013	2014	4.6%
2014	2015	4.7%
2015	2016	2.0%
2016	2017	2.0%
2017	2018	3.9%

*No action was taken on an Experience Apportionment in this year.

Unless otherwise noted, for Active Members, Terminated Vested Members, and Disabled Members, the Experience Apportionment is applicable to credits accrued as of December 31 of the Operational Year. For Retired Pensioners, the Experience Apportionment is applicable to the pension benefit payable on the Effective Date stated in the Board's grant. Typically, that date is July 1 or the first day of the month following the Board's grant.

APPENDIX C
HISTORY OF DISABILITY BENEFIT INCREASES

The Plan in Sec. 11.3(i) grants to the Board discretion to determine Disability Benefit Increases. The following table provides a history of the Disability Benefit Increases.

Year	Disability Increase
1988	5.0%
1989	7.0%
1990	8.0%
1991	*
1992	8.0%
1993	4.0%
1994	8.0%
1995	3.0%
1996	8.0%
1997	6.0%
1998	4.0%
1999	3.0%
2000	4.0%
2001	3.0%
2002	2.0%
2003	*
2004	4.0%
2005	3.0%
2006	4.0%
2007	4.0%
2008	4.0%
2009	*
2010	3.0%
2011	1.5%
2012	3.0%
2013	2.0%
2014	2.0%
2015	1.0%
2016	1.0%
2017	2.0%
2018	2.0%

*No action was taken on a Disability Benefit Increase in this year.

APPENDIX D TOP-HEAVY RULES

The Pension Plan provides that this Appendix D shall apply for purposes of determining whether the Pension Plan is a Top-Heavy Plan under Section 416(g) of the Code for Plan Years beginning after December 31, 2001, except as otherwise set forth herein, and whether the Pension Plan satisfies the minimum benefits requirements of Section 416(c) of the Code for such years. The following provision shall apply automatically to the Pension Plan and shall supersede any contrary provisions for each Plan Year in which the Pension Plan is a Top-Heavy Plan (as defined below).

- (a) **Definitions:** The following definitions shall supplement those set forth in Sec. 2.1 of the Plan:

“Aggregation Group” means, for any Plan Year,

- (1) each qualified retirement plan (including a frozen plan or a plan which has been terminated during the 60-month period ending on the Determination Date) of an employer in which a Key Employee is a participant;
- (2) each other qualified retirement plan (including a frozen plan or a plan which has been terminated during the 60-month period ending on the Determination Date) of an employer which enables any plan in which a Key Employee participates to meet the requirements of Sections 401(a)(4) and 410 of the Code (to the extent applicable to a church plan); and
- (3) any or all other qualified retirement plans (including a frozen plan or a plan which has been terminated during the 60-month period ending on the Determination Date) of an employer if (a) the plans in the Aggregation Group would be Top-Heavy Plans if each such plan were not included in the Aggregation Group but are not Top-Heavy Plans when such plan is included in the Aggregation Group, and (b) the Aggregation Group, including such plan, meets the requirements of Sections 401(a)(4) and 410 of the Code (to the extent applicable to a church plan).

“Determination Date” means, for any Plan Year, the last day of the preceding Plan Year.

“Key Employee” means, with respect to any Plan Year, any employee or former employee (including any deceased employee) of an employer participating in the Pension Plan who at any time during the Plan Year that includes the Determination Date was an officer of the employer having annual compensation greater than \$130,000 (as adjusted under Section 416(i)(1) of the Code for Plan Years beginning after December 31, 2002). For this purpose, “annual compensation” means compensation within the meaning of Section 415(c)(3) of the Code. The determination of who is a Key Employee will be made in accordance with Section 416(i)(1) of the Code and the applicable regulations and other guidance of general applicability issued thereunder.

“Key Employee Ratio” means, for any Determination Date, the ratio of the amount described in Paragraph (1) of this subsection to the amount described in Paragraph (2) of this subsection, after deducting from each such amount any portion thereof described in Paragraph (3) of this subsection, where:

- (1) the amount described in this paragraph is the sum of (A) the present value of all accrued benefits of Key Employees under all qualified defined benefits plans included in the Aggregation Group, (B) the balances in all of the accounts of Key Employees under all qualified defined contribution plans included in the Aggregation Group, and (C) the amounts distributed from all plans in such Aggregation Group to or on behalf of any Key Employee during the one-year period ending on the Determination Date, except any benefit paid on account of death to the extent it exceeds the accrued benefits or account balances immediately prior to death; however, in the case of a distribution made for a reason other than separation from service, death or disability, this subsection shall be applied by substituting “five-year period” for “one-year period”;
- (2) the amount described in this paragraph is the sum of (A) the present value of all accrued benefits of all participants under all qualified defined benefit plans included in the Aggregation Group, (B) the balances in all of the accounts of all participants under all qualified defined contribution plans included in the Aggregation Group, and (C) the amounts distributed from all plans in such Aggregation Group to or on behalf of any participant during the one-year period ending on the Determination Date; however, in the case of a distribution made for a reason other than separation from service, death, or disability, this subsection shall be applied by substituting “five-year period” for “one-year period”; and
- (3) the amount described in this paragraph is the sum of (A) all rollover contributions (or fund-to-fund transfers) to the Pension Plan by a Member after December 31, 1983, from a plan which is not sponsored by an employer; (B) any amount that is included in Paragraphs (1) and (2) of this subsection for a person who is a Non-Key Employee as to the Plan Year of reference but who was a Key Employee as to any earlier Plan Year; (C) for Plan Years beginning after December 31, 1984, any amount that is included in Paragraphs (1) and (2) of this subsection for a person who has not performed any services for any employer during the Plan Year that includes the Determination Date; and (D) for Plan Years beginning after December 31, 2001, any amount for an individual who has not performed services for an employer during the one-year period ending on the Determination Date.

The present value of accrued benefits under any defined benefit plan shall be determined on the basis of the assumptions described in Appendix A or, otherwise, the slowest accrual method permitted under Section 411(b)(1)(C) of the Code.

“Non-Key Employee” means, for any Plan Year, (1) a Member or former Member who is not a Key Employee with respect to such Plan Year; and (2) a beneficiary of an individual described in Paragraph (1) of this subsection.

“Super Top-Heavy Plan” means, for any Plan Year, each plan in the Aggregation Group for such Plan Year if, as of the applicable Determination Date, the Key Employee Ratio exceeds ninety percent (90%).

“Top-Heavy Compensation” means, for any Member for any Plan Year, the average of his or her annual compensation over the period of five consecutive Plan Years (or, if shorter, the longest period of consecutive Plan Years during which the Member was in the employ of any employer) yielding the highest average, disregarding compensation for Plan Years after the close of the last Plan Year in which the Pension Plan was a Top-Heavy Plan.

“Top-Heavy Plan” means, for any Plan Year, each plan in the Aggregation Group for such Plan Year if, as of the applicable Determination Date, the Key Employee Ratio exceeds sixty percent (60%).

“Year of Top-Heavy Service” means, for any Member, a Plan Year in which he or she completes one thousand (1,000) or more Hours of Service, excluding (1) Plan Years commencing prior to January 1, 1984, and (2) Plan Years in which the Plan is not a Top-Heavy Plan.

(b) Minimum benefits

- (1) If the Pension Plan is a Top-Heavy Plan in any Plan Year, each Member who is a Non-Key Employee in such Plan Year (other than a Member who was a Key Employee as to any earlier Plan Year) shall have a minimum Accrued Benefit. Such Accrued Benefit shall be the lesser of:
 - (i) two percent (2%) of the Member’s Top-Heavy Compensation multiplied by the Member’s Years of Top-Heavy Service, or
 - (ii) twenty percent (20%) of the Member’s Top-Heavy Compensation.
- (2) If a Non-Key Employee described in this subsection participates in both a defined benefit plan and a defined contribution plan, the Member shall have the minimum Accrued Benefit described in this subsection, offset by the benefit provided by the defined contribution plan. In making the offset calculation for a given Plan Year, the employer-derived interest of the Member in the defined contribution plan shall be valued as of the last valuation date preceding such Plan Year. This defined contribution plan interest shall be converted into a defined benefit by use of the assumptions described in Appendix A.
- (3) Contributions under other plans. The employer may provide in an election filed with the Board specifying the name of the other plan, the minimum

benefit that will be provided under such other plan, and the names of the Plan Members who will receive the minimum benefit under such other plan.

(c) Adjustment to Maximum Benefit Limitation

For Limitation Years beginning before January 1, 2000:

- (1) For each Plan Year in which the Pension Plan is (1) a Super Top-Heavy Plan or (2) a Top-Heavy Plan and the Board does not make the election to amend the Pension Plan to provide the minimum benefit described in Subsection (c) and for which a similar election has not been made as to another plan in the Aggregation Group, the 1.25 factor in the defined benefit and defined contribution factors described in Section 415(e) of the Code shall be reduced to 1.0. The adjustment described in this subsection shall not apply to a Member who earns no additional accrued benefit under any defined benefit plan and has no employer contributions, forfeitures, or voluntary nondeductible contributions allocated to his or her accounts under any defined contribution plan.
- (2) If, in any Plan Year in which the Pension Plan is a Top-Heavy Plan but not a Super-Top-Heavy Plan, the Aggregation Group also includes a defined contribution plan, the Board may elect to use a factor of 1.25 in computing the denominator of the defined benefit and defined contribution factors described in Section 415(e) of the Code. In the event of such election, the minimum benefit described in Subsection (b) for each Non-Key Employee who is not covered under a defined contribution plan providing the minimum benefit described in the following sentence shall be increased as follows:
 - (i) “Three percent (3%)” shall be substituted for “two percent (2%)” in Subsection (b)(1)(i).
 - (ii) Subsection (b)(1)(ii) shall be deemed to read, “the Participant’s Top-Heavy Compensation multiplied by the sum of (A) twenty percent (20%) and (B) one percent (1%) for each Year of Top-Heavy Service, up to a maximum of 10 such Years of Top-Heavy Service.”

The minimum benefit in the preceding sentence shall not apply to any Non-Key Employee who is covered under a defined contribution plan (as described in Subsection (c)) providing a minimum contribution for such Non-Key Employee of seven and one-half percent (7½%) of the Non-Key Employee’s annual compensation.

(d) Suspension of Benefits

Notwithstanding the other provisions of the Pension Plan, the payment of a Member's benefits shall not be suspended during the Member's reemployment during any period in which the Pension Plan is a Top-Heavy Plan.

APPENDIX E

SPECIAL PENSION PLAN PROVISIONS FOR PUERTO RICO MEMBERS

This Appendix E, Special Pension Plan Provisions for Puerto Rico Members, modifies the terms of the Pension Plan as they relate to Puerto Rico Members. The modifications reflect the applicable tax-qualification provisions of the Puerto Rico Internal Revenue Code of 2011 (“2011 PR Code”). For purposes of this Appendix E, a “Puerto Rico Member” is a Member who, in accordance with Section 1010.01(a)(30) of the 2011 PR Code, is considered a bona fide resident of the Commonwealth of Puerto Rico. Members who may be temporarily working in Puerto Rico are not Puerto Rico Members.

To the extent that a provision of the Pension Plan is not modified by this Appendix E, that Pension Plan provision will apply to a Puerto Rico Member in the same manner that it applies to any other Member. The special provisions of this Appendix E shall be interpreted and construed so as to satisfy the requirements of the 2011 PR Code, and such regulations and other guidance as may be issued from time to time by the Puerto Rico Treasury Department.

(a) **Compensation.** Effective January 1, 2012, a Puerto Rico Member’s Compensation for determining benefits, nondiscrimination testing, and limits on benefits each Plan Year under the Pension Plan is limited to the amount provided under 2011 PR Code Section 1081.01(a)(12), as adjusted from time to time.

(b) **Highly Compensated Employees.** Effective as of January 1, 2011, any employee as defined in Section 1081.01(d)(3)(E)(iii) of the 2011 PR Code shall be used for the application of the nondiscrimination tests under Sections 1081.01(a)(3) and 1081.01(a)(4) of the 2011 PR Code.

(c) **Coverage, Nondiscrimination Tests, and Aggregation Rule.** Effective as of January 1, 2012, all employees of any corporation, partnership, or other persons that, pursuant to the 2011 PR Code Section 1081.01(a)(14), are members of a controlled group of corporations, of a group of related entities, of an affiliated services group, or are under common control, as such terms are defined in 2011 PR Code Section 1081.01(a)(14), and that have employees who are bona fide residents of Puerto Rico, must be considered employees of the Board for purposes of Section 1081.01(a) of the 2011 PR Code.

(d) **Maximum Annual Benefit.** Effective as of January 1, 2012, the maximum annual benefit payable to a Puerto Rico Member under the Pension Plan (including benefits payable to any alternate payee(s) entitled to benefits in lieu of the Puerto Rico Member) shall not exceed the lesser of (i) the maximum annual benefit determined under Section 8.6 of the Pension Plan, or (ii) the maximum annual benefit determined under the requirements of Section 1081.01(a)(11)(A) of the 2011 PR Code.

(e) **Direct Rollovers.** Effective as of January 1, 2011, with respect to distributions to Puerto Rico Members or the beneficiaries thereof, any direct rollover provisions of the Pension Plan shall be modified to the extent required to conform to the provisions of Section 1081.01(b)(2)(A) of the 2011 PR Code.

(f) **Puerto Rico Taxation of Lump-Sum Distributions.** Under Section 1081.01(b) of the 2011 PR Code, the distribution of the entire interest of a Puerto Rico Member in the Pension Plan (in excess of his or her after tax contributions), within the same taxable year, and as a result of his or her termination of employment, shall be treated as a long-term capital gain taxable at a 20% rate. However, effective as of January 1, 2011, if the Pension Plan: (i) uses a trust organized in Puerto Rico or a Puerto Rico co-trustee which will act as paying agent, and (ii) invests no less than 10% of its assets (determined on an average balance basis) in the Plan Year of the distribution and the two preceding Plan Years, in certain assets treated as located in Puerto Rico (as defined in the 2011 PR Code, and the regulations issued thereunder), the long-term capital gain arising from the distribution will be taxed instead at a rate of 10%. The Plan will choose investments, in its discretion and to the extent reasonably possible, that will meet the requirements of Section 1081.01(b)(1)(B) of the 2011 PR Code.

(g) **Top-Heavy Rules.** The Top-Heavy Rules set forth in Appendix D hereto are not applicable with respect to the Puerto Rico Members.

(h) **Employer Contributions.** Each contribution made by an Employer to the Plan is expressly conditioned on the deductibility of such contribution under Section 1023(n) of the 1994 PR Code or Section 1033.09 of the 2011 PR Code, as applicable, for the taxable year in which contributed.

APPENDIX F
MEDICAL PLAN – SUMMARY OF MEMBER COST-SHARING OBLIGATIONS AND
OTHER BENEFIT DESIGN FEATURES FOR PPO, EPO and HDHP BENEFITS
OPTIONS

The Board’s Healthcare Committee is responsible for reviewing this Appendix at least annually and approving changes based on negotiated contract terms and other Plan actuarial data.

2019 SCHEDULE

PPO Benefits Option

Copays

Type of Visit	Member Cost	
	In Network	Out of Network
Preventive Care	\$0	50% of plan allowance
EAP (6 visits)	\$0	Not Covered
Telemedicine	\$10	Not Covered
Primary Care	\$25	50% of plan allowance
Behavioral Health Counseling	\$25	50% of plan allowance
Vision Exam	\$25	Reimbursement up to \$45 with \$25 copay
Specialist/Urgent Care	\$45	50% of plan allowance

Deductibles and Copayment Maximums

(for covered medically necessary services; does not include prescription drug costs and office copays)

Salary Range ¹	Deductible ^{2,3,4,5}		Copayment Maximum ⁶	
	Network & Non-Network 1.50%	Out of Network 2.50%	Network & Non-Network 5%	Out of Network 15%
\$0 - \$48,759	\$660	\$1,100	\$2,200	\$6,600
\$48,760 - \$53,514	\$735	\$1,220	\$2,440	\$7,320
\$53,515 - \$58,269	\$805	\$1,340	\$2,680	\$8,040
\$58,270 - \$63,024	\$875	\$1,460	\$2,915	\$8,745
\$63,025 - \$67,779	\$950	\$1,580	\$3,155	\$9,465
\$67,780 - \$72,534	\$1,020	\$1,695	\$3,390	\$10,170
\$72,535 - \$77,289	\$1,090	\$1,815	\$3,630	\$10,890
\$77,290 - \$82,044	\$1,160	\$1,935	\$3,865	\$11,595
\$82,045 - \$86,799	\$1,235	\$2,055	\$4,105	\$12,315
\$86,800 or more	\$1,305	\$2,170	\$4,340	\$13,020

¹Deductibles and copayment amounts are based on salary range, subject to a minimum and maximum salary.

² Completion of Call to Health in the current year reduces the member's deductible in the following year.
³ Members with Eligible Family member(s) are responsible for two deductibles, one for the member and one for all other family members combined. Deductibles do not count toward the copayment maximum.
⁴ The Annual Deductible for a Disabled Member and his/her eligible family is based on the greater of the Disabled Member's Effective Salary on the date the Disability began or the current congregational ministers' Median.
⁵ The Annual Deductible for individuals enrolled for Medical Continuation coverage shall be established on the basis of the congregational ministers' Median.
⁶ After a member reaches the annual copayment maximum; the Medical Plan pays 100 percent of eligible expenses up to the plan allowance, except for office visit copays. The copayment maximum applies to the member and family combined. <i>Note: The combined individual and family medical and prescription drug copays, deductibles and copayment maximums are capped at the Affordable Care Act annual limitations of \$7,900 and \$15,800 (2019).</i>

Prescription Drug Benefit

Prescription Type	Member Cost		
	Retail (30 day)	Retail (90 day)	Mail Order (90 day) ¹
Generic	\$10	\$30	\$25
Brand Formulary	30% of cost; \$20 min. to \$100 max	30% of cost; \$60 min. to \$300 max	30% of cost; \$50 min. to \$250 max
Brand Non-Formulary ²	50% of cost; \$50 min. to \$150 max	50% of cost; \$150 min. to \$450 max	50% of cost; \$125 min. to \$375 max
Annual Family Copayment Maximum	\$3,000		
¹ Maintenance medications filled by mail may be subject to lower copayment.			
² Non-formulary brand drugs do not count toward annual family copayment maximum.			

Preventive Prescription Drug Benefit

Prescription Type	Member Cost		
	Retail (30 day)	Retail (90 day)	Mail Order (90 day)
Generic	\$5	\$15	\$12.50
Brand Formulary	\$20	\$60	\$50
Brand Non-Formulary	No incentive		

Limitations

Service Reimbursement	Maximum (subject to Deductible and Copayment)
Temporomandibular Joint Dysfunction (TMJ)	\$500
Hearing Aid (device and fitting)	\$2,500 every three years

EPO Benefits Option

Copays

Type of Visit	Member Cost	
	In Network	Out of Network
Preventive Care	\$0	Not Covered
EAP (6 visits)	\$0	Not Covered
Telemedicine	\$10	Not Covered
Primary Care	\$40	Not Covered
Behavioral Health Counseling	\$40	Not Covered
Vision Exam	\$25	Reimbursement up to \$45 with \$25 copay
Specialist/Urgent Care	\$60	Not Covered

Deductibles and Copayment Maximums

	Individual	Family
Deductible	\$2,000	\$4,000
Total Maximum Out of Pocket Cost	\$7,900	\$15,800

Prescription Drug Benefit

Prescription Type	Member Cost		
	Retail (30 day)	Retail (90 day)	Mail Order (90 day) ¹
Generic	\$12	\$36	\$30
Brand Formulary	35% of cost; \$35min. to \$150 max	35% of cost; \$105 min. to \$450 max	35% of cost; \$85 min. to \$375 max
Brand Non-Formulary	Not Covered	Not Covered	Not Covered
Annual Family Copayment Maximum	None	None	None
¹ Maintenance medications filled by mail may be subject to a lower cost.			

Preventive Prescription Drug Benefit

Prescription Type	Member Cost		
	Retail (30 day)	Retail (90 day)	Mail Order (90 day)
Generic	\$6	\$18	\$15
Brand Formulary	\$30	\$90	\$75
Brand Non-Formulary ²	Not covered		

Limitations

Service Reimbursement	Maximum (subject to Deductible and Copayment)
Temporomandibular Joint Dysfunction (TMJ)	\$500
Hearing Aid (device and fitting)	\$2,500 every three years

HDHP Benefits Option

Type of Visit	Member Cost	
	In Network	Out of Network
Preventive Care	\$0	Not Covered
EAP (6 visits)	\$0	Not Covered
Telemedicine	Member pays 100% prior to deductible; Member pays 20% after deductible	Not Covered
Primary Care		Not Covered
Behavioral Health Counseling		Not Covered
Vision Exam		Reimbursement up to \$45 with \$25 copay
Specialist/Urgent Care		Not Covered

Deductibles and Copayment Maximums

	Individual	Family
Deductible	\$3,000	\$6,000 ¹
Total Maximum Out of Pocket Cost	\$6,750	\$13,500

¹ Members with covered spouses and/or children are responsible for the entire family deductible amount.

Prescription Drug Benefit

Prescription Type	Member Cost		
	Retail (30 day)	Retail (90 day)	Mail Order (90 day) ²
Generic	Member pays 100% prior to deductible; Member pays 30% after deductible subject to \$150 (30 day), \$450 (90 days) or \$375 (90 day mail) max		
Brand Formulary			
Brand Non-Formulary	Not Covered	Not Covered	Not Covered
Annual Family Copayment Maximum	None	None	None

² Maintenance medications filled by mail may be subject to a lower cost.

Preventive Prescription Drug Benefit*

Drugs scheduled for reimbursement under this provision are limited to prescriptions intended to prevent a condition or reoccurrence of a condition.

Prescription Type	Member Cost		
	Retail (30 day)	Retail (90 day)	Mail Order (90 day)
Generic	\$6	\$18	\$15
Brand Formulary	\$30	\$90	\$75
Brand Non-Formulary	Not covered		

Limitations:

Service Reimbursement	Maximum (subject to Deductible and Copayment)
Temporomandibular Joint Dysfunction (TMJ)	\$500
Hearing Aid (device and fitting)	\$2,500 every three years



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