



**The Board of Pensions**  
of the Presbyterian Church (U.S.A.)

# **The Benefits Plan**

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

**2011**

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of the  
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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, Death and Disability Plan, Medical Plan and the Optional Benefits Plans, including Supplemental Disability Benefits coverage and the Dental Plan, Retirement Savings Plan and Supplemental Death Benefits coverage. Subject to the Benefits Plan’s eligibility, participation and enrollment requirements, an employing organization may elect to provide its employees with Traditional or Affiliated Benefits Program coverage under the Benefits Plan as described in Article V.

**Sec. 1.2 Purpose.** The Benefits Plan has been established by the Presbyterian Church (U.S.A.) to provide retirement, disability, death, medical and optional benefits programs to Members of the Benefits Plan 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 Benefits Plan shall be construed and administered in accordance with the laws of the Commonwealth of Pennsylvania.

### ARTICLE II

#### DEFINITIONS

**Sec. 2.1 Definitions.** When used in the Benefits Plan, the following capitalized terms shall have the meanings set forth below. Additional defined terms are set forth elsewhere in the Benefits Plan.

**ACTIVE MEMBER.** A Member who is eligible and currently enrolled for coverage in the Benefits Plan as an active employee under Sec. 3.1 or enrolled in Transitional Participation Coverage under Sec. 4.4 and whose dues are not delinquent.

**ACTUARIAL (OR ACTUARIALLY) EQUIVALENT.** Equality in value of the aggregate amounts expected to be received under different forms of payment based upon such mortality and interest assumptions as may, from time to time but not more than once in any Plan Year, be recommended by the Actuary of the Plan and adopted by the Board as set forth in Appendix A, as it may be amended from time to time.

**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 Benefits Plan.

**AFFILIATED BENEFITS PROGRAM.** The Benefits Plan program that an employing organization may offer to a classification of its employees, other than Mandated Members, on a partially contributory or non-contributory basis.

**BENEFIT COMMENCEMENT DATE.** The date as of which the first benefit is due to a Member under the terms of a component program of the Benefits Plan.

**BOARD.** The Board of Pensions of the Presbyterian Church (U.S.A.), a Pennsylvania non-profit corporation.

**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 with a total disability.

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

**COVERED MEMBER.** A Member who is eligible for and currently enrolled in a designated Benefits Plan program or plan and whose dues for such coverage are not delinquent.

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

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

**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 with a total disability age 26 or over.

**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 or any other type of work that would afford a reasonably comparable level of income, 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.

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

**EFFECTIVE DATE.** The Benefits Plan became effective on January 1, 1987. The Effective Date of this Restatement is January 1, 2011.

**EFFECTIVE SALARY.** Any compensation received during a Plan Year by a Benefits Plan Member from an employing organization, including but not limited to any sums paid as a housing (including utilities and furnishings) allowance. Effective Salary shall also include any deferred compensation (funded or unfunded) credited to or contributed on account of a Member by an employing organization 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 same employment classification, and 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.

**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, any employment with an employing organization regardless of whether such employing organization participates in the Benefits Plan, or validated service of an ordained minister of the Word and Sacrament, any of which the Board deems to be appropriate for participation in the Benefits Plan.

**EMPLOYMENT CLASSIFICATION MEDIAN.** The annual churchwide median Effective Salary 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 less than one thousand eight hundred twenty (1,820) hours compared to one thousand eight hundred twenty (1,820) hours.

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

**MANDATED MEMBER.** An ordained minister of the Word and Sacrament who is serving in a called and installed relationship with a local church and enrolled by the Church for full participation in the Traditional Program of the Benefits Plan as required by Section G-14.0534 of the *Book of Order of the Presbyterian Church (U.S.A.)*.

**MANSE.** Housing, which may include rental or other living accommodations, that is furnished to a Member without charge to the Member.

**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(b) shall be based. Effective January 1, 2006, the Maximum Disability Benefits Basis shall be ninety thousand dollars (\$90,000).

**MEDICAL PARTICIPATION BASIS.** The greater of (i) Effective Salary or (ii) sixty-five percent (65%) of the Pastors' Median. For Members employed on less than a full-time basis, the Medical Participation Basis shall be based on the greater of the equivalent full-time Effective Salary or sixty-five percent (65%) of the Pastors' Median. For purposes of determining annual deductible and copayment maximum amounts, the Board may in its sole discretion establish bands of Medical Participation Basis on which to apply the applicable percentage, provided that the Member shall not be placed in a band that exceeds his or her actual Medical Participation Basis.

**MEDICAL PLAN.** Articles I through VI, XIII, XIV, XVIII and XIX of the Benefits Plan describing the benefits available under the Active Medical Plan, the Medical Continuation Program and the Medicare Supplement Plan, which plans and programs collectively constitute the Medical Plan.

**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.

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

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

**OPTIONAL BENEFITS PLANS.** The optional benefits plans and programs sponsored by the Board on behalf of churches and employing organizations for Members of the Benefits Plan, including the Supplemental Disability Benefits described in Sec. 11.11, the Dental Plan, Retirement Savings Plan and Supplemental Death Benefits coverage described in Article XV and such other plans and programs as the Board may adopt in the future, constitute the Optional Benefits Plans.

**PASTORS' MEDIAN.** The annual churchwide median Effective Salary of ordained ministers serving churches of the Church for the immediately preceding Plan Year as the same may be determined by the Board from time to time.

PENSION COVERAGE. Entitlement of a Member who has satisfied the applicable participation requirements of Article V.

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.

PENSION PARTICIPATION BASIS. The greater of (i) Effective Salary or (ii) twenty-five percent (25%) of the Pastors' 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.

PENSION PLAN. Articles I through IX, XVIII and XIX of the Benefits Plan constitute the Pension Plan.

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

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

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

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 Sec. 8.8 as not causing a temporary suspension of retirement benefits for such Member.

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.

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

RULE OF SEVENTY. The minimum age and participation a Member must satisfy to be eligible for designated benefits under the Benefits Plan. To satisfy the Rule of Seventy, the Member must have: (1) participated as an Active Member of the Benefits Plan for at

least five years; (2) attained at least age 55 at the time he or she ceased being a 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 Benefits Plan at the time of termination of service are added together.

**SPOUSE.** An individual who is legally married to a Member.

**SURVIVING SPOUSE.** The Spouse of a Member on the date of a Member's death who survives the death of the Member.

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

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

**TRADITIONAL PROGRAM.** The Benefits Plan program in which an employing organization is required to enroll a Mandated Member and in which it may enroll other Active Members for full or limited participation under Secs. 5.2 and 5.3. The Active Medical Plan of the Traditional Program is administered by the Board as a grandfathered health plan within the meaning of Section 1251 of the Patient Protection and Affordable Care Act. See Sec. 13.2 for more information.

**TRANSITIONAL PARTICIPATION COVERAGE.** The coverage available to a Member who was enrolled for coverage in the Benefits Plan as an active employee under Sec. 3.1 and who has been approved for coverage following a change in employment status in accordance with Sec. 4.4.

**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 Benefits Plan.

**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 Sect. 401(a)(37) of the Code and applicable regulations.

## **ARTICLE III**

### **ELIGIBILITY**

**Sec. 3.1 Eligibility.** An employing organization may enroll as a Member of the Benefits Plan any person employed in Eligible Service who (1) has commenced employment and (2) is normally scheduled to work for twenty (20) or more hours per week in active service (excluding overtime).

Subject to the Medical Plan's enrollment and subscription provisions 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 benefits while enrolled in full-time study and upon payment of the applicable dues.

## **ARTICLE IV**

### **DUES**

#### **Sec. 4.1 Required Dues.**

- (a) **TRADITIONAL PROGRAM.**
  - (1) Dues required to provide Pension and Death and Disability coverage for a Member enrolled on a full participation basis in accordance with Sec. 5.2 shall not exceed a total of twelve percent (12%) of a Member's Pension Participation Basis.
  - (2) Dues required to provide Death and Disability coverage for a Member enrolled on a limited participation basis in accordance with Sec. 5.3 shall be a percentage established annually by the Board, which it in its sole discretion determines to be necessary, which percentage shall be multiplied by the Member's Pension Participation Basis as if he or she had Pension coverage.
  - (3) Unless otherwise specifically designated by the Board, dues required to provide Medical coverage for both full and limited participation under Secs. 5.2 and 5.3 shall be a percentage established annually by the Board, which it in its sole discretion determines to be necessary, taking into consideration claims experience and administrative expenses, which percentage shall be multiplied by the Member's Medical Participation Basis. The Board may establish a maximum Medical Participation Basis upon which Medical Plan dues shall be based.
  - (4) Dues for Traditional Program coverage are to be paid by the employing organization with no contribution by the employee either required or permitted.
- (b) **AFFILIATED BENEFITS PROGRAM.** The Board, in its sole discretion, shall establish annually the dues required to provide Death and Disability Plan and Medical Plan coverage under the Affiliated Benefits Program, taking into account the claims experience and administrative expenses of the Affiliated Benefits Program. The Board, in its sole discretion, may establish dues for the Affiliated Benefits Program on other than a percentage basis.

- (c) **OTHER PROGRAMS.** The Board, in its sole discretion, may establish dues for the Medicare Supplement Plan coverage under Sec. 14.1 and Medical Continuation Program coverage under Sec. 13.15 on other than a percentage basis. The Board, in its sole discretion, shall establish the dues required for coverage under the Optional Benefits Plans.

**Sec. 4.2 Payment of Dues.** The required dues shall be remitted to the Board by the employing organization of the Member or, where the Member is self-employed or enrolled for Transitional Participation Coverage or as a Medical Continuation Program subscriber, by the Member, 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 benefit entitlement of any Member for whom dues payments are delinquent, i.e., if on a monthly billing basis, not paid in full by the first day of the next month.

**Sec. 4.3 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 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.

**Sec. 4.4 Transitional Participation Coverage.** A Member enrolled in the Traditional Program who is, in the sole determination of the Board, temporarily unemployed or on an approved leave of absence, may apply to replace his or her Traditional Program coverage with Transitional Participation Coverage and continue the same coverage under all or some of the following: the Pension Plan, Death and Disability Plan, Medical Plan and Optional Benefits Plans other than the Dental Plan at his or her discretion, but only to the extent the Member was enrolled in such plans prior to the change in employment status, for such period as may be determined by the Board by paying the required dues. With respect to Pension Plan, Death and Disability Plan and Medical Plan coverage, the Member must elect to pay dues on the basis of one of the following: the Member's most recent Effective Salary or the applicable percentage of the Pastors' Median. Optional Benefits Plans coverage may only be continued in conjunction with coverage under the Pension Plan or Medical Plan. A terminated Member must apply for Transitional Participation Coverage at the time of the change in employment status.

**Sec. 4.5 Vacancy Dues.** During the first twelve (12) months of a vacancy in the position of a minister of a local church of the Church, dues shall be paid by the local church at twelve percent (12%) of the Pension Participation Basis of the most recent minister of the local church who occupied the ministerial position which has become vacant, provided that such vacancy dues shall be used by the Board for the purpose of financing the Medicare Supplement benefits of Sec. 14.3.

**Sec. 4.6 Continuation of Death and Disability Benefits for Member upon Termination of Eligible Service.** An Active Member in the Traditional Program, upon termination of Eligible Service, shall continue to have the protection of the Death and Disability Plan, at no additional cost to the Member or his or her employing organization, for (a) thirty (30) days after one (1) Year of Plan Participation in the Traditional Program, (b) sixty (60) days after two (2) Years of Plan Participation in the Traditional Program, or (c) ninety (90) days after three (3) or more of

either Years of Plan Participation in the Traditional Program and/or years in seminary under the care of a presbytery, provided that the seminarian becomes an ordained minister and commences service in validated ministry of the Church. Such continuation of coverage under the Death and Disability Plan shall commence on the date of termination of Eligible Service from the employing organization.

## **ARTICLE V**

### **PARTICIPATION**

**Sec. 5.1 Enrollment.** Each individual meeting the eligibility requirements of Sec. 3.1 may be enrolled for participation as a Member of the Benefits Plan in the applicable program upon fulfilling the following requirements:

- (a) Executing in writing and filing with the Board within the time period specified an application for membership on a form supplied by the Board, which application is accepted by the Board as being complete and evidencing entitlement to membership in the Benefits Plan; and
- (b) Payment of all dues required by Article IV.

**Sec. 5.2 Traditional Program - Full Participation.**

- (a) Full participation in the Traditional Program consists of enrollment for coverage for retirement (Article VIII), survivor's pension (Article IX), death (Article X), disability (Article XI) and medical (Article XIII) benefits.
- (b) Mandated Coverage: An employing organization must enroll all Mandated Ministers for full participation in the Traditional Program of the Benefits Plan.
- (c) Non-Mandated Ministers and Lay Employees: In accordance with Sec. 5.1, an employing organization may elect to enroll eligible employees (other than Mandated Members) for full participation in the Traditional Program of the Benefits Plan. In the event that any employing organization desires to enroll employees on a full participation basis, the employing organization may do so but only if the coverage is provided on the same basis to all of its eligible employees within the same employment classification subject to the satisfaction of any employment orientation period of one (1) year or less from the date of first employment in Eligible Service of each such employee by each such employer. Any employment classification established by an employing organization for purposes of Benefits Plan enrollment must be established on a reasonable, non-discriminatory basis in accordance with the provisions of the Benefits Plan and its administrative rules. Each eligible member of a designated employment classification must be provided and offered coverage on the same terms and conditions as each other member of that employment classification.

**Sec. 5.3 Traditional Program - Limited Participation.** In accordance with Sec. 5.1, an employing organization may elect to enroll eligible employees (other than Mandated Members) for limited participation in the Traditional Program provided that the employing organization provides the coverage on the same basis to each eligible employee within the same employment classification. The employing organization may impose an employment orientation period of up to one (1) year or less from the date of first employment of each such employee by such employing organization.

- (a) Limited participation in the Traditional Program consists of enrollment for coverage for medical (Article XIII), death (Article X) and disability (Article XI) benefits only during the first three (3) years of an employee's Plan participation with that employing organization. Under limited participation, the Member is not enrolled for retirement (Article VIII) or survivor's pension (Article IX) coverage during his or her first three (3) Years of Plan Participation with that employing organization. A Member initially enrolled for limited participation shall be automatically enrolled for full participation upon the completion of three (3) years of Plan Participation with such employing organization.
- (b) If an employing organization elects to enroll a classification of employees for limited participation coverage, the dues applicable to coverage for retirement benefits (Article VIII) and survivor's pension (Article IX) in such amounts as may be set by the Board from time to time shall not be payable, nor shall Pension Credits accrue, during the first three (3) Years of Plan Participation of such Member, although Years of Service shall accrue during this period. Any employment classification established by an employing organization for purposes of Benefits Plan enrollment must be established on a reasonable, non-discriminatory basis in accordance with the provisions of the Benefits Plan and its administrative rules. Each eligible member of a designated employment classification must be provided and offered coverage on the same terms and conditions as each other member of that employment classification.

**Sec. 5.4 Affiliated Benefits Program.**

- (a) The Affiliated Benefits Program consists of enrollment for coverage for medical benefits (Article XIII) or medical benefits and death and disability benefits (Articles X, XI and XIII).
- (b) In accordance with Sec. 5.1, an employing organization may elect to enroll eligible employees (other than Mandated Members) in the Affiliated Benefits Program. A Member enrolled in the Affiliated Benefits Program is not covered by the Pension Plan and shall not accrue Pension Credits during such enrollment. Any employment classification established by an employing organization for purposes of Benefits Plan enrollment must be based on a reasonable, non-discriminatory basis in accordance with the rules of the Benefits Plan and its administrative rules. Each eligible member of a designated employment classification must be offered coverage on the same terms and conditions as each other member of that employment classification.

**Sec. 5.5 Optional Benefits Plans.** An employing organization that has elected to enroll employees in the Traditional Program must and the Affiliated Benefits Program may offer those employees who meet the applicable program's eligibility requirements the opportunity to enroll in any Optional Benefits Plans offered by the Board.

# 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. 3.1 commences Eligible Service.

**Sec. 6.3 Termination of Period of Service.** Except for a Disabled Member or a 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 an ordained 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 Benefits 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 (1 ¼%) 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 less 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. 4.4 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 does not otherwise have 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 (1 ¼%) 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 less than one thousand eight hundred twenty (1,820) hours, bears to one thousand eight hundred twenty (1,820) hours.

Members who become Totally Disabled while participating in the Pension Plan under the Transitional Participation Coverage option of Sec. 4.4 shall accrue credits on the basis of their Transitional Participation Coverage, not their Effective Salary. No credits shall accrue to a Member for whom dues are not paid in full or who does not otherwise have Pension Coverage.

**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 BENEFITS

**Sec. 8.1 Normal Pension.** A Member of the Pension Plan shall be entitled to initiate annual retirement benefits, payable monthly, equal to 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) executed in writing and filed with the Board a signed application on a form supplied by the Board for retirement benefits, which application has been accepted by the Board as being complete and evidencing entitlement to retirement 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 (1) the Actuarial Equivalent of the Pension Credits that had accrued as of the Member's early retirement Benefit Commencement Date and that would be payable at Normal Retirement or (2) 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, Covered 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. 8.4, 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. The adjusted early retirement benefit initially payable under this Sec. 8.2(b) will be approximately equal to the aggregate of:
  - (1) 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

- (2) the Member's actuarially adjusted early retirement benefit payable at age 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 expected payments made under this option shall, in the aggregate, be the Actuarial Equivalent of the retirement benefit payable to a Member pursuant to Sec. 8.2(a) above. The survivor's pension payable under Sec. 9.1 shall not be affected by electing early retirement benefits on a level income basis. 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 Age Benefit Commencement Date shall be the Actuarial Equivalent of the Pension Credits accrued as of the Member's Post-Normal Retirement Age Benefit Commencement Date adjusted for the deferred Benefit Commencement Date.

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. 8.4, the annual survivor's pension payable monthly under Sec. 9.1 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 Section and dies prior to commencing benefits, the survivor's pension payable under Sec. 9.1 shall be equal to one-half (1/2) of the Pension Credits accrued by the Member as of the date of death increased by the applicable factors for deferred Benefit Commencement Date (the date of death) set forth in Appendix A.

**Sec. 8.4 Joint and Survivor Options (Combined Retirement Pension and Survivor's Pension Benefits Options).**

(a) ELECTION OF JOINT AND SURVIVOR COVERAGE. A legally married Member 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 described in Sec. 9.1. An election is valid and effective when made in writing on a form supplied by 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. The expected payments made under any of the joint and survivor options described below shall, in the aggregate, be the Actuarial Equivalent of 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. 9.1.

**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. 8.5 Small Benefit Distribution.**

- (a) **MANDATORY CASH-OUT.** Notwithstanding any other provision of the Pension Plan, if the Actuarially Equivalent 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 Actuarially Equivalent single-sum present value of the accrued Pension Credits in a single lump sum.
- (b) **VOLUNTARY CASH-OUT.** With the consent of the Member, the Board shall distribute the Actuarially Equivalent single-sum present value of a Terminated Vested Member's accrued Pension Credits in a single 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 this Sec. 8.5(a) and (b) shall be made as soon as practicable after termination of service with his or her most recent Eligible Service employer. Upon payment of any lump sum under Section 8.5, neither the Member nor his or her eligible survivor(s) shall be entitled to any further benefits under the Pension Plan and the Death and Disability Plan.
- (d) **SMALL PENSION SETTLEMENT.** Where the amount of a given monthly pension payment to a person under Secs. 8.1, 8.2 or 8.3 is less than an amount which the Board may fix from time to time as being large enough to effectively administer, the Board may pay the Actuarial Equivalent of all future retirement pension and survivor's pension benefits payable on account of such Member's vested Pension Credits in one lump sum in lieu of the continuing monthly payments.

**Sec. 8.6 Maximum Annual Benefit.** Notwithstanding anything in this Benefits 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. 8.7 Temporary Suspension of Retirement Pension.** In the event a Retired Pensioner returns to Eligible Service with an employing organization providing Pension Coverage to employees in the Member's employment classification, except in the case of approved Post-Retirement Service under Sec. 8.8, 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 a Covered 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.

**Sec. 8.8 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. 8.7 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. 8.9 Payment of Benefits.** All benefits payable under the Pension Plan, other than lump sum distributions pursuant to Sec. 8.5, 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. 9.2, or an Alternate Payee as defined in

Sec. 18.2. and acceptance of the retirement benefits application by the Board as being complete and evidencing entitlement to retirement benefits.

**Sec. 8.10 Sole and Exclusive Benefit.** The Board shall administer the Pension Plan and the assets attributable thereto solely in the interest and for the exclusive benefit of the Members of the Benefits Plan with Pension Credits, Members receiving retirement benefits and other persons entitled to receive benefits under the Pension Plan.

**Sec. 8.11 Top Heavy Rules.** The rules set forth in Appendix D shall apply to the Pension Plan pursuant to their terms.

**Sec. 8.12 Direct Rollovers.** A Member (or a Surviving Spouse, former Spouse of a Member, or other Dependent) who is entitled to receive a lump sum distribution under Secs. 8.5(a), (b) or (d) or 9.3 may direct the Board to transfer all or a portion of the distribution amount to (a) an individual retirement account described in section 408(a) of the Code, (b) an individual retirement annuity described in section 408(b) of the Code, (c) a Roth individual retirement plan described in section 408A(b) of the Code, (d) a qualified defined contribution retirement plan described in section 401(a) of the Code, the terms of which permit the acceptance of rollover contributions, (e) an annuity contract described in section 403(b) of the Code, or (f) an eligible plan under section 457(b) of the Code that is maintained by a state, political subdivision of a state, or any agency or instrumentality of a state or political subdivision of a state that agrees to separately account for amounts transferred into such plan from this Plan. A lump sum distribution to a Dependent may only be directly transferred to an individual retirement account described in (a), (b) or (c) above.

## ARTICLE IX

### SURVIVOR'S PENSION

#### Sec. 9.1 Survivor's Pension.

(a) Upon the death of a Retired Pensioner, except to the extent an optional form of benefit was elected under Sec. 8.4 in lieu of the survivor's pension payable under this Sec. 9.1, 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. 9.2 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 was 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. 8.4 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 was 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. 9.2 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. 9.2 Classes of Survivors.** For purposes of Sec. 9.1 above, 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 unmarried Dependent Children under age twenty-one (21) (including unmarried Totally Disabled Children age twenty-one (21) or over) 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 an unmarried Totally Disabled Child, 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 unmarried Dependent siblings under age twenty-one (21) (including unmarried Totally Disabled siblings age twenty-one (21) or over) 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 an unmarried Totally Disabled sibling, until marriage or the Board in its sole discretion determines that such individual is no longer Totally Disabled.

**Sec. 9.3 Survivor's Small Pension Settlement.** 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 pay the Actuarial Equivalent of all future survivor's pension benefits due to such survivor in a single lump sum payment in lieu of continuing monthly benefits. Upon payment of such lump sum, no survivor of any class shall be entitled to any further benefits under the Pension Plan.

# DEATH AND DISABILITY PLAN

## ARTICLE X

### DEATH BENEFITS

#### Sec. 10.1 Salary Continuation Benefit.

(a) DEATH OF AN ACTIVE OR DISABLED MEMBER. Upon the death of a Covered Member of 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 Covered 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. 8.5, 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 eight thousand dollars (\$8,000). 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 eight thousand dollars (\$8,000).

(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 Seventy, the beneficiary or beneficiaries of such Retired Pensioner shall be entitled to one single lump sum payment of eight thousand dollars (\$8,000).

(c) DEATH OF A TERMINATED VESTED MEMBER. Upon the death of a Terminated Vested Member whose participation in the Plan satisfied the Rule of Seventy, the beneficiary or beneficiaries of such Terminated Vested Member shall be entitled to one single lump sum payment of eight thousand dollars (\$8,000).

(d) A Member shall be entitled to only one Salary Continuation Benefit under this Sec. 10.1, which shall be the greatest of the Salary Continuation Benefit calculated under Secs. 10.1(a), (b) or (c). The Salary Continuation Benefit under this Sec. 10.1 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 in writing on a form provided by the Board which designation shall only be effective 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.

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 unmarried Dependent Children under age twenty-one (21) (including unmarried Totally Disabled Children age twenty-one (21) or over) 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. 10.2 Lump Sum Death Benefit.**

- (a) **MEMBER WITH DEPENDENT COVERAGE.** Upon the death of a Covered Member of the Death and Disability Plan who is survived by an eligible survivor as set forth in Sec. 9.2, 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 ninety thousand dollars (\$90,000), 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. 9.2:

<b>Member's Age at Death</b>	<b>Benefits as a Percentage of Death Benefit Basis</b>
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%

<b>Member's Age at Death</b>	<b>Benefits as a Percentage of Death Benefit Basis</b>
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%

The survivor or survivors entitled to receive the lump sum death benefit shall have the option of being paid the amount to which they may be entitled in the form of a monthly annuity, which annuity shall be the actuarial equivalent of the lump sum death benefit.

- (b) **MEMBER WITHOUT DEPENDENT COVERAGE.** Upon the death of a Covered Member of the Death and Disability Plan who is not survived by an eligible survivor as set forth in Sec. 9.2, 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 ninety thousand dollars (\$90,000) shall be paid to the Member's estate.

**Sec. 10.3 Children's Education Benefit.** Upon the death of a Covered Member of 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 nine thousand dollars (\$9,000) 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 benefit for any one Child is thirty-six thousand dollars (\$36,000).

**Sec. 10.4 Living Needs Benefit.** A Covered 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. 10.2(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. 10.4 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 exists: (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.

## **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 a Covered Member of 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 only payable for a Disability that continues for more than ninety (90) consecutive days. Disability benefits shall be payable to the Member beginning on the 91<sup>st</sup> day of the period during which the Member is Disabled except that 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.
- (b) **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(c). 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.

- (c) **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 employing organization on a non-contributory 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.
- (d) **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.
- (e) **IF 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 Normal Retirement Age, the amount of the disability benefit shall be reduced beginning the first month after the Member attains 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 Normal Retirement Age.
- (f) **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 employing organization 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 employing organization 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.

(g) DURATION OF DISABILITY BENEFIT. Disability benefits shall continue as long as a Member remains Disabled but not beyond the date or duration 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; or

- (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.
  
- (h) **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 Waiver of Dues and Accrual of Pension Credits.** No dues shall be required for a Disabled Member for the continuation of coverage under the Pension, Death and Disability, and Medical Plans, after the Disability Benefits Commencement Date, to the extent that coverage under such Plans was in effect on the date the Disability began. Pension Coverage under this Section shall only continue until the Member's Normal Retirement Date and no additional Pension Credits shall accrue to such Disabled Member thereafter.

**Sec. 11.6 Protection for Survivors.** In the event of the death of a Member who is receiving benefits under this 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 under the Medical Plan 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 as recommended by the Board;
- (b) Remain under the proper and adequate medical care of a duly licensed Physician, and follow any reasonable medical advice of the Board's medical counsel or medical case management representatives;
- (c) Participate in vocational rehabilitative services as recommended by the Board; or
- (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.
- (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 Section 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 91<sup>st</sup> 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(h).
- (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 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 employing organization may offer coverage for 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 employing organization (or Member in the case of dues paid in accordance with Sec. 4.2) 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 programs.

## ARTICLE XII

(RESERVED)

## ARTICLE XIII

### MEDICAL PLAN

**Sec. 13.1 Medical Plan Definitions.** When used in Articles XIII and XIV, the following words shall have the meanings set forth below:

- (a) **ACTIVE MEDICAL PLAN.** The Medical Plan coverage available under Article XIII for Active Members of the Traditional and Affiliated Benefits Programs, Disabled Members under Sec. 11.5 and individuals eligible for Medical Plan coverage under Sec. 13.14. A Member, Spouse and Children enrolled for the Medical Continuation Program are also eligible for Active Medical Plan benefits as specified in Sec. 13.15.
- (b) **AMBULATORY SURGICAL CENTER.** A duly licensed medical facility which performs surgery, has an organized staff of Physicians and continuous medical and registered nursing services whenever a patient is there, keeps adequate medical records on all patients, has a utilization review plan, maintains transfer arrangements with a Hospital, and does not provide overnight accommodations.
- (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 Medical Costs. See Sec. 13.9(b)(12).

- (d) **ELIGIBLE FAMILY.** The Spouse (including a Surviving Spouse and former Spouse where applicable) and all Children enrolled for Medical Plan coverage under the Active Medical Plan. See also Sec. 13.2.

- (e) **EXTENDED CARE FACILITY.** A duly licensed facility, other than a Hospital, approved as a skilled nursing facility under Medicare which is supervised by a Physician or registered graduate nurse on a full-time basis, provides room and board and skilled nursing services twenty-four (24) hours per day, maintains daily records for each patient, and is authorized to administer medication to patients on the order of a Physician.
- (f) **HOSPICE FACILITY.** A duly licensed facility which meets the standards of the National Hospice Organization, which is directed by medical professionals and coordinated by registered nurses and is specifically designed to provide supportive and palliative care to persons who have received a diagnosis of terminal illness with a prognosis of one (1) year or less to live.
- (g) **HOSPITAL.** A state licensed, Joint Commission accredited medical facility providing inpatient medical services, room and board and graduate nursing services twenty-four (24) hours per day, and established facilities for diagnosis and major surgery.
- (h) **NETWORK MEDICAL COSTS.** Medical Costs for services or supplies furnished by a Network Provider as of the date the services are rendered.
- (i) **MEDICAL CONTINUATION PROGRAM.** The Medical Plan coverage available on a subscription basis under Articles XIII and XIV to certain Members and their Eligible Family under Secs. 13.15 and 14.1 upon termination of eligibility as an Active Member.
- (j) **MEDICAL COSTS.** Subject to the managed care provisions of Sec. 13.7 and the exclusions and limitations of Sec. 13.9, the Medical Plan covers the Usual, Customary and Reasonable Charges incurred for the following Medically Necessary health care services and treatment for sickness or bodily injury:
  - (1) Charges by a Hospital for semi-private accommodations or services in an intensive care unit. If private accommodations are used, the rate shall be the average cost of semi-private accommodations for that Hospital or if that Hospital has no semi-private accommodations, then the average cost of semi-private 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. 13.7.
  - (2) Charges for diagnosis, treatment and surgery by a Physician or certified healthcare practitioner duly licensed in the State to provide such services.
  - (3) Charges for the administration of anesthetics by a Physician or professional anesthetist duly licensed in the State to provide such services.
  - (4) Charges for diagnosis or treatment by a radiologist, physiotherapist or laboratory.

- (5) Charges by a registered or licensed practical nurse for private duty nursing in a Hospital or elsewhere if an intensive care unit is not available at the facility. Custodial care is not a covered Medical Cost. See Sec. 13.9(b)(12), relating to exclusions and limitations.
- (6) Charges for 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.
- (7) Charges for drugs, medicines or medical supplies requiring a written prescription by a Physician. Charges for outpatient prescription drugs are subject to the reimbursement limits and exclusions of the Prescription Drug Program. See Secs. 13.1(w) and 13.9(b)(22).
- (8) Charges for use of 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 Board, in its discretion, may authorize the purchase of certain medical equipment. Charges for the routine maintenance of rented or purchased medical equipment are not reimbursable medical costs and are the sole responsibility of the Member.
- (9) Charges related to pregnancy and childbirth, 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. Charges for these services are subject to the reimbursement limits set forth in Sec. 13.9(a)(2).
- (10) Charges for treatment of nervous, mental and substance abuse disorders in a Hospital, Treatment Facility for Substance Abuse, or Residential Treatment Center, or for outpatient treatment provided by a psychiatrist, clinical psychologist Ph.D., Diplomate or Fellow Member of the 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 Board. In addition to the providers designated in this paragraph, the Board 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 state licensing requirements of a state that has been pre-approved by the Board.

Charges for services reimbursed under this subparagraph are subject to the managed care provisions set forth in Sec. 13.7 and the exclusions and limitations set forth in Sec. 13.9.

- (11) Charges for dental care for:
  - (a) 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;
  - (b) removal of up to four (4) bony impacted wisdom teeth; and
  - (c) treatment of temporo mandibular joint dysfunction, by whatever name called. Charges for these services are subject to the reimbursement limits set forth in Sec. 13.9(a)(1).
- (12) Charges related to the adjustment and manipulation of the spinal column and associated nervous system in restoration of health. Charges for these services are subject to the reimbursement limits set forth in Sec. 13.9(a)(3).
- (13) Charges by a duly licensed podiatrist for diagnosis, treatment and surgery. Charges for these services are subject to the exclusions and limitations set forth in Sec. 13.9(b)(21).
- (14) Charges for home health care in the Member's home furnished by a home health care 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:
  - (a) part-time or intermittent nursing care by or under the supervision of a registered nurse;
  - (b) part-time or intermittent home health aide services Medically Necessary for the care of a person covered under Article XIII; and
  - (c) services for physical and occupational and speech therapy by a licensed or certified therapist.
- (15) Charges by an ophthalmologist or optometrist for diagnosis and treatment of a disease or injury to the eye, but only in those states where optometrists are licensed to diagnose and treat diseases and injuries to the eye, and allowed charges for an annual eye examination under the Plan's preventive services program.

- (16) Charges for 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. 13.1(k)(2), relating to Habilitative Services for Children with Developmental Disabilities, charges for services that are determined to be primarily developmental are not covered Medical Costs. See Secs. 13.1(j)(20) and 13.9(b)(15) relating to exclusions and limitations.
- (17) Charges for acupuncture treatment but only if provided by a Physician (or an acupuncturist duly licensed in the State to provide such services).
- (18) Charges for 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.
- (19) Charges for foot orthotics prescribed by a physician for treatment of metabolic, peripheral-vascular disease or other medical condition except (i) foot orthotics prescribed for non-surgical 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 Sec. 13.9(b)(21). Orthotic shoes are only covered when they are prescribed as an integral part of a brace.
- (20) Charges for the following Habilitative Services for Children with Developmental Disabilities.

**(a) Covered Conditions**

<b>Developmental Disabilities</b>	<b>Diagnoses Codes</b>
Autism Spectrum Disorder	299
Cerebral Palsy	343
Down syndrome	758.0
Intellectual Disability	317-319
Spina Bifida	741

**Autism Spectrum Disorder**

- ICD-9 Diagnosis codes
  - 299.00 Autistic disorder current or active state
  - 299.01 Autistic disorder residual state
  - 299.10 Childhood disintegrative disorder
  - 299.11 Childhood disintegrative disorder residual state
  - 299.80 Other specified pervasive developmental disorders current or active state

- 299.81 Other specified pervasive developmental disorders residual state
- 299.90 Unspecified pervasive development disorder current or active state
- 299.91 Unspecified pervasive developmental disorder residual state

**Cerebral Palsy**

- ICD-9 Diagnosis code 343

**Down Syndrome**

- ICD-9 Diagnosis code 758.0

**Intellectual Disability**

- ICD-9 Diagnosis code 317-319

**Spina Bifida**

- ICD-9 Diagnosis code 741 and 756.17

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

(i) “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.

(ii) “Autism” means a pervasive, neurologically based developmental disability of extended duration which 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.

(iii) “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.

(iv) “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.

(v) “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.

(vi) “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.

(vii) “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.

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

- (a) Arrive at a correct medical diagnosis.
- (b) Prevent the onset of an illness, condition, injury or disability.

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

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

(ix) “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.

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

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

(i) Behavioral Therapy (Applied Behavioral Analysis or “ABA”) – Charges for ABA sessions are limited to an annual maximum of \$36,000 per Child, and a lifetime maximum of \$125,000 per Child. Eligibility for reimbursement requires case management (as defined in (b) above) of services.

(ii) Specialized Therapies, including Speech, Occupational and Vocational Therapies – Medically necessary services (as defined in subsection (b) 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 medical necessary in subsection (b) above and be subject to case management (as defined above).

(21) Charges for advanced reproductive technology, including in vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intra-fallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery; and for the supplies and prescription drugs related to such therapies. See Sec. 13.9(b)(2) relating to exclusions and limitations.

(k) **MEDICALLY NECESSARY.** Except as more specifically defined in 13.1(j)(20)(b)(viii) for Habilitative Services for Children, services or supplies provided or prescribed by a Hospital, Physician or other provider licensed to

diagnose, treat or prevent a sickness or bodily injury that the Board, in its sole discretion, determines are:

- (A) Appropriate to the symptom and diagnosis or treatment of the sickness or injury;
  - (B) Not custodial or for the convenience of the patient, Physician, or other provider;
  - (C) Not educational, experimental or investigational in nature;
  - (D) Of demonstrated medical value; and
  - (E) 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.
- (l) **MEDICARE SUPPLEMENT PLAN.** The Medical Plan program that offers supplemental benefits coverage to Medicare Parts A and B and 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 Section 14.2.
- (m) *(Description of Mental Health/Substance Abuse Program deleted by action of the Board, effective 1/1/2003.)*
- (n) **NETWORK AREA.** A geographical area designated by the Board as an area where the Board 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 of the Medical Plan and their Eligible Families.
- (o) **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 Board has contracted to provide services to Members of the Medical Plan and their Eligible Families for prescribed charges.
- (p) **NON-NETWORK AREA.** A geographical area designated by the Board, in its sole discretion, as an area where the Board, 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 of the Medical Plan and their Eligible Families.
- (q) **NON-NETWORK MEDICAL COSTS.** Medical Costs for services or supplies provided by a Non-Network Provider.

- (r) **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 Board has a contractual relationship.
- (s) **OUT-OF-NETWORK MEDICAL COSTS.** Medical Costs for services or supplies provided in a Network Area by an Out-of-Network Provider.
- (t) **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 Board has contracted in the Network Area.
- (u) **PHYSICIAN.** An individual legally licensed to practice medicine or surgery acting under or in accordance with the scope of his or her license.
- (v) **PRE-EXISTING CONDITION.** Any condition (physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, treatment, care or medication was recommended or received within the six (6) month period ending on the enrollment date for Medical Plan coverage. Pregnancy is not considered a Pre-Existing Condition.
- (w) **PRESCRIPTION DRUG PROGRAM.** The managed Prescription Drug Program, administered by the Board or such other organization as may be designated by the Board, under which a Member or an Eligible Family member enrolled for Medical Plan coverage purchases outpatient prescription drugs and is reimbursed through a separate administrative program. The Board may, from time to time, establish separate rules for the Prescription Drug Program, relating to reimbursement based upon the types of providers, 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 Program of the Medical Plan.
- (x) **RESIDENTIAL TREATMENT CENTER.** A facility duly licensed by a state government and accredited by the Joint Commission to provide post-hospital residential care which is supervised by a Physician.
- (y) **TREATMENT FACILITY FOR SUBSTANCE ABUSE AND DEPENDENCIES.** A duly licensed medical facility supervised by a Physician on a full-time basis which provides room and board and inpatient medical services twenty-four (24) hours per day, maintains daily records for each patient, is authorized to dispense medication on the order of a Physician and is specifically designed to provide treatment to persons suffering from substance abuse dependencies.

- (z) **USUAL, CUSTOMARY AND REASONABLE CHARGES.** The rates or allowances (“Plan Allowances”) set by the Board, in its sole discretion, as the reasonable charges to be reimbursed for Medically Necessary diagnosis, treatment or care provided by a Physician based on the contract rates or other fee schedules medical care 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.

**Sec. 13.2 Eligibility for Active Medical Plan Coverage.**

- (a) **TRADITIONAL PROGRAM - ACTIVE MEDICAL PLAN.** All Members and their Eligible Family members who are enrolled automatically in the Traditional Program and covered for the medical benefits and programs described in Article XIII.

The Active Medical Plan of the Traditional Program is administered by the Board as a grandfathered health plan within the meaning of Section 1251 of the Patient Protection and Affordable Care Act (the “ACA”). A grandfathered plan may preserve certain basic health coverage provisions in effect when the law was enacted. As a grandfathered plan, the Traditional Program coverage is not required to include all of the consumer protections of the Act that apply to non-grandfathered plans. However, grandfathered health plans must comply with certain consumer protections in the ACA—for example, the elimination of the lifetime dollar limits on benefits. The Traditional Program coverage includes many of the consumer protections that grandfathered plans are not required to address. For example, most preventive health benefits are covered under the Traditional Program without any cost-sharing. The Traditional Program has not addressed all the consumer protections under the law. For example, the Traditional Program is maintaining its current claims appeal process. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan can be directed to the Board’s Senior Vice President, Benefits. You may also contact the U.S. Department of Health and Human Services at [www.healthreform.gov](http://www.healthreform.gov).

A Member, on behalf of the Member’s Eligible Family members, may apply for a waiver of Medical Plan coverage for the Member’s Eligible Family members if other comparable employer group or military services health care coverage is in effect for such person. The Member may apply for a waiver by filing a written application with the Board on a form supplied by the Board, together with evidence of the other coverage, which application is subject to the approval of the Board. The waiver shall be effective as of the date of approval by the Board.

Notwithstanding the availability of such other coverage, the Member may elect to re-enroll the Eligible Family member(s) during any enrollment period and such coverage shall be effective as of January 1 of the new Plan Year.

If the other coverage becomes unavailable to the individual, the Member may re-enroll the Eligible Family member(s) within sixty-three (63) days of the termination of the other coverage to be effective the day following the loss of other coverage with no pre-existing coverage exclusion. If the Member does not re-enroll the Eligible Family member(s) within sixty-three (63) days of the other coverage termination event, the re-enrollment shall be effective as of the date of the Board's approval of the re-enrollment and the coverage shall be subject to the Pre-Existing Condition limitations in the Medical Plan.

The Medical Plan dues to be paid by a church or employing organization shall not be reduced if a Member elects to waive coverage for an Eligible Family member.

The Board, in its sole discretion, may adopt more specific requirements for the waiver and re-enrollment in an administrative rule.

- (b) **AFFILIATED BENEFITS PROGRAM - ACTIVE MEDICAL PLAN.** Such Members and Eligible Family member(s) who are enrolled in the Affiliated Benefit Program are covered for the medical benefits and programs described in Article XIII.
- (c) **COVERAGE FOR CHILDREN.** Children shall be eligible for Active Medical Plan coverage until attainment of age twenty-six (26). A Dependent Totally Disabled Child shall continue to be covered under the Active Medical Plan beyond the attainment of age twenty-six (26), for such period of time as such Child remains a Dependent and unmarried.
- (d) **COVERAGE FOR DISABLED MEMBERS AND DEPENDENT TOTALLY DISABLED CHILDREN.** Coverage under Article XIII shall not be available to a Medicare eligible Disabled Member or Dependent Totally Disabled Child eligible for continued coverage after the attainment of age twenty-six (26) under Sec. 13.2(c) for any period of time during which such Disabled Member is not enrolled in both Part A and Part B of Medicare.

**Sec. 13.3 Pre-Existing Conditions.** For a Member and Eligible Family member(s) desiring coverage provided by Article XIII, the Board shall have the right to limit the coverage under this Article XIII for such Member, Spouse or Child age 19 or older for any Pre-Existing Condition (as defined in Sec. 13.1(v)).

**Sec. 13.4 Medical Costs Reimbursement.** Subject to the managed care provisions set forth in Sec. 13.7 and the exclusions and limitations set forth in Sec. 13.9, and upon satisfaction by the Member and Eligible Family members of any applicable annual deductible set forth in Sec. 13.5, the Medical Plan shall reimburse the Member or his or her assignee for the allowed Medical Costs of the Member and his or her Eligible Family as follows:

- (a) **FOR MEDICAL COSTS OTHER THAN PRESCRIPTION DRUGS.**
  - (1) ***Physician Office Visits.***

- (A) Network and Non-Network. The Member shall pay a twenty-five dollar (\$25) copayment per visit with a Network or Non-Network primary care Physician and a thirty-five dollar (\$35) copayment per visit with a specialist Physician. The Medical Plan shall pay the balance of the contracted rate.
- (B) Out-of-Network. The Medical Plan will pay 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 Section 13.4(a)(1) shall not be subject to the annual deductible requirement set forth in Sec. 13.5.
- (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 Medical Costs for an office visit for prevention screenings covered by the Medical Plan's preventive health program.

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

- (A) Reimbursement after Satisfaction of Deductibles in Sec. 13.5. Upon satisfaction by the Member and Eligible Family members of the applicable annual deductible amount set forth in Sec. 13.5, the Medical Plan shall reimburse a Member:
  - (i) *Network and Non-Network Providers*: Eighty percent (80%) of the reimbursable Medical Costs incurred by the Member and the Eligible Family members. The remaining 20% is the Member's Copayment responsibility.
  - (ii) *Out-of-Network Providers*: Sixty percent (60%) of the reimbursable Medical Costs incurred by the Member and the Eligible Family members. The remaining 40% is the Member's Copayment responsibility.
- (B) Reimbursement After Satisfaction of Annual Copayment Maximums in Sec. 13.6. Upon satisfaction by the Member and Eligible Family members of any applicable annual Copayment Maximum amount set forth in Sec. 13.6, the Medical Plan shall reimburse a Member:
  - (i) *Network and Non-Network Providers*: One hundred percent (100%) of the reimbursable Medical Costs incurred by the Member and the Eligible Family members.

(ii) *Out-of-Network Providers*: The lesser of one hundred percent (100%) of the reimbursable Medical Costs incurred by the Member and Eligible Family members or one hundred percent (100%) of the Plan Allowance (as defined in Sec. 13.1(y)).

(b) PRESCRIPTION DRUG PROGRAM COSTS.

For outpatient prescription drug costs reimbursable under the Prescription Drug Program, the Member shall be responsible for a copayment in the amount of:

(1) *if purchased at a retail pharmacy*:

- (a) Generic Drugs: \$8 per prescription for each generic drug;
- (b) Brand Formulary: Thirty percent (30%) of the contracted cost, with a minimum of \$20 and a maximum of \$100 per prescription for each brand-name formulary drug;
- (c) Non-Formulary Brand Drugs: Fifty percent (50%) of the contracted cost, with a minimum of \$50 and a maximum of \$150 per prescription for any non-formulary prescription drug; and
- (d) Maintenance Drug Surcharge: In addition to the copayment amounts set forth in (1), the Member shall also be responsible for a surcharge of \$5 for each generic prescription drug refill, \$10 for each brand-name prescription drug refill and \$15 for each non-formulary prescription drug refill at a retail pharmacy beyond the first two fills of the prescription.

(2) *if purchased through mail order, for a supply of up to ninety (90) days*:

- (a) Generic Drugs: \$20 for each generic prescription drug;
- (b) Brand Formulary: Thirty percent (30%) of the contracted cost, with a minimum of \$50 and a maximum of \$300 for each brand-name formulary prescription drug; and
- (c) Non-Formulary Brand Drugs: Fifty percent (50%) of the contracted cost, with a minimum of \$125 and a maximum of \$450 for each non-formulary prescription drug.

- (c) The Board may, from time to time, offer regional medical plans or provider network options, pilot programs and 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 health care services, contain costs and promote good health habits.

**Sec. 13.5 Annual Deductibles.** Reimbursement for Medical Costs under Sec. 13.4 is subject to the Member's satisfaction of the following Annual Deductible requirements.

- (a) **MEDICAL COSTS OTHER THAN PRESCRIPTION DRUG PROGRAM COSTS.**
  - (1) ***Physician Office Visits.*** There are no annual deductibles for Medical Costs incurred for Physician office visits.
  - (2) ***Other Medical Services.*** The Annual Deductibles for Medical Costs other than costs incurred for Physician office visits and under the Prescription Drug Program shall be:
    - (A) For Network and Non-Network Medical Costs: One percent (1%) of the Member's Medical Participation Basis plus all other earned income of the Member for the preceding one (1) year period and an additional one percent (1%) of the Member's Medical Participation Basis plus all other earned income of the Member for the preceding one (1) year period, for the Member's Eligible Family, in the aggregate.
    - (B) For Out-of-Network Medical Costs: Two percent (2%) of the Member's Medical Participation Basis plus all other earned income of the Member for the preceding one (1) year period and an additional two percent (2%) of the Member's Medical Participation Basis plus all other earned income of the Member for the preceding one (1) year period, for the Member's Eligible Family, in the aggregate.
    - (C) Out-of-Network Medical Costs are applied to satisfy the Network and Non-Network Medical Costs Deductibles.
    - (D) Network and Non-Network Medical Costs are applied to satisfy the Out-of-Network Medical Costs Deductibles.
  - (3) ***Annual Caps on Deductibles.*** Notwithstanding subparagraph (a)(2) above,
    - (A) The aggregate Annual Deductibles for Medical Costs (Network, Non-Network and Out-of-Network) shall not exceed two percent (2%) of Medical Costs for a Member and an additional two percent (2%) of Medical Costs for the Member's Eligible Family.
    - (B) In no event shall the basis for calculating any Annual Deductibles for Medical Costs exceed one hundred and fifty percent (150%) of the Pastors' Median, as such median shall be established from time to time by the Board.

- (C) No more than two (2) Annual Deductibles for Medical Costs shall be applicable to a Member and such Member's Eligible Family in any one (1) calendar year.
  - (D) A Member's aggregate maximum annual deductible responsibility shall not exceed the sum of two (2) Annual Deductibles for Medical Costs.
- (4) ***Annual Deductible for Disabled Members.*** The Annual Deductibles for Medical Costs for a Disabled Member for whom Medical Plan Coverage is being continued in accordance with Sec. 11.5 shall be established each year at the lesser of the Member's Effective Salary or the Pastors' Median on the date the Disability began, but not less than the current annual minimum Medical Participation Basis, as determined by the Board.
  - (5) ***Annual Deductible for Medical Continuation Coverage.*** The Annual Deductibles for Medical Costs for individuals covered under the Continuation of Coverage provisions (Sec. 13.15) shall be established on the basis of the Pastors' Median.
- (b) PRESCRIPTION DRUG PROGRAM COSTS. There are no annual deductibles for Medical Costs incurred under the Prescription Drug Program.
  - (c) Reimbursable Medical Costs credited toward satisfaction of the Annual Deductibles for Medical Costs are not credited toward satisfaction of the Annual Medical Costs Copayment Maximum Amounts.
  - (d) For Out-of-Network Medical Costs, only Medical Costs up to the Plan Allowance shall be credited toward the satisfaction of the Annual Deductibles for Medical Costs.

**Sec. 13.6 Copayment Maximum Amounts.** Reimbursement for Medical Costs under Article 13.4(a)(2)(B) is subject to the following annual Copayment Maximums:

- (a) MEDICAL COSTS OTHER THAN PRESCRIPTION DRUG PROGRAM COSTS ("THE ANNUAL MEDICAL COSTS COPAYMENT MAXIMUM").
  - (1) For Network and Non-Network Medical Costs, a Member's Annual Medical Costs Copayment Maximum is four percent (4%) of the lesser of the Member's Medical Participation Basis or one hundred and fifty percent (150%) of the Pastors' Median.
  - (2) For Out-of-Network Medical Costs, a Member's Annual Medical Costs Copayment Maximum is twelve percent (12%) of the lesser of the Member's Medical Participation Basis or one hundred and fifty percent (150%) of the Pastors' Median.

- (3) For a Disabled Member for whom Medical Plan coverage is being continued in accordance with Sec. 11.5, the amount of the Copayment Maximum in (a)(1) and (2) above shall be established on the basis of the lesser of the Member's Effective Salary on the date the Disability began or the current Pastors' Median, but not less than the current annual minimum Medical Participation Basis, as determined by the Board.
  - (4) For individuals covered under the Continuation of Coverage provisions (Sec. 13.15), the amount of the Copayment Maximum in (a)(1) and (2) above shall be established on the basis of the Pastors' Median.
  - (5) Notwithstanding subparagraphs (a)(1) and (a)(2) above, the aggregate Annual Medical Costs Copayment Maximum shall not exceed twelve percent (12%) of all reimbursable Medical Costs.
  - (6) Reimbursable Medical Costs credited toward satisfaction of the Annual Medical Deductibles are not credited toward satisfaction of the Annual Medical Costs Copayment Maximum Amounts.
  - (7) For Out-of-Network Medical Costs, only Medical Costs up to the Plan Allowance shall be credited toward satisfaction of the Annual Medical Costs Copayment Maximum Amounts.
- (b) **PRESCRIPTION DRUG PROGRAM COSTS** ("THE PRESCRIPTION DRUG ANNUAL COPAYMENT MAXIMUM"). In the event that during a given calendar year, the Prescription Drug Program copayment charges paid by a Member and a Member's Eligible Family, exclusive of copayment charges for non-formulary brand-name drugs and the maintenance drug retail surcharge, exceed two thousand five hundred dollars (\$2,500), no further copayments under Sec. 13.4(b) shall be required for the balance of that calendar year and all reimbursable Prescription Drug Program charges (other than copayments for non-formulary brand-name drug charges and maintenance drug retail surcharges) 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. 13.7(h) below.

**Sec. 13.7 Managed Care Provisions.** Reimbursement for Medical Costs is subject to the following additional provisions:

- (a) **PRE-ADMISSION TESTING.** Subject to the deductible provisions of Sec. 13.5, the Medical Plan shall reimburse a Member for one hundred percent (100%) of the eligible Medical Costs incurred by the Member 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 Member or Eligible Family member 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 Board, a certification authorizing such inpatient confinement. If a Member, or someone on behalf of the Member, fails to obtain from the Board, or its designee, timely certification of the emergency treatment admission and length of stay, the Board 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) **PRE-CERTIFICATION 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 Board, or such other organization as may be designated by the Board, pre-certification of any non-emergency inpatient admission to a Hospital or other residential health care facility of a Member or Eligible Family member. If a Member, or someone on behalf of the Member, fails to obtain pre-certification of a non-emergency admission to a Hospital or other residential health care facility from the Board, or its designee, the Board 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 Board to cover the cost of the review.
- (d) **PRAUTHORIZATION OF NON-EMERGENCY DIAGNOSTIC, SURGICAL, AND OUTPATIENT SERVICES AND PROCEDURES.** The Board may specify that certain non-emergency diagnostic, surgical, and outpatient services and procedures shall be subject to prospective review and approval by the Board or such other organization as may be designated by the Board, 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 Board, or its designee, the Board 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 shall be reduced by an amount designated by the Board 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 eligible Medical Costs without regard to the deductible.
- (e) **PRIMARY PREVENTIVE SERVICES.** The Board shall designate in its sole discretion certain primary preventive health services that shall be reimbursed under the Medical Plan without being subject to the office visit, deductible and/or annual copayment provisions of Secs. 13.5 and 13.6.

- (f) *(Pre-certification requirements applicable to outpatient mental health treatment only deleted by action of the Board, effective 1/1/2010.)*
- (g) MEDICAL CASE MANAGEMENT. A Member shall only be reimbursed for fifty percent (50%) of the Medical Costs incurred where the Member or other covered person has refused case management when required by the Board, or by such organization as may be designated by the Board.
- (h) PRESCRIPTION DRUG PROGRAM. A Member shall only be reimbursed for outpatient prescription drug costs incurred by the Member or other covered person if (1) the prescription is for a generic drug unless the Board, in its sole discretion, determines it is Medically Necessary to prescribe a brand-name drug; (2) the drug is covered under the drug formulary published by the Board or its designated Prescription Drug Program administrator and prescribed for uses approved by the Prescription Drug Program administrator in accordance with general medical practices; (3) the prescription is written in accordance with FDA approved usages; and (4) the order is filled in the quantity specified by the Board or its designated Prescription Drug Program administrator. Reimbursement for prescriptions filled at non-participating pharmacies shall be limited to the reimbursable amount established for participating pharmacies.

**Sec. 13.8 Time Limit for Submission of Claims for Reimbursement.** In order to be eligible for reimbursement, all claims must be received by the Board 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. 13.9 Exclusions and Limitations.** The following exclusions and limitations shall apply to the reimbursement of claims under the Medical Plan:

- (a) MAXIMUM ANNUAL TREATMENT REIMBURSEMENT LIMITS. The maximum annual benefits payable under Article XIII for the Member and the Member's Eligible Family for essential benefits shall be three million five hundred thousand dollars (\$3,500,000) for each covered person.
- (b) TREATMENT REIMBURSEMENT LIMITS. Certain covered Medical Costs are also 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 maximum of five hundred (\$500) for each covered person's lifetime.
  - (2) ***Reimbursement for Medically Necessary Use of Advanced Reproductive Technology.*** A Member shall be reimbursed for Medical Costs relating to the use of advanced reproductive technology under Sec. 13.1(j)(21) for a maximum of three (3) procedures for each covered person's lifetime. This

limitation shall also apply to the supplies and infertility drugs prescribed to support these procedures.

- (3) ***Reimbursement for Chiropractic-Type Services.*** The maximum benefits payable for services allowed under Sec. 13.1(j)(12) shall be limited to two thousand dollars (\$2,000) per person in any one (1) calendar year.
  - (4) ***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 of at least three (3) days, 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 Medical Costs actually paid for each day up to a lifetime maximum 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 semi-private accommodations for the Hospital from which discharged.
  - (5) ***Reimbursement for Hospice Care.*** If a Member or an Eligible Family member, pursuant to a written certification by a supervising Physician, is required to be confined in a Hospice Facility, then and in that event the Member shall be reimbursed for his or her Medical Costs actually paid for each day up to a lifetime maximum of one hundred eighty (180) days of treatment in such a Hospice Facility up to a maximum of fifty percent (50%) of the average daily room rate for semi-private accommodations in such neighboring Hospital or Hospitals as may be selected by the Board. Hospice care in the home shall be reimbursed on a comparable basis to the hospice care in a Hospice Facility and shall also be subject to the lifetime maximum of a total of one hundred eighty (180) days for hospice care.
- (c) **MEDICAL COSTS NOT COVERED.** Charges for the following services 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, 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. 13.1(j)(11).
  - (3) Except for the annual eye examination coverage described in Sec. 13.1(j)(15), 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) Hearing aids or the fitting thereof.
- (5) Cosmetic surgery or treatment procedures, except (i) in connection with treatment for a bodily injury resulting from an accident occurring while covered under Article XIII, 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. 13.1(j)(18). For purposes of this Section, 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.
- (6) *(Exclusion of coverage for injury or sickness which is the result of armed conflict deleted by action of the Board, effective 1/1/2003.)*
- (7) Any injury or sickness for which benefits are paid or are payable under any Workers’ Compensation Law or similar legislation.
- (8) Medical Costs where the Member or other covered person hereunder is not actually required to pay for such services.
- (9) Medical Costs incurred while the Member’s benefits are suspended because the dues have not been paid in accordance with Sec. 4.2 and are not guaranteed by a presbytery.
- (10) Medical Costs incurred for any person who is not or is no longer eligible for coverage pursuant to Secs. 13.2, 13.13, 13.14, 13.15 or 14.1.
- (11) All charges relating to a diagnosis and treatment procedure which is in the sole determination of the Board deemed to be experimental, investigative, unproven, for purposes of research, not Medically Necessary, or not generally accepted by the medical profession.
- (12) All charges related to Custodial Care (as defined in Sec. 13.1(c)) rendered to a Member or an Eligible Family member. (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.)

- (13) All charges relating to the reversal of a previous sterilization procedure for either sex, unless the initial sterilization was required because of an accident or disease.
- (14) All charges relating to a radial keratotomy.
- (15) All charges or costs which are primarily for the Member's or Eligible Family member'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. 13.1(k)).
- (16) Services or supplies provided primarily for personal hygiene, comfort or convenience.
- (17) All charges by providers for 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.
- (18) Charges for services rendered by a person who ordinarily resides in a Member's home or who is related to the patient, including parents or children, siblings or spouses, whether the relationship is by blood or exists by law.
- (19) All charges relating to any Pre-Existing Condition (as defined in Sec. 13.1(u)) for a twelve (12) month period beginning with the first day of the Member's medical coverage under the Benefits Plan. The twelve (12) month Pre-Existing Condition exclusion period applicable to a Member or an Eligible Family member age 19 and older shall be reduced by the length of the aggregate of the periods of creditable coverage (if any) under other health coverage applicable to that Member or the Eligible Family member as of the enrollment date. No credit shall be given for any period of creditable coverage if after such period and before the enrollment date there was a sixty-three (63) day period during all of which that Member or Eligible Family member was not covered under any creditable coverage.
- (20) *(Exclusion of coverage for non-emergency Hospital admissions on a Friday or Saturday deleted by action of the Board, effective 1/1/2010.)*
- (21) All charges for 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. 13.1(j)(19). Charges for orthopedic

shoes or orthopedic prescription devices to be attached to or placed in shoes are not covered except as provided in Sec. 13.1(j)(19).

- (22) Charges for outpatient prescription drugs that were not purchased in accordance with the provisions of the Medical Plan's Prescription Drug Program. See Secs. 13.1(w), 13.4, 13.5, 13.6 and 13.7(h).
- (23) Charges for routine maintenance of medical equipment.
- (24) Charges for Out-of-Network Providers in excess of the Plan Allowance established by the Board as the Usual, Customary and Reasonable Charge for a service, procedure or supply.

**Sec. 13.10 Rights of Recoupment, Subrogation and Reimbursement.**

- (a) Medical Costs otherwise reimbursable by the Medical Plan shall not be payable to or for a Member or an Eligible Family member or anyone acting on behalf of a Member or Eligible Family member covered under the Medical Plan when such Medical Costs 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. 13.11) maintained by or on behalf of the Member or Eligible Family member.
- (b) However, the Board may, in its sole discretion, advance sums from the Medical Plan to a Member or Eligible Family member or anyone acting on his or her behalf for eligible Medical Costs that are excluded under Subsection (a) of this Section until such time as the Member or the Eligible Family member or person acting on behalf of the Member or Eligible Family member recovers the reimbursement from the other source. Member or Eligible Family member or person acting on behalf of the Member or Eligible Family member shall be required:
  - (1) to repay the Board in full all sums advanced by the Board for Medical Costs 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 Board in assisting it to protect its legal rights under the agreement and this Section.
- (c) The rights of reimbursement, recoupment and subrogation granted under this Section shall constitute a lien and first priority claim against any person or entity, to be paid before any other claims are paid, 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, not only the part specifically allocated to Medical Costs, shall be made available by the Member or Eligible Family member for the repayment of the reimbursement and subrogation obligation under this Section.

**Sec. 13.11 Dual Coverage.** Reimbursement of Medical Costs under the Medical Plan shall be limited to the extent that other coverage is available to the Member or his or her Eligible Family. The Medical 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 Medical Plan shall be coordinated as provided in Subsection (a) below. For purposes of this Section, 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 Medical Plan is secondary, the Medical Plan shall coordinate benefits on a maintenance of benefits basis. In such event, the Medical Plan shall pay an amount equal to the reimbursable amount under the Medical Plan (as if the Medical Plan were primary) less any amount actually paid by the primary plan. If the Medical Plan is both the primary and secondary plan by reason of direct coverage by multiple Members in an Eligible Family (as defined in Sec. 13.1(d)), the Medical Plan shall pay on a coordination of benefits basis. In such event, the Medical 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 reimbursable Medical Costs 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, 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, 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 the person as a Child whose parents are married or are living together, whether or not they have ever been married, the plan of the parent whose birthday falls earlier in the calendar year is primary or if both parents have the same birthday, the plan that has covered a parent longest is primary.
- (5) The benefits of a plan which covers the person as a Child whose parents are divorced or 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 health care 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 health care expenses or health care coverage or if a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Child, the provisions of Sec. 13.11(a)(4) shall determine the order of benefits.
  - (c) If there is no court decree allocating responsibility for the Child's health care expenses or health care coverage, the order of benefits for the Child are 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. 13.11(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 expenses shall be shared equally between the plans; however, the Medical 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 Medical 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 Medical Plan shall not cover any charges in excess of what that participating provider has agreed to accept as payment.
  - (11) When the Medical 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 Medical 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 expenses. The Medical Plan shall credit to its deductible any amounts it would have credited to its deductible in the absence of any other health care 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 Medical 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. 13.12 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 Benefits 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. 13.16. All other uses and disclosures of information by the plan shall be as set forth in the plan's Notice of Privacy Practices provided to Members under the HIPAA Rules.

**Sec. 13.13 Termination of Coverage.** Active Medical Plan coverage shall terminate upon the occurrence of any one of the events described in (a) through (e) below. Upon termination of Active Medical Plan coverage upon the occurrence of any one of the events described in (a) through (d) below, an affected Member and/or his or her Eligible Family members may be eligible for continued coverage under the Medical Continuation Program or the Medicare Supplement Plan as set forth in Secs 13.14, 13.15, 14.1 and 14.2. Active Medical Plan coverage shall terminate upon:

- (a) The retirement of a Member.
- (b) The date of termination of Eligible Service of a Member, except that Members and their Eligible Family members who were enrolled in the Traditional Program on the date of termination of coverage under this subsection shall continue to be covered under Active Medical Plan coverage (or Medicare Supplement coverage if Medicare eligible) for an additional thirty (30) days after one (1) year of Plan Participation by the Member. Such continuation of Active Medical Plan coverage, at no additional dues to the church, employing organization or Member, shall commence on the date of termination of Eligible Service. Thereafter, the Member and the Eligible Family members may be eligible for the Medical Continuation Program (for Terminated Vested Members) or Medicare Supplement coverage (for Retired Pensioners) under Secs. 13.15, 14.1 and 14.2.
- (c) The date of death of a Member except that the Eligible Family of such Member may be eligible for Active Medical Plan Coverage under Secs. 13.13(b) and 13.14 and, thereafter, Medical Continuation Program or Medicare Supplement coverage under Secs. 13.15, 14.1 and 14.2.
- (d) 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 Board by the date required.
- (e) The date the employing organization terminates Active Medical Plan coverage and withdraws its employees or a class of its employees from Medical Plan participation.

**Sec. 13.14 Extension of Active Medical Plan Coverage on Traditional Program Member's Death or Divorce.** If a Traditional Program Member dies or becomes divorced while enrolled in the Active Medical Plan, the Active Medical Plan coverage shall be continued for the Member's Eligible Family member(s) who were enrolled in the Active Medical Plan on

the date of such Member's death or divorce for a period of twelve (12) months from the date of death and ninety (90) days from the date of divorce of such Member. No payment of dues or other subscription charges shall be required during this free coverage period. Thereafter, the Member's Eligible Family member(s) who were enrolled under the Active Medical Plan may subscribe for Medical Continuation Program coverage under Secs. 13.15 and 14.1 or the Medicare Supplement Plan under Sec. 14.2 as appropriate.

**Sec. 13.15 Medical Continuation Coverage.** On or before the expiration of 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. 13.13(a) through (d) or on the date of death or divorce of the Member shall have the option of subscribing for continued Medical Plan coverage under the Medical Continuation Program for the duration specified below. To be eligible for Medical Continuation Program coverage, a Member or Eligible Family member must complete and forward the appropriate application form for continuation of coverage to the Board prior to the expiration of coverage, 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 Program coverage. Any Children born to, adopted by or placed for adoption with a Member, Spouse, Surviving Spouse or divorced Spouse subscribing for Medical Continuation Program coverage shall also be eligible for coverage for the duration of the parent's subscription period.

Medical Continuation Program coverage is not available to a Member and his or her Eligible Family members if the termination of Active Medical Plan coverage is due to an event described in Sec. 13.13(e) (relating to termination of participation by employing organization).

Except as otherwise provided herein, Medical Continuation Program coverage shall be available for the following periods, unless otherwise provided by applicable law:

- (a) A Surviving or divorced Spouse may subscribe from the last date of coverage under the Active Member's eligibility until the first day of eligibility for Medicare;
- (b) Children may subscribe from the last date of coverage under the Active Member's eligibility for a period of time that is the greater of thirty-six (36) months or the attainment of age twenty-six (26);
- (c) A Dependent Totally Disabled Child may subscribe from the last date of coverage under the Active Member's eligibility for such period that the Child remains Totally Disabled;
- (d) If a Member or Eligible Family member is or becomes totally disabled (as defined by the Social Security Act) at any time during the first sixty (60) days of Medical Continuation Program coverage, the subscription period shall be extended from eighteen (18) months to twenty-nine (29) months; and
- (e) Members terminated from Eligible Service and their Eligible Family members may subscribe for a period of eighteen (18) months from the last date of eligibility for Active Medical Plan coverage. Notwithstanding the foregoing sentence, if the

Member, on the date active coverage terminated, either satisfied the Rule of Seventy or met the requirements for retirement of the employing organization that enrolled the Member in the Affiliated Benefits Program with the retiree medical coverage option, the Member and his or her Eligible Family members (as long as they continue to remain Eligible Family members) may subscribe for Medical Continuation Program coverage until the first day of eligibility for Medicare.

Failure to pay any subscription amount required by Sec. 13.15 when due shall terminate coverage.

If a Surviving Spouse, divorced Spouse or a Terminated Vested Member who meets the requirements of the Rule of Seventy maintains enrollment in the Medical Continuation Program 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, divorced Spouse or Terminated Vested Member is eligible to subscribe for Medicare Supplement Plan coverage under Sec. 14.2.

**Sec. 13.16 Use of Protected Health Information by Board.** The provisions of this Section 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.

- (a) **Definitions.** Each capitalized term used in this Section that is not otherwise defined in the Benefits 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 Plan, and any other health plan that is part of the Benefits Plan's Organized Health Care Arrangement (individually and collectively referred to herein as "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 Health and Human Services, when required by the Secretary for its investigation or determination of the compliance of the Health Plan with the HIPAA Rules;
  - (2) for disclosure to a Member, Spouse or Child of that individual's Protected Health Information upon the individual's written request or in appropriate response to an exercise by the Member, Spouse or Child 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 Section 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 Section) 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 Section;
- (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 Section and of which the Board becomes aware;

- (5) make the Protected Health Information of a Member, Spouse or Child 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 Member, Spouse or Child as, and to the extent, required by the HIPAA Rules;
- (7) make available to a Member, Spouse or Child 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 health care operations purposes (not treatment purposes), if the Protected Health Information pertains solely to a health care item or service for which the health care 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 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:

- (a) Healthcare Benefits;
- (b) Member Services;
- (c) Information Technology;
- (d) Mailroom/Fax Delivery;
- (e) Finance/Treasury;
- (f) Appeals Board;
- (g) Legal;
- (h) Accounting; and
- (i) Audit.

(f) **Security of Electronic Protected Health Information.** With respect to electronic Protected Health Information, 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 Section (e)(2) 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) **Non-compliance.** If the Health Plan becomes aware of any issues relating to non-compliance with the requirements of this Sec. 13.16, the Health Plan's privacy or security official shall undertake an investigation to determine the extent, if any, of such non-compliance; the individuals, policies, or practices responsible for the non-compliance; 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 non-compliance and preventing such non-compliance in the future. Any individual or entity who is determined by the Health Plan to be responsible for such non-compliance, 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 Member, Spouse or Child as if the individual were the Member, Spouse or Child 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 Section or may delegate, in writing and in its sole discretion, any and all of its functions under this Section 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 Section shall supersede any provisions of the Health Plan to the extent those provisions are inconsistent with this Section.

## ARTICLE XIV

### POST-RETIREMENT MEDICAL BENEFITS

#### Sec. 14.1 Medical Plan Coverage Prior to Eligibility for Medicare.

- (a) **MEDICAL CONTINUATION PROGRAM COVERAGE.** Medical Plan 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. 13.15 (the Medical Continuation Program).

- (b) **CONTINUOUS MEDICAL PLAN COVERAGE REQUIREMENT.** Except as otherwise provided herein, Members and/or Eligible Family members must maintain continuous Medical Plan coverage (Active Medical Plan or Medical Continuation) up to the date of Medicare eligibility to be eligible to enroll for Medicare Supplement Plan benefits under Sec. 14.3.
- (c) **WAIVER OF CONTINUOUS MEDICAL PLAN REQUIREMENT.** A Member, on behalf of the Member and/or the Member's Eligible Family members may apply for a waiver of the continuous Medical Plan coverage requirement described in Sec. 14.1(b) (including the subsequent waiver of Medicare Supplement) if other comparable employer group medical coverage is in effect for such person (including retiree coverage). Such person may apply for a waiver of the continuous Medical Plan coverage requirement by filing a written application with the Board on a form supplied by the Board, together with evidence of the other coverage, which application is subject to the approval of the Board.

**Sec. 14.2 Post-Retirement Medicare Supplement Coverage Following Eligibility for Medicare.** Members who satisfy the Rule of Seventy and/or their Eligible Family members shall each have the option to subscribe for the Medicare Supplement Plan benefits as set forth in Sec. 14.3. An eligible individual may continue an existing waiver or apply for a waiver of the continuous coverage requirement if other comparable employer group medical coverage is in effect for such person (including retiree coverage). Coverage will commence as of the latest of the date of termination of Active Medical Plan coverage, the cancellation of any Waiver of Continuous 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 Medical Plan coverage until the date of eligibility for Medicare Supplement Plan coverage (or received a waiver thereof under Sec. 14.1(c) and Sec. 14.2) and
  - (2) had a minimum of five (5) Years of Plan Participation or has met the requirements for retirement of the employing organization that enrolled the Member in the Affiliated Benefits Program with the retiree medical coverage option.
- (d) Medicare Supplement Plan coverage shall not be available to any person enrolled in a Medicare Advantage program.

- (e) Medicare Supplement Plan 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 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.** Medicare Supplement Plan coverage for those subscribing persons eligible under Sec. 14.2 shall be a supplement to the benefits provided by Medicare. Medicare Supplement Plan 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.** Subject to the managed care provisions of Sec. 13.7, the exclusions and limitations in Sec. 13.9, 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 Medical Costs allowable under Medicare other than Prescription Drug Program charges, as defined in Sec. 13.1(w), less any amount reimbursable by Medicare for such Medical Costs regardless of whether or not such allowable amount is reimbursed by Medicare. Prescription Drug Program charges shall be reimbursed as set forth in Secs. 13.4, 13.7(h), 14.3(b)(4) and (5), 14.3(c)(2), 14.3(d) and 14.3(g).
- (b) **MEDICARE SUPPLEMENT REIMBURSEMENT EXCLUSIONS AND LIMITATIONS.** The Medical Costs reimbursed under Sec. 14.3(a) shall not include charges:
  - (1) exceeding one hundred dollars (\$100.00) 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; or
  - (4) incurred when the Medicare Supplement subscriber is enrolled in a Medicare Advantage program.
- (c) **ANNUAL MEDICARE SUPPLEMENT DEDUCTIBLES.** No benefits under Sec. 14.3 shall be paid until the reimbursable Medical Costs of an individual exceed the Annual Deductibles set forth below:
  - (1) The Annual Deductible for reimbursement of Medical Costs other than those eligible for payment under the Prescription Drug Program shall be one-half of one percent (0.5%) of the Pastors' Median.

- (d) **ANNUAL MEDICARE SUPPLEMENT COPAYMENT MAXIMUM LIMITS.** In the event that during a given calendar year the twenty percent (20%) copayments of reimbursable Medical Costs incurred by an individual under Sec. 14.3(a), when combined with the applicable deductible under Sec. 14.3(c)(1), exceed four percent (4%) of the Pastors' Median, such excess of Medical Costs 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 Program 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 Program 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. 13.7(h).
- (e) **SUBSCRIPTION CHARGE FOR MEDICARE SUPPLEMENT.** The charges to provide coverage under 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. 13.14 or 14.1. The determination of the amount of the subscription charge shall take into account any funds received by the Board from vacancy dues, 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(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 under the Medicare Supplement Plan to the extent necessary to qualify the Medicare Supplement Plan for the subsidy under Part D of Title XVIII of the Social Security Act (42 U.S.C. 1302 and 1395w-101 et seq.).
- (f) **TERMINATION OF MEDICARE SUPPLEMENT COVERAGE.** Coverage under 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), Prescription Drug Program charges shall be reimbursed as set forth in Secs. 13.4, 13.7(h) and 14.3(d).
  - (2) The Board may establish from time to time prescription drug programs for Medicare-eligible beneficiaries, as part of the Medicare Supplement Plan

or as a carve-out stand-alone plan or program, including without limitation, pilot programs, provider networks and incentives to 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 Prescription Drug Plan shall be limited to medical and behavioral health benefits under 14.3 only. The Medicare Part D Prescription Drug Plan shall be the only outpatient prescription drug coverage for such enrollees. The Medicare Supplement Plan shall 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 Plan 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 Section 14.3(g). Medicare Supplement reimbursement for any Medicare Supplement Plan 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 Program 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 Plan coverage.

# OPTIONAL BENEFITS PLANS

## ARTICLE XV

### DENTAL BENEFITS

**Sec. 15.1 Dental Plan.** 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 a dental plan to be offered to the Members of this Benefits 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 Plan shall be as set forth in the Certificate of Coverage or equivalent document provided by the Carrier.

**Sec. 15.2 Dental Plan 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 enrolled for Traditional Plan coverage and Affiliated Benefits Program coverage whose employing organizations elect to offer Dental Plan coverage and their Eligible Family members, as defined in Sec. 13.1(d), shall be eligible for participation in the benefits of Article XV for Dental Plan coverage.

**Sec. 15.4 Commencement of Coverage.** Coverage for Dental Plan benefits shall commence upon an eligible Member (a) executing and filing in writing with the Board an application on a form supplied by the Board, which application is accepted by the Board and 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, the Dental Plan shall reimburse an individual covered under the provisions of Article XV on the terms provided in administrative rules established by the Board or, if the Board has selected a Carrier to underwrite and administer the coverage provided in Article XV, in the group insurance policy of the Carrier underwriting the coverage contained in Article XV.

**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 Dental Plan shall include only those dental services defined in administrative rules established by the Board or, if the Board has selected a Carrier to underwrite and administer 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 Pre-Determination of Benefits.** Any person covered under Article XV may submit to the Carrier in advance of treatment a treatment plan which will permit the 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 Plan Coverage.** 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 members 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.
- (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

### SUPPLEMENTAL DEATH BENEFITS

**Sec. 16.1 Eligibility.** Any Members enrolled for Death and Disability Plan coverage under Sec. 5.4 whose employing organizations elect to offer Supplemental Death Benefits Plan coverage are eligible to subscribe for the Supplemental Death Benefits Plan coverage of Article XVI for themselves, their Spouses, and/or their unmarried Dependent Children until attainment of age 21 (or attainment of age 25 if the unmarried Dependent Child is attending an accredited college, university or other institution of higher learning on a full-time basis). A Member may continue to subscribe for coverage for an unmarried Dependent Child who is Totally Disabled beyond age 21. Members subscribing for Supplemental Death Benefits Plan coverage as of the date of retirement shall have the option of continuing to subscribe for the same or lesser Supplemental Death Benefits Plan coverages as were in effect on the date of such retirement until attainment of age 70 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.

**Sec. 16.2 Commencement of Coverage and Evidence of Insurability.** Subject to the satisfaction of any insurability requirements set forth below, coverage in the Supplemental Death Benefits Plan shall commence upon an eligible Member (a) executing in writing 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 participation in the benefits of Article XVI, and (b) paying all dues required by Article XVI. The Board shall designate the amounts of coverage for which Members may subscribe to cover the Member and/or the Member's Spouse and unmarried Dependent Children and the medical insurability requirements for such coverage. The Board shall provide for one or more minimum levels of coverage that a Member may apply for within thirty-one days of initial eligibility in the Plan, which minimum levels of coverage shall not be subject to the Plan's medical insurability requirements. All other coverage levels under this Article shall be subject to satisfaction of the Board's medical insurability requirements. Application by a Member for coverage of a Spouse shall be subject to satisfaction of the Board's evidence of insurability requirements. Enrollment of unmarried Dependent Children shall not be subject to insurability requirements.

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.

**Sec. 16.3 Amount of Supplemental Death Benefits.** A Member may within thirty-one (31) days of first becoming eligible under Sec. 16.1 elect one, but not more than one, of the Supplemental Death Benefits coverage options authorized by the Board.

- (a) A Member may only be enrolled for Supplemental Death Benefits Plan coverage as either a Member or a Spouse at any one time. If both parents are Members of the Benefits Plan, only one may subscribe for coverage of an eligible Child.

After such thirty-one (31) day initial period a Member may elect or change from one or more of the Supplemental Death Benefits Plan coverage levels to another only during such open enrollment period as may be 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.

Should the Board determine, in its sole discretion, that the assets of the Supplemental Death Benefits Plan exceed the required reserves for the program, the Board may, at its sole discretion, grant a dues credit, an increase in the amount of coverage for a specified term, or other form of additional coverage.

**Sec. 16.4 Dues for Supplemental Death Benefits.** Dues shall be paid by the Member through payroll deduction or other arrangement with the employing organization and remitted to the Board by the employing organization. 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 for the applicable coverage options. 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.

**Sec. 16.5 Payment of Supplemental Death Benefits.** Upon the death of a Member covered under Article XVI, the amount set forth in the applicable coverage options in effect shall be paid in one lump sum 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 in writing on a form provided by the Board, which designation shall only be effective 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.

In the event that a Member fails to properly designate a beneficiary, or no named beneficiary survives the Member, the Supplemental Death Benefits Plan benefits 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 unmarried Dependent Children under age twenty-one (21) (including unmarried Totally Disabled Children age twenty-one (21) or over) 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).

Upon the death of a Spouse or Child covered under Article XVI, the amount set forth in the applicable coverage option 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 Plan benefits shall be paid to the estate of the Member.

The Board may require such proof of death as it, in its sole discretion, deems necessary.

**Sec. 16.6 Coverage during Disability.** If a Member who is covered under Sec. 16.2 becomes Disabled in accordance with the provisions of Article XI of the Death and Disability Plan, no further dues shall be required to continue coverage for the Member, including the Spouse's and/or Children's coverage, under Article XVI during the period of Disability, or until the first receipt of any applicable retirement benefit under the Pension Plan, if earlier.

**Sec. 16.7 Termination of Coverage.** Coverage under Article XVI 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 XVI has been made if the subsequent dues payment is not made on the date required; or (3) at the end of the month in which a Retired Pensioner attained the age of seventy (70) years.

**Sec. 16.8 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 XVII**

### **RETIREMENT SAVINGS PLAN**

**Sec. 17.1 Retirement Savings Plan.** 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 a Retirement Savings Plan of the Church to be offered to the Members of this Benefits Plan as an optional benefit.

# ADMINISTRATIVE PROVISIONS

## ARTICLE XVIII

### ADMINISTRATION

**Sec. 18.1 Administration of Benefits Plan.** The Board shall administer the Benefits 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 Benefits Plan at all times and to administer the Benefits Plan and the Benefits Plan assets solely in the interest of the Members and their eligible Dependents in accordance with its terms. Notwithstanding the foregoing, in the event that the Board, based on the advice of its actuarial and legal counsel, determines that the Death and Disability Plan, the Medical Plan, or a program of the Medical Plan, or an Optional Benefits Plan has current assets on hand that exceed the existing and future benefit liabilities and obligations, the Board may, in its sole discretion, allocate such excess assets for other plans or programs of the Benefits Program, 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.** The interest of Members and all other persons entitled to receive any benefit or payment under the Benefits Plan shall not be subject to anticipation, assignment, attachment, or to voluntary or involuntary alienation except as provided hereinafter. A Spouse, former Spouse, Child or other Dependent of a Member ("Alternate Payee") may, in the event of a divorce 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 only be payable to an Alternate Payee pursuant 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 Benefits 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 Benefits Plan to provide increased benefits (determined on the basis of an actuarial valuation of the Actuary of the Benefits 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 Board's Appeals Board 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, are then maintaining or have 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 Benefits 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 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. 18.6 Notices.** Any notice required by the terms of the Benefits Plan shall be in writing and, if sent by U.S. Mail, postage pre-paid to a Member or other payee to his or her last known address as shown on the records of the Board, or to the Board at its registered office, shall be conclusively presumed to have been given to such party for all purposes under the Benefits Plan.

**Sec. 18.7 Rules Applicable to Specialized Ministries and Other Church Groups.** The Board shall, from time to time, make such rules and regulations as it, in its sole discretion, deems necessary or appropriate to administer the Benefits 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. 18.8 Administrative Rules.** The Board shall, from time to time, make such rules and regulations as it, in its sole discretion, deems necessary or appropriate to administer the Benefits Plan or any part thereof. The determination of any amount due or eligibility for any benefits pursuant to the Benefits Plan shall be conclusive and binding.

**Sec. 18.9 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 Board's notice of denial of the claim or adverse eligibility determination.

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

- (1) the specific reasons for the denial;
- (2) the specific reference to the Plan provision on which the denial is based;
- (3) a description of any additional information necessary for the Member to perfect the claim and an explanation of why such information is necessary; and
- (4) 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 Section shall be the exclusive means for contesting a decision denying benefits or eligibility under the Plan. Determinations of the Board's appeals Board shall be conclusive and binding.

#### **Sec. 18.10 Recoupment of Benefit Overpayments.**

The Board 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 Board or its designee in error, after the Member or the Member's beneficiary Benefits Plan 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 Board 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 Board, the Member and the Member's beneficiary will be ineligible for all future benefits under the Benefits Plan until the money is repaid in full, or until the Board 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 Board may require. In the event the Member or the Member's beneficiary should fail to make a timely payment under the repayment plan, the Board 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 Board is repaid in full.

In the event that legal action is required to recover Benefits 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. 18.11 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. The Board shall not 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 the failure of any Church or Employing Organization to enroll an eligible employee, spouse or dependent of the employee for coverage under the

Benefits Plan in accordance with the policies and practices of such employer, 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 Board or any representative of the Board has actual knowledge of such failure to enroll. The Board shall not be liable to any Member, Spouse, former Spouse, dependent or the personal representative, heir, successor or assign of any Member, Spouse or dependent for the failure of any church or employing organization to pay the dues for such person's coverage under the Benefits Plan, whether or not the Board or any representative of the Board has actual knowledge of such failure to pay.

## ARTICLE XIX

### ALTERATIONS OR AMENDMENTS

**Sec. 19.1 Right To Alter or Amend Plans.** The right to alter or amend the Benefits Plan is reserved solely to the Board. Notice of any amendment to the Benefits 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 benefit 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 benefit 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 Plan.** The Board, in its sole discretion, taking into consideration claims experience, administrative expenses, changes in the health care industry, and other relevant factors, shall have the right, from time to time, to amend the Medical Plan and report any such amendment to the next succeeding General Assembly of the Church.

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

**Sec. 19.5 Amendment of Optional Benefits Plans.** The Board, in its sole discretion, shall have the right from time to time to amend the Optional Benefits Plans or adopt such other additional optional benefits plans or programs as it deems in the best interest of the Members of the Benefits Plan. Any such amendment or additional optional benefit 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 Benefits Plan in its entirety or to terminate one or more of the Medical Plan, the Death and Disability Plan or any of the Optional Benefits Plans. 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 Plan, the Medical Plan, or a program of the Medical Plan, or an Optional Benefits Plan is terminated, after all existing benefit obligations are satisfied, any remaining assets shall revert to the Board for use, in its sole discretion, for other plans or programs of the Benefits Program, 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 an Actuarially Equivalent, single-sum basis will be determined based on the following assumptions and procedure:

Interest: 4.5%

Mortality: 1983 Table a-Individual Annuity Mortality Table, Male and Female Tables. Table a was developed by the Society of Actuaries for individual annuity valuation.

Form of Benefits:

Retirement: Joint and 50% Survivor

Survivor: Life Annuity

Spouse Age:

Active: For a married Member, the factors are based on the Member's age and Spouse's age on their birthdays nearest to the determination date. For an unmarried Member, 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:

- 1) Factor based on 1983 male Table a for Member and 1983 female Table a for survivor
- 2) Factor based on 1983 female Table a for Member and 1983 male Table a for survivor

The two factors are averaged.

## **Joint and Survivor Option Factors**

Benefits payable under an Actuarially Equivalent joint and survivor option will be determined 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 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	
55	.99	1.06	1.055	1.09	1.085	.96
56	.99	1.05	1.045	1.08	1.075	.95
57	.99	1.04	1.035	1.07	1.065	.94
58	.99	1.03	1.015	1.06	1.045	.93
59	.99	1.02	1.005	1.05	1.035	.92
60	.99	1.01	.995	1.04	1.025	.91
61	.98	1.00	.985	1.03	1.015	.90
62	.96	.99	.965	1.02	.995	.89
63	.95	.98	.955	1.01	.985	.87
64	.94	.97	.945	1.00	.975	.86
65	.93	.96	.935	1.00	.975	.85
66	.93	.96	.935	1.00	.975	.85
67	.93	.96	.935	1.00	.975	.84
68	.92	.95	.925	1.00	.975	.84
69	.92	.95	.925	1.00	.975	.83
70 or older	.92	.95	.925	1.00	.975	.83

**TABLE B**

<b>Age</b>	<b>Option I (75% to Spouse)</b>	<b>Option II (75% to Survivor)</b>		<b>Option III (66 2/3% to Survivor)</b>		<b>Option IV (100% to Survivor)</b>
		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	
	.003*	.006	.003	.006	.003	.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**

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

<b>Age</b>	<b>Board of Pensions Factors</b>	<b>Board of Annuity &amp; Relief Factors</b>
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**

Benefits payable on an Actuarially Equivalent Social Security Leveling Option will be determined based on the following table and procedures:

<b>Age</b>	<b>Factor</b>
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**

Actuarially Equivalent benefits payable on a post-normal retirement age Benefit Commencement Date will be increased 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.

<b>Plan Operational Year</b>	<b>Amendment Year</b>	<b>Experience Apportionment</b>
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	*

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.

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

**APPENDIX C  
HISTORY OF DISABILITY BENEFIT INCREASES**

The Benefits Plan in Sec. 11.3(h) grants to the Board discretion to determine Disability Benefit Increases. The following table provides a history of those increases for the Disability income benefits.

<b>Year</b>	<b>Disability Increase</b>
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%

\*No action was taken on a Disability Income Benefit increase in this year.

## APPENDIX D TOP-HEAVY RULES

The Pension Plan in Sec. 8.11 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,

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 employing organization in which a Key Employee is a participant,

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 employing organization 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

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 employing organization 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 employing organization participating in the Pension Plan who at any time during the Plan Year that includes the Determination Date was an officer of the employing organization 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 benefit 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 employing organization; (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 employing organization during the Plan Year that includes the Determination Date; and (D) for Plan Years beginning after December 31, 2001, any amount of an individual who has not performed services for an employing organization 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 employing organization) 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 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 employing organization 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 (b) 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), and
  - (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 (b)) 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.

