THE BOARD OF PENSIONS

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

THE BENEFITS PLAN

OF THE

PRESBYTERIAN CHURCH (U.S.A.)

2025

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1.1 Benefits Plan

The terms and conditions of the integrated benefits plans of the Church are set forth in "The Benefits Plan of the Presbyterian Church (U.S.A.)." The Benefits Plan offers Eligible Employers' retirement, financial protection, and health benefits, consisting of the Defined Benefit Pension Plan, Retirement Savings Plan, Death and Disability Plan, Term Life and Accidental Death and Dismemberment Plan, Temporary Disability Plan, Long-Term Disability Plan, Medical Plan, Employee Assistance Plan, Dental Plan, Vision Eyewear Plan, and Post-Retirement Medical Plan. Subject to each plan's eligibility, participation, and enrollment requirements, an Eligible Employer may elect to offer its Eligible Employees the coverage options described in § 2.3.

1.2 Purpose

The Church assigned the Board the responsibility to administer pension and other employee benefits plans for its Congregations, associated employers, Ministers, missionaries and other Church-related workers. Consistent with this assigned responsibility, the Board administers the Benefits Plan to offer a comprehensive range of employee benefits.

1.3 Construction and Applicable Law

The Benefits Plan is a non-electing "church plan" as defined in Section 414(e) of 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 and the dues paid to the Board for coverage are entrusted to the Board to fund the provision of benefits of all eligible Members and their beneficiaries enrolled in the applicable Benefits Plan program. The Benefits Plan will be construed and administered in accordance with the applicable trust laws of the Commonwealth of Pennsylvania. None of the Benefits Plan, any Benefits Plan communications, or enrollment forms will be deemed to be an express or implied contract or an employment agreement between the Board and a Congregation, associated employers, any Benefits Plan Member, or beneficiary. With respect to Puerto Rico Members enrolled in the Defined Benefit Pension Plan, the Defined Benefit Pension Plan also will be governed and construed in accordance with the applicable provisions of the Puerto Rico Tax Code as set forth in Appendix F hereto.

1.4 Administrative Provisions

1.4.1 *Administration of Benefits Plan*.

The Board will administer the Benefits Plan and have the sole and exclusive discretion and authority to interpret its provisions and construe its terms.

1.4.1.1 The Board will maintain the financial and actuarial soundness of the Benefits Plan and administer the Benefits Plan and its assets solely in the interest of the Members, their beneficiaries and survivors, in accordance with its terms. The Board maintains

separate accountings of the dues receipts and investment returns for each Benefits Plan offering.

1.4.1.2 The Board may assess administrative charges on Benefits Plan assets.

1.4.1.3 The Board will have the authority to waive a deadline required by the Benefits Plan, if the Board, in its sole discretion, determines that meeting the deadline was not reasonably possible and that action was taken to meet the Benefits Plan requirement as soon as it was reasonably possible.

1.4.1.4 The Board may, from time to time in its sole discretion, adopt Benefits Plan offerings for regional plans or benefits options and pilot programs and offer employer dues concessions and other incentives to encourage the use of Benefits Plan plans or programs.

1.4.2 *Assignment of Benefits*.

1.4.2.1 The interest of Members and all other persons entitled to receive any benefit or payment under the Benefits Plan will not be subject to anticipation, assignment, attachment, or to voluntary or involuntary alienation, except as provided in § 1.4.2.2.

1.4.2.2 A Spouse or former Spouse of a Member ("Alternate Payee") may, in the event of a divorce, dissolution of marriage, or legal separation (in states where recognized) between a Member and such Member's Spouse, become entitled to receive a portion of the Member's retirement, survivor's pension, or Retirement Savings Plan benefits. Such a benefit, or portion thereof, will be payable to an Alternate Payee pursuant only to a domestic relations order issued by a court of competent jurisdiction and accepted by the Board; provided, however, that no such order will be valid and binding upon the Board if such order entitles an Alternate Payee to receive a benefit that (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, except that Alternate Payees will be permitted to initiate payment of their retirement Pension Benefits or Retirement Savings distributions at the earliest retirement date of the Member permitted by the Retirement Program; (c) requires the Benefits Plan to provide increased benefits (determined on the basis of an actuarial valuation of the Actuary of the plan); or (d) requires the payment of benefits that are being paid to another Alternate Payee pursuant to a previous domestic relations order issued by a court of competent jurisdiction. The Board will reduce any such entitlement paid to an Alternate Payee by 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 of the Member, as the case may be, to the extent of the entitlement paid to the Alternate Payee. Determinations of the Benefits

Plan's Appeals Board as to the interpretation of an order or the reduction in Member benefits as a result of such order will be conclusive and binding.

1.4.3 *Payments to Incapacitated Payee*.

If any payee hereunder is, in the judgment of the Board, legally, physically, or mentally incapable of personally receiving and receipting for any payments due hereunder, or is deceased, the Board may make payments thereof to such other person, persons, or institution as, in the Board's sole opinion, is then maintaining or has custody of such payee, until a guardian, committee, or other legal representative of such payee will 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 will constitute a full discharge of the liability of the Board to the extent thereof.

1.4.4 *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, liability for the full commuted value or amount of said benefit or payment will be extinguished and no person will have a further right or claim to the benefit or payment. No person will have the right or claim to any benefit or payment provided to such person from the Benefits Plan assets but not cashed or deposited within two years. In no event will a Benefits Plan benefit or payment escheat to, or otherwise be paid to, any governmental unit under any escheat or unclaimed property law.

1.4.5 *Proof of Loss*.

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

1.4.6 *Comity Agreements*.

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

1.4.7 *Notices*.

Any notice required by the terms of the Benefits Plan will be in writing and delivered to a Member or other Covered Person by email, U.S. Mail, or nationally recognized and reputable express delivery service, postage pre-paid to a Member or other

Covered Person to their last known address as shown on the records of the Board. Unless the Board has established an electronic communication or notification option for a required benefit application or notice requirement, any notice to the Board by an Eligible Employer or Member must be made in writing, delivered at its registered office, and directed to the Board's Plan Operations Department.

1.4.8 *Specialized Ministries and Other Church Groups*.

The Board may, from time to time, adopt 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, Ministers engaged in a validated ministry, and other groups within the Church.

1.4.9 *Administrative Rules*.

The Board may, from time to time, adopt such rules and regulations as it, in its sole discretion, deems necessary or appropriate to administer the Benefits Plan or any part thereof. The Board, in its sole discretion, may determine any amount due, eligibility for, or time periods applicable to any benefits under the Benefits Plan, which determination will be conclusive and binding.

1.4.10 *Appeals*.

The Board will establish a process by which a Member or a Member's duly authorized representative may obtain a review of (a) any denial of all or a portion of a claim for benefits by a Member or a Member's beneficiary or (b) an adverse eligibility determination. The Member or the Member's authorized representative must make an initial request for a review of a claim denial or adverse eligibility determination within one hundred eighty (180) days of the date of the Benefits Plan's notice of denial of the claim or adverse eligibility determination.

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

1.4.10.1.1 the specific reasons for the denial;

1.4.10.1.2 the specific reference to the Benefits Plan provision on which the denial is based;

1.4.10.1.3 a description of any additional information necessary for the Member to perfect the claim and an explanation of why such information is necessary; and

1.4.10.1.4 appropriate information as to the steps to be taken if the Member wishes to submit the claim for further review.

1.4.10.2 The appeals procedure adopted by the Board pursuant to this § 1.4.10 will be the exclusive means for contesting a decision denying benefits or eligibility under the Benefits Plan. Determinations of the Benefits Plan's Appeals Board will be conclusive and binding.

1.4.11 *Recoupment of Benefit Overpayments*.

1.4.11.1 To the extent permitted by applicable law, the Board on behalf of the Benefits Plan will have the right to pursue repayment of any payment to the Member or the Member's beneficiary, or on the Member's or the Member's beneficiary's behalf, that was made (a) by the Benefits Plan or its designated administrator in error, (b) after the Member or the Member's beneficiary benefits entitlement had expired, or (c) 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 the Board's 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 Benefits Plan receives the initial repayment in accordance with the terms of a voluntary repayment plan agreed to between the Member or the Member's beneficiary and the Board. Such repayment plan will contain such terms and conditions as the Benefits Plan may require. In the event the Member or the Member's beneficiary should fail to make a timely payment under the repayment plan, the Board may suspend coverage, effective as of the paid-through date, for the Member, a Spouse and the Member's Children, and the Member (and the Member's Spouse and Children) will thereafter be ineligible for all future benefits until the entire amount owed to the Benefits Plan is repaid in full.

1.4.11.2 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 will be liable for all costs of collection, including reasonable attorneys' fees and costs.

1.4.12 *Limitation of Liability*.

1.4.12.1 The Board will not be liable to any person or entity for any acts carried out hereunder in good faith and based upon the information available to the Board or its designated agents at the time. Neither the Board nor the Benefits Plan will be liable to any Member, Spouse, former Spouse, Child, beneficiary or the personal representative, heir, successor, or assign of any Member, Spouse, former Spouse, Child or beneficiary for:

1.4.12.1.1 the failure of any Eligible Employer to enroll an Eligible Employee, Spouse, or Child of the employee for coverage under the Benefits Plan in accordance with the policies and practices

of such Eligible Employer or the *Book of Order* of the Church or in accordance with any contract between the Eligible Employee and the Eligible Employer, whether or not the Benefits Plan or any representative of the Benefits Plan has actual knowledge of such failure to enroll;

1.4.12.1.2 the failure of any Eligible Employer to pay the dues for such person's coverage under the Benefits Plan, whether or not the Benefits Plan or any representative of the Benefits Plan has actual knowledge of such failure to pay;

1.4.12.1.3 the failure of any Eligible Employer to report accurately or to update in a timely manner an Eligible Employee's Effective Salary or salary used to determine any benefits under the Plan; and

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

1.4.12.2 The Board will not be liable to any Member, Spouse, former Spouse, Child, beneficiary, or the personal representative, heir, successor, or assign of any Member, Spouse, former Spouse, Child, or beneficiary for any coverage or for the payment of benefits under the Benefits Plan if a Member, Spouse, former Spouse, or Child is enrolled in benefits for which they were not eligible under the terms of the Benefits Plan and such enrollment, or continued enrollment after the facts became known to the Member or Employer, is determined by the Board to have been based on misrepresentation, fraud, or other act of dishonesty on the part of the Employer, Member, Spouse, former Spouse, Child or beneficiary or their personal or authorized representative, heir, successor, or assign.

1.5 Alterations or Amendments

The right to alter or amend the Benefits Plan is reserved solely to the Board. Notice of any amendment to the Benefits Plan will be provided by the Board to the General Assembly, Members, Congregations, and Presbyteries in such manner as the Board deems reasonable and appropriate based on the nature of the amendment.

1.5.1 *Amendment of Defined Benefit Pension Plan*.

The Board, in its sole discretion, will have the right, from time to time, to amend the Defined Benefit Pension Plan, except that any alteration or amendment that is in the nature of a benefits reduction to the Members will be effective only with the approval of

the General Assembly of the Church. Any amendment to the Defined Benefit Pension Plan, other than a benefits reduction or a dues increase (which amendments require the approval in advance of the General Assembly of the Church), will require an affirmative two-thirds majority vote of the Directors of the Board of Directors present at a duly constituted meeting. Notice of any proposed alteration or amendment to the Defined Benefit Pension Plan requiring the approval of General Assembly of the Church will be given by the Board to Members, Congregations, 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.

1.5.2 *Amendment of Benefits Other Than Defined Benefit Pension Plan*.

The Board, in its sole discretion, taking into consideration claims experience, administrative expenses, changes in the health and welfare benefits industry, and other relevant factors, will have the right, from time to time, to amend the Death, Disability & Life Plans and the Health & Wellness Plans, or adopt such other additional benefits plans or coverage options as it deems in the best interest of the Members of the Benefits Plan. Any such amendment or additional benefits coverage options will be reported to the next succeeding General Assembly of the Church. The Board, in its sole discretion, will also have the right to pilot Benefits Plan offerings and dues pricing packages for a temporary period to employers or groups of employers without the necessity of a formal plan amendment for the purpose of testing the employers and employees' interest in new benefits or incentivizing participation in a plan. The terms of any pilot will be reported to the Board's Board of Directors or one of its committees in advance of its offering.

1.5.3 *Right to Terminate the Benefits Plan or Its Offerings*.

The Board, in its sole discretion, may terminate the Benefits Plan in its entirety or one or more of the Benefits Plan offerings. The Board may only terminate the Defined Benefit Pension Plan if granted approval in advance by the General Assembly of the Church and subject to the terms of the Pension Plan Trust. The termination of any other Benefits Plan offering will be reported to the next succeeding General Assembly of the Church. After all existing benefits obligations are satisfied, any remaining assets will revert to the Board for use, in its sole discretion, for other Benefits Plan offerings, for the Board's Assistance Program, or for such other purposes that are consistent with the mission of the Board.

1.6 Definitions

When used in the Benefits Plan, the following capitalized terms will have the meanings set forth below in the table below.

Defined Term	***Meaning***
Accidental Bodily Injury	This term is specific to the Term Life and Accidental Death and Dismemberment Plan and is defined in § 7.2.1.

Defined Term	*Meaning*
Accidental Death	This term is specific to the Term Life and Accidental Death and Dismemberment Plan and is defined in § 7.2.2.
Active Medical Plan	This term is specific to the Medical Plan and is defined in § 10.1.1.
Active Member	An employee who is eligible and currently enrolled in the Benefits Plan under § 2.4, an individual enrolled in Benefits Plan offerings under §§ 6.5, 6.6, or 6, or enrolled in Ministers Bridge Coverage under § 3.1.1 and whose dues are not delinquent.
Actuarial (or Actuarially) Equivalent	This term is specific to the Defined Benefit Pension Plan and is defined in Appendix B.
Actuary or Actuaries of the Benefits 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.
Aggregation Group	This term is specific to the Defined Benefit Pension Plan and is defined in Appendix E.
Allowable Charges	This term is specific to the Medical Plan and is defined in § 10.1.2.
Alternate Payee	This term is specific to the Defined Benefits Pension Plan and the Retirement Savings Plan and is defined in § 1.4.2.2.
Annual Maximum Compensation Amount	The maximum compensation amount at which certain income-based benefits will be based. Unless otherwise determined by the Board, the Annual Maximum Compensation Amount is the then current annual amount permitted for consideration for a qualified plan under Section 401(a)(17) of the Code.
Applied Behavior Analysis	This term is specific to the Medical Plan's Developmental Disability benefits and is defined in § 10.2.22.3.1.
Autism	This term is specific to the Medical Plan and is defined in § 10.2.22.2.2.
Benefit Commencement Date	The date as of which the first benefit is due to a Member under the terms of the Benefits Plan coverage option.
Benefits Plan	The official terms and conditions of "The Benefits Plan of the Presbyterian Church (U.S.A.)" adopted by the Board, as such terms may be amended from time to time.
Board	The Board of Pensions of the Presbyterian Church (U.S.A.), a Pennsylvania nonprofit corporation.
Carrier	This term is specific to the Dental Plan and is defined in § 12.2.2.
Case Management	This term is specific to the Medical Plan and is defined in § 10.2.22.2.3.
Cerebral Palsy	This term is specific to the Medical Plan and is defined in § 10.2.22.2.4.

Defined Term	*Meaning*
Children (or Child)	A Member's natural children, legally adopted children, stepchildren, or related children under legal custody.
Church	The Presbyterian Church (U.S.A.)
Code	The Internal Revenue Code of 1986
Congregation	A formally organized community chartered and recognized by a Presbytery.
Congregational Pastoral Leader	A Minister or Commissioned Pastor employed by a Congregation and sanctioned by the Presbytery.
Congregational Pastors Package	The Benefits Plan offering that a Congregation must provide to Installed Pastors and may provide to any other Congregational Pastoral Leaders that includes, on a non-contributory basis, the Defined Benefits Pension Plan, Death and Disability Plan, Temporary Disability Plan, and Medical Plan PPO (Member only) coverage and, on a non-contributory or contributory basis at the Congregation's election, enrollment in the Retirement Savings Plan (§ 5), Dental Plan (§ 12), and Vision Eyewear Plan (§ 13). Optionally, with this package, a Congregation may offer Medical Plan PPO coverage for Eligible Family members on a non-contributory or contributory basis. The Congregational Pastors Package is priced as described in Appendix A.
Cosmetic Procedure	This term is specific to the Medical Plan and is defined in § 10.3.2.4.
Covenant Package	The Benefits Plan offering that an Eligible Employer may opt to provide to Eligible Employees, which, if elected by an Eligible Employer, includes, on a non-contributory basis, the Defined Benefit Pension Plan, Death and Disability Plan, Temporary Disability Plan, and Employee Assistance Plan. The Covenant Package is priced as described in Appendix A. An Eligible Employer may also offer, in addition to the Covenant Package benefits, on a non-contributory or contributory basis at the Eligible Employer's election, participation in the Retirement Savings Plan (§ 5), Medical Plan, Dental Plan (§ 12), and Vision Eyewear Plan (§ 13). The pricing for any additional offerings is as described in Appendix A.
Covered Benefit Amount	This term is specific to the Term Life and Accidental Death and Dismemberment Plan and is defined in § 7.2.3.
Covered Loss	This term is specific to the Term Life and Accidental Death and Dismemberment Plan and is defined in § 7.2.4.
Covered Person	A Member, Spouse, and their eligible Children and a Surviving Spouse, provided that each individual is enrolled in the Benefits Plan and the dues required for their coverage, if any, are not delinquent.
Custodial Care	This term is specific to the Medical Plan and is defined in § 10.1.3.

Defined Term	*Meaning*
Death and Disability Plan	The Benefits Plan offering of certain death and disability benefits described in § 6.
Defined Benefit Pension Plan	The Benefits Plan offering of defined benefit Pension Benefits, including survivor's Pension Benefits, described in § 4.
Dentist	This term is specific to the Dental Plan and is defined in § 12.2.1.
Dependent	When used in the Benefits Plan offerings, Dependent means an individual 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 Child under the Medical Plan, the support requirement is only applicable in the case of extended coverage for an adult Child age 26 or older who is Totally Disabled.
Determination Date	This term is specific to the Defined Benefits Pension Plan and is defined in Appendix E.
Developmental Disability	This term is specific to the Medical Plan and is defined in § 10.2.22.2.5.
Disability (or Disabled)	This term is specific to the Death and Disability Plan and is defined in § 6.9.2.
Disability Benefits	The benefits payable to a Disabled Member under the Death and Disability Plan.
Disability Benefits Basis	The amount upon which Death and Disability Plan benefits will be based, specifically, the greater of (i) Effective Salary as reported to the Board or (ii) the Median Effective Salary as of the Benefit Commencement Date, but no more than the Annual Maximum Compensation Amount.
Disability Benefits Increase	This term is specific to Death and Disability Plan and is defined in § 6.9.7.
Disabled Member	A Member who is Disabled and enrolled in the Death and Disability Plan.
Effective Date	January 1, 2025
Effective Salary	The total compensation received by a Member and reported to the Board by the Eligible Employer during a Plan Year, including, but not limited to, any sums paid as a Housing Allowance (including utilities and furnishings). Effective Salary includes (1) any deferred compensation (funded or unfunded) credited to or contributed on account of a Member by an Eligible Employer during a Plan Year, with the exception of any amounts contributed as an Eligible Employer contribution to the Retirement Savings Plan under a matching contribution program that is available to at least all employees of the Eligible Employer in the same employment classification, and (2) any salary reduction contributions to a plan or other arrangement providing a tax-favored benefit. Effective Salary does not include amounts received for reimbursement of professional

Defined Term	*Meaning*
	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 will be at least thirty percent (30%) of all other compensation described above; if no Manse is provided, the amount will be the actual Housing Allowance. For a Minister Member serving in concurrent multiple Eligible Services, for purposes of benefit accruals and the allocation of dues, Effective Salary is the aggregate of the compensation reported to the Board by each Eligible Employer for purposes of benefit accruals and the allocation of dues. The allocation of dues between the Eligible Employers and the designation of the Eligible Employer responsible for the Employer Agreement and dues remittance must be approved by the Board.
Eligible Employees	Individuals employed by Eligible Employers who satisfy (1) the eligibility requirements established by the Eligible Employer as reported in the Employer Agreement and (2) any eligibility requirement of the Board as specified in a Benefits Plan offering.
Eligible Employers	This term applies to all employers eligible to offer the Benefits Plan to its Eligible Employees as further defined in § 2.1.
Eligible Family	A Spouse (including a Surviving Spouse and former Spouse where applicable) and all Children enrolled in a Benefits Plan offering.
Eligible Life Change Event	Eligible life change events include: (i) birth, adoption, or the legal custody of a Child; (ii) marriage, (iii) divorce or legal separation, (iv) entitlement to Medicare for the Member or Spouse; (v) loss of other medical coverage for Member or Eligible Family members; (vi) Eligible Employer change in coverage for Member or Eligible Family member; or (vii) any other life change events as required by law.
Eligible Service	Employment by the Church, or any board, agency, Congregation, fellowship or other organization under the jurisdiction of or associated with the Church; any employment approved by the General Assembly or a Presbytery of the Church; employment by an organization eligible for participation in the Benefits Plan under § 2.2; or any validated service of a Minister, regardless of the source of such Minister's compensation or employer.
Emergency Services	This term is specific to the Medical Plan and is defined in § 10.1.4.
Employee Assistance Plan (or EAP)	The Benefits Plan offering of counselling and support benefits to Eligible Employers and Eligible Employees as described in § 14.
Employer Agreement	The form that an Eligible Employer must complete and submit to the Board to enroll Eligible Employees for coverage in the Benefits Plan. In the Employer Agreement, the Eligible Employer designates its eligible

Defined Term	*Meaning*
	employment classifications, coverage elections for each class, contribution requirements for employees (if any and where permitted), and other participation terms elected by the Eligible Employer and for which the Eligible Employer agrees to remit the requisite dues.
Exclusive Provider Organization (EPO)	This term is specific to the Medical Plan and is defined in § 10.15.
Fixed Benefit Amount	This term is specific to the Term Life and Accidental Death and Dismemberment Plan and is defined in § 7.3.1.
Former Plans	The former United Presbyterian Pension and Benefits Plan, and Ministers' Annuity Fund and Employees' Annuity Fund of the Presbyterian Church in the United States.
Full Amount	This term is specific to the Term Life and Accidental Death and Dismemberment Plan and is defined in § 7.2.5.
Habilitation	This term is specific to the Medical Plan's Developmental Disability benefits and is defined in § 10.2.22.2.6.
Health Insurance Portability and Accountability Act (HIPAA)	This term is specific to the Medical Plan and is defined in § 10.9.
Health Plan	This term is specific to the Medical Plan and is defined in § 10.12.2.
High Deductible Health Plan (HDHP)	This term is specific to the Medical Plan and is defined in § 10.16.
Housing Allowance	An amount provided by the Eligible Employer of a Minister (in-kind or in cash) for the reasonable living expenses of the Minister. Housing Allowances may be excluded from federal income tax by the Minister as set forth in § 105 of the Code.
Income-Based Benefit Amount	This term is specific to the Long-Term Disability Plan and is defined in § 7.3.2.
Injury	This term is specific to the Term Life and Accidental Death and Dismemberment Plan and is defined in § 7.2.6.
Installed Pastor	A Minister who is serving in an installed pastoral relationship with a Congregation as defined in § G-2.0504a of the *Book of Order* of the Church.
Intellectual Disability	This term is specific to the Medical Plan's Developmental Disability benefits and is defined in § 10.2.22.2.7.
Intoxicated	This term is specific to the Term Life and Accidental Death and Dismemberment Plan and is defined in § 7.2.7.

Defined Term	*Meaning*
Key Employee	This term is specific to the Defined Benefits Pension Plan and is defined in Appendix E.
Key Employee Ratio	This term is specific to Defined Benefits Pension Plan and is defined in Appendix E.
Living Needs Benefit	This term is specific to the Death and Disability Plan and is defined in § 6.5.
Long-Term Disability (or Long-Term Disabled)	This term is specific to Long-Term Disability Plan and is defined in § 9.2.1.
Long-Term Disability Benefits Basis	The amount upon which Long-Term Disability Plan benefits will be based, specifically, an amount equal to seventy percent (70%) of the Member's salary as reported to the Board but no more than the Annual Maximum Compensation Amount.
Long-Term Disability Benefits Commencement Date	This term is specific to Long-Term Disability Plan and is defined in § 9.2.2.
Loss of a Foot	This term is specific to the Term Life and Accidental Death and Dismemberment Plan and is defined in § 7.2.8.
Loss of a Hand	This term is specific to the Term Life and Accidental Death and Dismemberment Plan and is defined in § 7.2.9.
Loss of Hearing	This term is specific to the Term Life and Accidental Death and Dismemberment Plan and is defined in § 7.2.10.
Loss of Sight	This term is specific to the Term Life and Accidental Death and Dismemberment Plan and is defined in § 7.2.11.
Loss of Speech	This term is specific to the Term Life and Accidental Death and Dismemberment Plan and is defined in § 7.2.12.
Loss of Thumb and Index Finger	This term is specific to the Term Life and Accidental Death and Dismemberment Plan and is defined in § 7.2.13.
Manse	Housing, which may include rental or other living accommodation that is furnished to a Minister by an Eligible Employer without charge to the Member.
Median Effective Salary	The annual Median Effective Salary of Ministers serving Congregations of the Church and enrolled in Benefits Plan coverage for the immediately preceding Plan Year as the same may be determined by the Board from time to time. When applicable, benefits for a Member based on a Median Effective Salary will be reduced proportionally using the following ratio: the number of hours of employment of the Member during such Plan Year

Defined Term	*Meaning*
	that are fewer than one thousand eight hundred twenty (1,820) hours compared to one thousand eight hundred twenty (1,820) hours.
Medical Continuation	This term is specific to the Medical Plan and is defined in § 10.1.6.
Medical Plan	Refers to § 10 of the Benefits Plan, which collectively describes the coverage options and benefits covered under the Active Medical and Medical Continuation benefits.
Medical Plan Coverage Options	The Medical Plan's coverage options, including the PPO, EPO and HDHP. This term is specific to the Medical Plan and is further defined in §§ 10.1.5 and 10.3.
Medically Necessary	This term is specific to the Medical Plan and is defined in § 10.1.7 and § 10.2.22.2.8.
Medicare Advantage Group PPO	The Benefits Plan Medical Plan Coverage Option that an Eligible Employer may offer to certain Members and their Eligible Families, who are enrolled in Medicare coverage. This term is specific to the Medical Plan and is further defined in § 10.1.8.
Member	An individual who is (i) currently enrolled in the Benefits Plan, (ii) a Terminated Vested Member of the Defined Benefit Pension Plan, (iii) a Participant of the Retirement Savings Plan; (iv) receiving benefits for a disability under the Death and Disability Plan, Long-Term Disability Plan or Temporary Disability Plan, or (v) a Retired Pensioner.
Minister	A Minister of the Word and Sacrament (sometimes referred to as a teaching elder), who is an ordained minister of the Church, as defined in G-2.0501 of the *Book of Order* of the Church.
Minister Member	A Minister who is a Member of the Benefits Plan.
Ministers Bridge Coverage	The coverage available to a Minister Member who is eligible for Benefits Plan coverage following a change in employment status in accordance with § 3.1.1.
Network Area	This term is specific to the Medical Plan and is defined in § 10.1.9.
Network Medical Costs	This term is specific to the Medical Plan and is defined in § 10.1.10.
Network Provider	This term is specific to the Medical Plan and is defined in § 10.1.11.
Non-Key Employee	This term is specific to the Defined Benefit Pension Plan and is defined in Appendix E.
Non-Network Area	This term is specific to the Medical Plan and is defined in § 10.1.12.
Non-Network Medical Costs	This term is specific to the Medical Plan and is defined in § 10.1.13.
Non-Network Provider	This term is specific to the Medical Plan and is defined in § 10.1.14.

Defined Term	*Meaning*
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
Pastor's Participation	Pastor's Participation coverage offered by the Benefits Plan prior to January 1, 2025, which included a specific package of benefits an Eligible Employer may provide to Minister Members for non-contributory participation in the Defined Benefit Pension Plan, Death and Disability, Temporary Disability and Medical PPO full family coverage. Beginning January 1, 2025, Transitional Pastor's Participation replaced this coverage offering.
Pension Benefit	A monthly payment based on the total amount of Pension Credits accrued by the Member in the Defined Benefit Pension Plan. The monthly amount may be adjusted based on the payment option elected by the Member, as described in §§ 4.5 through 4.9.
Pension Coverage	Enrollment of a Member in the Defined Benefit Pension Plan (§ 4).
Pension Credits	This term is specific to the Defined Benefit Pension Plan and is defined in § 4.1. Under the Normal Retirement Benefit, each Pension Credit accrued by a Member is equal to One Dollar ($1.00) in annual Pension Benefits.
Pension Participation Basis	The amount upon which Pension Credits will be accrued in the Defined Benefits Pension Plan, specifically, the greater of (i) Effective Salary as reported to the Board or (ii) twenty-five percent (25%) of the Median Effective Salary, but no more than the Annual Maximum Compensation Amount.
Plan Allowance	This term is specific to the Medical Plan and is defined in § 10.1.2.
Plan Year	A consecutive twelve (12)-month period commencing January 1 and terminating December 31
Post-Normal Retirement	The commencement of Defined Benefit Pension Plan benefits by a Member on a date subsequent to the Member's Normal Retirement Date.
Post-Retirement Service	This term is defined in § 4.13.
Preferred Provider Organization (PPO)	This term is specific to the Medical Plan and is defined in § 10.14.
Presbytery	The council serving as a corporate expression of the Church within a certain district and composed of all the Congregations and Ministers in that district as defined in § G-3.0307 of the *Book of Order*.
Prescription Drug Benefit	This term is specific to the Medical Plan and is defined in § 10.1.17.
Protected Health Information	Individually identifiable health information protected by HIPAA. This term is specific to the Medical Plan and is defined in § 10.9.

Defined Term	*Meaning*
Qualified Domestic Partner	An individual who is in a legally sanctioned same-gender union other than a marriage (such as a state-licensed civil union or state-licensed domestic partnership) with a Member affording rights of inheritance under the laws of the jurisdiction where the union occurred. A Qualified Domestic Partner enrolled by a Member for benefits coverage during the period January 1, 2013, through December 31, 2016, based on a state-licensed civil union or state-licensed domestic partnership with the Member (and not a marriage under state law) will be deemed a "Spouse" under the Benefits Plan and may continue to be enrolled in benefits coverage as a Spouse of the Member on and after January 1, 2017, for the duration of that relationship. Effective January 1, 2021, upon approval of the Board, in its sole discretion, and subject to eligibility requirements established by the Board, an Eligible Employer may offer coverage under the Benefits Plan's Health and Wellness Plans (§§ 10-13) to an individual who is in a domestic partnership (opposite or same sex) with a Member. Any domestic partner enrolled in the Medical, Retiree Medical, Dental, and Vision Plans under this provision will be deemed a "Spouse" and, with their Children, an "Eligible Family" solely for purposes of administration of the Health and Wellness Plans.
Required Beginning Date	The date by which a Member with accrued vested Pension Credits in the Defined Benefits Pension Plan or an account balance in the Retirement Savings Plan, or such Member's surviving Spouse or eligible beneficiary, must begin retirement Pension Benefits under the Defined Benefit Pension Plan or distributions under the Retirement Savings Plan under Code section 401(a)(9)(c) to avoid federal income tax penalties.
Retired Pensioner	A Member who has initiated retirement benefits under the Defined Benefit Pension Plan.
Retirement Savings Plan	Defined in Code § 403(b)(9) as a defined contribution retirement income account plan and more fully described in § 5, permitting elective deferrals and employer and matching contributions.
Shared Ministry (Ministries)	A Minister's employment approved by the Presbytery involving employment by two or more Congregations as a Congregational Pastoral Leader for each Congregation. The Effective Salary for a Congregational Pastoral Leader serving in a Shared Ministry is the aggregate of all compensation received from the Congregations being served.
Sickness	This term is specific to the Term Life and Accidental Death and Dismemberment Plan and is defined in § 7.2.14.
Specialized Therapies	This term is specific to the Medical Plan and is defined in § 10.2.22.2.9.
Spina Bifida	This term is specific to the Medical Plan and is defined in § 10.2.22.2.10.
Spouse	An individual who is legally married to a Member. A Qualified Domestic Partner enrolled by a Member for benefits as a covered partner during the

Defined Term	*Meaning*
	period January 1, 2013, through December 31, 2016, based on a state-licensed civil union or state-licensed domestic partnership with the Member will be deemed to be a Spouse under the Benefits Plan and may continue to be enrolled in benefits coverage and qualify for spousal benefits on and after January 1, 2017.
Super Top-Heavy Plan	This term is specific to the Defined Benefit Pension Plan and is defined in Appendix E.
Surviving Spouse	The Spouse of a Member on the date of a Member's death who survives the death of the Member.
Temporary Disability (or Temporarily Disabled)	This term is specific to the Temporary Disability Plan and is defined in § 8.2.
Temporary Disability Benefits Basis	The amount upon which Temporary Disability Plan benefits will be based, specifically, the Effective Salary or salary as reported by the Eligible Employer to the Board, capped at the Annual Maximum Compensation Amount.
Term Life and Accidental Death and Dismemberment Plan	The Benefits Plan offering of life, accidental death, and dismemberment benefits described in § 7.
Terminated Vested Member	An individual with accrued vested Pension Credits who is not an Active Member, a Disabled Member, or a Retired Pensioner.
Top-Heavy Compensation	This term is specific to the Defined Benefit Pension Plan and is defined in Appendix E.
Top-Heavy Plan	This term is specific to the Defined Benefit Pension Plan and is defined in Appendix E.
Totally Disabled	A physical, emotional, or mental condition which, in the sole opinion of the Board or its designated medical counsel, so seriously impairs an individual that the individual is unable to live independently, even in a supportive environment.
Transitional Pastor's Participation	Transitional Pastor's Participation coverage includes a specific package of benefits an Eligible Employer may provide to Minister Members that includes non-contributory participation in the Defined Benefit Pension Plan, Death and Disability Plan, Temporary Disability Plan, and Medical Plan PPO full family coverage, and, on a non-contributory or contributory basis, enrollment in the Retirement Savings Plan (§ 5), Dental Plan (§ 12), and Vision Eyewear Plan (§ 13). In Plan Years 2025 through 2027, an Eligible Employer may continue to enroll a Minister Member in Transitional Pastor's Participation, provided that such Minister Member was enrolled by that Eligible Employer in Pastor's Participation in Plan Year 2024. Dues for Transitional Pastor's Participation are priced as a

Defined Term	*Meaning*
	percent of Effective Salary for Plan Year 2025 as described in Appendix A.
U.S. Department of Health and Human Services (HHS)	This term is specific to the Medical Plan and is defined in § 10.12.2.1.
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 in the Benefits Plan.
Year of Top-Heavy Service	This term is specific to the Defined Benefit Pension Plan and is defined in Appendix E.
Years of Service	This term is specific to the Defined Benefit Pension Plan and is defined in § 4.2.1.

2 Eligibility and Enrollment

2.1 Eligible Employers

Congregations, employers controlled by or associated with the Church, and employers of Ministers engaged in the exercise of ministry validated by the Church, regardless of the source of the Minister's compensation for such ministry, may participate in the Benefits Plan by entering into an Employer Agreement with the Board. An employer that is neither a Congregation nor an organization controlled by or associated with the Church may only enroll Minister Members for Benefits Plan coverage. A Minister Member who is self-employed in the exercise of ministry will be considered the employer for purposes of enrolling the Minister for coverage and will enter into an Employer Agreement as the employer with the Board to elect coverage under the Benefits Plan.

2.2 Eligible Individuals

2.2.1 *Employees*. An Eligible Employer's Employer Agreement will specify the employee classifications that the Eligible Employer determines are eligible for enrollment for benefits coverage under the Benefits Plan, subject to the eligibility requirements of each plan. To be eligible for enrollment, employees must (i) have commenced employment and started job responsibilities, (ii) be normally scheduled to work at least twenty (20) hours per week or one thousand (1,000) hours per year in Eligible Service, and (iii) satisfy any Eligible Employer eligibility requirement, subject to the following exceptions.

2.2.1.1 The twenty (20) hour per week or one thousand (1,000) hours a year in Eligible Service requirement does not apply for participation in the Retirement Savings, Dental, Vision Eyewear, or Employee Assistance Plans.

2.2.1.2 Minister Members serving in installed positions at Congregations and subject to § G-2.0804 of the *Book of Order* of the Church are not

subject to the minimum twenty (20) hour per week or one thousand (1,000) hours a year in Eligible Service requirement.

2.2.2 *Self-Employed Ministers*. A Minister working in the exercise of ministry in self-employed service validated under § G-2.0503a of the *Book of Order* of the Church is eligible to participate in the Benefits Plan, provided that the Minister enters into an Employer Agreement as the Eligible Employer with the Board under § 2.1. The minimum twenty (20) hour per week or one thousand (1,000) hours a year in Eligible Service requirement for participation in the Medical Plan will not apply to self-employed Minister Members.

2.2.3 *Members Leaving Active Service*.

2.2.3.1 Members enrolled in the Medical Plan may enroll to continue medical coverage in the Medical Continuation Plan.

2.2.3.2 Minister Members enrolled in Congregational Pastors Package, Transitional Pastor's Participation, or Covenant Package who are, in the sole determination of the Board, temporarily unemployed or on an approved leave of absence, may enroll for Ministers Bridge Coverage to continue all or some of the Benefits Plan offerings, at the Minister Member's own cost, but only to the extent the Minister Member was enrolled in such benefits coverage immediately prior to the change in employment status. A Minister Member may enroll for such period as may be determined by the Board. Ministers Bridge Coverage will only include Transitional Pastor's Participation through Plan Year 2027.

2.2.4 *Seminarians*. Subject to the Medical Plan's enrollment requirements for seminarians, a seminary student who is an inquirer or candidate for ordination in the Church may enroll in Medical Plan coverage under § 10 while enrolled in study and upon payment of the applicable dues listed in Appendix A.

2.3 Employer Coverage Election Options

An Eligible Employer may elect to offer all Eligible Employees, or classifications of its employees, the opportunity to be enrolled in all or some of the Benefits Plan offerings by designating in the Employer Agreement its eligibility requirements, coverage enrollment options, and contribution requirements, if any.

The Benefits Plan includes the following Benefit Plan offerings for an Eligible Employer to elect for their Eligible Employees:

2.3.1 Retirement Plans

2.3.1.1 Defined Benefit Pension Plan

2.3.1.2 Retirement Savings Plan

2.3.2 Death, Disability & Life Plans

2.3.2.1 Death and Disability Plan

2.3.2.2 Term Life and Accidental Death and Dismemberment Plan

2.3.2.3 Temporary Disability Plan

2.3.2.4 Long-Term Disability Plan

2.3.3 Health & Wellness Plans

2.3.3.1 Active Medical Plan

2.3.3.1.1 Preferred Provider Organization (PPO)

2.3.3.1.2 Exclusive Provider Organization (EPO)

2.3.3.1.3 High Deductible Health Plan (HDHP)

2.3.3.1.4 Medicare Advantage Group PPO

2.3.3.2 Post-Retirement Medical Plan

2.3.3.2.1 Pre-Medicare Extended Continuation

2.3.3.2.2 Medicare Advantage Group PPO

2.3.3.3 Dental Plan

2.3.3.4 Vision Eyewear Plan

2.3.3.5 Employee Assistance Plan

2.4 Employer Enrollment Responsibilities

2.4.1 *Employer Agreement*. To enroll employees in coverage under the Benefits Plan, an Eligible Employer must:

2.4.1.1 Complete an Employer Agreement selecting the plan options, designating the employee classifications eligible for enrollment in such options and specifying any required employee contributions for the dues if the employee enrolls for such coverage, which Agreement must be accepted by the Board as being complete and submitted within the time period specified;

2.4.1.2 Cause its Eligible Employees to enroll in coverage within the time periods specified under § 2.4.2, and

2.4.1.3 Pay all dues required by § 3.

2.4.2 *Dues Pricing Packages*. Eligible Employers may elect in their Employer Agreement one or more dues pricing packages for their Benefits Plan offerings to certain employment classifications, including the Congregational Pastors Package and the Covenant Package. Appendix A sets forth the pricing of the available benefits packages.

2.4.3 *Transitional Pastor's Participation*. In Plan Years 2025 through 2027, an Eligible Employer may continue to enroll a Minister Member in Transitional Pastor's Participation, provided that such Minister Member was enrolled by that Eligible Employer in Pastor's Participation in Plan Year 2024. Appendix A sets forth the minimum pricing of the Transitional Pastor's Participation for Plan Year 2025.

2.4.4 *Shared Ministry*. For a Minister Member serving in a Shared Ministry arrangement, the Eligible Employers of the Minister Member must designate one of the Eligible Employers as the party responsible for the Minister Member's Benefits Plan enrollment and such Eligible Employer must report the coverage elected for the Minister and the allocation of dues between the Eligible Employers in its Employer Agreement.

2.4.5 *Dual Enrollment*. A Minister Member in one or more Eligible Services may not be enrolled in any of Transitional Pastor's Participation, Congregational Pastors Package, or the Covenant Package at the same time.

2.4.6 *Employment Classification*. An Eligible Employer must offer each member of a designated employment classification enrollment on the same terms and conditions as each other member of that employment classification. Any employment classification established by an Eligible Employer for purposes of Benefits Plan participation should be based on reasonable job classifications and be non-discriminatory under applicable law.

2.4.7 *Reporting Changes*. An Eligible Employer has the obligation to report any Effective Salary, salary, or other changes in the status of any Eligible Employee reported on its Employer Agreement no later than thirty (30) days of the effective date of the change.

2.5 Employee Enrollment.

Employees may enroll in the Benefits Plan coverage options selected by their Eligible Employer in its Employer Agreement: (1) within thirty (30) days of commencement of employment upon initial employment or reemployment with the Eligible Employer, or the initial benefit eligibility date established by the Eligible Employer (if later), and the coverage will be effective as of the later of the first date of employment, reemployment, or eligibility, or (2) during any annual enrollment period offered by the Board and the coverage will be effective as of January 1 of the next Plan Year. An Eligible Employee who is also a Spouse or Child of a Member may not enroll in concurrent coverage in the Medical Plan if already enrolled in the Medical Plan as a Spouse or Child of the other Member.

2.5.1 Coverage will commence for any benefits elected by an employee effective as of the later of (i) the date the employee commences eligible employment, (ii) the expiration of any Eligible Employer waiting period after the employee becomes eligible for the coverage, or (iii) January 1 of the year for which the Eligible Employer first elected to offer the coverage to the employee's employment classification. Any waiting period for initial benefit eligibility established by an Eligible Employer must apply to an employee's eligibility for all coverage under the Benefits Plan, be applicable to all employee classifications, and may not exceed any limit established by applicable law.

2.5.2 An employee may enroll in or change a plan election within sixty (60) days of becoming eligible for any special enrollment period as a result of an Eligible Life Change Event and the change in coverage will commence as of the date of the life change event.

2.6 Termination of Enrollment

2.6.1 An Eligible Employer may establish, modify, or terminate the Benefits Plan coverage it has selected for its employees, or classifications thereof, annually by completing a new Employer Agreement, and such changes will be effective as of January 1 of the next Plan Year.

2.6.2 An Eligible Employer may terminate enrollment of its employees in all or some of the Benefits Plan offerings at the end of the calendar year by terminating such coverage in the Employer Agreement for the next Plan Year.

2.6.3 The Board may terminate an employer's participation in the Benefits Plan as an Eligible Employer on account of a dues delinquency. In such event, each Active Member's benefits coverage will also terminate.

2.6.4 An Active Member's coverage, and the Eligible Employer's obligation to pay dues for such coverage, will terminate as of the last day of the month in which the Member's Eligible Service terminates for that Eligible Employer.

2.6.4.1 The Eligible Employer will report an Active Member's termination of employment to the Board before, on or immediately following the Member's termination of Eligible Service with the Eligible Employer.

2.6.4.2 Failure to report a Member's termination of employment on a timely basis may result in the Eligible Employer's continued responsibility to pay dues for the terminated employee for the period between the termination of employment and the notice to the Board.

2.6.4.3 In the case of a Minister Member enrolled in Transitional Pastor's Participation or Congregational Pastors Package, the Eligible Employer's obligation to pay dues and the Member's coverage for the Defined Benefit Pension Plan, Death and

Disability Plan, Dental Plan, and Vision Eyewear Plan coverage will terminate the last day of the month in which the Minister's service for the Eligible Employer terminated. A Minister Member's coverage under the Medical Plan will continue until the last day of the month following the month in which such Minister's employment terminated and the Eligible Employer's obligation to pay dues for such coverage will terminate on the last day of the month in which the Minister's service for the Eligible Employer terminated.

2.6.4.4 In the case of a Member enrolled in the Death and Disability Plan, where employment terminates due to the Member's death, Medical Plan coverage for the Spouse and Eligible Children of the Member may continue without the obligation to pay dues under § 6.5 for a period of one (1) year.

2.6.5 Employees may change or terminate their Benefits Plan coverage elections only (i) during any annual enrollment period offered by the Board with such change to be effective as of January 1, or (ii) within sixty (60) days of becoming eligible for a special enrollment period as a result of an Eligible Life Change Event with such enrollment election change to be effective as of the date of the Eligible Life Change Event.

3 Dues

3.1 Required Dues.

The Board, in its sole discretion, sets the dues for each plan separately. Except as otherwise provided below, the Eligible Employer is responsible for remitting to the Board all required dues for each employee's enrollment in plan options, including any employee contributions required by the Eligible Employer. When employee contributions are permitted, an Eligible Employer may elect to impose employee contributions on all or an employment classification of its employees, subject to any limits established by the Board or required by law. Appendix A sets forth the dues established by the Board for each Benefits Plan offering and certain pricing packages available to Eligible Employers.

3.1.1 *Ministers Bridge Coverage*. A Minister Member enrolled in Ministers Bridge Coverage may elect to pay dues based on either the Member's most recent Effective Salary or the Median Effective Salary, and the coverage provided will be based on the same.

3.1.2 *Dues Reductions*. The Board, in its sole discretion, may offer targeted dues reductions or waivers of dues for the purpose of encouraging employers to offer coverage under the Benefits Plan to employees or classifications of employees.

3.1.3 *Post-Retirement Dues*. An Eligible Employer will be assessed dues in the amount set forth in Appendix A for any Retired Pensioner employed by such Eligible Employer and approved for Post-Retirement Service.

3.2 Payment of Dues

The required dues will be remitted to the Board by (a) the Eligible Employer of the Member, (b) the Minister Member if personally remitting dues as a self-employed minister or enrollment in Ministers Bridge Coverage, or (c) the Member or Covered Person for Medical Continuation and Post-Retirement Medical Plan coverage, in equal monthly installments in advance or at such other time or times as may be specified by the Board. The Board reserves the right to terminate or suspend the benefits entitlement or coverage of any Covered Person for whom dues payments are delinquent. Dues are delinquent if on a monthly billing basis, they are not paid in full by the end of the last business day of the month.

3.3 Late Charge.

A dues payment will be considered delinquent if it is not made by the last business day of the period designated by the Board for payment of dues. An additional fee or charge for loss of interest earnings and additional administrative costs of collection will 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.

BENEFITS PLAN OFFERINGS

RETIREMENT PLANS

4 Defined Benefit Pension Plan

In addition to the applicable terms and conditions set forth in §§ 1 through 3 of this Benefits Plan, the following provisions apply to the Defined Benefit Pension Plan only.

4.1 Accrual of Pension Credits

For each Plan Year, or part thereof, during which a Member is enrolled in the Defined Benefit Pension Plan, such Member will accrue Pension Credits equal to the greater of one and one-quarter percent (1¼%) of:

4.1.1 the Member's Pension Participation Basis for that year; or

4.1.2 the annual Median Effective Salary. Pension Credits accrued under this § 4.1.2 will be reduced proportionally to the same ratio that the number of hours of employment of the Member during the Plan Year, which are fewer than one thousand eight hundred twenty (1,820) hours bears to one thousand eight hundred twenty (1,820) hours.

4.1.3 Members participating in the Defined Benefit Pension Plan under the Ministers Bridge Coverage option of § 3.1.1 will accrue Pension Credits on the same basis on which they are paying dues for Pension Coverage. No credits will accrue to a Member for whom dues are not paid in full or who is not enrolled in Pension Coverage.

4.2 Vesting of Pension Benefits

An Active Member or Disabled Member will become fully vested in the benefits provided by the Defined Benefit 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 Defined Benefit Pension Plan, or (d) discontinuance of their Eligible Employer's participation in the Defined Benefit Pension Plan for such Member's employment classification. After completing three (3) Years of Service, a Member will be fully vested and eligible to receive all benefits to which he or she may be entitled by the terms of the Defined Benefit Pension Plan, to the extent of their accrued Pension Credits.

4.2.1 *Years of Service*. For purposes of this Section 4, the term "Years of Service" will 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, provided that the seminarian becomes a Minister.

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

4.2.3 *Period of Service*. In determining a Member's vested status under the Defined Benefit Pension Plan, all Years of Service will be considered.

4.2.4 *Commencement of Period of Service*. A period of service for purposes of calculating a person's Years of Service will commence on the date a person is first employed in Eligible Service.

4.2.5 T*ermination of Period of Service*. Except for a Disabled Member or a Minister Member enrolled in Ministers Bridge Coverage, a period of service for purposes of calculating a person's Years of Service will end upon termination of enrollment as an Active Member in the Defined Benefit Pension Plan.

4.3 Experience Apportionments.

Based on the funded status of the Defined Benefit Pension Plan, the Board, acting in its sole discretion, may increase 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 will 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 will 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 C.

4.4 Normal Retirement.

A Member of the Defined Benefit Pension Plan will be entitled to initiate annual retirement benefits, payable monthly in an amount equal to 1/12 of such Member's Pension Benefit based on the Member's accrued Pension Credits, provided that such Member has:

4.4.1 attained age sixty-five (65);

4.4.2 terminated employment with their most recent Eligible Service; and

4.4.3 completed the Board's application for retirement benefits, which application has been accepted by the Board as being complete and evidencing entitlement to retirement Pension Benefits.

4.5 Early Retirement Options

A vested Member who satisfies § 4.4.2 and § 4.4.3 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:

4.5.1 *Standard Early Retirement*. Under this option, the amount of the annual pension beginning as of the Benefit Commencement Date will be adjusted as of the Member's early retirement Benefit Commencement Date on the basis of the Early Retirement Option Factors listed in Appendix B or on such other basis as may have been applicable to Pension Credits accrued prior to December 31, 1986.

4.5.2 *Level Income Basis Early Retirement*. A vested Member in the Defined Benefit 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 § 4.8, may elect to initiate early retirement benefits on a level income basis, payable monthly.

4.5.2.1 Under this option, the amount of the annual early retirement benefit (calculated in accordance with § 4.5.1, above) payable beginning as of the Member's Benefit Commencement Date until the Member attains age sixty-two (62) will 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 will be decreased on the basis of the Social Security Leveling Option Factors listed in Appendix B. The adjusted early retirement benefit initially payable under this § 4.5.2 will be approximately equal to the aggregate of: (i) the Member's estimated Social Security primary insurance amount if commenced at age sixty-two (62), calculated on the basis of the provisions of the federal Social Security Act in effect at the date of early retirement (the "Estimated Social Security Benefit"), and (ii) the Member's adjusted early retirement benefit payable at age sixty-two (62) under the benefit option selected by the Member under § 8.2 and § 8.4 of the Defined Benefit Pension Plan.

4.5.2.2 Upon attaining age sixty-two (62), the Member's annual early retirement benefit will be reduced by the amount of the Estimated Social Security Benefit. The survivor's pension payable under § 4.6 will not be affected by electing early retirement benefits on a level income basis under this § 4.5.2. 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.

4.6 Post-Normal Retirement Age Option

4.6.1 Under this option, a vested Member may defer commencement of their retirement Pension Benefits beyond the Normal Retirement Date but no later than the Required Beginning Date. The amount of the annual pension payable beginning on the Post-Normal Retirement Benefit Commencement Date will be adjusted as of the Member's Post-Normal Retirement Benefit Commencement Date for the deferred Benefit Commencement Date based on the Post-Normal Retirement Option Factors listed in Appendix B.

4.6.2 Upon the death of a Member who has elected to commence their retirement pension under this § 4.6, except to the extent an optional joint and survivor option was elected under § 4.8, the annual survivor's pension payable monthly under § 4.6 will 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 § 4.6 and dies prior to commencing benefits, the survivor's pension payable under § 4.6 will be equal to one-half (1/2) of the Pension Credits accrued by the Member as of the date of death and adjusted for the deferred Benefit Commencement Date (the date of death) based on the Post-Normal Retirement Option Factors set forth in Appendix B.

4.7 Survivor's Pension

4.7.1 Upon the death of a Retired Pensioner, except to the extent an optional form of benefit was elected under § 4.8 in lieu of the survivor's pension payable under this § 4.6, an annual survivor's pension will be payable monthly in the amount of one-half (1/2) of the annual Pension Credits accrued to such Member at the time of their death (or such other amount as appropriate under§ 4.6) to the survivors of such Member in one, and only one, of the classes set forth in § 4.9, below, in the order of numerical priority set forth therein.

4.7.2 Upon the death of a vested Member who dies prior to their Benefit Commencement Date who is survived by an eligible Surviving Spouse, an annual survivor's pension will 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 § 4.8 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 their death.

4.7.3 Upon the death of a vested Member who dies prior to their Benefit Commencement Date who is not survived by an eligible Surviving Spouse, an annual survivor's pension will be payable monthly in the amount of one-half (1/2) of the annual Pension Credits accrued to such Member at the time of their death (or such other amount as appropriate under § 4.6) to the survivors of such Member in one, and only one, of the classes set forth in § 4.9, below, in the order of numerical priority set forth therein.

4.7.4 Notwithstanding any provision of the Defined Benefit 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 will be entitled to any additional benefits under the Defined Benefit 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 Defined Benefit Pension Plan.

4.8 Joint and Survivor Options (Combined Retirement Pension and Survivor's Pension Benefits Options)

4.8.1 *Election of Joint and Survivor Coverage*. A Member with a Spouse who has attained age fifty-five (55) and whose marriage occurred at least one (1) year prior to their retirement Pension Benefit Commencement Date may elect one of the options set forth below, in substitution for both the retirement benefits described in § 4.4, § 4.5, or § 4.6 and the survivor's Pension Benefits described in § 4.6. An election is valid and effective when submitted to the Board and received and accepted as complete by the Board prior to the Member's Benefit Commencement Date.

4.8.2 *Joint and Survivor Benefit Options*. Based on the option elected, the combined retirement pension payable to a Member pursuant to § 4.4, § 4.5, or § 4.6, above, and survivor's pension payable to the Member's Surviving Spouse pursuant to § 4.6 will be adjusted based on the Joint and Survivor Option Factors listed in Appendix B. If a Member's Spouse predeceases the Member after the Benefit Commencement Date and the Member remarries and is in the marriage with the new Spouse for at least a year prior to the Member's death, the Spouse surviving the Member will be entitled to a survivor's Pension Benefit based on fifty percent (50%) of the Pension Credits accrued as of the date of the Member's death.

4.8.2.1 *Option I*. An adjusted retirement pension will 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 will be payable to such Member's Surviving Spouse for life.

4.8.2.2 *Option II*. An adjusted retirement pension will 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 will be payable to the survivor of them for life.

4.8.2.3 *Option III*. An adjusted retirement pension will 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 will be payable to the survivor of them for life.

4.8.2.4 *Option IV*. An adjusted retirement pension will 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 will be payable to the survivor of them for life.

4.8.3 *Effective Date of Election*. A Member's joint and survivor option election is effective as of their Benefit Commencement Date.

4.8.4 *Cancellation of Election*. A Member may cancel a joint and survivor option election at any time prior to the Member's Benefit Commencement Date. The Member must make any cancellation in writing on a form supplied by the Board, which cancellation must be accepted by the Board on or before the last date allowable for cancellation. A Member's joint and survivor option election will be canceled automatically upon the death of the Member's Spouse prior to the Member's Benefit Commencement Date.

4.9 Classes of Survivors

For purposes of §§ 4.7 and 4.8 above, unless otherwise assigned by court order pursuant to § 1.4.2, the survivor's pension will 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 will be paid among all living survivors in the next subsequent class, provided that the survivor met the conditions applicable to that class of survivor 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 Pension Benefit or (ii) at least one (1) year prior to the Member's death.

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

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

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

4.10 Small Benefit Distribution

4.10.1 *Mandatory Cashout*. Notwithstanding any other provision of the Defined Benefit Pension Plan, if the Actuarial Equivalent single-sum present value determined using the basis for single-sum factors described in Appendix B (the "Single-Sum Present Value") of a Terminated Vested Member's accrued Pension Credits is not greater than one thousand dollars ($1,000) and the Member has terminated service with their Eligible Service, the Board will distribute the Single-Sum Present Value of the accrued Pension Credits in a single lump-sum.

4.10.2 *Voluntary Cashout*. With the irrevocable consent of the Member, the Board may distribute the Single-Sum Present Value of a Terminated Vested Member's accrued Pension Credits in a lump-sum distribution if such value is not more than five thousand dollars ($5,000) and the Member has terminated their Eligible Service.

4.10.3 *Lump-Sum Distribution*. Any lump-sum distribution paid under § 4.10.1 and § 4.10.2 will be made as soon as practicable after termination of service with the Member's Eligible Service employer. Upon payment of a Single-Sum Present Value lump-sum under § 4.10.1 or § 4.10.2, neither the Member nor their eligible survivors will be entitled to any further benefits under the Defined Benefit Pension Plan or Death and Disability Plan.

4.10.4 *Small Pension or Survivor's Pension Settlement*.

4.10.4.1 Where the amount of a given monthly pension payment to a person under this § 4 is less than an amount that the Board may fix from time to time as being large enough to administer effectively, the Board may, with the consent of the Member, pay such Member the Single-Sum Present Value in a lump-sum in lieu of the continuing monthly retirement pension and survivor's Pension Benefits payments, and neither the pensioner nor a survivor of any class will be entitled to any further benefits under the Defined Benefit Pension Plan.

4.10.4.2 Where the amount of the monthly survivor's pension payment is less than an amount that the Board may fix from time to time as being large enough to administer effectively, the Board may, with the consent of the Surviving Spouse, pay the Single-Sum Present Value of all future survivor's Pension Benefits due to such survivor in a lump-sum in lieu of continuing monthly survivor's Pension Benefits payments.

4.10.4.3 Upon receipt of a lump-sum distribution under this § 4.9, no pensioner or survivor of any class will be entitled to any further benefits under the Defined Benefit Pension Plan.

4.11 Maximum Annual Benefit.

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

4.12 Temporary Suspension of Retirement Pension.

In the event a Retired Pensioner returns to Eligible Service with an Eligible Employer providing Pension Coverage to employees in the Member's employment classification and the Retired Pensioner is enrolled as an Active Member in the Defined Benefit Pension Plan, the Retired Pensioner will accrue additional Pension Credits for the new service and Pension Benefits payments will be suspended until such Member's enrollment in the Defined Benefit Pension Plan terminates. The annual pension beginning as of the Member's subsequent initiation of retirement benefits from the Defined Benefit Pension Plan will be actuarially adjusted to reflect the pension payments previously made to the Member using the interest and mortality basis for the single-sum factors defined in Appendix B.

4.13 Post-Retirement Service.

If a Retired Pensioner returns to Eligible Service with an employer other than the Eligible Employer with which the Retired Pensioner most recently terminated Eligible Service, the Board may, in its sole discretion, approve a return to such Eligible Service by the Retired Pensioner without causing a temporary suspension of the Retired Pensioner's retirement pension under § 4.12 for the period of time during which such Retired Pensioner is engaged in the approved Eligible Service. Such Member will not accrue Pension Credits during such approved Post-Retirement Service.

4.14 Payment of Benefits.

All benefits payable under the Defined Benefit Pension Plan, other than lump-sum distributions pursuant to § 4.10.3 or § 4.10.4, will be paid monthly at the beginning of each month. Payment of Defined Benefit Pension Plan benefits will commence as of the first day of the month consecutive with or next following the satisfaction of the applicable requirements of §§ 4.8 or 4.9 by a Member, an eligible survivor as defined in § 4.11, or an Alternate Payee as defined in § 1.4.2.2.

5 Retirement Savings Plan

5.1 Eligible Employees

An Eligible Employer may offer participation in the Retirement Savings Plan to all employees employed in Eligible Service (other than an employee located in Puerto Rico). There are no minimum hours of service requirement for participation in the Retirement Savings Plan.

5.2 Employer Options

Enrollment of a Member in the Congregational Pastors Package or Transitional Pastor's Participation benefits automatically includes the offer of enrollment in the Retirement Savings Plan for voluntary employee salary deferral contributions. On the Employer Agreement (described in § 2.3), an Eligible Employer may select the Retirement Savings Plan for employees, or a classification of its employees, which selection provides each Eligible Employee with the opportunity to enroll in the Retirement Savings Plan and to designate an annual elective deferral contribution amount. An Eligible Employer may select additional contribution provisions, including employer contributions and/or matching contributions.

5.3 Plan Document

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

5.4 Administration

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

DEATH, DISABILITY & LIFE PLANS

6 Death and Disability Plan

6.1 Benefits

The Death and Disability Plan provides the following benefits coverage: Disability, Salary Continuation Death Benefit, Lump-Sum Death Benefit, Children's Education Benefit, and the Living Needs Benefit option. A Member enrolled in the Death and Disability Plan may not enroll in coverage in the Term Life and Accidental Death and Dismemberment Plan or Long-Term Disability Plan.

6.1.1 A Member enrolled in Death and Disability Plan coverage under § 6 may also elect to enroll in Supplemental Death Benefits under § 6.8.

6.2 Salary Continuation Death Benefit.

6.2.1 Upon the death of an Active Member or Disabled Member enrolled in the Death and Disability Plan, a payment equal to one-twelfth (1/12) of the Member's

Disability Benefit Basis will be paid to the beneficiary or beneficiaries of such Member for a period of twelve (12) months following the death of the Member.

6.2.2 The Salary Continuation Death Benefit will be paid in equal shares to such beneficiary or beneficiaries as may be designated by the Member in conformance with the Board's beneficiary designation process. A Member may change a beneficiary designation at any time by completing the change process required by the Board, which designation will be effective only as of the date accepted by the Board. In the event that more than one beneficiary is named as a primary beneficiary, payment will be made in equal shares to all beneficiaries designated as primary who survive the Member unless otherwise designated in writing on the beneficiary form by the Member.

6.2.3 In the event that a Member fails to properly designate a beneficiary, or no named beneficiary survives the Member, the Salary Continuation Death Benefit will 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.

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

6.2.3.2 *Class II*. To the Member's Children (regardless of dependency or age).

6.3 Lump-Sum Death Benefit

6.3.1 *Active and Disabled Members With Eligible Survivors*. Upon the death of an Active Member enrolled in the Death and Disability Plan or Disabled Member who is survived by an eligible survivor as set forth in this section, a Lump-Sum Death Benefit, an amount equal to the applicable percentage from the following schedule multiplied by the Member's Disability Benefit Basis at the time of the Member's death will be paid in equal shares to such Member's eligible survivors described in § 6.3.4:

Member's Age at Death	**Benefits as a Percentage of Disability Benefit Basis**
Under age 31	400%
31 but under 32	390%
32 but under 33	380%
33 but under 34	370%
34 but under 35	360%
35 but under 36	350%
36 but under 37	340%
37 but under 38	330%
38 but under 39	320%
39 but under 40	310%

Member's Age at Death	Benefits as a Percentage of Disability Benefit Basis
40 but under 41	300%
41 but under 42	290%
42 but under 43	280%
43 but under 44	270%
44 but under 45	260%
45 but under 46	250%
46 but under 47	240%
47 but under 48	230%
48 but under 49	220%
49 but under 50	210%
50 but under 51	200%
51 but under 52	190%
52 but under 53	180%
53 but under 54	170%
54 but under 55	160%
55 but under 56	150%
56 but under 57	145%
57 but under 58	140%
58 but under 59	135%
59 but under 60	130%
60 but under 61	125%
61 but under 62	120%
62 but under 63	125%
63 but under 64	110%
64 but under 65	105%
65 and over	100%

6.3.2 *Active and Disabled Members Without Eligible Survivors*. Upon the death of an Active Member enrolled in or receiving benefits from the Death and Disability Plan or Disabled Member without an eligible survivor as described in § 6.3.4, a Lump-Sum Death Benefit in an amount equal to one hundred percent (100%) of the Member's Disability Benefit Basis, on which dues were being paid at the time of the Member's death, to the Member's estate.

6.3.3 *Death After Leaving Eligible Service*. Upon the death of a Member who (1) was enrolled in the Death and Disability Plan in their last employment in Eligible Service, (2) terminated such Eligible Service after attaining age fifty-five (55), and (3) was not a Disabled Member on the date of death, an amount equal to twelve thousand five hundred dollars ($12,500) will be paid in equal shares to such Member's eligible survivors described in § 6.3.4 or, in default thereof, to the Member's estate.

6.3.4 The Lump-Sum Death Benefit will be paid in equal shares to the Member's survivors in the first class in which there are eligible survivors of the following classes of survivors:

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

6.3.4.2 *Class II*. To such of the Member's Dependent Children who were, on the date of the Member's death, (i) not in a marriage; (ii) either under the age of twenty-six (26) or Totally Disabled prior to the age of twenty-six (26), and (iii) a Dependent of the Member during the twelve (12) months immediately preceding and on the date of the Member's death.

6.3.4.3 *Class III*. To the Member's Dependent parents.

6.3.4.4 *Class IV*. To such of the Member's Dependent siblings who were on the date of the Member's death (i) not in a marriage, (ii) either under the age of twenty-six (26) or Totally Disabled prior to age twenty-six (26), and (iii) Dependent during the twelve (12) months immediately preceding and on the date of the Member's death.

6.4 Children's Education Benefit

Upon the death of a Member eligible for a benefit under § 6.2 or § 6.3, there will be paid to each of such Member's Children who, on the date of death of such Member, is under the age of twenty-five (25) years, an amount up to ten thousand dollars ($10,000) a year for up to a total of four (4) years of study beyond high school from the date of death of such Member during which such Child is in attendance at an accredited school, college, university, or other institution of higher learning until such Child attains age 25. The maximum aggregate lifetime benefit for any one Child is forty thousand dollars ($40,000).

6.5 Extension of Medical Plan Coverage.

If an Active Member dies while enrolled in the Death and Disability Plan, any Medical Plan coverage then in effect will continue for the Member's Eligible Family members who were enrolled in the Active Medical Plan on the date of such Member's death for a period of one (1) year from the date that the Member died. If the Member's Spouse is or becomes Medicare eligible during the coverage extension, the coverage will transition to the Medicare Advantage Group PPO coverage for the duration of the extended coverage period. No dues will be required during this coverage period, but the Eligible Family members will be responsible for any deductible, copayment, and coinsurance obligations required under the Medical Plan option. Thereafter, the Member's Eligible Family members who were enrolled in the Medical Plan may elect to enroll in Medical Continuation coverage under § 10.11 or § 11.1 of the Post-Retirement Medical Plan, as appropriate.

6.6 Eligible Service Terminated

Upon a termination of Eligible Service, a Minister Member enrolled in the Congregational Pastors Package, Transitional Pastor's Participation, or the Covenant Package prior to termination, who has not elected to enroll in continuation of coverage under Ministers Bridge Coverage, will continue to have coverage for death benefits under § 6 for an additional one (1) month at no additional cost to the Minister Member or the Member's Eligible Employer.

6.7 Living Needs Benefit

6.7.1 Active Members and Disabled Members eligible for death benefits under § 6.2 or § 6.3, who are 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 Death Benefit and/or seventy-five percent (75%) of the Lump-Sum Death Benefit that would be payable to any Member under § 6.3 (Member without Eligible Survivors) 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.

6.7.2 Any amount paid to a Member as a Living Needs Benefit under this § 6.5 will be offset from the amount of death benefits payable under the Death and Disability Plan at the death of the Member.

6.7.3 Living Needs Benefit will not be available if any one or more of the following circumstances exist: (a) the Member's illness or physical condition is due to an intentionally self-inflicted injury; (b) the Member's enrollment in the Death and Disability Plan 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 Benefit will not be paid to any person or entity other than the Member.

6.8 Supplemental Death Benefits

Any Member enrolled in the Death and Disability Plan is eligible to enroll in the Supplemental Death Benefits described in this section.

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

6.8.1.1 A Member may continue to enroll in coverage for a Dependent Child who is not in a marriage and who was Totally Disabled prior to becoming age 26 and continues to be Totally Disabled beyond age 26.

6.8.1.2 A Member enrolled in Supplemental Death Benefits coverage who terminates employment in Eligible Service after attaining age fifty-five (55) will have the option of continuing to enroll in the same or lesser Supplemental Death Benefits coverage as was in effect for the Member and Spouse on the date of such termination of Eligible Service until a termination event under § 6.8.7 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.

6.8.2 *Coverage Amounts and Medical Insurability*. The Board will designate the amounts of coverage for which Members may enroll to cover the Member and/or the Member's Spouse, Children under the age of 26, and Dependent Children who are not in a marriage and Totally Disabled beyond age 26 and establish the medical insurability requirements for such coverage. The Board will provide for one or more minimum levels of coverage for which a Member may apply within thirty (30) days of initial eligibility for enrollment for Supplemental Death Benefits, which minimum levels of coverage will not be subject to the plan's medical insurability requirements.

6.8.3 *Enrolling for Coverage*. Subject to the satisfaction of any insurability requirements described in § 6.8.4, a Member may, within thirty (30) days of first becoming eligible for Death and Disability Plan coverage, elect to enroll in one, but not more than one, of the Supplemental Death Benefits coverage levels authorized by the Board. After such thirty (30) days initial period, a Member may elect or change from one or more of the Supplemental Death Benefits coverage levels to another only during an annual or special enrollment period specified by the Board and subject to the Member or Spouse providing evidence of insurability satisfactory to the Board if the new coverage election is for a higher level of benefit. A Member may be enrolled in Supplemental Death Benefits coverage only 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.

6.8.4 *Evidence of Insurability*. All coverage levels for Supplemental Death Benefits under this § 6.8, other than minimum coverage levels for Members described in § 6.8.2, will be subject to satisfaction of the Board's insurability requirements.

6.8.4.1 Application by a Member for coverage of a Spouse will be subject to satisfaction of the Board's evidence of insurability requirements.

6.8.4.2 Enrollment of Children will not be subject to insurability requirements.

6.8.4.3 Coverage for a Member who is not actively at work due to health-related reasons at the time the coverage would otherwise commence, and/or for a Spouse who is currently confined in a healthcare facility for treatment or unable due to sickness or injury to perform substantially all of the material duties of their regular work or daily responsibilities, will be delayed and not in effect, 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.

6.8.5 *Dues*. The dues required for Supplemental Death Benefits are described in Appendix A. The Board may, in its sole discretion, elect to establish different dues rates for persons who have used nicotine products during the previous twelve (12)-month period.

6.8.6 *Payment of Supplemental Death Benefits*.

6.8.6.1 Upon the death of a Member covered for benefits under § 6.8, the amount set forth in the applicable coverage level in effect will be paid in one lump-sum to such beneficiary or beneficiaries as may be designated by the Member in the enrollment records at the Board. A Member may change a beneficiary designation at any time in such manner as provided by the Board, which designation will only be effective as of the date approved and accepted by the Board. In the event that more than one beneficiary is named as a primary beneficiary, payment will be made in equal shares to all beneficiaries designated as primary who survive the Member unless otherwise designated by the Member. In the event that a Member does not have a valid beneficiary designation on record with the Board for these benefits, or no designated beneficiary survives the Member, the Supplemental Death Benefits will be paid in equal shares to the Member's survivors in the order set forth in § 6.2.2.

6.8.6.2 Upon the death of a Spouse or Child covered for benefits under § 6.8, the amount set forth in the applicable coverage election in effect will 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 will be paid to the estate of the Member.

6.8.7 *Termination of Coverage*. Coverage under § 6.8 of a Member, a Spouse, or Child will terminate:

6.8.7.1 on the first dues payment date following the termination of enrollment in the Benefits Plan under § 2.6 or termination of election for coverage under § 6.8 of the Benefits Plan;

6.8.7.2 on the last day of the period for which a dues payment for coverage under § 6 has been made if the subsequent dues payment is not made on the date required;

6.8.7.3 at the end of the month in which (a) a retired Member or their Spouse attains the age of seventy (70) years or (b) a Child attains the age of twenty-six (26) years unless eligibility continues under § 6.8.1.1; or

6.8.7.4 at the end of the month in which a Member died.

6.8.8 *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 Spouse in connection with a request for a change in the Supplemental Death Benefits coverage option.

6.9 Disability Benefits.

6.9.1 *Benefit Eligibility*. A Member enrolled in coverage under § 6, will be eligible for the disability benefits described in this section upon certification by the Board or its medical counsel that such Member became Disabled, as defined in § 6.9.2, while an Active Member enrolled in the Death and Disability Plan and approval by the Board of the Member's timely filed and completed online or telephonic application. Disability benefits under § 6.9 are intended to provide for a long-term disability and are payable only for a Disability that continues for more than ninety (90) consecutive days. Disability Benefits will be payable to the Member beginning on the Disability Benefits Commencement Date, as defined in § 6.9.3.

6.9.2 *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. For purposes of § 6.9, the term "Disability" or "Disabled" means the inability of a Member due to sickness or bodily injury to perform substantially all of the material duties of their regular work and, after a period of twenty-four (24) consecutive months of such Disability, the inability of a Member due to sickness or bodily injury to perform any type of work for which he or she is fitted by education, training, or experience, all of which conditions must be certified by the Board. For Members who commence receiving Disability Benefits on or after the attainment of age sixty-two (62), the definition of disability will be the inability to perform substantially all of the material duties of their regular work for the entire duration of such Member's Disability Benefits. In applying for Disability benefits, the Member will furnish such evidence of Disability as the Board will deem necessary. The Board will have the right to require evidence of continuing Disability from time to time.

6.9.3 *Disability Benefits Commencement Date*. The Disability Benefits under § 6.9 will commence as of the later of (i) the ninety-first (91st) day of the period during which the Member is Disabled or (ii) the day following the last of an Eligible Employer severance period. Notwithstanding the foregoing, no Disability benefits will 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.

6.9.4 *Duration of Disability Benefits*. Disability benefits under § 6.9 will continue as long as a Member remains Disabled but not beyond the dates or durations specified below:

6.9.4.1 The first day of the month following the date on which the Disabled Member attains age sixty-five (65), if the Disability

Benefits commenced prior to the Member's attainment of age sixty-two (62).

6.9.4.2 If the Disability Benefits commenced on or after the Member's attainment of age sixty-two (62), the Disability Benefits will be payable as follows:

6.9.4.2.1 For Disabled Members who are vested members of the Defined Benefit Pension Plan on the date of commencement of Disability Benefits:

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

6.9.4.2.2 For Disabled Members who are not vested members of the Defined Benefit Pension Plan on the date of commencement of Disability Benefits:

6.9.4.2.2.1 The first day of the month following the date on which the Disabled Member attains Social Security Normal Retirement Age.

6.9.4.2.2.2 If the Member's Disability Benefits commenced on or after the Disabled Member's attainment of age sixty-five (65) but before attainment of age sixty-nine (69), the Disability Benefits will be payable for two years.

6.9.4.2.2.3 If the Member's Disability Benefits commenced on or after the Disabled Member's attainment of age sixty-nine (69), the Disability Benefits will be payable for one year.

6.9.4.3 The death of the Member.

6.9.4.4 The return to work of a Member unless the work is approved pursuant to the provisions of § 6.9.9, relating to rehabilitation, at which point the Member's Disability Benefits may be reduced but not terminated.

6.9.5 *Amount of Disability Benefits*. For Disability Benefits commencing on or after January 1, 2025, the initial annual Disability Benefits amount, payable in 12 monthly installments, will equal seventy percent (70%) of the Member's Disability Benefits Basis

on the date the Disability began, as determined by the Board, less any offset for payments received on account of the Disability, as provided in § 6.9.6 through 6.9.6.2. In no event will such initial total annual amount of the Disability Benefits exceed the Member's Effective Salary on the date the Disability began.

6.9.6 *Disability Benefit Offsets*.

6.9.6.1 *For Pension, Social Security and Other Benefit Sources*. The total annual amount of the Disability Benefits paid under this § 6.9 will be offset by any amount received by the Member for monthly retirement Pension Benefit payments under the Defined Benefit Pension Plan and the Social Security retirement income program and any payments received from other sources on account of the Disability, including but not limited to the following: individual benefits under the Social Security disability income program; individual benefits under workers' compensation; veterans' and other governmental programs for which the Member becomes eligible on account of the Disability; any other disability benefit (group or individual) provided by the Member's Eligible Employer on a noncontributory basis, unless it is to cover the portion of Effective Salary in excess of the Annual Maximum Compensation 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 or insurance carrier for a claim related to the Disability. A disability benefit payment made to a Member under private disability coverage purchased by a Member will not be offset from the Disability Benefits. In the event a Member receiving a disability benefit from another source 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 will not reduce the sum the Member is receiving as a Disability Benefits from the Death and Disability Plan.

6.9.6.1.1 *When Not Participating in Social Security.* 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 will 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.

6.9.6.1.2 *Deferral of Benefits Beyond Normal Retirement Age.* If the Disabled Member elects to defer initiation of payment of the Defined Benefit Pension Plan beyond the attainment of the plan's Normal Retirement Age or the Social Security retirement income benefits beyond the

Member's attainment of Normal Retirement Age for full Social Security retirement income benefits, the amount of the Disability Benefits will be reduced beginning the first month after the Member attains such 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 and/or the full Social Security retirement income benefit if the Member had initiated the benefits upon attaining such Normal Retirement Age.

6.9.6.2 *Payments from Employers and Earned Income During Disability*. A Disabled Member may receive income, in the form of salary payments and/or a Manse or Housing Allowance from an employer or any form of earned income from an employer or other source (such as self-employment) while receiving Disability Benefits provided that the work is approved by the Board, as required under § 6.9.9, and the earnings are reported to the Board annually or more frequently upon request from the Board. If the total annual amount received by the Member whose Disability Benefits Commencement Date was on or after January 1, 2025 from these sources exceeds thirty percent (30%) 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 thirty percent (30%). For Disabled Members who commenced Disability Benefits on or before December 31, 2024, the annual amount a Disabled Member may earn from these sources before an offset under this section is forty percent (40%) of the Member's Effective Salary on the date the Disability began. If the Eligible Employer of a Disabled Member makes a salary payment to the Member and/or provides a Manse or Housing Allowance during the Disability, the amount of the Disability Benefits will be reduced only by the amount in excess of any such employer compensation exceeds the applicable percentage 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 the applicable percentage of the Member's Effective Salary on the date the Disability began, the Board may reduce the Disability Benefits by all or part of such excess.

6.9.6.3 *Minimum Annual Disability Benefits*. Regardless of any payments on account of the Disability from sources other than the Death and Disability Plan, the annual Disability Benefits payable pursuant to § 6.9.5 will not be less than six hundred dollars ($600).

6.9.7 *Disability Benefit Increases*. Based on the funded status of the Death and Disability Plan assets, the Board, acting in its sole discretion, may grant an increase in the Disability Benefits for Disabled Members who on the date of such grant are receiving Disability Benefits (a "Disability Benefits Increase"). No person will have a right to any such increase unless and until it has been authorized. Disability Benefit Increases granted by the Board since the adoption of the Benefits Plan in 1987 are listed in Appendix C.

6.9.8 *Benefits Plan Coverage While Disabled*. A Disabled Member's Defined Benefit Pension Plan (§ 4), Death Benefits under § 6.1.1 and § 6.8, and Medical Plan (§ 10) coverage, to the extent that such coverage was in effect on the Disability Benefits Commencement Date, will continue for the Member, including the Spouse's and/or Children's coverage under § 6.8, for the durations set forth below. An Eligible Employer's responsibility for a Disabled Member's Benefits Plan coverage will terminate on the Member's Disability Benefits Commencement Date and the Eligible Employer's obligation to pay dues will end as of that date.

6.9.8.1 *Continued Coverage*. For any period during which a Disabled Member is entitled to continued Defined Benefit Pension Plan coverage under § 4, such Member will accrue Pension Credits equal to the greater of one and one-quarter percent (1¼%) of the Member's Pension Participation Basis on the Member's Disability Benefits Commencement Date, as determined by the Board; or the Median Effective Salary.

6.9.8.1.1 Pension Credits accrued while Disabled will be reduced proportionally to the same ratio that the number of hours of employment of the Disabled Member during the Plan Year immediately preceding the commencement of the Disability which were fewer than one thousand eight hundred twenty (1,820) hours bears to one thousand eight hundred twenty (1,820) hours.

6.9.8.1.2 Defined Benefit Pension Plan coverage under this § 6.9.8 will continue only until the plan's Normal Retirement Date, and no additional Pension Credits will accrue to such Disabled Member thereafter.

6.9.8.1.3 No Pension Credits will accrue to a Disabled Member for whom dues are not paid in full or who was not enrolled in Defined Benefit Pension Plan coverage at the commencement of the Disability.

6.9.8.2 *Continued Coverage for Death Benefits Only*. As of the Disability Benefits Commencement Date, a Disabled Member will continue to be eligible for the death benefits provided in § 6.2 and § 6.3 of the Death and Disability Plan.

6.9.8.2.1 Disability Benefits coverage under § 6.9 will terminate as of the Member's Disability Benefits Commencement Date.

6.9.8.2.2 A Disabled Member may not apply for Disability Benefits under § 6.9 for a Disability that commences after the Disabled Member's Disability Benefits Commencement Date.

6.9.8.3 *Ministers Bridge Coverage*. Members who become Disabled while participating in the Defined Benefit Pension Plan and Death and Disability Plan under Ministers Bridge Coverage option will accrue Pension Credits and Death and Disability Benefits on the same basis as the Member elected to pay dues for the Ministers Bridge Coverage.

6.9.8.4 *Medical Plan Coverage*. A Disabled Member may continue to enroll in Active Medical Plan coverage for the Member until Member's Normal Retirement Date or the termination of Disability Benefits, if earlier. Medical Plan coverage for the Eligible Family will continue until the earlier of (i) three (3) years from the Disability Benefits Commencement Date or (ii) the Member's Normal Retirement Date, subject to the Disabled Member's payment of any contribution requirements imposed by the Member's last employer for such Medical Plan coverage or required under the Ministers Bridge Coverage.

6.9.8.5 *Disabled Members Coverage*. Disabled Members approved for and commencing Disability Benefits prior to January 1, 2017, will continue to be eligible for the plan enrollment in effect as of December 31, 2016, and the dues for such coverage will be waived.

6.9.8.6 *Protection for Survivors*. In the event of the death of a Member who is receiving Disability Benefits under the Death and Disability Plan, the benefits provided in § 6 will 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 Median Effective Salary in the year of the Disabled Member's last employment in Eligible Service.

6.9.9 *Rehabilitation and Return-To-Work Provisions*. 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.

6.9.9.1 The Board, in its sole discretion, may continue to pay all or a portion of Disability Benefits, or continue enrollment for coverage for 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 their duly licensed physician.

6.9.9.2 Any reduction in Disability Benefits will be made in accordance with § 6.9.6.2

6.9.10 *Time Limit for Application*. Application for Disability Benefits must be made to the Board or its designated administrator within twelve (12) calendar months after the date the Disability began unless it can be shown that an earlier filing was not reasonably possible and that the required disability documentation was furnished as soon as it was reasonably possible.

6.9.11 *Right To Suspend or Terminate*. The Board reserves the right to suspend or terminate the payment of Disability Benefits to any Member who fails to:

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

6.9.11.2 remain under the Appropriate Available Treatment (as defined herein) under the care of a duly licensed physician or psychologist in accordance with a treatment plan recommended by the Member's treating healthcare provider that the Board's medical counsel or medical Case Management representatives consider consistent with generally accepted medical standards of practice for the Member's diagnosis;

6.9.11.2.1 Appropriate Available Treatment for medical illness means care or services which are

6.9.11.2.1.1 generally acknowledged by physicians to cure, correct, limit, treat, or manage the disabling condition;

6.9.11.2.1.2 accessible within the Member's geographical region or available virtually;

6.9.11.2.1.3 provided by a physician who is licensed and certified by the American Board of Medical Specialties or the American Board of Physician Specialties qualified in a discipline suitable to treat the disabling injury or sickness, and

6.9.11.2.1.4 in accordance with generally accepted medical standards of practice.

6.9.11.2.2 Appropriate Available Treatment for behavioral illness means care or services which are

6.9.11.2.2.1 generally acknowledged by psychiatrists and psychologists to cure, correct, limit, treat, or manage the disabling condition; utilizing both psychotherapy and psychopharmacology modalities when indicated, occurring with a regular frequency, as defined by accepted guidelines, as long as the condition is significantly decreasing capacity, resulting in second opinions when there is little clinical improvement after six months;

6.9.11.2.2.2 accessible within the Member's geographical region;

6.9.11.2.2.3 provided by a professionally licensed mental health care practitioner, and

6.9.11.2.2.4 in accordance with American Psychological and American Psychiatric Associations' standards of practice.

6.9.11.2.3 participate in vocational rehabilitative services as recommended by the Board;

6.9.11.3 notify the Board immediately in the event of a return to active Eligible Service or other employment;

6.9.11.4 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 § 6.9.1; or

6.9.11.5 provide the Board with documentation requested by the Board or its designated administrator to substantiate earned income (or lack thereof), Social Security Disability Insurance retroactive payments, or any other information that the Board reasonably requires to administer the terms of the Disability provisions.

6.9.12 *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.

7 Term Life and Accidental Death and Dismemberment Plan

7.1 Employer Enrollment Election

An Eligible Employer may elect in its Employer Agreement to offer, on a non-contributory basis, Term Life and Accidental Death and Dismemberment Plan coverage to all employees, or an employment classification of employees, who are not enrolled in Death and Disability Plan coverage under § 6. This plan offering provides term life, accidental death, accidental dismemberment, and children's education benefits upon the death or occurrence of certain accidental injuries of an enrolled Member as described in this § 7.

7.2 Terms Used in Term Life and Accidental Death and Dismemberment Plan Only

7.2.1 "Accidental Bodily Injury" means bodily harm caused solely by external, violent and accidental means and not contributed to by any other cause.

7.2.2 "Accidental Death" means a loss of life caused by external, violent and accidental means and not contributed to by any other cause.

7.2.3 "Covered Benefit Amount" means the basis for the benefits the Term Life and Accidental Death and Dismemberment Plan will pay for a claim under the option

elected by the Eligible Employer in the Employer Agreement as specified in § 7.1. In no event may the Covered Benefit Amount exceed two hundred thousand dollars ($200,000), exclusive of any children's education benefit under § 7.5.4. The Eligible Employer will be responsible to report and withhold any income tax due if the elected Covered Benefit Amount exceeds the limit set forth in Section 79 of the Code.

7.2.4 "Covered Loss(es)" under the Term Life and Accidental Death and Dismemberment Plan include the Accidental Death, Loss of a Foot, Loss of a Hand, Loss of Hearing, Loss of Sight, and Loss of Speech, as those terms are defined in § 7.5.3.

7.2.5 "Full Amount" means the amount of benefit the Term Life and Accidental Death and Dismemberment Plan will pay for an Accidental Death or Accidental Bodily Injury based on the Coverage Benefit Amount elected by the Eligible Employer.

7.2.6 "Injury" means a bodily injury that is the direct result of an accident and not related to any other cause.

7.2.7 "Intoxicated" means that the Covered Person's blood alcohol level at the time of the accident equaled or exceeded the legal limit for operating a motor vehicle in the state where the accident occurred.

7.2.8 "Loss of a Foot" means that all of the foot is irreparably severed at or above the ankle joint.

7.2.9 "Loss of a Hand" means that all four fingers are irreparably severed at or above the knuckles joining each to the hand.

7.2.10 "Loss of Hearing" means the total and irrevocable loss of hearing in both ears.

7.2.11 "Loss of Sight" means the eye is totally blind and that no sight can be restored in that eye.

7.2.12 "Loss of Speech" means the total and irrecoverable loss of speech.

7.2.13 "Loss of Thumb and Index Finger" means that all of the thumb and index finger are cut off at or above the joint closest to the wrist.

7.2.14 "Sickness" means illness or disease.

7.3 Coverage Amounts

When enrolling its Eligible Employees for coverage under this plan, the Eligible Employer may elect one of the following two Covered Benefit Amount options in its Employer Agreement:

7.3.1 *Fixed Benefit Amount*. Fixed amount benefits will be periodically established by the Board but will not be less than five thousand dollars ($5,000) and no greater than the maximum Covered Benefit Amount.

7.3.2 *Income-Based Benefit Amount*. A benefit amount representing a percentage of the Member's salary, rounded up to the next highest thousand dollars. The Income-Based Benefit Amount is capped at the lesser of two times the Member's salary or the maximum Covered Benefit Amount.

7.3.3 *Imputed Income*. The Eligible Employer will be responsible for reporting any imputed income to the Member in the event that the Covered Benefit Amount exceeds fifty thousand dollars ($50,000).

7.3.4 *Aggregation*. In the event a claim is based on an Accidental Death, the benefits payable under the Term Life and Accidental Death and Dismemberment Plan will be the aggregate of the Term Life benefit and the Accidental Death benefit, but in no event more than Four Hundred Thousand Dollars ($400,000), exclusive of any children's education benefit under § 7.5.4.

7.4 Term Life Benefit

Upon the death of a Member enrolled in Term Life and Accidental Death and Dismemberment Plan coverage, the designated beneficiary or beneficiaries of such Member will be paid, in the aggregate, a term life benefit equal to the Covered Benefit Amount in effect for the Member in a lump sum.

7.4.1 Upon enrollment for benefits under this plan, the Member will designate the beneficiary(ies) for the benefit payment on the enrollment forms provided by the Board. A Member may change a beneficiary designation at any time in such manner as provided by the Board, which designation will only be effective as of the date approved and accepted by the Board.

7.4.2 In the event that more than one beneficiary is named as a primary beneficiary, payment will be made in equal shares to all beneficiaries designated as primary who survive the Member unless otherwise designated by the Member.

7.4.3 In the event that a Member does not have a valid beneficiary designation on record with the Board for the Term Life and Accidental Death and Dismemberment Plan, or no designated beneficiary survives the Member, the plan's benefits will 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 the Member's Children (regardless of dependency or age).

7.5 Accidental Death and Dismemberment Benefit Eligibility

Benefits will be paid for Covered Losses described in § 7.5.3 resulting from an Accidental Death or Accidental Bodily Injury while the individual is enrolled in Term Life and Accidental

Death and Dismemberment Plan benefits and the claim is not excluded from coverage under § 7.5.1.

7.5.1 *Exclusions*. Benefits will not be paid under this Term Life and Accidental Death and Dismemberment Plan if an Accidental Death or Accidental Bodily Injury is caused by, contributed to by, or resulting from:

7.5.1.1 Suicide or self-inflicted injury

7.5.1.2 Active participation in a riot

7.5.1.3 An attempt to commit or commission of a crime

7.5.1.4 Use of any prescription or non-prescription drug, poison, fume, or other chemical substance unless used according to the prescription or direction of your medical provider.

7.5.1.5 Disease of the body or diagnostic, medical or surgical treatment, or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders.

7.5.1.6 Intoxication

7.5.1.7 War, declared or undeclared, or any act of war.

7.5.1.8 Failure to use and properly fasten a seatbelt (where available) at the time of an accident.

7.5.1.9 Use of a private passenger car that has installed air bags that are not operational for the seat in which a Covered Person is seated.

7.5.2 *Certification*. The Board may, in its sole discretion, require an independent medical examination or case review to determine whether a claim for benefits should be paid.

7.5.3 *Accidental Death and Dismemberment Benefit Amounts*. Upon approval of the claim application, the Benefits Plan will pay the benefit amount listed opposite the corresponding Covered Losses below. The aggregate amount of benefits payable for any combination of Covered Losses for an Accidental Death or Accidental Bodily Injury from any one accident is capped at the Full Amount.

Covered Losses	**Benefit Amounts**
Accidental Death	Full Amount payable to designated beneficiary(ies)

Covered Losses	**Benefit Amounts**
Both Hands or Both Feet or Sight of Both Eyes	Full Amount
One Hand and One Foot	Full Amount
One Hand and Sight of One Eye	Full Amount
One Foot and Sight of One Eye	Full Amount
Speech and Hearing	Full Amount
One Hand and One Foot	Full Amount
Sight of One Eye	One Half of Full Amount
Speech or Hearing	One Half of Full Amount
Thumb and Index Finger of Same Hand	One Quarter of Full Amount

7.5.4 *Children's Education Benefit*. In addition to the benefits payable under § 7.5.3, upon the Accidental Death of an Active Member enrolled in the Term Life and Accidental Death and Dismemberment Plan, there will be paid to each of such Member's Children who, on the date of death of such Member, are under the age of twenty-five (25) years, an amount up to ten thousand dollars ($10,000) a year for up to a total of four (4) years of study beyond high school from the date of death of such Member during which such Child is in attendance at an accredited school, college, university, or other institution of higher learning until such Child attains age 25. The maximum aggregate lifetime benefit for any one Child is forty thousand dollars ($40,000).

7.6 Supplemental Death Benefits

A Member enrolled by an Eligible Employer for the Term Life and Accidental Death and Dismemberment Plan, whose Eligible Employer also elects to offer Supplemental Death Benefits, may enroll in additional Supplemental Death Benefits for the Member, a Spouse, and/or their Children until attainment of age 26 in accordance with the provisions of § 6.8.

8 Temporary Disability Plan

8.1 Employer Enrollment Election

An Eligible Employer may elect in its Employer Agreement to offer Temporary Disability Plan coverage to all employees, or an employment classification of employees, on a contributory or non-contributory basis. Members enrolled in the Congregational Pastors Package, Transitional Pastor's Participation, or Covenant Package benefits options are automatically enrolled in benefits under this § 8 on a non-contributory basis.

8.2 Benefit Eligibility.

A Member enrolled in Temporary Disability Plan benefits will be eligible to apply for Temporary Disability Benefits. For purposes of this § 8, "Temporary Disability" or "Temporarily Disabled" means the Member, due to sickness or bodily injury, is unable to perform substantially all of the material duties of their own job for at least seven (7) consecutive days, as certified by the Board or its designated administrator.

8.2.1 To be timely, a Member must apply for Temporary Disability Benefits by submitting a request to the Board or its delegated administrator within thirty (30) days after the Member's first absence from work on account of the Temporary Disability, unless it can be shown that an earlier filing was not reasonably possible and the disability application was received by the Board or its delegated administrator as soon as reasonably possible;

8.2.2 To become eligible for Temporary Disability Benefits, a Member must cooperate with the Board in its exercise of its rights to request and receive evidence of continued disability of the Member, and provide any documentation requested by the Board or its designated administrator to administer the terms of the Temporary Disability Plan provisions.

8.3 Certification of Temporary Disability.

Following written verification by the Member's Employer and treating physician that the Member has been Temporarily Disabled for more than seven (7) consecutive days from the date of Member's first absence from work on account of such Temporary Disability, the Board or its designated administrator will review and determine the Member's eligibility for Temporary Disability Benefits. A certification of disability under this § 8.3 does not constitute a certification of disability under § 6.9 of the Death and Disability Plan or under § 9 of the Long-Term Disability Plan.

8.4 Amount.

The amount of the Temporary Disability Plan benefits will be equal to seventy percent (70%) of the Member's Temporary Disability Benefits Basis.

8.4.1 *Offsets*. The total amount of the Temporary Disability Plan benefit will be offset by any amount received by the Member from any other income sources on account of the Temporary Disability, including, but not limited to, the following: state disability benefits, workers' compensation, any other disability benefit (group or individual) provided by the Member's Eligible Employer on a non-contributory 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 or insurance carrier for a claim related to the Disability, other than a disability benefit payment made to a Member under private disability coverage purchased by a Member.

8.4.2 *Notice of Return to Service*. A Member receiving Temporary Disability Benefits must notify the Board immediately in the event of a return to active Eligible Service or other employment.

8.5 Commencement Date and Duration.

8.5.1 Temporary Disability Benefits under § 8 are only available for the first ninety (90) consecutive days of a Member's disability. Temporary Disability Benefits will be payable to the Member beginning on the eighth (8^{th}) day of a Disability certified under § 8.3 and will continue until the earlier of the Member's return to work, the ninetieth (90^{th}) day of such Disability or the last day of the certification of such Disability.

8.5.2 If a Member returns to work within the ninety-day period and has a successive period of Disability within 14 days of returning to work, the Member is not required to reapply or satisfy another seven-day elimination period. In such event, the Member would only be entitled to the remaining amount of the 90-day benefit payment.

8.6 Continued Benefits Plan Enrollment While Receiving Temporary Disability Benefits.

During a period of Temporary Disability, the Member's Eligible Employer is responsible for the continued payment of dues for all Benefits Plan coverage in which the Member was enrolled at the time the Temporary Disability commenced. Any portion of the Benefits Plan dues for the Member's coverage that are contributory are to be collected and remitted to the Board by the Eligible Employer.

8.7 Status during Temporary Disability.

A Member receiving Temporary Disability Benefits will be considered an Active Member for the duration of the Temporary Disability period.

9 Long-Term Disability Plan

9.1 Employer Enrollment Election

An Eligible Employer may elect to offer Long-Term Disability coverage on a non-contributory basis under this § 9 to Active Members who are not enrolled in the Death and Disability Plan.

9.2 Terms Used in Long-Term Disability Plan Only.

For purposes of this § 9,

9.2.1 "Long-Term Disability" or "Long-Term Disabled" will mean the inability of a Member due to sickness or bodily injury to perform substantially all of the material duties of their regular work and, after a period of twenty-four (24) consecutive months of such Disability, the inability of a Member due to sickness or bodily injury to perform any

type of work for which he or she is fitted by education, training, or experience, all of which conditions must be certified by the Board.

9.2.2 "Long-Term Disability Benefits Commencement Date" will mean the ninety-first (91st) day of the period during which the Member is Disabled or the day following the last day of an employer severance period.

9.3 Benefit Eligibility

A Member will be eligible for Long-Term Disability Benefits as described in § 9 following (i) certification by the Board or its designated administrator that such Member became Long-Term Disabled while an Active Member enrolled in the Long-Term Disability Plan and (ii) approval by the Board or its designated administrator that the Member's disability application and documentation has been timely filed and is complete.

9.4 Certification of Long-Term 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 continue to be certified as a Long-Term Disability. In applying for Long-Term Disability Benefits, the Member will furnish such evidence of Long-Term Disability as the Board will deem necessary. The Board will have the right to require evidence of continuing Long-Term Disability from time to time.

9.5 Long-Term Disability Benefits Commencement Date.

Long-Term Disability Benefits under this § 9 are payable only for a Long-Term Disability that continues for more than ninety (90) consecutive days. Long-Term Disability Benefits will be payable to the Member beginning on the Long-Term Disability Benefits Commencement Date. Notwithstanding the foregoing, no Long-Term Disability Benefits will be paid to a Member for any Long-Term Disability arising during the first twelve (12) months of a Member's coverage under the Long-Term 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 the Long-Term Disability Plan.

9.6 Duration of Long-Term Disability Benefits.

Long-Term Disability Benefits will continue as long as a Member remains Long-Term Disabled but not beyond the dates or durations specified below:

9.6.1 The first day of the month following the Member's return to work.

9.6.2 The first day of the month following the date on which the Long-Term Disabled Member attains Social Security Normal Retirement Age, if the Long-Term Disability Benefits commenced prior to the Member's attainment of age sixty-two (62).

9.6.3 If the Member's Long-Term Disability Benefits commenced on or after the Member's attainment of age sixty-five (65) but before attainment of age sixty-nine (69), the Disability Benefits will be payable for two years.

9.6.4 If the Member's Long-Term Disability Benefits commenced on or after the Member's attainment of age sixty-nine (69), the Long-Term Disability Benefits will be payable for one year.

9.6.5 The death of the Member.

9.7 Amount of Long-Term Disability Benefits.

For a Member with a Long-term Disability Benefits Commencement Date of January 1, 2025 or thereafter, the benefit amount, payable monthly, will be equal to seventy percent (70%) of the Member's Long-Term Disability Benefits Basis.

9.7.1 *Offsets For Retirement, Social Security, and Other Benefit Sources*. The total annual amount of the Long-Term Disability Benefits paid under the Long-Term Disability Plan will be offset by any amount received by the Member for monthly retirement Pension Benefit payments under the Defined Benefit Pension Plan or other retirement plans, the Social Security retirement income program, and any payments received from other sources on account of the Long-Term Disability, including but not limited to the following: individual benefits under the Social Security disability income program; individual benefits under workers' compensation; veterans' and other governmental programs for which the Member becomes eligible on account of the Disability; any other disability benefit (group or individual) provided by the Member's Eligible Employer on a noncontributory basis, unless it is to cover the portion of salary in excess of the Annual Maximum Compensation 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 or insurance carrier for a claim related to the Long-Term Disability. A disability benefit payment made to a Member under private disability coverage purchased by a Member will not be offset from the Long-Term Disability Benefits. In the event a Member receiving a disability benefit from another source 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 will not reduce the sum the Member is receiving as a Long-Term Disability Benefit from the Long-Term Disability Plan.

9.7.1.1 *When Not Participating in Social Security.* 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 Long-Term Disability Benefits will be reduced by the benefit which the Board or its administrator determines would have been payable under the Social Security disability or retirement income program had the Member participated thereunder based on the record of salary reported to the Board on which FICA or SECA taxes would have been paid on behalf of the Member.

9.7.1.2 *Deferral of Benefits Beyond Normal Retirement Age.* If the Long-term Disabled Member elects to defer initiation of payment of any vested Defined Benefit Pension Plan benefits beyond the attainment of the plan's Normal Retirement Age or Social Security retirement income benefits beyond the Member's attainment of Normal Retirement Age for full Social Security retirement income benefits, the amount of the Long-Term Disability Benefits will be reduced beginning the first month after the Long-Term Disabled Member attains such 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 and/or the full Social Security retirement income benefit if the Member had initiated the benefits upon attaining such Normal Retirement Age.

9.7.1.3 *Offsets for Payments from Employers and Earned Income*. A Long-Term Disabled Member may receive income, in the form of salary payments and/or a Manse or Housing Allowance from an employer or any form of earned income from an employer or other source (such as self-employment) while receiving Long-Term Disability Benefits provided that the work is approved by the Board, as required under § 9.8, and the earnings are reported to the Board annually or more frequently upon request from the Board. If the total annual amount received by the Member whose Long-Term Disability Benefits Commencement Date was on or after January 1, 2025 from these sources exceeds thirty percent (30%) of the Member's Effective Salary on the date the Long-Term Disability began, the Board may reduce the Member's Long-Term Disability Benefits by the amount that the payments exceed the thirty percent (30%). For Long-term Disabled Members who had a Long-Term Disability Commencement Date on or before December 31, 2024, the reduction will only apply to the amount of any employer compensation in excess of forty percent (40%) of the Member's salary. If the Long-Term Disabled Member has other earned income which, together with any such employer compensation, exceeds thirty percent (30%) for any Member with a Long-Term Disability Commencement Date on January 1, 2025 or thereafter, or forty percent (40%) for Long-Term Disabled Members who had a Long-Term Disability Commencement Date on or before December 31, 2024, of the Member's salary as reported by the Eligible Employer on the date the Long-Term Disability began, the Board may reduce the Long-Term Disability Benefits by all or part of such excess.

9.8 Rehabilitation and Return-to-Work Provisions.

The Board, in its sole discretion, may consider reimbursement of costs for rehabilitation programs for Long-Term Disabled Members when funds are not available from any other source.

9.8.1 The Board, in its sole discretion, may continue to pay all or a portion of Long-Term Disability Benefits during a period of limited rehabilitation, trial work, or a partial return to work provided the Long-Term Disabled Member continues under the regular care of their duly licensed physician.

9.8.2 Any reduction in Long-Term Disability Benefits will be made in accordance with § 9.7.

9.9 Benefits Coverage while Long-Term Disabled.

An Eligible Employer's enrollment of a Long-Term Disabled Member as an Active Member of the Benefits Plan will terminate on the last day of the month of the Member's Long-Term Disability Benefits Commencement Date and the Eligible Employer's obligation to pay dues will end as of that date. Notwithstanding the foregoing, a Member enrolled in Medical Plan coverage prior to the Long-Term Disability Benefits Commencement Date may subscribe for Medical Continuation coverage under § 10.11 of the Medical Plan upon termination of the Member's enrollment by the Eligible Employer.

9.10 Time Limit for Application for Long-Term Disability Benefits.

Application for Long-Term Disability Benefits must be made to the Board's designated administrator within twelve (12) calendar months after the date the Long-Term Disability began unless it can be shown that an earlier filing was not reasonably possible and that the required Disability documentation was furnished as soon as it was reasonably possible.

9.11 Reservation of Right to Suspend or Terminate Benefits.

The Board reserves the right to suspend or terminate the payment of Long-Term Disability Benefits to any Member who fails to

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

9.11.2 remain under the Appropriate Available Treatment (as defined herein) under the care of a duly licensed physician or psychologist in accordance with a treatment plan recommended by the Member's treating healthcare provider that the Board's medical counsel or medical Case Management representatives consider consistent with generally accepted medical standards of practice for the Member's diagnosis;

9.11.2.1 Appropriate Available Treatment for medical illness means care or services which are

9.11.2.1.1 generally acknowledged by physicians to cure, correct, limit, treat, or manage the disabling condition;

9.11.2.1.2 accessible within the Member's geographical region;

9.11.2.1.3 provided by a physician who is licensed and certified by the American Board of Medical Specialties or the American Board of Physician Specialties qualified in a discipline suitable to treat the disabling injury or sickness, and

9.11.2.1.4 in accordance with generally accepted medical standards of practice.

9.11.2.2 Appropriate Available Treatment for behavioral illness means care or services which are

9.11.2.2.1 generally acknowledged by psychiatrists and psychologists to cure, correct, limit, treat, or manage the disabling condition; utilizing both psychotherapy and psychopharmacology modalities when indicated, occurring with a regular frequency, as defined by accepted guidelines, as long as the condition is significantly decreasing capacity, resulting in second opinions when there is little clinical improvement after six months;

9.11.2.2.2 accessible within the Member's geographical region or virtually;

9.11.2.2.3 provided by a professionally licensed mental health care practitioner, and

9.11.2.2.4 in accordance with American Psychological and American Psychiatric Associations' standards of practice.

9.11.3 participate in vocational rehabilitative services as recommended by the Board;

9.11.4 notify the Board immediately in the event of a return to active Eligible Service or other employment;

9.11.5 cooperate with the Board in its exercise of its rights to examinations and to receive evidence of continued Long-Term Disability of the Long-Term Disabled Member, or

9.11.6 provide the Board with documentation requested by the Board or its designated administrator to substantiate earned income (or lack thereof), Social Security Disability Insurance retroactive payments, or any other information that the Board reasonably requires to administer the terms of the Long-Term Disability provisions.

9.12 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 Long-Term Disability Benefits of a Long-Term Disabled Member who is incarcerated upon conviction for a felony.

10 Medical Plan

10.1 Terms Used in the Medical Plan Only.

When used in the Medical Plan, the following terms will have the meanings set forth below:

10.1.1 *Active Medical Plan*. Medical Plan coverage under this § 10 is available for Active Members, Disabled Members under § 6.9.8, and Minister Members eligible for Ministers Bridge Coverage under § 3.1.2. A Covered Person enrolled in Medical Continuation coverage is also eligible for Active Medical Plan benefits as specified in § 10.11.

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

10.1.3 *Custodial Care*. Care rendered to a patient who:

10.1.3.1 is mentally or physically Disabled and such Disability is expected to continue and be prolonged;

10.1.3.2 requires a protected, monitored, and controlled environment, whether in an institution or in the home;

10.1.3.3 requires assistance to support the essentials of daily living; and

10.1.3.4 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, and controlled environment as determined by the Board.

Charges for Custodial Care are not Covered Medical Services. Refer to § 10.3.2.10.

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

10.1.5 *Medical Plan Coverage Options*. The Medical Plan options available for an Eligible Employer to offer to its Eligible Employees as described in § 10.13.

10.1.6 *Medical Continuation*. The extension of Medical Plan coverage eligibility to certain Members and their Eligible Family under § 10 or 11 upon termination of employer eligibility.

10.1.7 *Medically Necessary*. Except as more specifically defined in § 10.2.22 for Habilitative Services for Children, services or supplies provided or prescribed by a hospital, physician, or other healthcare practitioner licensed to diagnose, treat, or prevent a sickness or bodily injury that the Board, in its sole discretion, determines are:

10.1.7.1 appropriate to the symptom and diagnosis or treatment of the sickness or injury;

10.1.7.2 not custodial or for the convenience of the patient, physician, or other healthcare practitioner;

10.1.7.3 not educational, experimental, or investigational in nature;

10.1.7.4 of demonstrated medical value; and

10.1.7.5 the most appropriate standard or level of services which accord with sound medical practice and can be safely provided to the patient. When applied to hospitalization, this further means that acute care as an inpatient is required and appropriate to the nature of services or condition of the patient and that the care cannot be rendered safely or adequately in another treatment setting.

10.1.8 *Medicare Advantage Group PPO*. The Medicare Part C employer group Medicare Advantage Preferred Provider Organization and Prescription Drug Plan described in § 11.2 and offered by the Board to certain Members who have attained age 65 and are enrolled in Parts A and B of Medicare. The Medicare Advantage Group PPO coverage is administered and insured by a licensed health insurance carrier designated by the Board.

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

10.1.10 *Network Medical Costs*. Charges for Covered Medical Services furnished by a Network Provider as of the date the services are rendered.

10.1.11 *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 Benefits Plan has contracted to provide services to Members and their Eligible Families for prescribed charges.

10.1.12 *Non-Network Area*. A geographical area designated by the Board, in its sole discretion, as an area where the plan, as of the date the services are rendered, has not established sufficient relationships with preferred providers or other managed care organizations to provide reasonable access to Network Providers to Members and their Eligible Families.

10.1.13 *Non-Network Medical Costs*. Charges for Covered Medical Services provided by a Non-Network Provider.

10.1.14 *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 Medical Plan has a contractual relationship.

10.1.15 *Out-Of-Network Medical Costs*. Charges for Covered Medical Services provided in a Network Area by an Out-of-Network Provider.

10.1.16 *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 Medical Plan has contracted in the Network Area.

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

10.2 Covered Medical Services.

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

10.2.1 Hospital charges for semiprivate accommodations or services in an intensive care unit. If private accommodations are used, the rate will be the average cost of semiprivate accommodations for that hospital or, if that hospital has no semiprivate accommodations, then the average cost of semiprivate accommodations of Network Provider hospitals in the same locale or region. Charges for services reimbursed under this section are subject to the managed care provisions set forth in § 10.4.

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

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

10.2.4 Diagnosis or treatment by a radiologist, physiotherapist, or licensed laboratory.

10.2.5 Registered or licensed practical nurse for private duty nursing in an inpatient facility or elsewhere if an intensive care unit is not available at the facility. Custodial care is not a Covered Medical Service. Refer to § 10.3.2.10, relating to exclusions and limitations.

10.2.6 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.

10.2.7 Drugs, medications, or medical supplies requiring a written prescription by a physician and reimbursable as a Prescription Drug Benefit of the applicable Medical Plan coverage option. Charges for outpatient prescription drugs are subject to the reimbursement limits and exclusions of the Prescription Drug Benefits. Refer to § 10.1.17.

10.2.8 Use of imaging technology, such as X-rays, radium or radioactive isotopes, for diagnosis or therapy; blood or blood plasma; anesthesia and fluids needed for surgery; artificial limbs or eyes, casts, splints, surgical dressings, trusses, braces, or crutches; oxygen and the rental of equipment for its use; rental of wheelchair or hospital-type bed; rental of an iron lung or other mechanical equipment required for treatment of respiratory paralysis. In appropriate circumstances, the Board, in its sole discretion, may authorize the purchase of certain medical equipment. Charges for the routine maintenance of rented or purchased medical equipment may be subject to restrictions under the medical policy followed by the Medical Plan, or by such organizations as may be designated by the Medical Plan to advise it on such matters.

10.2.9 Pregnancy and childbirth care, including a hospital stay of no more than forty-eight (48) hours following a vaginal delivery or more than ninety-six (96) hours following a delivery by cesarean section.

10.2.10 Behavioral health treatment of nervous, mental, and substance abuse disorders in a hospital, treatment facility for substance abuse and dependencies, or residential treatment center, or for outpatient treatment provided by a psychiatrist, clinical psychologist Ph.D., state-licensed 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 diagnosis of a nervous or mental disorder is furnished to the Medical Plan. In addition to the providers designated in this section, 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 licensing

requirements of a state and has been pre-approved by the Medical Plan. Charges for services reimbursed under this section are subject to the managed care provisions set forth in § 10.4 and the exclusions and limitations set forth in § 10.3.

10.2.11 Dental care for:

10.2.11.1 treatment of an injury to the jaw or sound natural teeth resulting from an accident provided that written notice of the injury to the jaw or teeth is received by the Board within ninety (90) days after the accident and treatment is completed within one (1) year after the accident;

10.2.11.2 removal of up to four (4) bony impacted wisdom teeth; and

10.2.11.3 treatment of temporomandibular joint dysfunction, by whatever name called. Charges for these services are subject to the reimbursement limits set forth in § 10.3.1.1.

10.2.12 The adjustment and manipulation of the spinal column and associated nervous system in restoration of health by a chiropractor duly licensed in the state where care is received to provide such services.

10.2.13 Diagnosis or treatment by a licensed podiatrist. Charges for these services are subject to the exclusions and limitations set forth in § 10.3.2.17.

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

10.2.14.1 part-time or intermittent nursing care by or under the supervision of a registered nurse;

10.2.14.2 part-time or intermittent home health aide services, and

10.2.14.3 services for physical and occupational and speech therapy by a licensed or certified therapist.

10.2.15 Diagnosis or treatment of a disease of or injury to the eye by a licensed ophthalmologist or optometrist, but only in those states where optometrists are licensed to diagnose and treat diseases and injuries to the eye, and Allowable Charges for an annual 3

10.2.16 vision examination under the Medical Plan's preventive services benefits.

10.2.17 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 § 10.2.22, relating to Habilitative Services for Children with Developmental Disabilities, charges for services that are determined to be primarily developmental are not Covered

Medical Services. Refer to § 10.3.2 relating to Medical Costs Not Covered for exclusions and limitations on Covered Medical Services.

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

10.2.19 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 lymphedema.

10.2.20 Foot orthotics prescribed by a physician for treatment of metabolic, peripheral-vascular disease or other medical condition except (i) foot orthotics prescribed for nonsurgical treatment of fractures, (ii) replacement foot orthotics unless the orthotic is irreparably damaged due to normal wear and tear or a change in the patient's condition or size necessitates the replacement, and (iii) foot orthotics prescribed for the conditions listed in this § 10.2.19. Orthotic shoes are covered only when they are prescribed as an integral part of a brace.

10.2.21 Charges for advanced reproductive technology, including in vitro fertilization, zygote intrafallopian transfer, gamete intrafallopian transfer, cryopreserved embryo transfers, intracytoplasmic sperm injection, and ovum microsurgery, and for the supplies and prescription drugs related to such therapies. Refer to § 10.3.1.2 relating to treatment reimbursement limits.

10.2.22 Habilitative Services for Children with Developmental Disabilities, subject to the following terms:

10.2.22.1 Covered Developmental Disabilities:

10.2.22.1.1 Autism Spectrum Disorders

ICD-10 Diagnosis codes

-- F84.0 Autistic disorder
-- F84.3 Childhood disintegrative disorder
-- F84.8 Other specified pervasive developmental disorders
-- F84.9 Pervasive developmental disorder, unspecified

10.2.22.1.2 Cerebral Palsy

ICD-10 Diagnosis code G80.0

10.2.22.1.3 Down Syndrome

ICD-10 Diagnosis code Q90.9

10.2.22.1.4 Intellectual Disability

ICD-10 Diagnosis codes F78.A1 and F78.A9

10.2.22.1.5 Spina Bifida

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

10.2.22.2 *Terms Used in Developmental Development*. The following definitions apply for the Covered Medical Services provided under this section:

10.2.22.2.1 "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.

10.2.22.2.2 "Autism" means a pervasive, neurologically based Developmental Disability of extended duration that causes severe learning, communication, and/or behavior disorders, with age of onset during infancy or childhood. Individuals with autism exhibit impairment in reciprocal social interaction, impairment in verbal and nonverbal communication and imaginative ability, and a markedly restricted repertoire of activities and interests.

10.2.22.2.3 "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.

10.2.22.2.4 "Cerebral Palsy" means a group of disabling symptoms of extended duration which result 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 purpose of this definition, cerebral palsy does not include those symptoms or impairments resulting solely from a stroke.

10.2.22.2.5 "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.

10.2.22.2.6 "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 their condition and environment and to raise the level of their physical, mental, and social efficiency.

10.2.22.2.7 "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 their age, cultural group, and community.

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

10.2.22.2.8.1 Arrive at a correct medical diagnosis.

10.2.22.2.8.2 Prevent the onset of an illness, condition, injury, or Disability.

10.2.22.2.8.3 Reduce, correct, or ameliorate the physical, mental, developmental, or behavioral effects of an illness, condition, injury, or Disability.

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

10.2.22.2.9 "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.

10.2.22.2.10 "Spina bifida" means a medical diagnosis of spina bifida cystica or myelomeningocele.

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

10.2.22.3.1 Behavioral Therapy (Applied Behavioral Analysis or "ABA"). ABA therapy services provided by healthcare practitioners trained to provide ABA therapy, with state licensure or credentialing (as required), and subject to approval by the Board or its delegate.

10.2.22.3.2 Specialized Therapies, including Speech, Occupational, and Vocational Therapies. Medically Necessary services are limited to an annual maximum of up to fifty (50) visits per Child. The first ten (10) visits prescribed by a physician will be covered without review for Medical Necessity. Subsequent visits must be prescribed by a physician, satisfy the definition of Medically Necessary in § 10.2.22.2.8, and be subject to Case Management.

10.3 Exclusions and Limitations

The following exclusions and limitations will apply to the reimbursement of Medical Plan claims:

10.3.1 *Treatment Reimbursement Limits*. Certain Covered Medical Services are subject to the following additional limitations:

10.3.1.1 *Temporomandibular Joint Dysfunction*. Such benefits will be limited to a dollar maximum described in Appendix G for each Covered Person's lifetime.

10.3.1.2 *Advanced Reproductive Technology*. Benefits for advanced reproductive technology defined in 10.2.21, subject to a maximum of three (3) attempts in the aggregate for each Member as a lifetime limit. This limitation will apply also to the supplies prescribed to support these procedures.

10.3.1.3 *Extended Care Facility*. If within seven (7) days of discharge from a Medically Necessary hospital confinement for an illness or injury, a Member or an Eligible Family member, pursuant to a written certification by a supervising physician, requires skilled nursing care in an extended care facility for the same or a related condition, then and in that event the Member will be reimbursed for Covered Medical Services actually paid for each day up to an annual maximum limit of one hundred eighty (180) days of treatment in such a facility up to a maximum of fifty percent (50%) of the hospital daily room rate for semiprivate accommodations for the hospital from which discharged.

10.3.1.4 *Loss of Hearing*. Hearing aids or the fitting or repair thereof are covered subject to reimbursement limits described in Appendix G.

10.3.2 *Medical Costs Not Covered*. Charges for the following medical services and supplies are not covered under the Medical Plan:

10.3.2.1 Medical care, supplies, or treatment received in facilities owned or operated by or furnished at the expense of the United States government or any agency thereof or the government of any state or country or agency thereof, or received elsewhere for which the Member is not, in the absence of this Medical Plan, legally obligated to pay.

10.3.2.2 Dentures, dental services (including orthodontic services that are ancillary to a covered Medical Cost), or dental X-rays, except as set forth in § 10.2.11.

10.3.2.3 Except for the annual eye examination coverage described in § 10.2.15, 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.

10.3.2.4 Cosmetic surgery or treatment procedures, except (i) in connection with treatment for a bodily injury resulting from an accident occurring while covered under the Medical Plan, provided such treatment is commenced within ninety (90) days of such accident, (ii) to correct a congenital disease or congenital anomaly which congenital condition results in an appearance that is not within the range of normal human variation, or (iii) for breast reconstructive surgery covered under § 10.2.19. For purpose of this § 10.3, a "cosmetic" procedure means a procedure or course of treatment that is performed or undertaken primarily to improve or alter the appearance of any portion of the body and that does not significantly improve the function of that body part.

10.3.2.5 Any injury or sickness for which benefits are paid or are payable under any workers' compensation law or similar legislation.

10.3.2.6 Covered Medical Services where the Member or other Covered Person hereunder is not actually required to pay for such services.

10.3.2.7 Covered Medical Services incurred while the Member's benefits are suspended because the dues have not been paid in accordance with § 3.2 and are not guaranteed by a Presbytery.

10.3.2.8 Covered Medical Services incurred for any person who is not or is no longer eligible for coverage pursuant to § 2.2, § 3.1, § 10.10, § 10.11, § 10.13, § 11.1, or § 11.2.

10.3.2.9 Diagnostic and treatment procedures which in the sole determination of the Board are deemed to be experimental, investigative, unproven, for purposes of research, not Medically Necessary, or not generally accepted by the medical profession.

10.3.2.10 Custodial Care rendered to a Covered Person. (A Custodial Care determination is not precluded by the fact that a patient is under the care of a supervising or attending physician and that services are being ordered and prescribed to support and generally maintain the patient's condition, or provide for the patient's comfort, or ensure the manageability of the patient. Further, a Custodial Care determination is not precluded because the ordered and prescribed services and supplies are being provided by an R.N., L.P.N., or L.V.N.)

10.3.2.11 Reversal of a previous sterilization procedure for either sex, unless the initial sterilization was required because of an accident or disease.

10.3.2.12 Radial keratotomy or LASIK.

10.3.2.13 Services which are primarily for the Covered Person's education, training, or development of skills needed to cope with an injury or sickness unless such services are approved in advance by the Board as Medically Necessary.

10.3.2.14 Services or supplies provided primarily for personal hygiene, comfort, or convenience.

10.3.2.15 Services other than Medically Necessary diagnosis, treatment, or surgery, including but not limited to charges for failing to keep an appointment, completion of claim forms, preparation of medical reports (other than reasonable costs related to reports requested by the Board), marriage counselors, or home studies.

10.3.2.16 Services rendered by a person who ordinarily resides in a Covered Person's home or who is related to the patient, including parents, Children, siblings, or Spouses, whether the relationship is by blood or exists by law.

10.3.2.17 Treatment or supplies for (a) weak, strained, flat, unstable, or unbalanced feet, metatarsalgia, or bunions, except open cutting operations, or (b) corns, calluses, or toenails, except foot orthotics prescribed for the treatment of metabolic, peripheral-vascular disease or other medical condition under § 10.2.20.

Orthopedic shoes or orthopedic prescription devices to be attached to or placed in shoes are not covered except as provided in § 10.2.20.

10.3.2.18 Outpatient prescription drugs that were not purchased in accordance with the Prescription Drug Benefits requirements or are excluded from benefits coverage under the Medical Plan option.

10.4 Managed Care Provisions.

Reimbursement for Covered Medical Services is subject to the following additional provisions:

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

10.4.2 *Certification for Inpatient Admission Following an Emergency*. When a Covered Person is admitted to a hospital or other residential inpatient treatment facility following emergency treatment, within forty-eight (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 Medical Plan, a certification authorizing such inpatient confinement. If a Member, or someone on behalf of the Member, fails to obtain from the Medical Plan, or its designated administrator, timely certification of the emergency treatment admission and length of stay, the Medical Plan may request an independent review of the Medical Necessity of the admission and stay prior to adjudicating the claim.

10.4.3 *Precertification for Inpatient Non-emergency Admissions*. A Member, or someone on behalf of the Member, must apply to and receive from the Medical Plan, or such other organization as may be designated by the Medical Plan, precertification of any non-emergency inpatient admission to a hospital or other residential healthcare facility of a Covered Person. If a Member, or someone on behalf of the Member, fails to obtain precertification of a non-emergency admission to a hospital or other residential healthcare facility from the Medical Plan, or its designated administrator, the Medical Plan may request an independent review of the Medical Necessity of the admission and duration of the inpatient stay prior to adjudicating the claim.

10.4.4 *Pre-Authorization Requirements*. The Medical Plan may specify that certain non-emergency diagnostic, surgical, and outpatient services and procedures will be subject to prospective review and approval by the Medical Plan or such other organization as may be designated by the Medical Plan, including a second opinion from another non-affiliated physician when required. If a Member, or someone on behalf of the Member, fails to obtain precertification required by the Medical Plan for a specified non-emergency diagnostic, surgical, or outpatient service or procedure from the Medical Plan, or its designated administrator, the Medical Plan may request an independent review of the Medical Necessity of the service or procedure prior to adjudicating the claim. 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) will be reimbursed to the Member on the basis of one hundred percent (100%) of the Benefits Plan Allowances for Covered Medical Services without regard to the deductible.

10.4.5 *Primary Preventive Services*. The Board will designate, in its sole discretion and consistent with federal Patient Protection and Affordable Care Act requirements, certain primary preventive health services that will be reimbursed without being subject to the applicable office visit, deductible, and/or annual coinsurance provisions.

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

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

10.4.8 *Office Visits by Telemedicine*. Subject to the satisfaction of all requirements of state law, a medical policy adopted by the Medical Plan or by such organizations as may be designated by the Medical Plan to advise it on such matters, and any credentialing requirements of the Medical Plan's claims administrator, visits with physicians and other eligible healthcare practitioners via telemedicine services may be reimbursed by the Medical Plan as an office visit.

10.4.9 *Centers of Excellence*. A Member may be reimbursed for facility fees with reduced copayments for specified procedures at facilities designated by the Board's designated claims administrator as preferred centers of excellence. Reasonable travel expenses incurred for the Covered Person and a travel companion for specified procedures at facilities designated by the Board's designated claims administrator as preferred centers of excellence will also be reimbursed.

10.5 Annual and Lifetime Limits.

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

10.5.2 In no event will the Annual Out-of-Pocket Limit for Covered Medical Services for essential health benefits exceed the annual limitation on out-of-pocket maximums described in § 1302(c) of the federal Patient Protection and Affordable Care Act.

10.6 Time Limit for Submission of Claims for Reimbursement.

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

10.7 Dual Coverage.

Reimbursement of Covered Medical Services under the Medical Plan will be limited to the extent that other coverage is available to the Member or their Eligible Family. The Medical Plan will take into account any coverage such person has under any other group and non-group insurance contract, health maintenance organization contracts, closed panel plans, or other forms of group or group-type coverage (e.g., a qualified health plan offered through the Health Insurance Marketplace) (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 will be coordinated as provided in § 10.7.1, below. For purpose of this § 10.7, benefits provided in the form of services rather than cash payments will be assigned a reasonable cash value, and benefits which may be payable but for which no claim has been made will be taken into account.

10.7.1 *Order and Priority of Benefits*. The primary plan will 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 will coordinate benefits on a maintenance of benefits basis. In such event, the Medical Plan will pay an amount equal to the reimbursable amount under the Medical Plan (as if the plan were primary) less any amount actually paid by the primary plan. Effective beginning January 1, 2025, an Eligible Employee who is also a Spouse or Child of a Member may not enroll for concurrent coverage in the Medical Plan if already enrolled for coverage in the Medical Plan as a Spouse or Child of the other Member.

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

10.7.1.1 A plan that does not have a coordination of benefits provision will be primary.

10.7.1.2 The benefits of a plan that covers the person as an active employee will be considered primary; however, in the event the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a Spouse or Child and primary to the plan covering the person as an active employee (under an exception to the Medicare Secondary Payer rules), then the plan covering the person as an active employee is the secondary plan and the other plan is the primary plan.

10.7.1.3 The benefits of a plan that covers the person as the covered member will be considered primary;

10.7.1.4 The benefits of a plan that covers a Child of the Member or the Spouse whose birthday falls earlier in the calendar year will be considered primary or, if both parents have the same birthday, the plan that has covered a parent the longest is the primary plan.

10.7.1.5 The benefits of a plan that covers the person as a Child whose parents are divorced/dissolved, separated, or not living together, whether or not they have ever been married, will be paid in the following order:

10.7.1.5.1 If a court decree has established financial responsibility for the healthcare expenses or healthcare coverage of a Child and the plan of that parent has actual knowledge of those terms, the plan of the parent responsible will be primary for those plan years commencing after the plan is given notice of the court decree.

10.7.1.5.2 If a court decree states that both parents are responsible for the Child's healthcare expenses or healthcare coverage, or if a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the Child, the provisions of § 10.7.1.4 will determine the order of benefits.

10.7.1.5.3 If there is no court decree allocating responsibility for the Child's healthcare expenses or healthcare coverage, the order of benefits for the Child is as follows:

10.7.1.5.3.1 The plan of the parent with custody will be primary.

10.7.1.5.3.2 The plan of the stepparent married to the parent with custody will be primary.

10.7.1.5.3.3 The plan of the parent not having custody will be primary.

10.7.1.5.3.4 The plan covering the Spouse of the parent not having custody will be primary.

10.7.1.6 For a Child covered under more than one plan of individuals who are not the parents of the child, the provisions of § 10.7.1.4 or 10.7.1.5 will determine the order of benefits as if those individuals were the parents of the Child.

10.7.1.7 When rules (1) through (6) above do not establish an order of benefit determination, the benefits of a plan that has covered the person for the longer period of time will be primary.

10.7.1.8 When rules (1) through (7) above do not establish an order of benefit determination, the Allowable Charges will be shared equally between the plans; however, the Medical Plan will not pay more than it would have paid had it been primary.

10.7.1.9 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 will be secondary to Medicare coverage.

10.7.1.10 In the case of a health maintenance organization-type plan or other form of plan with fixed maximum fees for providers, this Medical Plan will not cover any charges in excess of what that participating provider has agreed to accept as payment.

10.7.1.11 When the Medical Plan is secondary, it will 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.

10.7.1.12 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 Charges. The Medical Plan will credit to its deductible any amounts it would have credited to its deductible in the absence of any other healthcare coverage.

10.7.2 *Facility of Payment*. The Board in its sole determination will 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 will be deemed benefits paid under this Medical Plan.

10.7.3 *Right of Recovery*. The Board will have the right to recover from the Member any sum paid by the Board that should have been paid by another plan.

10.8 Rights of Recoupment, Subrogation, and Reimbursement.

10.8.1 Covered Medical Services otherwise reimbursable by the Medical Plan will not be payable to or for a Member or an Eligible Family member or anyone acting on behalf of a Covered Person when such Covered Medical Services are subject to recovery from another source, including, but not limited to, reimbursement for damages caused from the act or omission of a third party or reimbursement from other insurance coverage (other

than another group health plan subject to the dual coverage provision set forth in § 10.7) maintained by or on behalf of the Covered Person.

10.8.2 The Board may, in its sole discretion, advance sums from the Medical Plan to a Covered Person or anyone acting on their behalf for eligible Covered Medical Services that are excluded under § 10.8.1 until such time as the Member or the Eligible Family member or person acting on behalf of the Covered Person recovers the reimbursement from the other source. The Covered Person or person acting on behalf of the Covered Person will be required

10.8.2.1 to repay the Medical Plan in full all sums advanced by the Medical Plan for Covered Medical Services relating to the injury or illness from any judgment, settlement, or reimbursement he or she receives, regardless of how the proceeds of the judgment or settlement are characterized and without deduction for any costs or fees of any nature therefrom;

10.8.2.2 to subrogate any right of recovery he or she may have against the other source; and

10.8.2.3 to cooperate fully with the Medical Plan in assisting it to protect its legal rights under the agreement and this § 10.8.

10.8.3 The Medical Plan's rights of recoupment and reimbursement granted under this § 10.8 will constitute a lien and first priority claim against any person or entity, to be paid before any other claims are repaid, whether or not the Member or an Eligible Family member has been made whole or has recovered the total amount of damages incurred. The entire amount of any damages recovered, notably the part specifically allocated to Covered Medical Services, will be made available by the Covered Person for the repayment of the reimbursement obligation under this § 10.8.

10.9 Exchange of Medical Plan Information.

Subject to the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations promulgated thereunder, as they may be amended from time to time (collectively, "HIPAA") and, in particular, the rules under HIPAA pertaining to the privacy of individually identifiable health information ("Protected Health Information") and the security of electronic Protected Health Information as set forth in 45 C.F.R. Subtitle A, Part 164, Subpart E, as it may be amended from time to time (the "HIPAA Rules"), and any more stringent state law applicable to the Medical Plan, the Board will 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 will be required to furnish to the Board such information as the Board or the Medical Plan's agents may require in connection with any medical, dental, or vision benefit claim. The Board's use of the information will be subject to the provisions of § 10.12. All other uses and disclosures of information by the Medical Plan will be as set forth in the Medical Plan's privacy notice provided to Members under the HIPAA Rules.

10.10 Termination of Coverage

10.10.1 Active Medical Plan coverage will terminate for Members and/or Eligible Family members on the last day of the month in which any one of the events described below occurs.

10.10.1.1 The termination of the Member's employment in Eligible Service or reduction in hours that results in loss of eligibility, except that a Member and their Eligible Family who have been enrolled in the Congregational Pastors Package or for Transitional Pastor's Participation coverage will continue to be covered for Medical Plan PPO Benefits (or Medicare Advantage Group PPO coverage if Medicare-eligible) until the first day of the month following the month in which such Minister's employment terminated at no additional dues obligation to the Eligible Employer or Member.

10.10.1.2 The date of death of a Member.

10.10.1.3 For a Spouse, the date of divorce from the Member or legal termination of rights as a Spouse of the Member.

10.10.1.4 For a Child, the date of the Child's 26th birthday, unless the Child continues to be eligible due to Total Disability.

10.10.1.5 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 Medical Plan by the date required.

10.10.1.6 The last day of continued Medical Plan coverage of a Disabled Member or an Eligible Family member under § 6.9.8.4.

10.10.1.7 The date the Eligible Employer terminates Active Medical Plan coverage and withdraws its employees or a class of its employees from Medical Plan participation.

10.10.2 Upon termination of Active Medical Plan coverage under this § 10.10, an affected Member and/or their Eligible Family members may be eligible for Medical Continuation or the Medicare Advantage Group PPO benefits as set forth in § 10.11 and § 11.

10.11 Medical Continuation Coverage.

On or within sixty (60) days of the termination date for Active Medical Plan coverage, those persons for whom coverage was in effect on the date prior to the occurrence of an event described in § 10.10.1.1 through 10.10.1.6 will have the option of subscribing for Medical Continuation coverage.

10.11.1 Except as otherwise provided herein or as otherwise may be required by law, a Covered Person may subscribe for Medical Continuation coverage for the following durations:

10.11.1.1 Upon termination of coverage under §§ 10.10.1.1, 10.10.1.5, or 10.10.1.6, Members and their Eligible Family may subscribe for a period of eighteen (18) months.

10.11.1.1.1 If a Covered Person is or becomes Totally Disabled (as defined by the Social Security Act) at any time during the first sixty (60) days of Medical Continuation coverage, the subscription period will be extended from eighteen (18) months to twenty-nine (29) months.

10.11.1.1.2 If the Member, on the date the Active Medical Plan coverage under § 10.10.1.1 terminates, is age 55 or older, the Member and/or their Eligible Family members (as long as they continue to remain Eligible Family members) may subscribe until the Covered Person becomes eligible for Medicare.

10.11.1.2 Upon termination of coverage under § 10.10.1.2, surviving Eligible Family members may subscribe for Medical Continuation or Medicare Advantage Group PPO benefits for thirty-six (36) months from the date of the Member's death. Medical Continuation dues will be waived for any period that the Covered Person may be entitled to coverage under § 10.10.1.1.

10.11.1.3 Upon termination of coverage under § 10.10.1.3, a Spouse may subscribe for a period of thirty-six (36) months.

10.11.1.4 Upon termination of coverage under § 10.10.1.4, a Child may subscribe for a period of thirty-six (36) months.

10.11.2 To be eligible for Medical Continuation coverage, a Covered Person must complete and submit the appropriate application form for Medical Continuation benefits to the Board within sixty (60) days of the triggering event under § 10.10, and pay to the Board monthly in advance, or at such other time or times as may be specified by the Board, such amount as the Board may establish from time to time for Medical Continuation coverage. Any Children born to, adopted by, or placed for adoption with a Member, Spouse, Surviving Spouse, or former Spouse subscribing for Medical Continuation coverage will also be eligible for coverage for the duration of the parent's subscription period.

10.11.3 Medical Continuation coverage is not available to a Member and their Eligible Family members if the termination of Active Medical Plan coverage is due to an event described in § 10.10.1.7 (relating to termination of participation by Eligible Employer).

10.11.4 Medical Continuation coverage is not available to a Member's Spouse and Eligible Family members if the termination of Active Medical Plan coverage is due to the expiration of the Active Medical Plan coverage under § 6.9.8.4.

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

10.12 Use of Protected Health Information by Board.

The provisions of this § 10.12 are intended to comply with the HIPAA Rules relating to use by and disclosure of Protected Health Information (as defined in the HIPAA Rules) to plan sponsors. The Health Plans, including without limitation the Active Medical, Medical Continuation, Medicare Advantage Group PPO, and any other health plan subject to HIPAA provided by the Benefits Plan, constitute an organized health care arrangement.

10.12.1 *Terms Under HIPAA*. Each capitalized term used in this § 10.12 that is not otherwise defined in the Benefits Plan will have the meaning ascribed to it under HIPAA.

10.12.2 *Required Uses and Disclosures*. Except as otherwise set forth herein, the Medical Plan, and any other health plan that is part of the Medical Plan's organized health care arrangement (individually and collectively referred to herein as the "Health Plan") or any licensed 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:

10.12.2.1 for disclosure to the Secretary of the U.S. Department of Health and Human Services (HHS) when required by the Secretary of HHS investigation or determination of the compliance of the Health Plan with the HIPAA Rules;

10.12.2.2 for disclosure to a Covered Person of that individual's Protected Health Information upon the individual's written request or in appropriate response to an exercise by the Covered Person of any other of their individual rights with respect to Protected Health Information, all in accordance with the requirements of the HIPAA Rules; and

10.12.2.3 for use or disclosure to other persons, as required by applicable law other than HIPAA, provided that nothing in this § 10.12 will permit or require the use by or disclosure of Protected Health Information to the Board to the extent such disclosure is prohibited by HIPAA.

10.12.3 *Permitted Uses and Disclosures*. Except as otherwise set forth herein, the Protected Health Information created or received by the Health Plan or any licensed health insurance issuer providing benefits under the Health Plan will be permitted to be disclosed to the Board (upon receipt from the Board of a certification that it will comply with the restrictions as to the use of Protected Health Information and the other provisions set forth

in this § 10.12) for purposes of the Health Plan's administration functions that the Board performs on behalf of the Health Plan, or as otherwise required by HIPAA, including without limitation:

10.12.3.1 for Treatment, Payment, or Health Care Operations;

10.12.3.2 for other wellness, prevention, and disease management programs;

10.12.3.3 for benefits appeals and complaints;

10.12.3.4 for purposes relating to subpoenas and other court orders; and

10.12.3.5 pursuant to and in accordance with a valid authorization under the HIPAA Rules.

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

10.12.4 *Requirements of the Board*. The Board will:

10.12.4.1 not use or disclose Protected Health Information received from the Health Plan, or any licensed 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;

10.12.4.2 ensure that any agent (including a subcontractor) to whom the Board provides Protected Health Information received from the Health Plan, or any licensed 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 § 10.12;

10.12.4.3 not use or disclose Protected Health Information received from the Health Plan, or any licensed 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;

10.12.4.4 report to the Health Plan or licensed 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 licensed health insurance issuer providing benefits under the Health Plan, that is inconsistent with the uses or disclosures required or permitted under this § 10.12 and of which the Board becomes aware;

10.12.4.5 make the Protected Health Information of a Covered Person available to that individual, upon the individual's written request, in accordance with the requirements of the HIPAA Rules as modified by the Health Information Technology for Economic and Clinical Health Act;

10.12.4.6 incorporate amendments of Protected Health Information of a Covered Person as, and to the extent, required by the HIPAA Rules;

10.12.4.7 make available to a Covered Person upon the individual's written request the information necessary to provide an accounting of the disclosures of Protected Health Information as, and to the extent, required by the HIPAA Rules as modified by the Health Information Technology for Economic and Clinical Health Act;

10.12.4.8 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 licensed 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;

10.12.4.9 if feasible, return or destroy all Protected Health Information received from the Health Plan, or any licensed 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;

10.12.4.10 ensure that the requirements set forth in §§ 10.12.5.1 and 10.12.5.2 are satisfied with respect to Protected Health Information; and

10.12.4.11 grant a restriction, if requested, on Protected Health Information disclosure to a health plan for payment or healthcare operations purposes (not treatment purposes), if the Protected Health Information pertains solely to a healthcare item or service for which the healthcare provider has been paid out-of-pocket in full.

10.12.5 *Access to Protected Health Information*.

10.12.5.1 *Access*. Access to and use of Protected Health Information will 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 §§ 10.12.2 and 10.12.3, in order to perform such activities.

10.12.5.2 *Minimum Necessary*. Except as to a use or disclosure of information related to the treatment of an individual, when using or disclosing Protected Health Information or when requesting Protected Health Information from another entity, the Health Plan or any individual acting on behalf of the Health Plan, including the Board, must make reasonable efforts to limit the use or disclosure of

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

- Healthcare Benefits
- Plan Operations
- Information Technology
- Mailroom/Fax Delivery
- Finance/Treasury
- Appeals Board
- Legal
- Accounting
- Internal Audit
- Officers of the Board responsible for administration of the Medical Plan

10.12.6 *Security*. With respect to electronic Protected Health Information, the Board will:

10.12.6.1 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 Health Plan;

10.12.6.2 ensure that the adequate separation of the members of its Workforce who have access to electronic Protected Health Information pursuant to § 10.12.5.2 above is supported by reasonable and appropriate security measures;

10.12.6.3 report to the Health Plan any security incidents of which it becomes aware; and

10.12.6.4 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.

10.12.7 *Noncompliance*. If the Health Plan becomes aware of any issues relating to noncompliance with the requirements of this § 10.12, the Health Plan's privacy or security official will undertake an investigation to determine the extent, if any, of such noncompliance; the individuals, policies, or practices responsible for the noncompliance; whether the affected individuals should be notified of any unauthorized disclosure of unsecured Protected Health Information; and the appropriate means for curing or mitigating the effects of noncompliance and preventing such noncompliance in the future. Any individual or entity who is determined by the Health Plan to be responsible for such noncompliance will 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.

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

10.12.9 *Action by the Board*. The Board may act as prescribed in this § 10.12 or may delegate, in writing and in its sole discretion, any and all of its functions under this § 10.12 to a committee, to the Health Plan's privacy and security officials, privacy contact person responsible for receiving complaints, or other officer or employee, or to a group of officers or employees of the Board. The Board or such delegates will have the authority to establish rules and prescribe forms and procedures for performing its functions hereunder.

10.12.10 *Inconsistent Provisions*. This § 10.12 will supersede any provisions of the Health Plan to the extent those provisions are inconsistent with this § 10.12.

10.13 Medical Plan Coverage Options.

The Medical Plan provides three coverage options for Eligible Employers to elect to offer their employees. An Eligible Employer may offer one or more of these options to all or specific classifications of its employees. Those coverage options consist of PPO Benefits, EPO Benefits, and HDHP Benefits, as described in this Section.

10.13.1 *Enrollment Periods*. Members and Eligible Family members are eligible for enrollment in Medical Plan Coverage Options in accordance with the eligibility and enrollment rules of the Eligible Employer and any requirements of applicable law, the Benefits Plan, and the Board's administrative rules. A Member may elect to enroll Eligible Family members during any enrollment period established by the Board and such coverage will be effective as of the initial date of enrollment, January 1 of the new Plan Year, or within sixty (60) days of a triggering event qualifying for a special enrollment period upon a life change under the Board's administrative rules. Special enrollment coverage will be effective as of the day of the Eligible Life Change Event.

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

10.13.3 *Coverage for Disabled Members and Dependent Totally Disabled Children*. Continued Medical Plan coverage is only available to a Medicare-eligible

Disabled Member or a Dependent Totally Disabled Child of a Member after the attainment of age twenty-six (26) for such period of time during which such Disabled Member or Disabled Child is enrolled in both Part A and Part B of Medicare. The Dependent Totally Disabled Child will be enrolled in the same coverage as the Member, including the Medicare Advantage Group PPO.

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

10.14 PPO Benefits.

PPO Benefits consist of reimbursement to the Member or their assignee for Medically Necessary Covered Medical Services provided to the Member and their Eligible Family, subject to the Member's payment responsibilities for copayments, coinsurance, and deductibles as described in this § 10.14 and Appendix G, the provisions of § 11, and other applicable provisions of the Benefits Plan.

10.14.1 *Member Copayments and Coinsurance*.

10.14.1.1 *Physician Office Visits*.

10.14.1.1.1 *Network and Non-Network*. The Member will pay the copayment amount specified in Appendix G per visit with a Network or Non-Network primary care or behavioral health practitioner, specialist physician, or urgent care center.

10.14.1.1.2 *Out-of-Network*. The Member will pay fifty percent (50%) of the Plan Allowance for an office visit to an Out-of-Network primary care or behavioral health practitioner, or specialist physician.

10.14.1.1.3 *No Deductible for Office Visits*. Office visits reimbursed under this § 10.14.1 will not be subject to the annual deductible requirements in § 10.14.3.

10.14.1.1.4 *Preventive Health Screenings*. Notwithstanding the foregoing, the Member will not have a copayment obligation and the Medical Plan will reimburse one hundred percent (100%) of the eligible Covered Medical Services for an office visit for prevention screenings covered by the Medical Plan's preventive health benefits.

10.14.1.2 *Other Medical Services*.

10.14.1.2.1 *Reimbursement after Satisfaction of Deductibles*. Upon satisfaction by the Member and Eligible Family members of the applicable annual deductible amount set forth in § 10.14.3 and Appendix G, the Medical Plan will reimburse a Member:

10.14.1.2.1.1 *Network and Non-Network Providers*: Eighty percent (80%) of the Plan Allowance for Covered Medical Services incurred by the Member and the Eligible Family members. The remaining twenty percent (20%) is the Member's coinsurance responsibility.

10.14.1.2.1.2 *Out-of-Network Providers*: Sixty percent (60%) of the Plan Allowance for Covered Medical Services incurred by the Member and the Eligible Family members. The remaining forty percent (40%) is the Member's coinsurance responsibility.

10.14.1.2.2 *Reimbursement after Satisfaction of Annual Out-of-Pocket Limits*. Upon satisfaction by the Member and Eligible Family members of any applicable Annual Out-of-Pocket Limit amount set forth in § 10.14.4 and Appendix G, the Medical Plan will reimburse a Member:

10.14.1.2.2.1 *Network and Non-Network Providers*: One hundred percent (100%) of the Plan Allowance for Covered Medical Services incurred by the Member and the Eligible Family members.

10.14.1.2.2.2 *Out-of-Network Providers*: The lesser of one hundred percent (100%) of the charges for Covered Medical Services incurred by the Member and the Eligible Family members or one hundred percent (100%) of the Plan Allowance.

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

10.14.3 *Annual Deductibles*. Reimbursement for Covered Medical Services under this § 10.14 is subject to the Member's satisfaction of the annual deductibles specified in

Appendix G. For purpose of determining annual deductible amounts, the Board may, in its sole discretion, establish minimum, maximum, and graduated bands of Effective Salary ("Compensation Bands") on which to apply the applicable percentage stated below, provided that the Member will not be placed in a Compensation Band that exceeds the Member's Effective Salary.

10.14.3.1 *For Covered Medical Services Other than Prescription Drug Benefits Costs*.

10.14.3.1.1 *Physician Office Visits*. There are no annual deductibles for physician office visits.

10.14.3.1.2 *Other Medical Services*. The annual deductibles for Covered Medical Services other than costs incurred for office visits and for Prescription Drug Benefits will be:

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

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

10.14.3.1.2.3 *Out-of-Network Covered Medical Services*: applied to satisfy the Network and Non-Network Covered Medical Services Deductibles.

10.14.3.1.2.4 *Network and Non-Network Covered Medical Services*: applied to satisfy the Out-of-Network Covered Medical Services Deductibles.

10.14.3.2 *For Prescription Drug Benefits Costs*. There are no annual deductibles for Covered Medical Services incurred under the Prescription Drug Benefits.

10.14.3.3 *Annual Caps on Deductibles*. Notwithstanding § 10.14.3.1 above:

10.14.3.3.1 The aggregate annual deductibles for Covered Medical Services (Network, Non-Network, and

Out-of-Network) will not exceed two and one-half percent (2.5%) of the Member's Compensation Band for Covered Medical Services for a Member and an additional two and one-half percent (2.5%) of the Member's Compensation Band for Covered Medical Services for the Member's Eligible Family.

10.14.3.3.2 No more than two (2) annual deductibles will be applicable to a Member and such Member's Eligible Family in any one (1) calendar year.

10.14.3.3.3 A Member's aggregate maximum annual deductible responsibility will not exceed the sum of two (2) annual deductibles for Covered Medical Services.

10.14.3.4 *Annual Deductible for Disabled Members*. The annual deductibles for a Disabled Member and Eligible Family's Medical Plan coverage under § 6.9.8 will be as specified in Appendix G.

10.14.3.5 *Annual Deductible for Medical Continuation Coverage*. The annual deductibles for individuals enrolled in Medical Continuation benefits under § 10.11 will be as specified in Appendix G.

10.14.3.6 Reimbursable Covered Medical Services credited toward satisfaction of the annual deductibles for Covered Medical Services are not credited toward satisfaction of the Annual Out-of-Pocket Limits.

10.14.3.7 For Out-of-Network Covered Medical Services, only charges up to the Plan Allowance for Covered Medical Services will be credited toward the satisfaction of the annual deductibles.

10.14.4 *Out-of-Pocket Limits*. Reimbursement for Covered Medical Services under this § 10.14 is subject to the Annual Out-of-Pocket Limits specified in Appendix G. For purposes of determining the Annual Out-of-Pocket Limits, the Board may, in its sole discretion, use Compensation Bands on which to apply the applicable percentage stated below.

10.14.4.1 For Covered Medical Services Other than Prescription Drug Benefits Costs ("Annual Out-of-Pocket Limit").

10.14.4.1.1 *For Network and Non-Network Covered Medical Services*. A Member's Annual Out-of-Pocket Limit is five percent (5%) of the Member's Compensation Band.

10.14.4.1.2 *For Out-of-Network Covered Medical Services*. A Member's Annual Out-of-Pocket Limit is fifteen percent (15%) of the Member's Compensation Band.

10.14.4.1.3 *Disabled Members*. For Disabled Members and their Eligible Family enrolled in Medical Plan coverage under § 6.9.8, the Compensation Band for purposes of determining the Annual Out-of-Pocket Limit in § 10.14.4.1.1 and § 10.14.4.1.2 above will be the Compensation Band applicable to the greater of the Disabled Member's Effective Salary on the date the Disability began or the current Median Effective Salary.

10.14.4.1.4 *Individuals Enrolled for Medical Continuation Benefits*. For individuals enrolled in Medical Continuation benefits under § 10.11, the amount of the Annual Out-of-Pocket Limit in § 10.14.4.1.1 and 10.14.4.1.2 above will be established on the basis of the Median Effective Salary.

10.14.4.1.5 Notwithstanding §§ 10.14.3.1.2.1 and 10.14.3.1.2.2 above, the aggregate Annual Out-of-Pocket Limit will not exceed fifteen percent (15%) of all reimbursable Covered Medical Services.

10.14.4.1.6 For Out-of-Network Covered Medical Services, only charges for Covered Medical Services up to the Plan Allowance will be credited toward satisfaction of the Annual Out-of-Pocket Limit.

10.14.4.2 *For Prescription Drug Benefits Costs* ("Prescription Drug Annual Out-of-Pocket Limit"). In the event that during a given calendar year, the Prescription Drug Benefits copayment charges paid by a Member and a Member's Eligible Family, exclusive of copayment charges for non-formulary brand-name drugs, exceed the Annual Out-of-Pocket Limit for Prescription Drug Costs on Appendix G, no further copayments under § 10.14.2 will be required for the balance of that calendar year and all reimbursable Prescription Drug Benefits charges (other than copayments for non-formulary brand-name drug charges) in excess thereof will be reimbursed on the basis of one hundred percent (100%) of Allowable Charges, subject to the managed care provisions of § 10.4.7.

10.15 EPO Benefits.

EPO Benefits consist of reimbursement by the Medical Plan to the Member or their assignee for Medically Necessary Covered Medical Services provided by Network and Non-Network Providers to a Member and their covered Eligible Family, subject to the Member's payment responsibilities for copayments and deductibles as described in this § 10.15 and Appendix G, the provisions of § 11, and other applicable provisions of the Benefits Plan.

10.15.1 *Member Copayments and Coinsurance*.

10.15.1.1 *Physician Office Visits*.

10.15.1.1.1 *Network and Non-Network*. The Member will pay the copayment amount specified in Appendix G per visit with a Network or Non-Network primary care or behavioral health practitioner, specialist physician, or urgent care center.

10.15.1.1.2 *Out-of-Network*. No reimbursement will be made for Out-of-Network office visits.

10.15.1.1.3 *Preventive Health Screenings*. Notwithstanding the foregoing, the Member will not have a copayment obligation and the Medical Plan will reimburse one hundred percent (100%) of the eligible Covered Medical Services for an office visit for prevention screenings covered by the Medical Plan's preventive health benefits.

10.15.1.2 *Other Medical Services*.

10.15.1.2.1 *Reimbursement after Satisfaction of Deductibles*. Upon satisfaction by the Member and Eligible Family members of the applicable annual deductible amounts set forth in § 10.15.3 and Appendix G, the Medical Plan will reimburse a Member:

10.15.1.2.1.1 *Network and Non-Network Providers*: Eighty percent (80%) of the Plan Allowance for the Covered Medical Services incurred by the Member and the Eligible Family members. The remaining twenty percent (20%) is the Member's coinsurance responsibility.

10.15.1.2.1.2 *Out-of-Network Providers*: No reimbursement will be made for Out-of-Network Covered Medical Services, except Emergency Services.

10.15.1.2.2 *Reimbursement after Satisfaction of Annual Out-of-Pocket Limit*. Upon satisfaction by the Member and Eligible Family members of the Annual Out-of-Pocket Limit set forth in Appendix G, the Medical Plan will reimburse a Member:

10.15.1.2.2.1 *Network and Non-Network Providers*: One hundred percent (100%) of the Plan Allowance for Covered Medical Services incurred by the Member and the Eligible Family members.

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

10.15.2 Member Copayments for Prescription Drug Benefits Costs.

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

10.15.3 *Annual Deductibles*. Reimbursement for Covered Medical Services under this § 10.15 is subject to the Member's satisfaction of the annual deductibles specified in Appendix G.

10.15.3.1 There are no annual deductibles for Covered Medical Services incurred for office visits subject to § 10.15.1.2.1.1.

10.15.3.2 There are no annual deductibles for Covered Medical Services incurred under the Prescription Drug Benefits.

10.15.4 Annual Out-of-Pocket Limits. Reimbursement for Covered Medical Services under this § 10.15 is subject to the Annual Out-of-Pocket Limits specified in Appendix G.

10.15.5 *Exclusions and Limitations Applicable to EPO Benefits*.

In addition to the exclusions and limitations generally applicable to the Medical Plan as described in § 11, EPO Benefits also exclude from reimbursement services and supplies provided by Out-of-Network Providers, except Emergency Services.

10.16 HDHP Benefits.

HDHP Benefits consist of reimbursement by the Medical Plan to the Member or their assignee for Medically Necessary Covered Medical Services provided by Network or Non-Network Providers to a Member and their covered Eligible Family members, subject to the Member's payment responsibilities for copayments and deductibles as described in § 10.16 and Appendix G, the provisions of § 11, and other applicable provisions of the Benefits Plan.

10.16.1 *Annual Deductible*. Except for Covered Medical Services incurred for preventive office visits under § 10.16.2.1.2 or for Preventive Prescription Drug Services under § 10.16.2.3, reimbursement for Covered Medical Services under this § 10.16 is subject to the Member's satisfaction of the annual deductibles specified in Appendix G.

10.16.2 *Coinsurance for Covered Medical Services Other Than Prescription Drugs*. Upon satisfaction by the Member and Eligible Family members of the applicable annual deductible amounts specified in § 10.16.1 and Appendix G, the Member will be

responsible for the following copayments and coinsurance for the Covered Medical Services.

10.16.2.1 *Physician Office Visits*.

10.16.2.1.1 *Network and Non-Network*. The Member will pay the copayment and/or coinsurance amount specified in Appendix G per visit with a Network or Non-Network primary care or behavioral health practitioner, specialist physician, or urgent care center.

10.16.2.1.2 *Out-of-Network*. No reimbursement will be made for Out-of-Network office visits.

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

10.16.2.2 *Other Medical Services*.

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

10.16.2.2.2 *Out-of-Network Providers*. No HDHP Benefits are payable for Out-of-Network Covered Medical Services except Emergency Services. The Member will be solely responsible for any charges incurred for Covered Medical Services except Emergency Services.

10.16.2.3 *Prescription Drug Benefit*. For covered outpatient prescription drugs other than prescription drugs covered under the Preventive Prescription Drug Services benefit, until the Member has satisfied the annual deductible for HDHP Benefits specified in Appendix G, the Member will be responsible for the Plan Allowance for generic, brand, and specialty drugs based on the type of pharmacy (retail or mail-order), the amount supplied (up to 30 or 90 days) and whether the drug is on the applicable formulary. After satisfaction of the annual deductible, the Member will be responsible for a coinsurance payment of thirty percent (30%) of the Plan Allowance for covered Prescription Drugs.

10.16.3 *Annual Out-of-Pocket Limit*. Upon satisfaction of the Member or Family Annual Out-of-Pocket Limit specified in Appendix G, and any other requirements of the Medical Plan, the Member will be reimbursed for one hundred percent (100%) of Covered Medical Services.

10.16.3.1 *Network and Non-Network Providers*: One hundred percent (100%) of the Plan Allowance for Covered Medical Services incurred by the Member and the Eligible Family members.

10.16.3.2 *Out-of-Network Providers*: No reimbursement will be made for Out-of-Network services, except Emergency Services. Emergency Services will be reimbursed as described in § 10.16.2.1.3.

10.16.4 *Exclusions and Limitations Applicable To HDHP Benefits*.

10.16.4.1 In addition to the exclusions and limitations generally applicable to the Medical Plan as described in § 11, HDHP Benefits also exclude from reimbursement the services and supplies provided by Out-of-Network Providers, except Emergency Services.

10.16.4.2 The HDHP is a qualified high deductible health plan subject to the requirements of the Code for such plans. HDHP Benefits will be subject to any applicable exclusions, limitations and other terms and conditions in the Code.

11 Post-Retirement Medical Plan

11.1 Medical Plan Coverage Prior to Eligibility for Medicare.

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 § 10.11.

11.2 Medicare Advantage Group PPO Coverage Following Eligibility for Medicare.

The following groups will have the option to enroll in Medicare Advantage Group PPO benefits as set forth in § 11.3: (a) Members enrolled after 2017 in the Health Plan or the Defined Benefit Pension Plan, (b) Terminated Vested Members, and (c) Spouses of Active Medical Plan Members whose employers meet requirements. Coverage will commence as of the latest of (i) the date of termination of Active Medical Plan coverage, (ii) the first day of the month during which such person becomes eligible for Medicare and is enrolled in Medicare Parts A and B, or (iii) the first day of the Plan Year following an open enrollment or a special enrollment period, provided that the Member, former Member, or Eligible Family member satisfies the eligibility conditions for enrollment in the Medicare Advantage Group PPO established by the Board, which include each individual enrolling in and maintaining current coverage in Medicare Parts A and B.

11.3 Medicare Advantage Group PPO Benefits.

Medicare Advantage Group PPO coverage for those subscribing persons eligible under § 11.2 will comply with the federal requirements for Medicare Part C (Medicare Advantage programs) sponsored by employer group health plans.

11.3.1 *Medicare Advantage Group PPO Coverage*. The Medicare Advantage Group PPO coverage, exclusions, deductibles, copays, co-insurance and other provisions will be as set forth in the evidence of coverage provided by the Medicare Advantage Group PPO insurer selected by the Board.

11.3.2 *Subscription Charge*. The subscription dues for the Medicare Advantage Group PPO coverage will be as set forth in Appendix A and paid as set forth in section (b). Dues will be payable monthly in advance or at such other time or times as may be established by the Board and will be in such amounts as the Board, in its sole discretion, deems necessary to provide such coverage. The subscription dues for a person who becomes eligible under § 11.2 for coverage provided by this § 11.3 will be waived for the remainder of the month in which the Member is no longer employed in Eligible Service provided the dues for Medical Plan coverage for such person has not been previously waived under § 10.11.5.

11.3.3 *Termination of Medicare Advantage Group PPO Coverage*. Coverage under this § 11.3 will terminate upon the earlier of the death of the subscribing Covered Person, the Effective Date of a subscribing person's opt out of coverage, or the last day of the period for which a subscription dues payment has been received if the next subsequent payment is not made on the date required.

12 Dental Plan

12.1 Dental Benefits.

The Board will, from time to time, adopt such provisions, rules, and regulations applicable thereto and designate a claims administrator as it, in its sole discretion, deems necessary or appropriate for the administration of a Dental Benefits program to be offered to the Members enrolled in the Dental Plan. The Board may select an insurance company to underwrite and administer the group coverage provided in § 12, in which event, the terms of the Dental Benefits program will be as set forth in the evidence of coverage or equivalent document provided by the Carrier.

12.2 Terms Used in the Dental Plan Only.

When used in § 12, the following words will have the respective meanings set forth below unless the context clearly indicates otherwise:

12.2.1 *Dentist*. An individual legally licensed to practice dental medicine.

12.2.2 *Carrier*. The insurance company that the Board may select from time to time to underwrite and administer the coverage provided in § 12.

12.3 Eligibility

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

12.4 Commencement of Coverage.

Coverage for dental benefits will commence upon an eligible Member enrolling for the benefits as provided in § 4.2, provided that a Member also (a) completes and submits to the Board, its designated claim administrator, or the Carrier, any supplemental application or other forms required by the Board, which application and/or forms are accepted by the Board, its claim administrator, or the Carrier as being complete and evidencing entitlement to the coverage provided by § 12, and (b) pays all dues specified in Appendix A as required by § 12.

12.5 Reimbursement of Dental Expenses.

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

12.6 Deductible.

No benefits will 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.

12.7 Dental Services.

The dental services covered under this program will include only those dental services described in a schedule published by the Board, its claims administrator, or, if the Board has selected a Carrier to underwrite the coverage provided in § 12, as defined in the group insurance policy of the Carrier underwriting the coverage contained in § 12.

12.8 Predetermination of Benefits.

Any person covered under § 12 may submit to the claims administrator or Carrier in advance of treatment a treatment plan which will permit the claims administrator or Carrier to issue to such person a predetermination of benefits as to the approved course of treatment and an estimate of benefits payable.

12.9 Termination of Coverage.

Coverage for a Member and their Eligible Family members under § 12 will terminate upon the occurrence of any one of the following events:

12.9.1 The date of retirement of a Member.

12.9.2 The last day of the month in which Member's employment in Eligible Service terminated other than a Disabled Member (unless the Member enrolls to continue coverage under Ministers Bridge Coverage described in § 2.2.3.

12.9.3 The date of death of a Member.

12.9.4 The last day of the period for which a dues payment for coverage under § 12 has been made if the next subsequent dues payment is not made on the date required.

13 Vision Eyewear Plan

13.1 Eligibility.

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

13.2 Vision Eyewear Benefits.

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

13.3 Termination of Coverage.

Coverage for a Member and their Eligible Family members under § 13 will terminate upon the occurrence of one of the following events:

13.3.1 The date of retirement of a Member.

13.3.2 The last day of the month in which Member's employment in Eligible Service terminated other than a Disabled Member (unless the Member enrolls to continue coverage under Ministers Bridge Coverage (described in § 2.2.3).

13.3.3 The date of death of a Member.

13.3.4 The last day of the period for which a dues payment for coverage under § 13 has been made if the next subsequent dues payment is not made on the date required.

14 Employee Assistance Plan

14.1 Eligibility.

14.1.1 *Integrated EAP Benefits.* Members enrolled in coverage for Medical Plan benefits under §10 are eligible for EAP benefits as described in §14.2. Medical Plan and EAP benefits are provided to Medical Plan enrollees on an integrated basis.

14.1.2 *Standalone EAP Benefits.*

14.1.2.1 Minister Members enrolled in Covenant Package who are not enrolled in Active Medical Plan coverage are entitled to Employee Assistance Plan benefits.

14.1.2.2 An Eligible Employer may also enroll Eligible Employees not enrolled in § 10 Medical Plan coverage and any other employees in an eligible employment classification established by the Eligible Employer for EAP benefits.

14.1.3 *Costs*. The cost of EAP benefits is set forth on Appendix A. An Eligible Employer may offer standalone EAP benefits on a non-contributory or contributory basis.

14.2 Benefits.

The EAP benefits are provided by one or more independent third-party organizations under contract with the Board or its designated EAP administrator to provide counseling, crisis response guidance, and other work-life services and personal benefits available to Eligible Employers and Eligible Employees. Members may obtain more specific information about the services provided under this arrangement from the Board.

APPENDIX A: 2025 BENEFITS PLAN OFFERINGS DUES SCHEDULE

PART ONE: Dues Packages

Covenant Package

Benefits	Dues	Minimum Dues	Maximum Dues	Contribution Requirements
Defined Benefit Pension Plan*	8.5%	TBD**	TBD**	100% paid by Eligible Employer
Death and Disability Plan*	1.0%	TBD**	TBD**	
Temporary Disability Plan*	0.5%	TBD**	TBD**	
Total Dues	10%			

*The Defined Benefit Pension and Death and Disability Plans Dues are calculated based on the Pension Participation Basis. The Temporary Disability Dues are calculated based on the Effective Salary.

**The Minimum and Maximum Dues for these benefits are based on Median Salary and IRS guidelines respectively and are not available until several months before the applicable plan year.

Congregational Pastors Package

Benefits	Dues	Minimum Dues	Maximum Dues	Contribution Requirements
Defined Benefit Pension Plan*	8.5%	TBD**	TBD**	100% paid by Eligible Employer
Death and Disability Plan*	1.0%	TBD**	TBD**	
Temporary Disability Plan*	0.5%	TBD**	TBD**	
Medical Plan PPO - Member-only	16%	$6,000	$17,000	
Medical Plan PPO - Child(ren)	$8,950			May be paid by Eligible Employer, employee, or shared
Medical Plan PPO - Spouse	$11,000			
Medical Plan PPO - Family	$20,600			
Total Dues	26% + Flat dues amount (if applicable)			

*The Defined Benefit Pension and Death and Disability Plans Dues are calculated based on the Pension Participation Basis. The Temporary Disability Dues are calculated based on the Effective Salary.

**The Minimum and Maximum Dues for these benefits are based on Median Salary and IRS guidelines respectively and are not available until several months before the applicable plan year.

Transitional Pastor's Participation

2025 Benefits	Dues	Minimum Dues	Maximum Dues	Contribution Requirements
Defined Benefit Pension Plan*	8.5%	TBD**	TBD**	100% paid by Eligible Employer
Death and Disability Plan*	1.0%	TBD**	TBD**	
Temporary Disability Plan*	0.5%	TBD**	TBD**	
Medical Plan	33.0%	$15,000	$43,000	
Total Dues	43%			

*The Defined Benefit Pension and Death and Disability Plans Dues are calculated based on the Pension Participation Basis. The Temporary Disability Dues are calculated based on the Effective Salary.

**The Minimum and Maximum Dues for these benefits are based on Median Salary and IRS guidelines respectively and are not available until several months before the applicable plan year

PART TWO: Individual Benefits Plan Offerings Dues

PLAN	DUES AMOUNT	CONTRIBUTION REQUIREMENTS
Defined Benefit Pension Plan § 4	8.5% of Pension Participation Basis	100% paid by Eligible Employer
Death & Disability Plan § 6		
• With Defined Benefit Pension Plan	1.0% of Pension Participation Basis	100% paid by Eligible Employer
• Without Defined Benefit Pension Plan	2.5% of Pension Participation Basis	100% paid by Eligible Employer
Supplemental Death § 6, § 6.8	*Refer to chart below*	May be paid by Eligible Employer, employee, or shared

Supplemental Death Benefits
Rates based on enrollee's age as of January 1 each year.

Tobacco-Free Monthly / Annual Dues

	Member and Spouse Rates								Member Only Rates							
Age	**$25,000**		**$50,000**		**$75,000**		**$100,000**		**$150,000**		**$200,000**		**$250,000**		**$300,000**	
Up to 29	0.96	11	1.91	23	2.87	34	3.83	46	5.74	69	7.65	92	9.56	115	11.48	138
30 – 34	1.20	14	2.41	29	3.61	43	4.82	58	7.23	87	9.64	116	12.05	145	14.46	174
35 – 39	1.53	18	3.06	37	4.59	55	6.12	73	9.18	110	12.24	147	15.30	184	18.36	220
40 – 44	1.91	23	3.83	46	5.74	69	7.65	92	11.48	138	15.30	184	19.13	230	22.95	275
45 – 49	2.87	34	5.74	69	8.61	103	11.48	138	17.21	207	22.95	275	28.69	344	34.43	413
50 – 54	4.40	53	8.80	106	13.20	158	17.60	211	26.39	317	35.19	422	43.99	528	52.79	633
55 – 59	8.22	99	16.45	197	24.67	296	32.90	395	49.34	592	65.79	789	82.24	987	98.69	1,184
60 – 64	12.62	151	25.25	303	37.87	454	50.49	606	75.74	909	100.98	1,212	126.23	1,515	151.47	1,818
65 – 69	20.08	241	40.16	482	60.24	723	80.33	964	120.49	1,446	160.65	1,928	200.81	2,410	240.98	2,892
70 – 74	30.60	367	61.20	734	91.80	1,102	122.40	1,469	183.60	2,203	244.80	2,938	306.00	3,672	367.20	4,406
75 – 79	37.29	448	74.59	895	111.88	1,343	149.18	1,790	223.76	2,685	298.35	3,580	372.94	4,475	447.53	5,370
80 – 84	39.40	473	78.80	946	118.19	1,418	157.59	1,891	236.39	2,837	315.18	3,782	393.98	4,728	472.77	5,673
85 – 89	39.40	473	78.80	946	118.19	1,418	157.59	1,891	236.39	2,837	315.18	3,782	393.98	4,728	472.77	5,673
90 – 94	39.40	473	78.80	946	118.19	1,418	157.59	1,891	236.39	2,837	315.18	3,782	393.98	4,728	472.77	5,673
95+	39.40	473	78.80	946	118.19	1,418	157.59	1,891	236.39	2,837	315.18	3,782	393.98	4,728	472.77	5,673

Tobacco-User Monthly / Annual Dues

	Member and Spouse Rates								Member Only Rates							
Age	**$25,000**		**$50,000**		**$75,000**		**$100,000**		**$150,000**		**$200,000**		**$250,000**		**$300,000**	
Up to 29	1.47	18	2.95	35	4.42	53	5.89	71	8.84	106	11.78	141	14.73	177	17.67	212
30 – 34	2.05	25	4.09	49	6.14	74	8.19	98	12.28	147	16.37	196	20.46	246	24.56	295
35 – 39	2.68	32	5.36	64	8.03	96	10.71	129	16.07	193	21.42	257	26.78	321	32.13	386
40 – 44	3.96	48	7.92	95	11.88	143	15.84	190	23.75	285	31.67	380	39.59	475	47.51	570
45 – 49	6.83	82	13.66	164	20.48	246	27.31	328	40.97	492	54.62	655	68.28	819	81.93	983
50 – 54	12.18	146	24.37	292	36.55	439	48.73	585	73.10	877	97.46	1,170	121.83	1,462	146.19	1,754
55 – 59	20.98	252	41.96	504	62.94	755	83.92	1,007	125.88	1,511	167.84	2,014	209.80	2,518	251.76	3,021
60 – 64	25.49	306	50.99	612	76.48	918	101.97	1,224	152.96	1,836	203.95	2,447	254.94	3,059	305.92	3,671
65 – 69	33.53	402	67.05	805	100.58	1,207	134.10	1,609	201.16	2,414	268.21	3,219	335.26	4,023	402.31	4,828
70 – 74	49.29	591	98.57	1,183	147.86	1,774	197.14	2,366	295.71	3,549	394.28	4,731	492.85	5,914	591.42	7,097
75 – 79	55.90	671	111.80	1,342	167.71	2,012	223.61	2,683	335.41	4,025	447.22	5,367	559.02	6,708	670.83	8,050
80 – 84	74.15	890	148.30	1,780	222.44	2,669	296.59	3,559	444.89	5,339	593.18	7,118	741.48	8,898	889.77	10,677
85 – 89	98.17	1,178	196.34	2,356	294.51	3,534	392.67	4,712	589.01	7,068	785.35	9,424	981.69	11,780	1178.02	14,136
90 – 94	126.09	1,513	252.18	3,026	378.27	4,539	504.36	6,052	756.55	9,079	1008.73	12,105	1260.91	15,131	1513.09	18,157
95+	153.71	1,844	307.42	3,689	461.12	5,533	614.83	7,378	922.25	11,067	1229.66	14,756	1537.08	18,445	1844.49	22,134

All Eligible Dependent Children in the Family

$5,000 Coverage	**$**	**1.02**	**$**	**12**	**$10,000 Coverage**	**$**	**2.04**	**$**	**25**

PLAN	MONTHLY DUES AMOUNT	CONTRIBUTION REQUIREMENTS
Term Life and Accidental Death and Dismemberment Plan § 7	(Coverage Level / 1,000) x $0.20	100% paid by Eligible Employer
Temporary Disability Plan § 8	((Salary / 52) x $0.45) / $10 of weekly pay	May be 100% paid by Eligible Employer OR employee
Long-Term Disability Plan § 9	((Salary / 12) x $0.35) / $100 of monthly pay	100% paid by Eligible Employer
Medical Plan (PPO, EPO, HDHP) § 10	Four-tier coverage option monthly rates Individually determined for each Eligible Employer	May be fully or partially paid by Eligible Employer Minimum contribution by Eligible Employer of 50% of lowest coverage option member-only rate

Medical Continuation and Post-Retirement Medical Plan
§ 10.11 and § 11

	PPO	EPO	HDHP
Coverage level	**Monthly cost**		
Member-only	TBD	TBD	TBD
Member + Spouse	TBD	TBD	TBD
Member + Child(ren)	TBD	TBD	TBD
Member + Family	TBD	TBD	TBD

PLAN	MONTHLY DUES AMOUNT	CONTRIBUTION REQUIREMENTS
Group Medicare Advantage PPO § 11.2 Post-Retirement subscribers	$0 (subscriber responsible for copays and co-insurance)	100% paid by individual

PLAN	MONTHLY DUES AMOUNT		CONTRIBUTION REQUIREMENTS
Dental Plan § 12	**DMO**	**PPO/Passive PPO**	
Member-only	TBD	Four-tier coverage option rates individually determined for each Eligible Employer	May be paid by Eligible Employer, employee, or shared
Member + Spouse	TBD	Four-tier coverage option rates individually determined for each Eligible Employer	May be paid by Eligible Employer, employee, or shared
Member + Child(ren)	TBD	Four-tier coverage option rates individually determined for each Eligible Employer	May be paid by Eligible Employer, employee, or shared
Member + Family	TBD	Four-tier coverage option rates individually determined for each Eligible Employer	May be paid by Eligible Employer, employee, or shared
Vision Eyewear Plan § 13			
Member-only	TBD		May be paid by Eligible Employer, employee, or shared
Member + Spouse	TBD		May be paid by Eligible Employer, employee, or shared
Member + Child(ren)	TBD		May be paid by Eligible Employer, employee, or shared
Member + Family	TBD		May be paid by Eligible Employer, employee, or shared
Employee Assistance Plan § 14			
	$TBD/employee/month for Eligible Employees not enrolled in Active Medical Plan		100% paid by Eligible Employer

Single-Sum Factors

Actuarial Equivalent benefits payable on a single-sum basis will be determined using the following assumptions and procedure:

Interest: 4.5%

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

Form of Benefits:

Retirement: Joint and 50% Survivor

Survivor: Life Annuity

Spouse Age:

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

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

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

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

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

The two factors are averaged.

Joint and Survivor Option Factors

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

1. Determine the age of Member on their retirement pension commencement date based on the birthday nearest to the Benefit Commencement Date. Determine the number of full years between the birthdays of the Member and Spouse.

2. Determine the basic factor in Table A (below) using the age of the Member from Step 1.

3. Multiply the full years between the birthdays of the Member and Spouse by the factor from Table B.

4. Determine the joint and survivor option factor using the figures from Steps 2 and 3:

    a. If the Member is older than the Spouse, subtract the result of Step 3 from the result of Step 2.

    b. If the Member is younger than the Spouse, add the result of Step 3 to the result of Step 2.

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

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

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

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

Early Retirement Option Factors

Benefits payable on an early retirement Benefit Commencement Date will be determined based on the following table and procedures: [**TO BE UPDATED**]

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

1. The Member's age in years and completed months will be determined as of the early retirement date.

2. The factor will be determined by interpolation using the Board's factor in the preceding table.

3. The factor from Step 2 will be multiplied by the Member's Pension Credits.

4. For pension credits accrued under the former Ministers' Annuity Fund of the Presbyterian Church in the United States or the former Employees' Annuity Fund of the Presbyterian Church in the United States, the factor will be determined using the Board of Annuity and Relief's factors from the table.

Social Security Leveling Option Factors

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

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

1. The Member's age in years and completed months will be determined as of the early retirement date.

2. The factor will be determined by interpolation in the table.

3. The factor from Step 2 will be multiplied by the Member's estimated Social Security Primary Insurance Amount at age 62.

4. The Member's early retirement benefit will be increased by the result of Step 3 to determine the benefit beginning at commencement of retirement benefits.

5. The result of Step 4 will be reduced by the Member's estimated Social Security Primary Insurance Amount to determine the benefit at age 62.

6. If the result of Step 5 is negative, this option is not available.

Post-Normal Retirement Option Factors

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

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

1. The Member's age in years and completed months will be determined as of the Post-Normal Retirement date.

2. The factor will be determined by interpolation using the Board's factor in the preceding table.

3. The factor from Step 2 will be multiplied by the Member's Pension Credits.

4. No additional adjustment will be made beyond age 70.

APPENDIX C: DEFINED BENEFIT PENSION PLAN EXPERIENCE APPORTIONMENTS

The Defined Benefit Pension Plan in § 4.3 grants to the Board discretion to determine periodic Experience Apportionments. The following table provides a history of those Experience Apportionments for the Defined Benefit Pension Plan.

Plan Operational Year	Amendment Year	Experience Apportionment
1987	1988	5.0%
1988	1989	7.0%
1989	1990	8.0%
1990	1991	*
1991	1992	8.0%
1992	1993	4.0%
1993	1994	8.0%
1994	1995	3.0%
1995	1996	8.0%
1996	1997	6.0%
1997	1998	11.0%
1998	1999	10.0%
1999	2000	9.0%
2000	2001	3.0%
2001	2002	*
2002	2003	*
2003	2004	2.0%
2004	2005	3.0%
2005	2006	3.6%
2006	2007	3.7%
2007	2008	3.8%
2008	2009	*
2009	2010	*
2010	2011	*
2011	2012	*
2012	2013	1.0%
2013	2014	4.6%
2014	2015	4.7%
2015	2016	2.0%
2016	2017	2.0%
2017	2018	3.9%
2018	2019	3.6%
2019	2020	2.0%
2020	2021	2.0%
2021	2022	4.5%
2022	2023	4.2%

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

Unless otherwise noted, for Active Members, Terminated Vested Members, and Disabled Members, the Experience Apportionment is applicable to credits accrued as of December 31 of the Operational Year. For Retired Pensioners,

the Experience Apportionment is applicable to the Pension Benefit payable on the Effective Date stated in the Board's grant. Typically, that date is July 1 or the first day of the month following the Board's grant.

APPENDIX D: DEATH & DISABILITY PLAN DISABILITY BENEFIT INCREASES

The Death and Disability Plan in § 6.9.7 grants to the Board discretion to determine Disability Benefits Increases for Disabled Members receiving Disability Benefits. The following table provides a history of the Disability Benefits Increases.

Year	Disability Benefits Increase
1988	5.0%
1989	7.0%
1990	8.0%
1991	*
1992	8.0%
1993	4.0%
1994	8.0%
1995	3.0%
1996	8.0%
1997	6.0%
1998	4.0%
1999	3.0%
2000	4.0%
2001	3.0%
2002	2.0%
2003	*
2004	4.0%
2005	3.0%
2006	4.0%
2007	4.0%
2008	4.0%
2009	*
2010	3.0%
2011	1.5%
2012	3.0%
2013	2.0%
2014	2.0%
2015	1.0%
2016	1.0%
2017	2.0%
2018	2.0%
2019	2.0%
2020	2.0%
2021	1.5%
2022	7.0%
2023	7.0%

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

APPENDIX E: DEFINED BENEFIT PENSION PLAN TOP-HEAVY RULES

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

(a) **Additional Terms Used for Top-Heavy Rules**: The following definitions will supplement those set forth in § 1.6 of the Benefits Plan:

"Aggregation Group" means, for any Plan Year,

(1) each qualified retirement plan (including a frozen plan or a plan which has been terminated during the 60-month period ending on the Determination Date) of an Eligible Employer in which a Key Employee is a participant;

(2) each other qualified retirement plan (including a frozen plan or a plan which has been terminated during the 60-month period ending on the Determination Date) of an Eligible Employer that enables any plan in which a Key Employee participates to meet the requirements of §§ 401(a)(4) and 410 of the Code (to the extent applicable to a church plan); and

(3) any or all other qualified retirement plans (including a frozen plan or a plan which has been terminated during the 60 month period ending on the Determination Date) of an Eligible Employer if (a) the plans in the Aggregation Group would be Top Heavy Plans if each such plan were not included in the Aggregation Group but are not Top Heavy Plans when such plan is included in the Aggregation Group, and (b) the Aggregation Group, including such plan, meets the requirements of §§ 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 Eligible Employer participating in the Defined Benefit Pension Plan who at any time during the Plan Year that includes the Determination Date was an officer of the Eligible Employer having annual compensation greater than $130,000 (as adjusted under § 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 § 415(c)(3) of the Code. The determination of who is a Key Employee will be made in accordance with § 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 section to the amount described in Paragraph (2) of this section, after deducting from each such amount any portion thereof described in Paragraph (3) of this section, where:

(1) the amount described in this paragraph is the sum of (A) the present value of all accrued benefits of Key Employees under all qualified defined benefits plans included in the Aggregation Group, (B) the balances in all of the accounts of Key Employees under all qualified defined contribution plans included in the Aggregation Group, and (C) the amounts distributed from all plans in such Aggregation Group to or on behalf of any Key Employee during the one-year period ending on the Determination Date, except any benefit paid on account of death to the extent it exceeds the accrued benefits or account balances immediately prior to death; however, in the case of a distribution made for a reason other than separation from service, death or disability, this section will 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 section will 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 Defined Benefit Pension Plan by a Member after December 31, 1983, from a plan which is not sponsored by an Eligible Employer; (B) any amount that is included in Paragraphs (1) and (2) of this section 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 section for a person who has not performed any services for any Eligible Employer during the Plan Year that includes the Determination Date; and (D) for Plan Years beginning after December 31, 2001, any amount for an individual who has not performed services for an Eligible Employer during the one-year period ending on the Determination Date.

The present value of accrued benefits under any defined benefit plan will be determined on the basis of the assumptions described in Appendix B or, otherwise, the slowest accrual method permitted under § 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 section.

"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 their 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 Eligible Employer) yielding the highest average, disregarding compensation for Plan Years after the close of the last Plan Year in which the Defined Benefit 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 seventy percent (70%).

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

(b) Minimum benefits:

(1) If the Defined Benefit 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) will have a minimum Accrued Benefit. Such Accrued Benefit will 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 section participates in both a defined benefit plan and a defined contribution plan, the Member will have the minimum Accrued Benefit described in this section, offset by the benefit provided by the defined contribution plan. In making the offset calculation for a given Plan Year, the Eligible Employer derived interest of the Member in the defined contribution plan will be valued as of the last valuation date preceding such Plan Year. This defined contribution plan interest will be converted into a defined benefit by use of the assumptions described in Appendix B.

(3) Contributions under other plans. The Eligible Employer may provide in an election filed with the Board specifying the name of the other plan, the

minimum benefit that will be provided under such other plan, and the names of the Defined Benefit Pension 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 Defined Benefit 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 Defined Benefit Pension Plan to provide the minimum benefit described in Subsection (c) and for which a similar election has not been made as to another plan in the Aggregation Group, the 1.25 factor in the defined benefit and defined contribution factors described in § 415(e) of the Code will be reduced to 1.0. The adjustment described in this section will 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 their accounts under any defined contribution plan.

(2) If, in any Plan Year in which the Defined Benefit 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 § 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 will be increased as follows:

(i) "Three percent (3%)" will be substituted for "two percent (2%)" in Subsection (b)(1)(i).

(ii) Subsection (b)(1)(ii) will 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 will not apply to any Non-Key Employee who is covered under a defined contribution plan (as described in Subsection (c)) providing a minimum contribution for such Non-Key Employee of seven and one-half percent (7½%) of the Non-Key Employee's annual compensation.

(d) Suspension of Benefits:

Notwithstanding the other provisions of the Defined Benefit Pension Plan, the payment of a Member's benefits will not be suspended during the Member's

reemployment during any period in which the Defined Benefit Pension Plan is a Top-Heavy Plan.

APPENDIX F: SPECIAL DEFINED BENEFIT PENSION PLAN PROVISIONS FOR PUERTO RICO MEMBERS

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

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

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

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

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

(d) Maximum Annual Benefit. Effective as of January 1, 2012, the maximum annual benefit payable to a Puerto Rico Member under the Defined Benefit Pension Plan (including benefits payable to any Alternate Payees entitled to benefits in lieu of the Puerto Rico Member) will not exceed the lesser of (i) the maximum annual benefit determined under § 4.11 of the Defined Benefit Pension Plan, or (ii) the maximum annual benefit determined under the requirements of § 1081.01(a)(11)(A) of the 2011 PR Code.

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

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

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

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

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

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

2025 SCHEDULE

PPO Benefits Option
Copays

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

*Telemedicine visits other than through the Teladoc program will be subject to the same cost as an in-person visit.

Deductibles and Out-of-Pocket Maximums
(for covered Medically Necessary services; does not include prescription drug costs and office copays)

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

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

[2]Completion of Call to Health in the current year reduces the member's deductible in the following year.

[3]Members with Eligible Family members are responsible for two deductibles, one for the member and one for all other family members combined. Deductibles do not count toward the out-of-pocket maximum.

[4]The annual deductible for a Disabled member and their Eligible Family is based on the lowest deductible band.

[5]The Salary Range for individuals enrolled in Medical Continuation coverage will be $58,270-$63,024 for 2025.

[6]After a member reaches the annual out-of-pocket maximum; the Medical Plan pays 100 percent of eligible expenses up to the plan allowance, except for office visit copays. The out-of-pocket maximum applies to the member and family combined.

Prescription Drug Benefit

Prescription Type	Member Cost		
	Retail (30 day)	Retail (90 day)	Mail Order (90 day) [1]
Generic	$10	$30	$25
Brand Formulary	30% of cost; $20 min. to $100 max	30% of cost; $60 min. to $300 max	30% of cost; $50 min. to $250 max
Brand Non-Formulary[2]	50% of cost; $50 min. to $150 max	50% of cost; $150 min. to $450 max	50% of cost; $125 min. to $375 max
Specialty	Same percentages and minimums and maximums as above for Brand Formulary and Non-Formulary other than non-essential specialty pharmacy drugs, which will have no maximum coinsurance		
Annual Family Copayment Maximum	$3,000		

[1]Maintenance medications filled by mail may be subject to lower copayment.

[2] Non-formulary brand and non-essential specialty pharmacy drugs do not count toward annual family out-of-pocket maximum.

Preventive Prescription Drug Benefit

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

Total Maximum Out-of-Pocket (TMOOP): *The combined individual and family medical and prescription drug copays, deductibles, coinsurance, and out-of-pocket maximums are capped $5,000 and $10,000 in 2025. Certain non-essential specialty pharmacy drugs do not count toward the TMOOP.*

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

Limitations

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

EPO Benefits Option
Copays

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

*Telemedicine visits other than through the Teladoc program will be subject to the same cost as an in-person visit.

Deductibles

	Individual	Family
Deductible	$2,000	$4,000

Prescription Drug Benefit

Prescription Type	Member Cost		
	Retail (30 day)	Retail (90 day)	Mail Order (90 day)[1]
Generic	$12	$36	$30
Brand Formulary	35% of cost; $35min. to $150 max	35% of cost; $105 min. to $450 max	35% of cost; $85 min. to $375 max
Brand Non-Formulary	Not Covered	Not Covered	Not Covered
Specialty	Same percentages and minimums and maximums as above for Brand Formulary and Non-Formulary other than non-essential specialty pharmacy drugs, which will have no maximum coinsurance		
Annual Family Coinsurance Maximum	None	None	None

[1] Maintenance medications filled by mail may be subject to a lower cost.	

Preventive Prescription Drug Benefit

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

Total Maximum Out-of-Pocket (TMOOP): *The combined individual and family medical and prescription drug copays, deductibles, coinsurance, and out-of-pocket maximums are capped $5,000 and $10,000 in 2025. Certain non-essential specialty pharmacy drugs do not count toward the TMOOP.*

Limitations

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

HDHP Benefits Option

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

*The vision program is an excepted benefit and benefits are payable without meeting HDHP deductible first.

Deductibles

	Individual	Family
Deductible	$3,000	$6.000[1]
[1] Members with covered Spouses and/or Children are responsible for the entire family deductible amount.		

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

Prescription Drug Benefit

Prescription Type	Member Cost		
	Retail (30 day)	Retail (90 day)	Mail Order (90 day)[2]
Generic	Member pays 100% prior to deductible; Member pays 30% after deductible subject to $150 (30 day), $450 (90 days) or $375 (90-day mail) max		
Brand Formulary			
Brand Non-Formulary	Not Covered	Not Covered	Not Covered
Annual Family Coinsurance Maximum	None	None	None
[2] Maintenance medications filled by mail may be subject to a lower cost.			

Preventive Prescription Drug Benefit*

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

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

Total Maximum Out-of-Pocket (TMOOP): *The combined individual and family medical and prescription drug copays, deductibles, coinsurance, and out-of-pocket maximums are capped $5,000 and $10,000 in 2025.*

Limitations:

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

GROUP MEDICARE ADVANTAGE PPO:

Copays, deductibles, co-insurance, out-of-pocket maximums and RX coverage provisions, see Humana Group Medicare Advantage PPO Evidence of Coverage documents.