

Mennonite Church USA Dental Plan

Summary Plan Description

Comprehensive Coverage

Plan Information

This summary plan description (and accompanying membership card) is issued only to eligible employees of Mennonite Church USA, 3145 Benham Ave., Suite 1, Elkhart, IN 46517. Credentialed pastors and non-credentialed employees of participating area conference offices and congregations are considered to be employees of Mennonite Church USA for purposes of this plan.

Plan sponsor: Mennonite Church USA, 3145 Benham Ave., Suite 1, Elkhart, IN 46517; (574) 294-7523

Type of benefit plan: Group dental plan

Plan number: 511

Plan year: Jan. 1 — Dec. 31

Denomination's plan effective date: Sept. 1, 2002

Denomination's plan revision date: Jan. 1, 2020

Plan administrator, plan representative, trustee, and agent for service of legal process: Mennonite Church USA, 3145 Benham Ave., Suite 1, Elkhart, IN 46517; (574) 294-7523

Claims administrator: Everence Association, Inc., a fraternal benefit society, P.O. Box 483, Goshen, IN 46527; (800) 348-7468 or (574) 533-9511

Type of plan administrator: Contract administrator

The plan sponsor reserves the right to modify, suspend, or end the plan at any time.

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Schedule of Benefits

Coinsurance, per calendar year:

Preventive Services	Plan pays 100%, you pay 0%
Basic Services	Plan pays 75%, you pay 25%
Major Services.....	Plan pays 75%, you pay 25%
Orthodontia Services (under age 19).....	Plan pays 80%, you pay 20%

Annual maximum benefit for all services, combined:

Individual maximum	\$1,250
Family maximum	\$2,000

Plan payments for provider services are based on the reasonable and customary (R&C) charges for the type of care, service, or treatment received. If the provider's charges are more than the reasonable and customary (R&C) amount, you will be responsible for paying the difference. Any of these extra amounts you have to pay will not count toward your calendar-year coinsurance requirement.

Part I, Introduction

This summary plan description describes the dental benefits provided by the Mennonite Church USA Dental Plan, a self-funded plan from Mennonite Church USA for eligible employees of Mennonite Church USA. It will tell you how you can be covered by the plan, how to file a claim, and other important information about how the plan works. Please read it carefully.

You have joined a church-based network of employees to provide you with an excellent package of benefits.

Claims for the plan will be handled by a claims administrator who is trained in the benefits offered by the plan. The claim administrator's name, address and phone number are listed on the cover page.

If you have questions about the plan or about points in the plan that aren't covered in this summary plan description, please call the claims administrator at (574) 533-9511 or (800) 348-7468.

Part II, Definitions

The following words and terms are used in this summary plan description. When used, this is what they mean.

Assignment of benefits — Your authorization to the claims administrator to pay plan benefits directly to a service provider, for example, the dentist.

Calendar year — The 12-month period from Jan. 1 through Dec. 31 of any year.

Coinsurance — Your share of covered charges.

Covered person — An employee or dependent who meets the eligibility criteria outlined in *Part III* and is enrolled in and receiving benefits under this plan.

Dentally necessary — Services or supplies provided by a dentist that are:

1. Appropriate for the symptoms and diagnosis or treatment of the covered person's dental condition;
2. Provided for the diagnosis or the direct care and treatment of the covered person's dental condition;
3. In accordance with current standards of good dental practice; and
4. Not primarily for the convenience of the covered person or dentist.

Dentist — A licensed doctor of dental surgery or doctor of dental medicine.

Emergency — A non-elective, urgent, or immediate treatment due to a sudden and severe onset of a dental condition.

Eligible expense — Charges for services or supplies that are:

1. Dentally necessary for the treatment of a dental condition;
2. Reasonable and customary;
3. Listed under *Part VIII*; and
4. Incurred while covered under this plan.

Employee — Credentialed pastors working for a participating institution and non-credentialed employees employed and paid by a participating institution, as outlined in *Part III, Section A*.

Experimental dental treatment — Those services or supplies not recognized or proven to be effective treatment of a dental condition in accordance with generally accepted standards of dental practice. The service or supply must not be considered experimental, investigational or for research purposes by the American Dental Association.

Immediate family — A covered person's spouse, child, parent, sibling, or in-law.

Incurred — Charges for covered services are incurred on the date the covered service, treatment, or supply is received.

Injury — Bodily injury sustained by a covered person that:

1. Is directly caused by an accident, independent of other causes; and
2. Occurs while the coverage is in force for that person.

Medicare — Title XVIII of the Social Security Act of 1965 as amended.

Participating institution — A conference office or congregation that is enrolled in and participating in this plan.

Plan — The Mennonite Church USA Dental Plan which provides coverage for employees of participating institutions of Mennonite Church USA and their dependents who:

1. Meet the eligibility requirements outlined in *Part III*; and
2. Are enrolled in the plan.

Plan administrator — The person or entity that maintains the records of the plan, administers the plan, has discretionary authority to interpret the provisions of the plan, and makes all decisions necessary or proper to carry out the terms of the plan. The plan administrator may delegate its responsibilities to other persons or entities. The plan administrator for this plan is Mennonite Church USA.

Plan year — The plan's fiscal year. It is the 12-month period beginning each Jan. 1 and ending the following Dec. 31.

Qualified Medical Child Support Order — A medical child support order that:

1. Creates or recognizes the existence of a child's right to, or assigns to a child, the right to receive benefits for which a participant is eligible under the plan;
2. States the name and last known mailing address of the participant and the name and mailing address of each child (alternate recipient) covered by the order;
3. Contains a reasonable description of the type of coverage to be provided;
4. Specifies the period to which such order applies;
5. Identifies the plan to which such order applies; and
6. Does not require the plan to provide any type or form of benefit or any option not otherwise provided under the plan, except to the extent necessary to meet the requirements of a state law as described in Section 1908 of the Social Security Act, as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993.

Reasonable and customary (R&C) charge — The fee most commonly charged by dentists and service providers in the geographical area where the care, service, or treatment is given for the same type of care, service, or treatment, taking into consideration the nature and severity of the covered person's condition. The reasonable and customary (R&C) charge is determined by the claims administrator.

Spouse — The individual legally married to the employee (as determined under applicable laws of the state in which the marriage was validly entered into, regardless of the current state of domicile) while the employee is enrolled in this plan. *Spouse* does not include an individual who is legally separated from the employee.

You, your — The employee working for or employed and paid by a participating institution who is enrolled in this plan and to whom this summary plan description is issued.

Part III, Participation — Who Can Be Covered

A. Employees

You will automatically be enrolled in this plan if:

1. You are a pastor of a participating institution (see definition in *Part II*) who is:
 - a. Credentialed for ministry (ordained, licensed toward ordination, or licensed for specialized ministry) by an area conference of Mennonite Church USA or by a recognized and approved credentialing process as determined by the plan sponsor for pastors of participating institutions that are not formally affiliated with Mennonite Church USA; and
 - b. Working at least 20 hours per week in ministry to the congregation; **or**
2. You are a non-credentialed employee of a participating institution who is employed and paid for at least 30 hours per week*;
3. Your participating institution has elected to provide dental coverage for eligible employees; and
4. You are enrolled in the Congregational Employee Plan for Mennonite Church USA or you waived coverage in that plan due to having other health coverage through one of the valid health plan waive options.

*Non-credentialed employees of participating institutions who were enrolled in the Mennonite Church USA Dental Plan on Dec. 31, 2009, and regularly paid for at least 20 but less than 30 hours per week at that time may continue enrollment in this plan until employment ends or the number of hours of employment is reduced to less than 20 hours per week, whichever occurs first.

You must follow all enrollment procedures outlined in *Part IV*, if applicable.

FMLA Leave

Under any leave of employment that qualifies under the Family and Medical Leave Act of 1993 (FMLA), your coverage will be maintained under the plan on the same conditions as coverage would have been provided if you had been continuously working. This means that the same level of benefits and type of coverage available to similarly situated working employees will be available to you. You must pay the same level of premium contribution you were paying as an active employee.

If you do not return to work as an active employee working the applicable minimum employment requirement for non-credentialed employees and credentialed pastors listed above and performing the normal duties of your job on the first business day that follows the end of an FMLA leave, coverage under this plan will terminate.

Sabbaticals

You remain eligible for coverage if you are on a sabbatical approved by your participating institution according to the participating institution's written sabbatical policy in effect at the time of the sabbatical. The terms of the sabbatical must be within the Mennonite Church USA sabbatical guidelines in effect at the time of the sabbatical and the employee must agree to provide a minimum one year of service to the congregation following the sabbatical, as indicated in the Mennonite Church USA sabbatical guidelines.

If you do not return to work as an active employee working the applicable minimum employment requirement for non-credentialed employees and credentialed pastors listed above and performing the normal duties of your job on the first business day that follows the end of an approved sabbatical, coverage under this plan will terminate.

Military Leave

Employees and their dependents who are covered under this plan on the day the employee leaves employment for military service will have plan rights as mandated by the Uniformed Services Employment and Re-employment Rights Act (USERRA). These rights include the following:

1. The right to elect up to 24 months of extended plan coverage beginning on the day the employee would otherwise lose plan coverage because of entering military service*; and
2. Immediate plan coverage with no pre-existing conditions waiting periods or exclusions applied when the employee is re-employed by the participating institution upon return from military service, except for injuries or illnesses determined by the Secretary of Veterans' Affairs to have been incurred or aggravated during military service.

*If the period of military service is 30 days or less, the employee is responsible to pay the same level of premium contribution he or she was paying as an active employee. If the period of military service is 31 days or more, the employee is responsible to pay the entire cost of coverage plus a reasonable administration fee.

This provision is mandated by the Uniformed Services Employment and Re-employment Rights Act (USERRA) for all public and private employers. For more information, contact the plan administrator.

B. Dependents

If you are enrolled in this plan, your dependents will automatically be enrolled in the plan. A dependent is:

1. Your spouse (see definition in *Part II*), provided you are not divorced or legally separated.
2. Your children** under the age of 26. Your child's marital status, financial dependency, employment, residency, student status, or voluntary service status will not be considered in determining eligibility for plan coverage to age 26.
3. Any biological or legally adopted children of your dependents as defined in #2 as long as they are principally dependent on you for support and maintenance. You may be required to provide proof of this support.

A dependent also includes a child for whom you are required to provide medical coverage pursuant to a Qualified Medical Child Support Order (see definition in *Part II*).

**For the purposes of plan coverage, the word *children* means your biological children, children placed in your home for adoption, or stepchildren who meet the age requirements. The word *children* also includes a minor for whom you have accepted legal guardianship.

C. Dependents Who Are Disabled

Dependents who are physically or mentally disabled can continue to be covered under this plan after they reach age 26 if all of the following conditions apply:

1. Because of the disability, the child is not able to earn a living;
2. The child must have become disabled before his or her 26th birthday;
3. The child is entirely dependent on you for support and maintenance; and
4. You provide the claims administrator with a written notice from your physician that documents your child's disability within 30 days after your child's 26th birthday.

After the child's 26th birthday, the claims administrator may ask you to provide written proof from your physician once a year certifying your child's continuing disability. You will have to pay the full cost of any required proof or certification.

The premium charged for a disabled dependent will be the same as any other adult covered person age 26 or older who is not an employee.

Plan coverage for a disabled dependent will continue as long as you are covered by the plan or until the earliest of the following events:

1. Your child is no longer disabled;
2. Your child is no longer entirely dependent on you for support and maintenance;
3. You do not provide proof of your child's continuing disability when the claims administrator asks for it; or
4. Your child gets married.

D. General Provisions

If more than one family member works for a participating institution, plan benefits will be identical to those you would receive if only one family member works for a participating institution. If both you and your spouse work for the same participating institution, your children will be enrolled either as your dependents or your spouse's dependents, but not under both.

It is very important for the claims administrator to have correct, up-to-date information about you and your dependents. **Be sure to let the claims administrator know when any of your personal information changes**, such as your marital status, the number of your dependents, their names and birth dates, etc. Changes must be reported to the claims administrator within 30 days following the change. This information helps ensure that all individuals are properly enrolled and have the appropriate coverage.

Part IV, Enrollment — When Coverage Starts

A. When Coverage Begins

Coverage begins for employees and their dependents as follows:

1. For employees and dependents enrolling at the time of a participating institution's initial group formation, on the date of the formation.
2. For new employees (and their dependents) hired after initial group formation who are not transferring coverage from another participating institution, on the first day of employment.
3. For new employees (and their dependents) hired after initial group formation who are transferring coverage from another participating institution, on the first day of the month following the first day of employment.
4. For dependents added later as a result of marriage, on the first day they qualify as a dependent. See *Section C* in this *Part IV*.
5. For a newborn or newly-adopted child under age two (if the child is the first dependent added to the plan), on the child's second birthday. See *Section C* in this *Part IV*.
6. For a newborn or newly-adopted child added to dependent coverage already in force, on the first day the child qualifies as a dependent. See *Section C* in this *Part IV*.

B. Initial Enrollment

If you meet the eligibility criteria in *Part III, Section A*, you will automatically be enrolled in this dental plan, unless you waive coverage due to having other dental coverage (see *Part IV, Section D*).

If you are also enrolling in the Congregational Employee Plan, you do not need to provide any additional information to the claims administrator to complete the enrollment process for the dental plan. However, if you waive coverage in the Congregational Employee Plan because you have other health coverage through one of the valid health plan waive options, you must complete the *Employee Enrollment for Dental Coverage* form to provide information about yourself and your eligible dependents which is needed to complete enrollment in the dental plan. The enrollment form can be obtained from the claims administrator and must be completed as part of the hiring process or within the 90-day enrollment period that immediately follows your first day of employment.

If you are waiving dental coverage under this plan for someone in your family because they have other dental coverage, you must complete the waiver section of the *Employee Enrollment for Dental Coverage* form.

C. Enrolling New Dependents

If you meet the eligibility criteria in *Part III, Section A*, and have chosen dependent coverage under the Congregational Employee Plan, your new dependents will automatically be enrolled in this plan, unless you waive coverage due to having other dental coverage (see *Part IV, Section D*). You do not need to provide any additional information to the claims administrator to enroll your new dependents in this plan.

However, if you waived coverage under the Congregational Employee Plan because you have other health coverage through one of the valid health plan waive options, you must complete the *Employee Enrollment for Dental Coverage* form to provide information about your new dependent(s) that is needed to complete enrollment in the dental plan. The enrollment form can be obtained from the claims administrator and must be completed during the 90-day enrollment period that immediately follows the date your dependent first becomes eligible for coverage through birth, placement for adoption, adoption, or marriage.

Coverage for new dependents added through marriage begins on the day of marriage if the enrollment process is completed within the 90-day enrollment period that immediately follows the date of marriage.

Coverage for a newborn or newly-adopted child under age two who is the first dependent added to this plan will be effective on the child's second birthday. Coverage for a newborn or newly-adopted child added to dependent coverage already in force will be effective on the day of birth, adoption, or placement in your home, whichever is applicable.

If you are already enrolled in the plan when you add your first dependent, you will get a new membership card showing your family coverage.

D. Special Enrollment Periods

Waiver of Coverage

If you and/or your dependents are eligible for coverage under this plan but waive coverage due to enrollment in other dental coverage, you and/or your dependents may enroll in this plan later if employer contributions toward the other dental coverage terminate or if eligibility for the other dental coverage ends as a result of:

1. Termination of employment;
2. Involuntary termination of the other dental plan;
3. Reduction in the number of hours of employment;
4. Legal separation, divorce, or death of a spouse;
5. Discontinuance of dependent coverage by the other dental plan; or
6. Marriage.

You and/or your dependents will automatically be enrolled in this plan during the 90-day special enrollment period that immediately follows the day the other dental coverage ends (or employer contributions terminate). Coverage will be effective the day after the other dental coverage ends (or employer contributions terminate).

You must inform the claims administrator and complete the waiver section of the *Employee Enrollment for Dental Coverage* form if you are waiving coverage for yourself or any dependent.

Special Enrollment Period When New Dependents Become Eligible for Coverage

If you were not eligible to enroll in this dental plan because you chose not to enroll in the Congregational Employee Plan, you will automatically be enrolled in the plan at the same time a new dependent becomes eligible for coverage through marriage, birth, or adoption if you enroll in the Congregational Employee Plan at that time (or waive coverage due to having other health coverage). You and the new dependent will be enrolled in the plan during the 90-day special enrollment period that immediately follows the date the new dependent becomes eligible to enroll in the plan.

Similarly, an eligible spouse who has not enrolled in the plan will automatically be enrolled at the same time as a newborn or newly-adopted child if the spouse and new dependent enroll in the Congregational Employee Plan at that time (or waive coverage due to having other health coverage). Both will be enrolled in the plan during the 90-day special enrollment period that immediately follows the date the new dependent becomes eligible to enroll in the plan.

The effective date of coverage will be the date of marriage, birth, placement for adoption, or adoption, whichever is relevant.

Note: Special enrollment when a new dependent becomes eligible for coverage is available only if you enroll in the Congregational Employee Plan (or waive coverage in that plan due to having other health coverage through one of the valid health plan waive options) at the time of the qualifying event. There are no special enrollment rights under this plan if an individual does not enroll in or waive coverage under the Congregational Employee Plan at the time of the qualifying event.

E. Change in Hours

If you are already an employee of a participating institution but have not met eligibility requirements for coverage under this plan, you will be enrolled in the plan at the time you first become eligible. For example, if you are a credentialed pastor and increase your hours so you work at least 20 hours per week on a regular basis or if you are a non-credentialed employee and increase your hours so you are paid for at least 30 hours per week on a regular basis, you are eligible for plan coverage.

If you enroll in the Congregational Employee Plan at the time you first become eligible for coverage, you and your eligible dependents will automatically be enrolled in this plan and you do not have to provide any additional information to complete the enrollment process. If you waive coverage under the Congregational Employee Plan when you first become eligible because you have other health coverage through one of the valid health plan waive options, you must complete the *Employee Enrollment for Dental Coverage* form to provide information about yourself and your eligible dependents which is needed to complete enrollment in this plan. The enrollment form must be completed within the 90-day enrollment period that immediately follows your change in hours. Coverage will be effective on the same day as your change in hours.

Part V, Basis of Coverage — What Coverage Costs

This plan is currently funded by contributions made by participating institutions and employees. Each participating institution will contribute at least 50 percent of total funding for employees and dependents covered under the plan. All payments are the responsibility of each participating institution. The participating institution is responsible for informing employees of their premium contribution share. This information must be on file with the claims administrator. The employee's premium contribution share is to be paid to the participating institution. The claims administrator will notify participating institutions monthly of premium contributions due.

Employees who continue coverage during a leave of absence that qualifies under the Family and Medical Leave Act of 1993 (FMLA) or an approved sabbatical must pay the same level of premium contribution they were paying as an active employee.

Plan participants who extend plan coverage while on military leave (see *Part III, Section A*), must pay the same level of premium contribution they were paying as an active employee if the period of military service is 30 days or less. For periods of military service that exceed 30 days, the plan participant must pay the entire cost of coverage plus a reasonable administrative fee.

In addition to these contributions, all plan participants are responsible for paying:

1. Coinsurance;
2. Charges that exceed the reasonable and customary (R&C) charge; and
3. Charges for care, service, treatment, and supplies not covered by the plan.

Part VI, How Your Dental Coverage Works

Before reviewing plan benefits, there are some important points you need to know:

1. Plan payments for provider services are based on the reasonable and customary (R&C) charges for the type of care, service, or treatment received. The R&C charge is determined by the claims administrator and is the smaller of:
 - a. The normal charge the provider would make for a service or supply if you had no dental coverage; or
 - b. The prevailing charge made by other dentists in the area for the same type of service or supply, taking into consideration the seriousness of the covered person's condition.

If the actual provider charges are more than the reasonable and customary (R&C) charge, you will be responsible for payment of the difference. Any of these extra amounts you have to pay will not count toward your calendar-year coinsurance requirements.

2. The plan does not pay charges for dental treatment you or your covered dependent may receive as the result of any work for wage or profit (including self-employment). This provision applies to any dental treatment covered by workers' compensation, occupational disease, or similar law. However, if specific coverage for such dental treatment is not in effect **and** is not required by law, this plan will cover the treatment.

A. Calendar-year Coinsurance

- Preventive Services..... Plan pays 100 percent
- Basic Services Plan pays 75 percent
- Major Services Plan pays 75 percent
- Orthodontia Services..... Plan pays 80 percent

The plan will pay 100 percent of eligible charges for *Preventive Services*, 75 percent of eligible charges for *Basic Services* and *Major Services*, and 80 percent of eligible charges for *Orthodontia Services*, up to the calendar-year maximum listed in this *Part VI, Section B*. You are responsible for paying the remaining percent of eligible charges not paid by the plan. The amount you pay is your coinsurance requirement.

B. Calendar-year Maximum Benefit

The plan will pay up to a maximum of \$1,250 per covered person or \$2,000 per family each calendar year you or your dependents are covered by the plan for eligible dental care, services, and treatment.

Part VII, Pre-treatment Certification

When you or your covered dependent require non-emergency treatment that is likely to cost more than \$250, a treatment plan should be sent to the claims administrator. The treatment plan will be returned and will indicate in advance the services covered by the plan.

For the purposes of this provision, treatment plan means a dentist's written report that itemizes recommended dental services and includes the charge for each of these services. It is accompanied by pre-operative x-rays or other appropriate diagnostic procedures.

Part VIII, Covered Services

This plan covers a broad range of dental benefits. The plan pays the reasonable and customary (R&C) charges for covered services up to the limit listed in the *Schedule of Benefits*. All covered charges are subject to the coinsurance requirements outlined in *Part VI, Section A*.

The following are covered services under this plan:

A. Preventive Services

Preventive Services includes expenses incurred for:

1. Routine oral exams twice each calendar year;
2. Bitewing x-rays twice each calendar year;
3. Full mouth x-rays, once in any 36 consecutive months;

4. Prophylaxis (scaling and cleaning of teeth) twice each calendar year;
5. Topical application of fluoride twice each calendar year for covered persons under age 19;
6. Topical application of fluoride once each calendar year for covered persons age 19 and over;
7. Space maintainers used to replace prematurely lost teeth for covered persons under age 19. This includes adjustments made to the original space maintainer more than six months after it is installed; and
8. Sealants on permanent molars for covered persons under age 15.

B. Basic Services

Basic Services includes expenses incurred for:

1. Restorations of diseased or broken teeth with amalgam, silicate, acrylic, synthetic porcelain, or composites. All restorations on one surface are counted as a single restoration;
2. Endodontic treatment, including root canal therapy;
3. Extractions, including local anesthesia and routine post-operative care;
4. Oral surgery and routine post-operative care, not including periodontic services;
5. Dental x-rays needed to diagnose and treat a specific condition;
6. Apicoectomy (surgical removal of the apex or tip of the tooth root);
7. General anesthetics, when necessary as part of covered oral surgery;
8. Management of acute infection and oral lesions (wounds or sores in the mouth);
9. Emergency treatment for temporary relief of severe pain, but which does not effect a definite cure; and
10. Emergency treatment of an acute condition.

C. Major Services

Major Services includes expenses incurred for:

1. Restorations of diseased or broken teeth with inlays, onlays, gold fillings, or crowns — but only when these teeth cannot be restored with amalgam, silicate, acrylic, synthetic porcelain, or composites;
2. Dental implants;
3. First installation of removable full or partial dentures. Also included are adjustments on these dentures more than six months after they are installed;
4. First installation of fixed bridgework, including inlays and crowns as support;
5. Periodontal examination and other periodontal treatments, including gingival curettage, gingivectomy, gingivoplasty, and osseous surgery. These are all procedures used to treat the gums or the bony structures of the mouth which support the teeth;
6. Occlusal guards for bruxism;
7. Replacement of partial dentures, full removable dentures, or fixed bridgework with new ones, or teeth added to the existing dentures or bridgework — but only if:
 - a. The replacement or addition of teeth is needed because one or more natural teeth were extracted while covered under this plan;
 - b. The existing denture or bridgework:
 - 1) Cannot be made usable; and
 - 2) Is either at least five years old, or must be replaced due to an injury; or
 - c. The existing denture is an immediate temporary denture that cannot be made permanent, and is replaced within 12 months by a permanent denture.

Normally, dentures will be replaced with dentures. But when only bridgework will produce a professionally adequate result, then bridgework will be the eligible expense.

8. Repair or recementing of crowns, inlays, onlays, bridgework, or dentures; and
9. Relining and rebasing of present dentures — but only if they were installed more than six months earlier and if they have not been relined during the past 36 months.

D. Orthodontia Services

Orthodontia Services includes expenses incurred for:

1. Purchase and installation of orthodontic appliances;
2. Surgical exposure of impacted teeth for orthodontic reasons; and
3. Non-surgical correction of malocclusions.

Eligible expenses for orthodontia treatment must be for:

1. An overbite or overjet of at least four millimeters;

2. Maxillary or mandibular arches in either protrusive or retrusive relation of at least one cusp;
3. A crossbite; or
4. An arch length discrepancy of more than four millimeters.

Limitations for Orthodontia Services

Orthodontia services covered under this provision are limited as follows:

1. Orthodontia services are only available to covered persons under the age of 19;
2. The plan will only pay charges for orthodontia services and appliances incurred during a course of treatment that begins while the individual is covered under this plan;
3. The plan will pay for orthodontia treatment as services are rendered;
4. If orthodontia treatment is terminated for any reason before completion, only expenses incurred for orthodontia services rendered and supplies received prior to the date of termination will be included as covered orthodontia services; and
5. If a covered person receiving orthodontia services and supplies reaches age 19 during the course of treatment, expenses incurred for orthodontia services will be paid based on the treatment plan, as long as the bands are placed prior to the date the individual reaches age 19.

E. Benefits After Termination

This plan does not cover charges for dental services or supplies incurred before this coverage goes into effect or after coverage is terminated.

Part IX, What's Not Covered

There are some conditions and charges the plan does not cover. These are charges incurred for or in connection with:

1. Care, service, treatment, or supplies received before a covered person's effective date of coverage or after the termination date of coverage under this plan;
2. Dental services not furnished by a dentist;
3. Services or supplies for which you would not be required to pay if you didn't have coverage under this plan;
4. Treatment of a condition resulting from or prolonged by involvement in an illegal occupation, performance of, or attempted performance of an assault or other felony;
5. Treatment of a condition that results from participation in a civil insurrection, riot, or duty as a member of the armed forces of any country or state at war;
6. Military service for any country or organization, including service with military forces as a civilian whose duties do not include combat;
7. Treatment required as the result of any work for wage or profit (including self-employment), except as provided in *Part VI*;
8. Dental care, services, or treatment given to a covered person by an immediate family member or someone who ordinarily lives with the covered person;
9. Services or supplies by or on behalf of any government agency unless you are obligated by law to pay the charges;
10. Cosmetic services — unless needed to treat an injury. The following services, although not all inclusive, are always considered cosmetic:
 - a. Veneers, facings, or similar properties of crowns or pontics placed on or replacing teeth in back of the second bicuspid;
 - b. Personalization or characterization of dentures or other prosthetics; and
 - c. Bleaching of teeth or enamel microabrasion.
11. Services that are investigational or experimental for the condition being treated;
12. Treatment of temporomandibular joint disorder (TMJ);
13. Dental services or supplies that are:
 - a. In excess of the reasonable and customary (R&C) charges;
 - b. Not dentally necessary according to accepted dental standards as determined by the claims administrator; or
 - c. Not recommended or approved by the attending dentist;
14. Duplicate devices or appliances, including prosthetics;
15. Athletic mouth guards;
16. Replacing a lost, missing, or stolen device or appliance, including prosthetics and orthodontia appliances;
17. Plaque control programs, oral hygiene, or dietary instruction;
18. Services or supplies to correct a congenital malformation (one you were born with);
19. Dental visits at home;

20. Services or supplies provided for inpatient or outpatient hospital care, unless these services are in connection with emergency care;
21. Local anesthesia or partial anesthesia (analgesia), including intravenous sedation, except as provided in *Part VIII, Section B*;
22. Orthodontic diagnostic procedures, treatment, and appliances for covered persons age 19 and over;
23. Completion of insurance forms or failure to keep a dental appointment; and
24. Services eligible for payment under any other group plan sponsored by Mennonite Church USA or the participating institution that a covered person is enrolled in.

Part X, How to Submit a Claim

Whenever you have a claim, follow these three guidelines to ensure that you receive the best service possible:

1. Make sure the claim is covered by reviewing *Part VIII* and *Part IX*. If you're still not sure, call (574) 533-9511 or (800) 348-7468.
2. Send claims directly to the claims administrator as they are incurred. Send to Everence Association, Inc., P.O. Box 483, Goshen, IN 46527. Your dental provider may have a standard dental claim form that he or she will use to submit dental claims directly to the claims administrator.

For a claim to be valid, you must send written notice of the claim within one year after services are received or as soon as reasonably possible. After one year, a longer extension will be granted only if you were, and continue to be, legally incapable of submitting the claim.

3. Use a separate claim form for each family member submitting charges.

All claims may be submitted on a standard form titled *Health Insurance Claim Form* or as an itemized bill* furnished by the health care provider. If you use the standard form, always include an itemized statement with the form.

* Canceled checks, receipts, or bills simply stating "For Professional Service Rendered" or "Balance Forward" are not itemized bills and cannot be honored.

Whenever you submit a claim, the claims administrator needs to know whether other coverage also applies to the claim. This information is requested on the standard *Health Insurance Claim Form*. Likewise, the provider must notify the claims administrator whenever benefits are paid by another plan.

Assigning Payment Directly to the Provider

If you prefer, the claims administrator will pay benefits directly to the dentist, hospital, or other provider. Just check the appropriate box on the *Health Insurance Claim Form*.

A. Your Plan's Commitment

Any benefits will be paid as soon as you submit the completed claim form, except for losses requiring periodic payment. In this case, the claims administrator will pay benefits at the end of each 30 days. At the end of this period, any balance remaining will be paid.

The claims administrator will supply any requested claim forms within 15 days. If it takes any longer, the claim will automatically be valid if you send — within one year — an itemized bill of the services received to the claims administrator.

B. How to Appeal a Claim

If you have questions about a claim already processed, you can call the claims administrator at (574) 533-9511 or (800) 348-7468.

For the fastest service, have the claim number at hand when you call. It is printed on the *Explanation of Benefits*.

If you prefer to write, please send an explanation of your concern along with the claim number to Everence Association, Inc., P.O. Box 483, Goshen, IN 46527.

Time Limitation on Legal Action

You have the right to take legal action, but you may do so no earlier than 61 days after the claim is received and no later than three years after the original one-year deadline for reporting it.

Universality of Plan Interpretation

The plan administrator has the power and final discretionary authority to interpret the provisions of the plan. The plan administrator also determines eligibility for benefits and how benefit provisions are to be applied. These decisions apply to all plan participants regardless of special circumstances. Decisions will be applied in the same way for all the people covered by the plan.

Part XI, Termination of Coverage

Your coverage will end at midnight on the first of the following events:

1. The last day of the month in which you are no longer an employee working for or employed and paid by a participating institution;
2. The last day of the month in which you are no longer an employee eligible for these benefits because:
 - a. The number of hours you regularly work for a participating institution as a credentialed pastor is reduced to less than 20 hours per week; or
 - b. The number of hours you are employed and paid by a participating institution as a non-credentialed employee is reduced to less than 30 hours per week (20 hours per week, if you were enrolled in the plan that was in effect on Dec. 31, 2009 and working at least 20 but less than 30 hours per week as of that date).
3. The last day of the month in which you do not return to work as an active employee regularly working at least 20 hours per week (if you are a credentialed pastor) or employed and paid for at least 30 hours per week (if you are a non-credentialed employee) and performing the normal duties of your job on the first business day that follows the last day of a leave of absence that qualifies under the Family and Medical Leave Act of 1993 (FMLA) or an approved sabbatical;
4. The day the plan sponsor terminates this dental plan for all plan participants;
5. The last day of coverage for which your participating institution paid the required funding contribution; or
6. The last day of the month in which your participating institution terminates participation in this plan.

Coverage for your dependents will end the same day your coverage terminates or if earlier, the last day of the month in which they no longer qualify as dependents; for example, if a dependent child reaches the age limit outlined in *Part III*. In the event of an employee's death, coverage for the employee's dependents will end the last day of the month in which the employee's death occurs.

Part XII, Coordination of Benefits

If you or someone in your family are covered by this plan and another health and/or dental plan or any other insurance, the two plans coordinate benefits. If more than two plans are involved, all plans will be taken into account. The intent is to avoid paying twice on the same service while providing covered individuals with the benefits outlined in this summary plan description.

To coordinate benefits, one plan (the primary plan) pays benefits first, and the other plan (the secondary plan) pays if there are allowable expenses not paid by the first plan.

A. Definition of Plan

To coordinate benefits, a plan is defined as providing benefits, treatment, or services for medical or dental care. It includes the following:

1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, or individual practice coverage. It also includes coverage other than school accident-type coverage.
2. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs of the United States Social Security Act, as amended from time to time).
3. Motor vehicle insurance (including no-fault auto insurance).

Each contract or other arrangement for coverage under #1, #2, or #3 is a separate plan. Also, if an arrangement has two parts and coordination of benefit rules apply to only one of the two, each of the parts is a separate plan.

Medicaid is not a plan under this provision.

B. Determining Which Plan Is Primary

The following plans or programs will be deemed to be primary:

1. Plans that do not have a coordination of benefits provision;
2. Coverage that is required by law; and
3. Motor vehicle insurance coverage.

Otherwise, one of the following rules will apply.

If Covered under One Plan as an Employee and Another Plan as a Dependent

If you are covered by one plan as an employee, member, or subscriber and by another plan as a dependent, the plan you are covered by as an employee will be the primary plan.

If you are covered under a retiree plan, are on Medicare, and also have coverage as a dependent on your working spouse's plan, then:

1. The plan covering you as a dependent on your spouse's plan is the primary plan;
2. Medicare pays second; and
3. The plan covering you as a retiree pays last.

Active/Inactive Employee

The benefits of a plan that covers a person as an employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Continuation Coverage

If a person whose coverage is provided under a right of continuation provided by federal or state law is also covered under another plan, the order of benefits will be determined as follows:

1. First, the benefits of a plan covering the person as an employee, member, or subscriber (or as that person's dependent);
2. Second, the benefits under the continuation coverage.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Length of Coverage

If none of the above rules determines the order of benefits, the benefits of the plan that covered an employee, member, or subscriber longer is the primary plan.

If a Dependent Is Living with Both Parents and Has Coverage under Both Parents' Plans

1. The plan of the parent whose birthday falls earlier in a year will be the primary plan.
2. If the parents have the same birthday, the plan that has covered the parent the longest will be the primary plan.

If a Dependent's Parents Are Divorced or Separated and the Dependent Has Coverage under Two Plans

Determining the primary plan is done in the following order:

1. If a court has decreed that one parent is responsible for the health care expenses of the child, that parent's plan will be primary;
2. If a court has awarded joint custody without specifying who has responsibility for the child's health care expenses, the birthday rule will apply;
3. If there is no court ruling as stated in #1 and #2, the plan of the parent with custody will be primary;
4. Next, the plan of the spouse of the parent with custody will be primary;
5. Finally, the plan of the parent not having custody will be primary.

C. When This Is the Primary Plan

Benefits will be paid as described in this summary plan description.

D. When This Is the Secondary Plan

The plan will pay benefits only on allowable expenses that have not already been paid by the primary plan.

Definition of Allowable Expenses

An allowable expense means a necessary, reasonable, and customary item of expense for health care; when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. Outpatient prescription drugs are not included as an allowable expense.

The difference between the cost of a private hospital room and the cost of a semiprivate hospital room is not considered an allowable expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of such reduction will not be considered an allowable expense. Examples of such provisions are those related to second surgical opinions, precertification or admissions or services, and preferred provider arrangements.

Claim Determination Period

The claim determination period is a calendar year. However, it does not include any part of a year during which a person has no coverage under this plan, or any part of a year before the date this coordination provision or a similar provision takes effect.

Right to Exchange Information with the Other Plan

To coordinate benefits, the claims administrator reserves the right to exchange information with the other plan and require you to supply any information needed. In addition, the claims administrator may pay other plans any amounts found necessary and deem these payments as paid benefits.

Benefits Other than Cash

If the primary plan offers benefits other than cash, the claims administrator will assign these a reasonable cash value and regard them a paid benefit.

Overpayment of Benefits

If, as a result of this coordination of benefits provision, the amount of benefits paid by this plan on behalf of you or your dependents is more than should have been paid, the claims administrator may recover the overpayment on behalf of this plan. The claims administrator may recover the overpayment from:

1. You;
2. Your dependents;
3. Insurance companies; or
4. Other organizations.

Part XIII, Provision of Protected Health Information to Plan Sponsor

A. Permitted and Required Uses and Disclosure of Protected Health Information (PHI)

Unless otherwise permitted by law, and subject to the conditions of disclosure outlined in *Section B* of this *Part XIII* and obtaining written certification pursuant to *Section C* of this *Part XIII*, the plan may disclose PHI or electronic PHI to the plan sponsor, provided the plan sponsor uses or discloses such PHI or electronic PHI only to perform plan administration functions which the plan sponsor performs on behalf of the plan.

Plan administration functions do not include functions performed by the plan sponsor in connection with any other benefit or benefit plan of the plan sponsor or any employment-related actions or decisions. Enrollment and disenrollment functions performed by the plan sponsor are performed on behalf of plan participants and beneficiaries and are not plan administration functions. Enrollment and disenrollment information held by the plan sponsor is held in its capacity as an employer and is not PHI.

Notwithstanding the provisions of this plan to the contrary, in no event shall the plan sponsor be permitted to use or disclose PHI or electronic PHI in a manner that is inconsistent with 45 CFR §164.504(f).

B. Conditions of Disclosure for Plan Administration Purposes

Protected Health Information (PHI)

The plan sponsor agrees that with respect to any PHI disclosed to it by the plan (other than enrollment/disenrollment information, summary health information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508 which are not subject to these restrictions), the plan sponsor shall:

1. Not use or further disclose the PHI other than as permitted or required by the plan documents or as required by law.
2. Ensure that any agents, including a subcontractor, to whom it provides PHI received from the plan, agree to the same restrictions and conditions that apply to the plan sponsor with respect to such PHI.
3. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor.
4. Report to the plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which it becomes aware.
5. Make available to a plan participant who requests access, the plan participant's PHI in accordance with 45 CFR §164.524.
6. Make available to a plan participant who requests an amendment, the plan participant's PHI and incorporate any amendments to the plan participant's PHI in accordance with 45 CFR §164.526.
7. Make available to a plan participant the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528.
8. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the plan available to the Secretary of Health and Human Services for purposes of determining compliance by the plan with 45 CFR §164.504(f).
9. If feasible, return or destroy all PHI received from the plan that the plan sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
10. Ensure that the adequate separation between the plan and the plan sponsor (i.e., the firewall) required by 45 CFR §164.504(f)(2)(iii) is established.

Electronic Protected Health Information (PHI)

The plan sponsor further agrees that if it creates, receives, maintains, or transmits electronic PHI (other than enrollment/disenrollment information and summary health information and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508, which are not subject to these restrictions) on behalf of the plan, the plan sponsor will:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the plan;
2. Ensure that the adequate separation between the plan and the plan sponsor (i.e., the firewall), required by 45 CFR §164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;
3. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect such PHI; and
4. Report to the plan any security incident with respect to electronic PHI of which it becomes aware.

C. Certification of Plan Sponsor

The plan shall disclose PHI to the plan sponsor only upon the receipt of a certification by the plan sponsor that the plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the plan sponsor agrees to the conditions of disclosure set forth in *Section B* of this *Part XIII*.

D. Permitted Uses and Disclosure of Summary Health Information

The plan or a health insurance issuer or HMO with respect to the plan, may disclose summary health information to the plan sponsor, provided the plan sponsor requests such summary health information for the purpose of:

1. Obtaining premium bids from health plan providers for providing health insurance coverage under the plan; or
2. Modifying, amending, or terminating the plan.

E. Adequate Separation Between the Plan and the Plan Sponsor

The plan sponsor shall only allow the Director of the Corinthian Plan to have access to PHI. No other individual shall have access to PHI.

Such individual shall only have access to and use of PHI to the extent necessary to perform the plan administration functions that the plan sponsor performs for the plan. In the event that such individual does not comply with the provisions of this *Part XIII*, the individual shall be subject to disciplinary action by the plan sponsor for non-compliance pursuant to the plan sponsor's employee discipline and termination procedures.

The plan sponsor will ensure that the provisions of this *Part XIII* are supported by reasonable and appropriate security measures to the extent the individual designated in this *Section E* creates, receives, maintains, or transmits electronic PHI on behalf of the plan.

F. Definitions

For purposes of this *Part XIII*, the following terms shall have the meaning set forth below unless otherwise provided by the plan:

Electronic protected health information (electronic PHI) — PHI that is transmitted by or maintained in any electronic media.

Plan sponsor — The plan sponsor of the plan is Mennonite Church USA.

Protected health information (PHI) — Information that is created or received by the plan and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member; and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify the member. PHI includes information of persons living or deceased.

The following components of a member's information also are considered PHI: a) names; b) street address, city, county, precinct, zip code; c) dates directly related to a member, including birth date, health facility admission and discharge date, and date of death; d) telephone numbers, fax numbers, and electronic mail addresses; e) Social Security numbers; f) medical record numbers; g) health plan beneficiary numbers; h) account numbers; i) certificate/license numbers; j) vehicle identifiers and serial numbers, including license plate numbers; k) device identifiers and serial numbers; l) Web Universal Resource Locators (URLs); m) biometric identifiers, including finger and voice prints; n) full face photographic images and any comparable images; and o) any other unique identifying number, characteristic, or code.

Summary health information — Information: a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and b) from which the information described at 45 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information except that the geographic information described in 45 CFR §164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

Part XIV, Other Important Points

A. Subrogation

Subrogation means the plan's right to reimbursement – for loss under this summary plan description – for amounts you or any covered person recover for the same loss from any person or organization. It also means the plan's right to attempt to recover the amount of payment, including the right to initiate or intervene in legal proceedings. No person shall take or do anything to defeat the plan's rights of recovery or rights of subrogation.

Subrogation applies to all claims, demands, actions, and rights of recovery you or any covered person may have against a third party or parties and the third party's insurers for a covered person's dental treatment. The plan's subrogation rights apply to your own or any covered person's uninsured motorist, underinsured motorist, or no-fault automobile insurance coverage, too. You must reimburse the plan on whatever amount of money is received.

If the plan pays any benefits for a covered person because of required dental treatment that was caused by a third party, then the plan will pay benefits on the condition and with the agreement and understanding that you will reimburse the plan for the amount of benefits paid (including costs and legal or attorney's fees in recovering the money) from the amount you or any covered person recover from the third party.

The plan shall be reimbursed in full in first priority from any monies to the extent of any and all benefits paid by the plan. You will not be required to reimburse the plan for more than you or a covered person receive by way of settlement or recovery on a judgment. If you or a covered person recover less than the plan has paid, you will not have

to pay any additional money out of your pocket. If you or a covered person recover more than the plan has paid, you will be entitled to keep the difference between what was recovered and what the plan has paid.

If you or any covered person have a claim against a third party for a covered person's dental treatment, do not sign any releases or other papers that may compromise the plan's right to reimbursement or subrogation. **Be sure to check with the claims administrator before any papers are signed.** Any covered person must not hinder the plan's attempts to recover or resolve the claim with the third party unless the claims administrator gives prior written consent. Because of payments the plan makes on a covered person's behalf, you or any covered person have an obligation to cooperate fully with the plan in its efforts to seek reimbursement or recovery from a third party.

B. Overpayment

If for some reason the plan pays you more than you are entitled to, the plan has the right to subtract the overpayment from payments made to you in the future.

C. Right to Examine

If you or your dependent file a claim for benefits under this plan, the claims administrator shall have the right to ask the person to be examined by a dentist of its choice. In this case, the plan will pay the full cost of the requested examination.

D. Periodic Information Requests

In order to keep plan information up-to-date, the claims administrator may request basic information about you or your covered dependents that is required to pay claims according to plan provisions.

E. Assignment

The benefits provided by the plan are intended to provide for your family's dental needs. Therefore, you may not assign any of the benefits to which you may be entitled under the plan to any person or organization unless that person or organization has provided dental services to you or a covered member of your family.

F. Facility of Payment

The plan will pay its benefits directly to the service provider (dentist, hospital, or other provider, etc.) if you sign a valid assignment of benefits. There is an *Assignment of Benefits* on the claim form. This is where you should sign if you want the plan to pay the provider directly.

G. Payment of Claims

The plan may require proof of payment before reimbursing you for claims that were not assigned to the service provider.

If the claims administrator determines that a valid release cannot be given for payment of plan benefits, the claims administrator may, at its discretion, pay the individual who has assumed responsibility for your principal support and care. Because he or she has paid for your support and care, it is only fair for the plan to make payment to him or her.

If you should die before benefit payments have been made, the claims administrator may honor assignments you made before your death.

Any payment made by the claims administrator in accordance with this provision shall fully satisfy its liability for payment.

H. Misrepresentation

If you or your dependent intentionally misrepresent a material fact (either verbally or in writing) or commit fraud and because of that intentional misrepresentation or fraud, coverage is given to an individual who would otherwise not be eligible for coverage, the plan has the right to rescind coverage from the date it became effective and pursue recovery of any benefits received. At least 30 days advance notice will be provided before plan coverage is rescinded.

Likewise, if a covered person knowingly makes a statement, either verbally or in writing, which is not true and because of that statement, a claim which would otherwise not be paid is paid, the plan has the right to pursue recovery of benefits received by the covered person as a result of the claim.

I. Clerical Error

Any clerical error by the plan administrator or an agent of the plan administrator in keeping records pertaining to plan coverage or delays in making entries shall not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. An equitable adjustment will be made when the error or delay is discovered.

In addition, any clerical error or delay by the plan administrator or an agent of the plan administrator in enrolling an individual as required by the terms of the plan will not invalidate coverage for which an individual would otherwise be eligible.

J. Enforceability

The plan (as described in this summary plan description and related documents which together constitute the plan) is maintained for the exclusive benefit of the employees of participating institutions. As a participant in this plan, your rights to its coverage and any particular benefit that it provides are legally enforceable.

K. Amendment of the Plan

The plan sponsor reserves the right to amend the plan at any time without prior notice to plan participants. Any amendment to the plan will be in writing and shall be made by resolution of the person or persons who have been duly authorized by the plan sponsor to take such action. Properly executed amendments shall be delivered to the plan and the claims administrator. Plan participants will be notified of any amendment to the plan, in writing, by the plan administrator.

Any approved amendments to the plan become part of this summary plan description and may have retroactive effect (so long as they do not adversely affect the rights of plan participants to benefits provided by the plan after the effective date of the amendment but before the actual date of its adoption).

L. Termination of the Plan

The plan sponsor intends to maintain this plan indefinitely; however, it reserves the right to terminate the plan at any time, either in whole or in part, by an instrument properly executed and delivered to the plan and the claims administrator. Any such termination of the plan shall be made by resolution of the person or persons who have been duly authorized by the plan sponsor to take such action. Plan participants will be notified of any termination of the plan, in writing, by the plan administrator.

In the event the plan is terminated altogether, plan liability for payment of claims shall be limited to payment of those claims incurred as of the date the plan is terminated. Neither the plan nor the plan sponsor shall have any liability for charges, fees, or expenses incurred after the effective date of the termination of the plan.