

Dental Plan

Lourdes Health Network



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Introduction

Your dental care benefits cover a range of services from regular checkups to major dental reconstruction. The Ascension Health Dental Plan (the Plan) emphasizes preventive care, recognizing that regular checkups and diagnostic services are key to maintaining a healthy smile. Ascension Health, through your Employer, offers dental care benefits to both you and your covered family members.

The information in this Summary Plan Description (SPD) is intended to serve as a summary of the Ascension Health Dental Plan.

Certain words in this SPD are capitalized, and these words are defined in the Glossary in the next section. You may find it helpful to consult the Glossary as you read the SPD.

Please retain this SPD with your valuable papers. Coverage is effective only after enrollment is completed and your premium has been paid.

Right to Amend or Discontinue the Plan

The Plan is based on current tax laws and the Employee Retirement Income Security Act of 1974, as amended (ERISA). Ascension Health and its participating Employers expect and intend to continue the Plan and its benefits as described in this SPD. However, Ascension Health reserves the right to amend, modify or terminate the Plan or any benefits provided under the Plan at any time and for any reason. In addition, your eligibility and participation in the Plan described in this SPD should not be construed as an employment contract.

If there are any discrepancies between the information in this SPD and the official Plan documents, the terms of the Plan documents will prevail.

Glossary

The following terms may help you in reading and understanding this SPD.

Basic Restorative Services Dental services that involve certain preservation or restoration of a tooth or gums.

Birthday Rule The practice of assigning Primary payment responsibility to the Plan of the employee whose birthday occurs first in the calendar year.

Bruxism See *Harmful Habits*

Coinsurance The portion of covered dental expenses an individual pays after paying the deductible.

Deductible The portion of covered dental expenses an individual must pay each calendar year before he or she is eligible to receive dental benefits.

Employer Your W-2 employer, which is an eligible participating organization of Ascension Health.

Harmful Habits The parafunctional grinding of the teeth. Also known as Bruxism.

Major Restorative Services Certain dental services involving the creation or preservation of dentures and bridgework.

Non-Participating Dentist A general dentist or specialist who does not participate in the provider network offered through your Employer's carrier or claims administrator. Although you may choose to use a Non-Participating Dentist, you will be responsible for any difference between the dentist's usual fee and your Plan's payment. Non-Participating Dentists also are referred to as out-of-network dentists.

Orthodontic Services Services involving the straightening of teeth.

Participating Dentist A general dentist or specialist who participates in the network and has agreed to accept the carrier's or claims administrator reimbursement schedule as payment-in-full for services rendered. Participating Dentist's rates typically are below the average charges of dentists in a given geographical area. Participating Dentists also are known as network dentists.

Plan The group plan known as the Ascension Health Dental Plan.

Plan Outline A brief description of the key features of the Ascension Health Dental Plan offered by your Employer.

Preventive and Diagnostic Services Dental services associated with diagnosing and preventing dental disease.

Primary The plan whose benefits are paid first.

Secondary The plan(s) whose benefits are to be coordinated with the benefits paid by the Primary (first) plan.

Usual, Customary and Reasonable (UCR) Charge A fee for service based on what other area dentists with similar qualifications would charge for the same or similar procedure. The determination of the prevailing charge by your carrier or claims administrator does not suggest that your dentist's fee is not reasonable or proper.

Section 1: Participating in the Plan

Who Is Eligible

You are eligible for dental care coverage for yourself and your dependents if you meet the eligibility requirements listed on the Plan Outline. You may not enroll in more than one Ascension Health-sponsored Dental Plan.

If you have any questions about your eligibility, contact Human Resources.

The following dependents are eligible to participate in the Dental Plan:

- Your spouse
- Your child for whom a qualified medical child support order* is in effect
- Your unmarried child of any age who is physically or mentally disabled, if:
 - the child has the same principal residence as you for more than one-half of the Plan Year
 - the child has not provided over one-half of his or her own support during the Plan Year
 - the child becomes disabled before losing coverage under the Plan due to the dependent age limit
 - you and the child's physician submit an application at least 30 days before the date the child otherwise would lose coverage. (Contact your Human Resources representative for an application.)

*A Qualified Medical Child Support Order (QMCSO) is an order or judgment from a state court directing the Plan administrator to cover a child for benefits under the Plan. Payments will be made according to a valid order that is served on the Employer or the agent of legal process. A QMCSO may be appropriate, for example, for a child born out of wedlock; a child not claimed as a dependent on the parent's federal income tax return; or a child who does not reside with the parent or in an insurer's service area. When an order is received by the Employer, each affected

participant and each child covered by the order will be notified about the Employer's implementation procedure to determine if the order is valid.

- Except as otherwise specified in the Plan Outline, your unmarried dependent child, stepchild or legally adopted child, a child placed in your home for adoption or a child for whom you are the legal guardian if the child satisfies either Part A or Part B below:

Part A: To qualify as a dependent of yours, he or she must:

- not have attained the age of 19 (age 24 in the case of a student) as of the close of the Plan Year (Age limits can differ by ministry. Check the Plan Outline)
- have the same principal residence as you for more than one-half of the Plan Year
- not have provided over one-half of his or her own support during the Plan Year.

Part B: To qualify as a dependent of yours:

- he or she cannot be described in Part A above
- he or she must meet the age requirements specified in the Plan Outline
- you must provide over one-half of the support of your dependent during the plan year.

No person may be considered a Dependent of more than one participant. An unmarried child who is employed by an Employer and who is eligible to participate in the Plan may not be covered as a Dependent. A participant may not be covered as both an Employee and a Dependent.

Continuing Coverage Dependents who marry or reach the dependent age limit can

continue group coverage for a limited time by paying the cost of the coverage. To arrange for this coverage, notify Human Resources at least 30 days before a dependent reaches the dependent age limit.

When Coverage Begins and Ends

If you are a new employee and enrolled in the Plan, your coverage begins on the date shown on the Plan Outline.

Your coverage ends on the earliest of the following dates:

- The date the Plan ends
- The premium due date, if premiums are not paid when due
- The date you request, in writing, that your coverage be terminated
- The date you cease to be eligible for coverage under the Plan.
- Coverage may be extended through the end of the termination or retirement month.

Dependent coverage ends on the earliest of the following dates:

- The date your coverage ends
- The premium due date, if premiums are not paid when due
- The date you request, in writing, that coverage be terminated
- The date your dependents cease to be eligible for coverage under the Plan.
Coverage may extend through the end of the month.

How to Enroll

Your Human Resources representative will provide you with enrollment information. Be sure to list separately each dependent whom you want to cover under the Plan.

Coverage Options

Your options for coverage are listed on the Plan Outline.

Your Cost for Coverage

See your enrollment materials for cost information.

Section 2: Plan Benefits

The Ascension Health Dental Plan provides full coverage for preventive care and helps pay for dental care that is necessary. The payments your Plan makes for covered services are your “benefits.”

Benefit Amount

Dental care is considered to be necessary if it is required to treat a condition, disease or injury and, in the claims administrator’s judgment, is necessary and appropriate according to current standards of good dental practice. If dental records do not document that the type and level of care were necessary, the Plan cannot provide benefits.

Your Plan will help pay for dental care provided by dentists or other professionals licensed to provide dental care, as long as the care is covered under your Plan.

If you need non-emergency dental services, your dentist can submit a treatment plan to the claims administrator before treatment begins so that your benefits may be predetermined and you will know in advance what the Plan will pay (see *Predetermining Your Benefits* in this section).

Providers

The Dental Plan has a provider network. The Plan allows you to obtain dental care services from any licensed dentist, however, if you choose to obtain services from a Participating Dentist, your cost of covered care is less. In addition, if you use a Participating Dentist, you will not be balanced billed for amounts that exceed any Usual, Customary and Reasonable Charges.

You may choose between the two networks offered by Delta Dental of Missouri.

The Delta Dental PPO Network has the deepest discounts which results in lower out of pocket expense. The dentists file claims, accept assignments and guarantee their work.

The Delta Dental Premier Network provides the same services but has lower discounts than the PPO plan.

Non-participating dentists do not offer discounts and do not have to guarantee their work. They may or may not submit claims and in most cases cannot accept assignments.

For a list of Participating Dentists, log on to the Delta Dental’s Web site or call their Customer Service representatives (see Section 6, Plan and Contact Information).

Covered Expenses/Usual, Customary and Reasonable Charge

Your dental benefit payments are based on the “covered expense” or allowed charge for a specific service or supply. The Plan will pay a percentage of the covered expense. The covered expense may or may not be the same as the dentist’s actual charge.

The covered expense will be either the actual charge or what is considered the Usual, Customary and Reasonable (UCR) Charge for a particular service, whichever is less. The UCR Charge for a service is determined based on how the charge compares to “Usual, Customary and Reasonable” fees charged for that service by your dentist and by other area dentists with comparable qualifications. If the charge is higher than usual, it may still be reasonable because of unusual clinical circumstances.

These will be reviewed on a case-by-case basis.

You are responsible for paying the Non-Participating Dentist any amount that exceeds the Usual, Customary and Reasonable Charge.

Deductibles

See the Plan Outline for information about any Deductible amount that must be satisfied each calendar year.

Covered Services

After you satisfy your dental Deductible (if applicable), you pay a percentage of covered expenses *up to the UCR amount*, depending on the type of service required.

To learn what portion of the following services the Plan pays, see the Plan Outline. Additional covered services are also included on the Plan Outline.

Preventive and Diagnostic Services

- Routine periodic examinations, twice every year
- Periapical and bitewing X-rays, twice every year
- Full-mouth/panoramic X-rays, once every three years
- Dental prophylaxis (periodic cleaning, scaling and polishing) performed by a dentist or dental hygienist, twice every year
- Periodontal cleanings, maximum of four periodontal cleanings every year (combined with regular cleanings)
- Topical fluoride application for children to age 19, once a year
- Topical application of sealant on first and second permanent molars for covered children to age 16, one per tooth every three years

- Palliative treatment emergency services for pain
- Space maintainers to age 19, one per life per quadrant of the mouth.

EOBs are not sent to associates for preventive services only claims if services rendered by a Delta Dental provider have no write-off and nothing is payable to the patient.

Basic Restorative Services

- Restorative services using silver alloy or composite resin filling material*
- Gold or cast restorations (covered only when teeth cannot be restored with other filling materials), [inlays and onlays]
- Periodontics (treatment for diseases of the gums)
- Endodontics (root canal filling) and pulpal therapy (therapy for the soft tissue of a tooth)
- Simple extractions of teeth
- Oral surgery performed in the dentist's office
- General anesthesia administered in the dentist's office, when considered necessary and when administered in conjunction with oral surgery
- Osseous surgery
- Biopsy and examination of oral tissue
- Alternate treatments*.

Major Restorative Services

- Initial bridge, first installation of full or partial dentures and adding teeth
- Replacement or alteration of dentures or fixed bridge, once every five years
- Replacement of full denture, once every five years
- Repair of bridges and dentures
- Relining dentures
- Harmful habits (bruxism)
- Congenital missing tooth

- Crowns and buildup for crowns, once every five years (refer to the Plan Outline for coverage)
Implants*
(Refer to the Plan Outline for coverage)
- Alternate treatments*.

Orthodontia

Refer to the Plan Outline for coverage.

If alternate treatments are available, the Plan will be liable for the least costly professionally satisfactory treatment. This would include, but is not limited to:

- Basic Restorative Services
- Major Restorative Services (such as composite resin fillings on molar teeth, in which case the benefits are based on the cost of an amalgam (silver) filling; or crowns, implants and fixed bridges, in which case the benefits may be based on the cost of a removable partial denture).

This provision may also apply to periodontal treatment and oral surgery.

Annual Maximum

The Plan pays a maximum amount in benefits per person each calendar year (Refer to the Plan Outline).

Predetermining Your Benefits

For non-emergency dental care, your dentist can submit a treatment plan to the Claims Administrator at least 14 days before treatment is to begin so that your benefits can be predetermined.

Regardless of anticipated expense, if you ask the dentist to submit a treatment plan before beginning a procedure (e.g., crowns, bridges, periodontics, inlays and onlays and complex oral surgery), you will know in advance what the expected cost will be. The Claims Administrator will then send a Notice of Predetermined Benefits to your dentist.

Section 3: Other Plan Provisions

Exclusions

Your Plan Outline specifies what the Plan covers. In addition, your dental coverage does not provide benefits for:

- Dietary planning, plaque control or oral hygiene instruction
- Treatment for temporomandibular joint dysfunction (TMJ)
- Local anesthesia when billed separately by a dentist
- Replacement of a dental appliance or device that is lost, stolen or missing
- Athletic mouthguards
- Protective cases used to store dental devices or appliances
- Duplicate prosthetic devices or appliances
- Treatment or surgery for cosmetic purposes
- Treatment or appliances for restoring vertical dimension
- Services or supplies considered experimental or under clinical investigation
- Any charges incurred while the patient is not covered by the dental Plan
- Charges exceeding Usual, Customary and Reasonable amounts
- Charges that exceed Plan maximums
- Services or supplies that are not required according to accepted standards of dental practice
- Services or supplies that are not recommended, prescribed or approved by a dentist
- Charges for missed appointments or completion of required claim forms
- Charges resulting from an injury suffered in committing a crime
- Charges for sterilization of equipment
- Charges for infection control
- Any illness or injury for which Workers' Compensation benefits are paid, or may be paid, if claimed
- Services or benefits for the treatment of any sickness or injury caused by a war or any act of war (declared or undeclared) or service in the armed forces of any country
- Services or benefits that the Plan is unable to provide because of any law or regulation of the federal, state or local government, or any action taken by any agency or federal, state or local government with regard to the law or regulation
- Treatment furnished by a state or federal hospital
- Services or supplies that are provided or payable by any governmental agency
- Services or supplies that are furnished primarily for the convenience of an enrolled individual, the family or a dentist
- Services for which the patient incurs no charge
- Myofascial pain dysfunction syndrome
- Any services not specifically stated, including hospital charges
- Services rendered by a dentist beyond the scope of his/her license
- Hypnosis, hypnotic anesthesia, acupuncture or acupressure
- Complete occlusal adjustments (adjustments affecting the contact between the upper and lower teeth)
- Bases, liners, anesthetics and application of caries removal solutions used in conjunction with restorations
- Charges covered under a terminal liability, extension of benefits or similar provision of a plan being replaced by this Plan
- Charges for home or hospital visits
- Temporary or treatment crowns, bridges or dentures, or crowns or bridges used for periodontal splinting

- Orthognathic surgery (surgical repositioning of the jaw) or any service or supply to correct deformities of the jaw
- Analgesia and nitrous oxide
- Routine postoperative care, if billed separately
- General anesthesia or intravenous sedation, unless administered during oral surgery
- Dental care not expressly specified in this SPD
- Dental care for treatment of complications arising out of or from dental care that is not a benefit
- Charges for duplication of records or radiographs
- Charges for precision attachments
- Dental care to replace tooth structure loss due to attrition or abrasion
- Claims not received by the end of the year after the year in which the services and supplies were received
- Charges for multiple visit services, which commenced prior to the membership effective date (including, but not limited to prosthetics and orthodontia care)
- Other services as indicated on the Plan Outline.

Leave of Absence

If you require a leave of absence for any reason, contact Human Resources. They will inform you of your Employer's leave of absence policy.

Family and Medical Leave Act of 1993

If you take a leave under the Family and Medical Leave Act of 1993, you have the option of continuing or discontinuing your dental coverage. Consult with Human Resources before taking the leave to discuss your options.

Continuation of Coverage (COBRA)

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you have the option of continuing dental plan coverage for yourself and your eligible dependents for up to 18 months at group rates if you would otherwise lose coverage because of any of the following events:

- You no longer are employed by your Employer (whether voluntarily or involuntarily, except if terminated for gross misconduct)
- You are laid off for economic reasons
- Your work hours are reduced below the minimum level necessary to be eligible for this Plan.

Eligible dependents can continue to be covered under the Plan for up to 36 months through you or they can apply for coverage on their own. Coverage is available if your eligible dependents would otherwise lose coverage due to any of the following events:

- You die
- You divorce or become legally separated
- Medicare becomes your Primary coverage
- The dependent no longer qualifies as an eligible child due to marriage or reaching the dependent age limit (See the Plan Outline).

If you become entitled to Medicare benefits under Title XVIII of the Social Security Act before you lose coverage because of termination of employment or reduction in hours, the continuation coverage of eligible dependents of that covered employee will end on the later of:

- 36 months after you became entitled to Medicare benefits
- 18 months (or 29 months if there is a

disability extension) after the date of your termination of employment or reduction in hours.

You must make your election of continuation coverage within 60 days after the later of the date regular coverage is lost or the date that you receive notice of your right to elect continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment for continuation coverage no later than 45 days after the date of your election.

COBRA participants are subject to the same rights and rules as active associates of their Employer who participate in the Ascension Health Dental Plan.

Extended Coverage for Disabled Individuals

You or covered family members who are disabled on the date of eligibility for continuation coverage or who become disabled within the first 60 days of the continuation coverage period may be able to extend coverage for themselves and other covered family members for up to an additional 11 months.

To qualify, the Social Security Administration must officially determine that the person became disabled prior to the 61st day of the continuation coverage period. Also, that person must notify the Employer of this disability determination before the first 18 months of continuation coverage ends and within 60 days of receiving notification from Social Security that the disability determination has been made.

If the disability ends during the 11 months of extended coverage, that person must notify the Employer within 30 days. Continuation coverage will end on the last day of the month in which the disability ended.

Cost If you choose continuation coverage, you can be charged up to 102% of the cost of coverage for the type of plan and coverage you choose.

For disabled people and their family members who choose to continue coverage beyond their initial 18-month eligibility period, your Employer can charge up to 150% of the cost of coverage during the 11 month extension. Contributions must be paid from the date continuation coverage otherwise would have ended.

Second Qualifying Event If you accept continuation coverage, you can experience a second qualifying event that may allow you or your family member to extend coverage further, but only up to a total of 36 months. The second qualifying event must occur while you have continuation coverage.

Example: The family of an associate who is laid off becomes eligible for continuation coverage for up to 18 months. They accept the coverage and, seven months later, the associate dies. The surviving spouse and children are then entitled to 36 months of continuation coverage, less the seven months for which they already have been covered.

Notification The associate or family member is responsible for notifying the Employer within 60 days after a divorce or legal separation occurs or a child loses eligible status.

The Employer sends a continuation of coverage notice to the individual(s) in question along with a continuation of coverage form, which allows them to indicate whether they want such coverage.

Termination Continuation coverage will stop before the specified time period if one of these events occurs:

- You fail to make contributions on time
- You become entitled to Medicare after you have elected continuation coverage under this Plan
- The Employer stops providing a group dental plan for employees
- You become covered under another group dental plan after you have elected continuation coverage under this Plan
- You cease to be disabled during the 11-month disability extension period.

If you become covered under another dental plan, your continuation coverage would not have to terminate early if your new plan excludes or limits coverage of preexisting conditions. Under those circumstances you could continue to receive the full benefits of your continuation coverage (not only benefits for preexisting conditions) until your original eligibility period of 18, 29 or 36 months ends or until the preexisting conditions limitation or exclusion ends, whichever occurs first.

Section 4: Filing a Claim

If your dentist does not submit claims, obtain a dental claim form from Human Resources, complete the relevant sections and give it to your dentist at the time of your appointment. Or, at your appointment, ask the dentist to complete the Dentist section of a standard American Dental Association-approved claim form. Then complete the Patient section, sign the form and mail it to the claims administrator at the address listed in Section 6, Plan and Contact Information.

If you need dental care while traveling and a claim form is unavailable, obtain an itemized bill from the dentist. The bill must include the following:

- Dentist's name and office address
- Patient's name
- Reason for treatment
- Charge for each service provided
- Dental procedure code for each service provided.

Send this bill to the Claims Administrator at the address listed in Section 6, Plan and Contact Information, and include the following information:

- Your name, address and Social Security number
- Your Employer's name
- The patient's name, date of birth and relationship to you
- Other insurance information if applicable for coordination of benefits (COB).

Whenever you or your dentist files a claim on your behalf, whenever there is a patient payable amount you will receive an Explanation of Benefits (EOB) form that explains what services were covered and which, if any, were not. In some instances, you may receive more than one EOB regarding the same claim. To be considered

for reimbursement, claims must be filed by the end of the year following the year in which the claim was incurred.

Determination of Benefits

The Claims Administrator must notify you of its benefits determination within certain time periods described below. The length of those time periods depends upon the type of claim you submit.

For this purpose, claims are divided into three types:

Pre-determination Claims are requests for pre-authorization or pre-certification that are not required but recommended when dental claims exceed \$300 in order that you will know what services are covered and what is payable under the Plan.

Post-service Claims are requests for payment for services that have already been rendered.

Claims relating to an ongoing course of treatment are claims for services that will be provided (or are being provided) over a period of time or a number of treatments.

If you have a claim involving urgent care and you provide the required information, the Claims Administrator will notify you of its determination within 72 hours after the receipt of the claim.

However, if your claim does not provide enough information to determine whether the Plan will cover the services, the Claims Administrator will notify you within 24 hours after receipt of your claim and will request specific information that is required to complete the claim. You will have at least 48 hours to provide the information. The Claims Administrator will notify you of its determination within 48 hours after the earlier of:

- Receipt of the information or

- The end of the period allowed for providing the information.

If you or your authorized representative fails to follow the Plan's procedures for filing an urgent care claim, Claims Administrator will notify you of the failure and the proper procedures for filing a claim for benefits within 24 hours following the failure. Notice may be provided orally, unless you or your authorized representative request written notification.

If the Plan Administrator has approved an ongoing course of treatment, the Claims Administrator will notify you of any reduction or termination of the course of treatment far enough in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the benefit is reduced or terminated.

If you make a request to extend the course of treatment beyond the period of time or number of treatments and the claim is a claim involving *urgent care*, the Claims Administrator will decide the claim as soon as possible, taking into account the medical urgency. The Claims Administrator will notify you of the benefit determination (whether adverse or not) within 24 hours after receipt of the claim, provided that you make any such claim at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

In the case of a *pre-service* claim, the Claims Administrator will notify you of its determination within 15 days after receipt of the claim. This period may be extended one time for up to 15 days if an extension is necessary due to matters beyond the control of the Plan. If such an extension of time is taken, the claims administrator will notify you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If such

an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information. You must provide the specified information within 45 days after receipt of such notice.

If you or your authorized representative fail to follow the Plan's procedures for filing a pre-service claim, the claims administrator will notify you of the failure and the proper procedures for filing a claim for benefits within five days following the failure. Notice may be provided orally, unless you or your authorized representative request written notification.

In the case of a *post-service* claim, the Claims Administrator will notify you of an adverse benefit determination within 30 days after receipt of the claim. This period may be extended one time for up to 15 days if an extension is necessary due to matters beyond the control of the Plan. If such an extension of time is taken, the Claims Administrator will notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information. You must provide the specified information within 45 days after receipt of such notice.

Every notice of an adverse benefit determination will be provided in writing or electronically and will include:

- The specific reason or reasons for the adverse determination
- In the case of a claim involving *urgent care*, a description of the expedited review process applicable to such claims

including the standard appeal process and the right to file suit under ERISA.

Every notice of an adverse benefit determination will be provided in writing or electronically and also may include:

- Reference to the specific Plan provisions on which the determination is based
- A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary.

In the case of an adverse benefit determination concerning a claim involving *urgent care*, the notice may be provided orally, provided that a written or electronic notice is furnished not later than three days after the oral notice is provided.

You are entitled to receive, upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

Appeal of Adverse Benefit Determination

If you make a request for review within 180 days after you receive notice of an adverse benefit determination, you are entitled to review of the decision by the Claims Administrator. You may submit written comments, documents and other information and you may receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim.

In the case of a claim involving *urgent care*, a request for an expedited review may be submitted orally or in writing and all necessary information, including the benefit determination on review, will be transmitted

by telephone, facsimile or other available similarly expeditious method. The Claims Administrator will notify you of the benefit determination on review within 72 hours after receipt of your request for review.

In the case of a *pre-service* claim, the Claims Administrator will notify you of the benefit determination on review within 30 days after receipt of your request for review.

In the case of a *post-service* claim, the Claims Administrator will notify you of the benefit determination on review within 60 days after receipt of your request for review.

Notice of the decision on review will be provided in writing or electronically and will include:

- The specific reason or reasons for the benefit determination
- Reference to the specific Plan provisions on which the benefit determination is based
- A description of any available voluntary appeal procedures and information about such procedures.

You are entitled to receive, upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) if you are not satisfied with the decision on review. You and the Plan administrator may have other voluntary alternative dispute resolution options such as mediation. One way to find out what may be

available is to contact your local U.S. Department of Labor office.

All claims for benefits and requests for review of claim denials should be submitted to the Claims Administrator at the address listed in Section 6, Plan and Contact Information.

Any suit based on a denial of a claim must be filed no later than three years after the period for filing claims expires.

Coordination of Benefits Provision

The Plan has a coordinating provision for individuals who have more than one plan that provides dental coverage. A general description is provided here.

Coordination of your benefits depends on which dental plan is Primary.

- *If the Plan is Primary:* You will receive benefits as if it were the only plan.
- *If the Plan is Secondary:* You may receive a payment from the Plan in addition to the payment you receive from the Primary plan. Your payment will not be more than 100% of your out-of-pocket expense.
- *If the other dental plan does not have a coordinating provision:* That plan is considered Primary.

When all dental plans have coordinating provisions:

- The plan covering the patient as an associate is Primary, and the plan covering the patient as a dependent is Secondary.
- If the patient is covered under both plans as an employee or if the patient is covered under both plans as a dependent, the plan covering the patient the longest is Primary, with the following exceptions:

- *For covered children of married parents:* The Birthday Rule applies unless the plan considered Primary does not honor the Birthday Rule. In that case, the Coordination of Benefits provision of the other plan will be used to determine which plan is Primary.
- *For covered children of divorced or legally separated parents:*
 - If a court has decreed financial responsibility, the dental plan of the parent who has financial responsibility for the child is Primary.
 - If there is no court financial decree, the plan of the parent with custody is Primary.
 - If there is no financial decree and the parent with custody remarries, that parent's plan remains Primary and the stepparent's plan is Secondary.
 - If none of the above applies, the plan that has covered the child the longest is Primary.

If you or any family members are covered under another dental plan and that plan is Primary, file a claim with that plan first. Then, when you receive an explanation of what the other plan paid, include a copy of that EOB when you file a claim with this Plan. This will help speed up the processing of your claim.

Subrogation and Right of Reimbursement

As a condition to receiving dental benefits under this Plan, you and your covered dependents agree to transfer to the Plan their rights to recover damages in full for such benefits when the injury or illness occurs through the act or omission of another person. Alternatively, if you and your covered dependent receives any recovery, by way of judgment, settlement or otherwise, from another person or business entity, you or your covered dependent agrees to reimburse the Plan in full, in first priority, for any dental expenses paid by it.

The obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the settlement or judgment specifically designates the recovery, or a portion thereof, as including dental expenses. If a repayment agreement is required to be signed, this clause remains in effect regardless of whether it is actually signed. The Plan's rights of full recovery, either by way of subrogation or rights of reimbursement, may be from funds you, your covered dependent or guardian receives or is entitled to receive from the third party, any liability or other insurance covering the third party, your, your covered dependents' or guardians' own uninsured motorist insurance, underinsured motorist insurance, any medical payments, no-fault or school insurance coverages which are paid or payable.

The Plan may enforce its reimbursement or subrogation rights by requiring you, your covered dependent or guardian to assert a claim to any of the foregoing coverages to which he/she may be entitled. The Plan will not pay attorney fees or costs associated with a claim or lawsuit without express written authorization.

Misrepresentations

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud, submits an application or files a claim containing a false, incomplete or misleading statement is guilty of fraud. The Plan Administrator reserves the right to take appropriate action in any instance where fraud is an issue.

Section 5: Your ERISA Rights

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). They are described below.

Receiving Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continuing Group Dental Coverage

You have the right to continue dental coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your

dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan for the rules that explain your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcing Your Rights

If your benefit claim is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan Administrator and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree

with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact your Human Resources representative. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Section 6: Plan and Contact Information

Official Plan and Trust Names	Ascension Health Dental Plan (Restated as of January 1, 1998) Ascension Health Welfare Benefits Trust (Amended and Restated as of January 1, 1998)
Employer Identification Number	31-1662309
Plan Number	512
Plan Description	Health benefits/dental care
Plan Sponsor and Plan Administrator	Ascension Health 11775 Borman Drive, Suite 106 St. Louis, MO 63146-4134 (314) 733-8000
Trustee	State Street Bank and Trust Company P. O. Box 1992 Boston, MA 02105-1992
Claims Administrator	Delta Dental of Missouri 12399 Gravois Road St. Louis, MO 63127
Type of Administration	The Plan is jointly administered by Ascension Health and the Claims Administrator. Ascension Health is responsible for benefit design and Plan administration and the Claims Administrator is responsible for processing claims and issuing benefit payments.
Plan Year	Plan records are maintained on a Plan-year basis beginning January 1 and ending December 31 each year.

Agent for Service of Legal Process	Ascension Health 11775 Borman Drive, Suite 106 St. Louis, MO 63146-4134 (314) 733-8000
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Type of Funding	You and your Employer pay the cost of this benefit.
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To File a Claim	Delta Dental of Missouri P. O. Box 8690 St. Louis, MO 63126 Web site: www.deltadentalmo.com/ascension Customer service: (800) 335-8266 Local telephone number: (314) 656-3000 Toll-free telephone number (800) 392-1167 Group number: 6990
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** Delta Dental customer service representatives are available Monday through Friday from 8:00 a.m. until 5:00 p.m. CST. Delta Dental's interactive voice response system is available 24 hours a day, seven days a week.*

To Appeal a Claim	Delta Dental of Missouri Appeals Committee 12399 Gravois Road St. Louis, MO 63127
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