Summary
Plan Description
For
The Christ Hospital

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE DENTAL CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DENTISTS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS.

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INTRODUCTION

YOUR DENTAL CARE PLAN

The Christ Hospital is pleased to present its self-insured dental plan, which is administered by Dental Care Plus (DCP), a comprehensive plan to help you meet the dental needs of your family and to protect you from the high cost of dental services. The Plan, as described in this booklet, became effective January 1, 2008 and provides dental coverage for you and your eligible dependents. It is very important that you read this booklet so that you become familiar with your benefits and how to use them.

THIS BOOKLET

This booklet outlines eligibility requirements, services covered and Plan limits as well as how to file a claim and how to find an answer when you have a question.

We recommend that you use this booklet as your first source of reference when you have questions about the Plan, your benefits, and your rights. If you have questions that don't appear to be covered in this booklet, please do not hesitate to contact the Claims Administrator, Dental Care Plus. DCP keeps records of individual Plan participants and supervises the administration of the Plan. DCP's address is listed on the back cover.

WHAT IS DENTAL CARE PLUS?

Dental Care Plus is the Claims Administrator for the Plan, and also maintains a network of Participating Dentists who have signed a contract with DCP and have agreed to accept a fee schedule developed by DCP for Covered Dental Services provided to Members of plans administered by DCP.

2100 DENTISTS TO CHOOSE FROM

There are approximately 2100 dentists who participate in the Dental Care Plus network of Participating Dentists. Except for out of area emergencies, you are required to receive dental services from a Participating Dentist. Chances are your dentist is already a Participating Dentist.

EASE OF USE

When you are covered under a plan administered by DCP, claim forms are eliminated. Your Participating Dentist will work directly with DCP. When you obtain dental services, just show your DCP identification card. Your dentist will file a claim for you.

VALUE FOR YOUR MONEY

DCP's package of administrative services and Participating Provider Network makes high quality dental care affordable. Out-of-pocket expenses are minimized. DCP Participating Dentists have agreed to a fee schedule developed by DCP for Covered Dental Services provided to patients who are Members of plans administered by DCP. DCP and your Participating Dentist are committed to providing the best in dental care.

PLAN DEFINITIONS

Accidental Injury - an accidental physical injury to the body caused by unexpected means that does not arise out of or in the course of employment.

Actively at Work - an Employee, as hired by the Employer, working full-time and paid regular earnings (temporary or seasonal employment is excluded) for a specific task or set of responsibilities.

This includes:

- working a specified number of hours each week, and
- working at the Employer's usual place of business or at a location to which your Employer's business requires you to travel.

An Employee who does not complete his/her work assignments due to leave of absence, disability, strike, or layoff is not Actively at Work.

Allowable Expense - any necessary expense covered in full or in part under your Plan.

Annual Maximum Benefit - the maximum amount payable under your Plan for Covered Dental Services received by a Member in a Benefit Year.

Benefit Year (Calendar Year) - the calendar year begins January 1 and ends December 31st.

Claims Administrator - Dental Care Plus, Inc. (which is part of The Dental Care Plus Group), the organization designated by the Employer to administer claims for the Plan.

Company - The Christ Hospital.

Copayment - the amount which the Member is required to pay for certain dental services covered under the Plan. Copayments may be a fixed dollar amount or a percentage of the Allowable Expense. The Member is responsible for payment of the Copayment directly to the Participating Dentist. See Schedule of Benefits for Copayment levels.

Covered Dental Services - services which are covered under the Plan and for which the Plan will pay part or all of the Allowable Expense. Covered Dental Services are described in the Covered Dental Services section of this Summary Plan Description.

Covered Dependent - a spouse, domestic partner or dependent child who is eligible for coverage and enrolled under the Plan.

Deductible - the amount which the Member is required to pay for Covered Dental Services before benefits are paid under the Plan.

Disability - the inability of an Employee (because of injury or illness) to perform the material duties pertaining to his/her employment with the Employer. Disability of a Covered Dependent is the inability (because of injury or illness) to perform all regular and customary activities usual to that Covered Dependent's age and family status. An Employee or Covered Dependent is not considered to be suffering from a disability if he/she is performing any work or engaging in any occupation or employment for wage or profit, unless related to rehabilitation.

Employee - an Employee of the Employer who is regularly scheduled to work at least 20 hours per week is eligible for coverage under the Plan.

Employer - The Christ Hospital, its subsidiaries, and the affiliated businesses that are designated by The Christ Hospital as participating Employers in the Plan.

Experimental - any care, procedure, treatment protocol, or technology that is not widely accepted as safe, effective, and appropriate for the treatment of injury or sickness throughout the recognized medical profession and established medical societies in the United States; or is in the research or investigational stage or conducted as part of research protocol; or has not been proven by statistically significant randomized clinical trials to establish increased survival or improvement in the quality of life over other conventional therapies. This also includes drugs, tests, and technology that the Food and Drug Administration has not approved for general use; that which is considered experimental; that which is for investigational use; or that which is approved for a specific medical condition but applied to another condition.

Family Dependent - means a spouse, domestic partner or dependent child who is enrolled in the Plan and eligible for coverage under the Plan. See Eligibility Information for specific guidelines regarding eligibility.

Injury - an accidental physical injury to the body caused by unexpected external means which does not arise out of or in the course of employment. All injuries sustained in connection with one accident are considered to be one injury. The term "injury" does not include disease or infection, except pyogenic infection occurring through an accidental cut or wound.

Lifetime Maximum Benefit - the maximum amount payable under your Plan for Covered Dental Services received by a Member during the Member's lifetime.

Medically Necessary/Medical Necessity - means that the treatment, services, or supplies received by a Member are determined to be:

1. appropriate and necessary for the symptoms, diagnosis, or direct care and treatment of the Member's condition;
2. within the standards the organized dental community deems good dental practice for the Member's condition;
3. not primarily for the convenience of the Member, the Member's Dentist or another person or provider;
4. not investigational or unproven, as recognized by the organized dental community, or which are used for any type of research program or protocol; and
5. not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment.

The fact that a Dentist may prescribe, order, recommend, or approve a service, supply, or level of care does not, of itself, make the treatment Medically Necessary or make the charge a Covered Dental Service under the Plan.

Member - means the Subscriber and Family Dependents enrolled in the Plan who are eligible to receive Covered Dental Services under the Plan.

Military Service - includes service in the Army, Navy, Air Force, Marine Corps, Coast Guard, or any other recognized branch of service, pertaining to the military of any country.

Participating Dentist - means any dentist who has entered into an agreement with Dental Care Plus to provide Covered Dental Services to Members.

Placed for Adoption - means the assumption or retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with a person terminates upon the termination of that legal obligation.

Plan - The Christ Hospital Employee Dental Plan and its Schedule of Benefits as amended from time to time. The Plan is self-insured by The Christ Hospital.

Plan Administrator - The Christ Hospital. The Plan Administrator has the discretionary authority to interpret the Plan including those provisions relating to eligibility and benefit determination. The Plan Administrator's interpretations and determinations are final and binding.

Plan Document - the legal document governing the administration and interpretation of The Christ Hospital Employee Dental Plan.

Plan Participant - see Member and Subscriber definitions.

Plan Sponsor - The Christ Hospital.

Plan Year - the 12-consecutive month period that ends on December 31.

Subscriber - means any Employee, eligible by virtue of employment and proper enrollment, to receive Covered Dental Services under the Plan.

Total Disability - a person's complete inability to perform any and every duty of his/her occupation or any other work or employment for wage or profit, or his/her Covered Dependent's complete inability to perform the normal activities of a person of his/her age and sex in good health.

Work In Progress - services or procedures started prior to the effective date of the coverage, with the exception of orthodontia if covered by the Plan. Prosthetic devices and crowns will not be covered if impressions are taken before the effective date of coverage. If final impressions were taken while coverage is in effect, but the prosthetic device or crown is installed more than thirty (30) days after coverage terminates, then charges for the prosthetic device or crown will not be covered.

ELIGIBILITY INFORMATION

Eligible Family Dependents are a Subscriber's legally married spouse or domestic partner and Dependent Children, as defined below.

Under the Plan, your eligible Family Dependents are defined as:

- Your legally married spouse or domestic partner. A domestic partner is defined as someone who:
  - is in a committed relationship of mutual caring with the Subscriber.
  - shares the Subscriber's principal place of residence and intends to do so indefinitely.
  - shares domestic and financial responsibilities for the Subscriber's household.
  - has been in this relationship with the Subscriber for at least one calendar year and sharing a residence.
  - is not related by birth or marriage.
  - is not legally married to or the domestic partner of any other person
  - is over the age of 18
- Your or your legally married spouse's Dependent Children defined as:
  - Biological child(ren)
  - Child(ren) named in a divorce decree or Qualified Medical Child Support Order as being the responsibility of the Subscriber for dental benefits coverage. If the child resides outside of the Dental Care Plus service area, evidence of the Qualified Medical Child Support Order will be required. You may obtain without charge from the Plan Administrator a copy of the Plan's procedures for reviewing Qualified Medical Child Support Orders.
  - Legally adopted child(ren), foster child(ren), or child(ren) for which you have legal custody.
  - Child(ren) who have been Placed for Adoption with you, if legal adoption is anticipated but not yet finalized.
  - Child(ren) of any age who are incapable of incapable of self-support because of permanent mental or physical Disability, if the mental or physical Disability occurred before attainment of age 19. The Subscriber must principally support the disabled child and proof of the permanent Disability must be submitted to Dental Care Plus.

Dependent Children (who are not disabled) can be covered until:

- the end of the month in which they attain age 26, regardless of financial dependency, residency, student status or marital status.

Coverage for Dependent Children does not include coverage for such Dependent Child's spouse or children.
In no event shall the term Family Dependent include (a) a spouse or child on active duty in any Military Service of any country, (b) a child who is eligible for coverage under the Plan as a Subscriber.

ENROLLMENT AND EFFECTIVE DATE OF INDIVIDUAL COVERAGE

Enrollment

An eligible Employee shall be eligible for coverage on the first day of the month after his date of hire and may enroll himself and any Family Dependent during the initial eligibility period by following the enrollment procedures of the Employer. A newly acquired Family Dependent is eligible to enroll in the Plan for a period of thirty-one (31) days beginning on the date he becomes a Family Dependent.

The Employer will notify Dental Care Plus in writing of any enrollments, terminations or changes in the coverage classification of any Member. The time period of notification cannot exceed thirty-one (31) days following the effective dates of such changes.

Effective Date of Coverage

The coverage of a Member shall become effective on the date the Plan takes effect, or on the first day of the month after he becomes an eligible Employee

Unless otherwise provided by the Plan, a Subscriber not Actively at Work (except while on paid vacation or unpaid leave under FMLA) on the date the Plan takes effect, shall have his coverage become effective on the date of his return to active work.
In no event shall a Family Dependent of any Subscriber be covered under this Plan until the Subscriber's coverage becomes effective.

Changes in Plan Coverage

You can change your level of coverage before the next annual enrollment period if you experience a change in your family status. If you experience a change in family status and wish to change your level of coverage, you must submit written notification to the Employer within 31-days* of your change in family status. The Plan reserves the right to require the applicant to submit proof of any

change of status. The following are examples of qualifying events for a change in family status:

- marriage
- divorce
- birth or adoption of a Dependent Child
- death of a Family Dependent
- loss of your spouse's employment
- employment of your spouse
- you are called to active military duty and obtain a military leave of absence
- you change from full-time status to part-time status or vice versa
- you change from active status to an unpaid leave of absence
- your spouse's change from full-time status to part-time status or vice versa
- your spouse's change from active status to an unpaid leave of absence
- a spouse's change in employment that significantly changes your spouse's or your own dental care coverage

* The 31-day notification period is waived if court/administrative ordered coverage is required for a Dependent Child. This waiver applies when written notification/enrollment is made by either the Subscriber or other parent. The Dependent Child's coverage will not be terminated unless the Subscriber's coverage is terminated, the court/administrative order has expired or other comparable coverage is in effect.

IDENTIFICATION CARD

You will be issued Identification Card(s) which will list the names of all enrolled Family Dependents. The Identification Card should be presented whenever dental services are being received. This will assist in assuring that bills for Covered Dental Services are sent directly to Dental Care Plus.

DENTAL SERVICE AREA

The following are the counties currently within the DCP service area:

Ohio Counties	**Kentucky Counties**		**Indiana Counties**
Adams	Anderson	Jessamine	Decatur
Brown	Bath	Kenton	Dearborn
Butler	Boone	Lewis	Fayette
Clark	Bourbon	Madison	Franklin
Clermont	Bracken	Mason	Jefferson
Clinton	Bullitt	Meade	Jennings
Darke	Campbell	Mercer	Ripley
Fayette	Carroll	Montgomery	Switzerland
Greene	Clark	Nelson	Ohio
Hamilton	Fayette	Nichols	Union
Highland	Fleming	Oldham	
Miami	Franklin	Owen	
Montgomery	Gallatin	Pendleton	
Preble	Garrard	Robertson	
Warren	Grant	Scott	
	Hardin	Shelby	
	Harrison	Spencer	
	Henry	Trimble	
	Jefferson	Woodford	

PARTICIPATING DENTISTS

Members must seek service from a Participating Dentist. In most cases, Members can retain their own dentist since all licensed dentists in the service area of Dental Care Plus are eligible to participate in the Dental Care Plus network. To access the most current listing of Participating Dentists, please visit our website at www.dentalcareplus.com. Or, if you would prefer to receive a paper copy of the directory, please contact us at (513) 554-1100 or (800) 367-9466.

NON-PARTICIPATING DENTISTS

Members seeking service from a Non-Participating Dentist will be responsible for the full payment to the dentist for dental services which would have otherwise been covered under the Plan, unless prior plan approval has been obtained from the Plan. Prior plan approval may or may not be granted based upon the circumstances of each individual situation. The decision to grant or deny prior plan approval is final and is at the sole discretion of the Plan.

EMERGENCY CARE WITHIN THE SERVICE AREA

Emergency Care within the service area is available through Participating Dentists. In emergency situations, such as relief of pain, bleeding, swelling, or other acute conditions, the Participating Dentist will provide the appropriate services and schedule an appointment for follow-up care.

EMERGENCY COVERAGE OUTSIDE SERVICE AREA

If emergency dental treatment is provided to a Member by a Non-Participating Dentist when the Member is 50 miles or more away from the service area, the Member must submit a statement of services provided for approval and payment determination. Emergency treatment outside of the service area by a Non-Participating Provider is limited to relief of pain, bleeding, swelling, or other acute conditions.

COPAYMENT AND MAXIMUM BENEFITS

Copayments are amounts that are directly payable by a Member to the dentist for Covered Dental Services. Participating Dentists must seek compensation solely from the Plan, except for Copayments and Deductibles, for all Covered Dental Services. Your Plan may also have an Annual or Lifetime Maximum Benefit level after which no benefits are paid by the Plan. See the Schedule of Benefits for Copayment, Deductible, and Annual and Lifetime Maximum Benefit levels.

DEDUCTIBLE PROVISION

Your Deductible is per Covered Member, per Benefit Year. The Deductible amount is identified in the Schedule of Benefits.

After you pay the Deductible, this Plan pays a percentage of the remaining Allowable Expenses up to the specified maximum(s). You pay for the balance, which is your Copayment.

DEDUCTIBLE CARRYOVER

Any Allowable Expenses incurred in the last three months of the Benefit Year which were applied toward the Deductible, may be carried forward and applied against the Deductible for the next following Benefit Year.

FINANCIAL OBLIGATION OF NON-COVERED SERVICES

The Member is responsible for payment to the dentist for any service that is not covered by the Plan. Non-covered services include (but are not limited to) the following:

- any service specifically listed as an exclusion of this Plan.
- any service not covered by the Plan due to a specified limitation of this Plan. For examples of such limitations, please see the Covered Dental Services section.
- any service that is denied because a Member has exceeded the Annual or Lifetime Maximum Benefits payable under this Plan. See Schedule of Benefits for the Annual and Lifetime Maximum Benefit levels of your Plan.

RELATIONSHIP BETWEEN PARTIES

The relationship between Dental Care Plus and Participating Dentists is a contractual relationship between independent contractors. Participating Dentists are not agents or employees of Dental Care Plus, nor is Dental Care Plus, or any employee of Dental Care Plus, an agent or employee of any Participating Dentists.

The relationship between a Participating Dentist and any Member is that of a dentist and patient. The Participating Dentist is solely responsible for the dental services provided to any Member.

ALTERNATIVE BENEFIT POLICY

Many dental conditions can be treated in more than one way. This Plan has an "alternative benefit policy" which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If two or more alternative treatments are both covered under the Plan, and you choose a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the covered treatment which provides professionally satisfactory results at the most cost-effective level. The Member will pay the difference in cost.

COVERED DENTAL SERVICES

Important Note: Your Employer offers multiple benefit plans to choose from. This following section describes benefit services when they are available and covered through the benefit plan you have chosen.

All payments made by the Plan for Preventive, Basic, and Major services will apply to the Annual Maximum Benefit level referenced in the Schedule of Benefits.

PREVENTIVE BENEFITS
(Deductible Does Not Apply)

Preventive & Diagnostic Services

Routine oral examinations.....	limited to two visits each year
Prophylaxis (cleaning)	limited to two each year
Topical application of fluoride.....	limited to two treatments each year to children under age 18
Bitewing xrays.....	limited to one set each year
Vertical Bitewing xrays..... (7 - 8 films)	limited to once every three years
Periapical xrays	limited to 5 films per year
Full mouth x-rays..... (complete series or panoramic)	limited to once every three years

Space Maintainers

Fixed band type	only under a treatment plan filed with DCP, limited to children under age 19
Recementation of space maintainers	

BASIC BENEFITS
(Deductible Applies)

Emergency Services

Emergency/limited oral examinations

Office visit after hours .... for emergencies only

Emergency palliative treatment

Diagnostic Services

Referral consultations and examinations performed by a specialist.

Extraoral xrays

Sealants

Permanent molar teeth only.....	limited to children under 15 years of age and once every five years per tooth

Oral Surgery (Includes local anesthesia and routine postoperative care)

Extractions

Simple single tooth extractions

Root removal - exposed roots

Surgical Extractions

Removal of an erupted tooth (uncomplicated)

Removal of impacted tooth - soft tissue

Removal of impacted tooth - partially bony

Removal of impacted tooth - completely bony

Removal of impacted tooth - completely bony, with complications

Surgical removal of residual roots

Other Oral Surgery

Alveoloplasty and vestibuloplasty

Incision and drainage of abscess

Biopsy and examination

General anesthesia or intravenous sedation.....	only when necessary and provided in connection with oral surgery

Periodontic Services (Includes local anesthesia and routine postoperative care)

Emergency treatment (periodontal abscess, acute periodontitis, etc.)

Periodontal scaling and root planing.....	limited to four quadrants each year, as a definitive treatment when pocket depths of at least

4mm are demonstrated.

Surgical periodontics (including post-surgical visits)..... limited to two additional recalls in the first year following complex surgery

Gingivectomy

Osseous and muco-gingival surgery

Gingival grafting

Guided tissue regeneration

Periodontal maintenance procedure..... limited to two each year following a history of periodontal disease.

Endodontic Services (Includes local anesthesia and routine postoperative care)

Root canal therapy, traditional

Retreatment of previous root canal..... must be at least three years following previous root canal treatment on the same tooth

Recalcification and apexification

Restorative Services (Includes local anesthesia. Multiple restorations on a single surface will be considered as a single restoration.)

Restorations (amalgam, composite and sedative fillings)..... limited to once every two years per tooth (same surfaces only)

Pins-pin retention as part of restoration when used instead of gold or crown restoration

Recementation of inlays, onlays, crowns, and bridges

Repairs to crowns and bridges

Prosthodontic Services

Full and partial denture repairs

Repair broken, complete or partial dentures. Replacement of broken teeth on complete or partial denture. Additions to partial dentures to replace extracted natural teeth.

Relining and rebasing……..… limited to once every three years

MAJOR BENEFITS
(Deductible Applies)

Restorative Services..... limited to once every five years on same tooth

(Gold restorations and crowns are covered only as treatment for decay or traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a covered partial denture or fixed bridge.)

Inlays

Onlays

Crowns

Stainless Steel Crowns

Prosthodontic Services

Fixed bridge.....	limited to one original or replacement prosthesis every five years
Complete upper or lower denture	limited to one original or replacement prosthesis every five years
Partial upper or lower denture.....	limited to one original or replacement prosthesis every five years

ORTHODONTIC BENEFITS
(Deductible Does Not Apply)

Orthodontic Benefits may not be covered under your Plan. Please refer to the Schedule of Benefits to determine whether Orthodontic Benefits are covered under your Plan.

Orthodontic Treatment may be subject to a Lifetime Maximum Benefit. Refer to the Schedule of Benefits for the Lifetime Maximum Benefit of your Plan.

Comprehensive Orthodontic Treatment	
Other Orthodontic Treatment.....	(limited to one appliance per individual)

Appliance for tooth guidance

Appliance to control harmful habits

Orthodontic retention appliance

Coverage includes orthodontic procedures provided under a treatment plan that has been submitted by your dentist to DCP. The dentist providing this service must supply DCP with films and study models upon request.
The Plan will make an Initial Payment of benefits, based on the schedule submitted under the treatment plan, and additional payments will be made in installments beginning when appliances are inserted. The payments will be monthly or quarterly for the length of the estimated treatment plan. The first Member payment for the Initial Charge will be at the discretion of the Orthodontist. Under the Plan, up to 25% of the total treatment cost may be recognized as the Initial Charge, of which the Plan's payment will be the benefit level specified in the Schedule of Benefits.

If a Member is receiving orthodontic treatment which was covered under another company's benefit plan(s) prior to the effective date of the Plan, payments made by the other company's benefit plan(s) will be deducted from the Lifetime Maximum Benefits. All benefits paid toward orthodontic services by all previous benefit programs will be applied to the Lifetime Maximum Benefit.

All limitations can be appealed under the appeals procedure.

PRETREATMENT REVIEW

Pretreatment Review is a voluntary program designed to assist you and your dentist in understanding your dental coverage before services are provided.

If you or your dentist would like to submit a treatment plan for pretreatment review, your dentist must file that request for pretreatment review. When Dental Care Plus receives a proposed treatment plan for services that are expected to exceed $400, DCP will designate a dentist to review those services for coverage under the Plan. After the review is complete, your dentist will be provided with an estimate of the amount payable, in whole or in part (if any), by the Plan on the proposed treatment. Pretreatment review only provides an estimate of covered services and does not constitute a guarantee of payment. Exact benefits are determined based upon the eligibility of the Member and Benefit Plan in effect at the time services are actually rendered.

Dental Care Plus will notify your dentist of the pretreatment estimate within a reasonable period of time appropriate to the dental circumstances, but generally not later than 15 days after receipt of the request for pretreatment review. In certain circumstances, this time period may be extended for an additional 15 days, and DCP will notify you or your dentist of any extension. If additional information is necessary to process your request for pretreatment review, Dental Care Plus will notify you or your dentist, and you or your dentist will have 45 days from receipt of the notice to provide the additional information. If you or your dentist do not provide the additional information within the 45 day period, your request for pretreatment review may be denied. In cases where the additional information is provided to Dental Care Plus within the 45 day period, Dental Care Plus will notify your dentist of the pretreatment estimate within 15 days after receipt of the additional information. The notice will inform you and your dentist of the specific basis for the pretreatment estimate, and describe your right to information concerning the estimate and your right to appeal.

A pretreatment estimate that has been approved may be modified at any time, and DCP will notify your dentist of the modification in advance and provide you with an opportunity to appeal the modification before it is effective. Your dentist may request that the time for the treatment plan to be completed or the number of treatments included in the pretreatment estimate be increased at any time. A request for an extension of time or increase in the number of treatments will be approved or denied within 24 hours of our receipt of a completed request.

Pretreatment Review of Urgent Conditions:

If your request for pretreatment review is for treatment of an urgent condition, and failure to obtain treatment quickly would jeopardize your health or, in the opinion of your dentist, would subject you to severe pain which cannot be managed without the treatment, your request for pretreatment review will be processed as soon as possible taking into account the dental circumstances, but

not later than 72 hours after Dental Care Plus receives the request. If additional information is needed to process the request, Dental Care Plus will notify you or your dentist as soon as possible, but no later than 24 hours after Dental Care Plus receives the request, and you or your dentist will have at least 48 hours to provide the additional information. If you or your dentist do not provide the additional information within the time period allowed, the request for a pretreatment estimate may be denied. If you or your dentist provide the additional information requested, DCP will notify your dentist of the pretreatment estimate as soon as possible, but not later than 48 hours after receipt of the additional information. The notice will include the specific basis for the estimate, and describe your right to information concerning the estimate and your right to appeal.

CLAIM FORMS

You do not have to worry about filing a claim form. Your Participating Dentist will file the claim directly with DCP and payment will be made by DCP directly to the provider of dental services. Your responsibility is to always show your Identification Card to your Participating Dentist when you receive care. You will be responsible for paying the appropriate Copayment or Deductible.

Claims sent to Dental Care Plus from Non-Participating Dentists will be denied unless prior plan approval has been obtained.

CLAIMS PROCESSING PROCEDURES

When claims are received from your dentist, Dental Care Plus will process those claims and make a determination in accordance with Plan documents. If the claim is paid, payment will be sent directly to your dentist, and you will receive an explanation of the payment.

If the claim is denied in whole or in part, Dental Care Plus will notify you and your dentist within a reasonable period of time, but generally not later than 30 days after Dental Care Plus receives the claim. In certain circumstances, Dental Care Plus may extend the 30 day time period for an additional 15 days, and will notify you that the time period has been extended.

If additional information is required to process your claim, Dental Care Plus will notify you or your dentist, and you or your dentist will have 45 days from receipt of the notice to provide the additional information. If you or your dentist do not provide the additional information within the 45 day period, your claim may be denied. In cases where the additional information is provided to Dental Care Plus within the 45 day period, Dental Care Plus will notify you and your dentist if the claim is denied in whole or in part within 30 days after the claim was initially received or 15 days after receipt of the additional information by Dental Care Plus, whichever is later. The notice of a denial will inform you and your dentist of the specific reason for the denial, and describe your right to information concerning the claim and your right to appeal.

EXCLUSIONS

The following are services specifically excluded from coverage under this Plan. The Member is financially obligated for payment to the dentist of the full charge for any service that is excluded/not covered under this Plan.

1. Services performed by a Non-Participating Dentist, except for emergencies out of the service area, unless prior plan approval has been obtained.
2. Services performed for cosmetic reasons, including personalization or characterization of prosthetic devices and the bleaching of teeth.
3. Services or supplies which are considered experimental according to standard dental practice.
4. Charges which are incurred before the Member's effective date of coverage or after the date a Member's coverage terminates.
5. Services or procedures started prior to the effective date of the Member's coverage, with the exception of orthodontic services if covered by the Plan. Prosthetic devices and crowns will not be covered if impressions are taken before the effective date of coverage. If final impressions were taken while coverage is in effect, but the prosthetic device or crown is installed more than thirty (30) days after coverage terminates, then charges for the prosthetic device or crown will not be covered.
6. Dentures, implants and bridgework (including crowns and inlays forming their abutments) if in replacement of natural teeth which were extracted while the individual was not covered under this group plan.
7. Porcelain coverage on posterior crowns.
8. Missed appointment charge.
9. Completion of claim forms.
10. Replacement of lost, stolen or broken prosthetic devices or appliances unless it is after the limitation date.
11. Analgesics, nitrous oxide, non-intravenous conscious sedation and other drugs and prescriptions.
12. Localized delivery of antimicrobial or chemotherapeutic agents.
13. Hospital related charges.
14. Appliances, restorations, and procedures other than full dentures, for the primary purpose of increasing vertical dimension, restoring the occlusion or treatment of bruxism.
15. Veneers or similar properties of crowns and pontics.
16. Services for educational purposes.
17. Splinting (if tooth does not otherwise need to be restored).

18. Services related to work conditions if the claimant is eligible for benefits under any workers' compensation act or similar law.
19. Surgical implants or transplants of any type (including prosthetic devices, such as crowns, attached to them) and all related services.
20. Services performed by other than a licensed dentist, except for legally delegated services to a licensed hygienist or licensed expanded functions auxiliary.
21. Treatment for Temporomandibular Joint Disease (TMJ) or Myofacial Pain Dysfunction Syndromes (MPD).
22. X-rays for TMJ.
23. Orthognathic surgery.
24. Services or supplies rendered, or furnished in connection with, any duplicate appliance.
25. Services or supplies which are not Medically Necessary.
26. Expenses incurred for more than two oral examinations and/or prophylaxis treatments during a Benefit Year.
27. Expenses incurred for the replacement of amalgams and/or composites more often than once in any two (2) year period.
28. Expenses incurred for the replacement of fixed bridgework, crowns, gold restorations and jackets more often than once in any five (5) year period.
29. Expenses incurred for the replacement of partial or full dentures more often than once in any five (5) year period.
30. Expenses incurred for replacement of an existing denture which is or can be made satisfactory.
31. Expenses incurred for relining of dentures more often than once in any three (3) year period.
32. Expenses incurred for a temporary full denture.
33. Expenses incurred for the retreatment of root canals if it has not been at least three (3) years since the previous root canal treatment.
34. Services which are determined to be eligible expenses under any medical plan in which the Member is enrolled.
35. House calls.
36. Dental services or supplies for a condition resulting from civil disobedience, active participation in a riot or in the commission of a felony, self-inflicted injury, nonaccidental injury, or an act of war.
37. Any services not specifically listed as a Covered Dental Service.
38. Treatment by a member of the immediate family or a resident in the covered employee's home; self-treatment.

39. Acid etches.
40. Expenses for the completion of periodontal charting.
41. Asepsis.
42. Claims that are not received by Dental Care Plus within one calendar year from the date of service.
43. Charges for services received after a Member has reached the Annual or Lifetime Maximum Benefits payable under the Plan.
44. Expenses for gold restorations and crowns, except when used as treatment for decay or traumatic injury when teeth cannot be restored with a filling material or when the tooth is an abutment to a covered partial denture or fixed bridge.

COORDINATION OF BENEFITS (C.O.B.)

"Coordination of benefits" is the procedure used to pay dental care expenses when a person is covered by more than one plan. The Plan follows certain rules defined below to decide which plan pays first and how much the other plan must pay. The objective is to make sure the combined payments of all plans are no more than your actual bills.

When you or your family members are covered by another group plan in addition to this Plan, you must submit all bills first to the primary plan. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies the claim or does not pay the full bill, you may then submit the balance to the secondary plan.

The Plan pays for dental care only when you follow the Plan's rules and procedures. If the Plan's rules conflict with those of another plan, it may be impossible to receive benefits from both plans, and you will be forced to choose which plan to use.

Plans that do not Coordinate

The Plan will pay benefits without regard to benefits paid by the following kinds of coverage.

- Medicaid
- Group hospital indemnity plans which pay less than $110 per day
- School accident coverage
- Some supplemental sickness and accident policies

How the Plan Pays As Primary Plan

- When the Plan is primary, the Plan will pay the full benefit allowed by the Plan as if you had no other coverage.

How the Plan Pays As Secondary Plan

- When the Plan is secondary, payments will be based on the balance left after the primary plan has paid. The Plan will pay no more than that balance. In no event will the Plan pay more than the Plan would have paid had the Plan been primary.
- The Plan will pay only for dental care expenses that are covered by the Plan.
- The Plan will pay only if you have followed all of the Plan's procedural requirements, including care obtained from or arranged by your Participating Dental Provider, precertification, etc.
- The Plan will pay no more than the "Allowable Expenses" for the dental care involved. If the Plan's Allowable Expense is lower than the primary plan's, the primary plan's Allowable Expense will be used. The Allowable Expense may be less than the actual bill.

Which Plan is Primary?

To decide which plan is primary, both the coordination provisions of the other plan and which member of your family is involved in a claim must be considered. The primary plan will be determined by the first of the following which applies:

1. *Non-coordinating Plan*

   If you have another group plan which does not coordinate benefits, it will always be primary.

2. *Employee*

   The plan which covers you as an Employee (neither laid off nor retired) is always primary.

3. *Children (Parents Divorced or Separated)*

   If the court decree makes one parent responsible for dental care expenses, that parent's plan is primary.

   If the court decree gives joint custody and does not mention dental care the Plan follows the birthday rule.

   If neither of those rules applies, the order will be determined in accordance with the Ohio Insurance Department rule on Coordination of Benefits.

4. *Children and the Birthday Rule*

   When your children's dental care expenses are involved, the Plan follows the "birthday rule." The plan of the parent with the first birthday in a calendar year is always primary for the children. If your birthday is in January and your spouse's birthday is in March, your plan will be primary for all of your children.

   However, if your spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), the Plan will follow the rules of the other plan.

5. *Other situations*

   For all other situations not described above, the order of benefits will be determined in accordance with Department of Insurance rules of Coordination of Benefits.

TERMINATION OF INDIVIDUAL COVERAGE

Benefits for the Member under the Plan will automatically terminate on the earliest of the following dates:

1. The date the Plan is terminated, or with respect to any specific coverage item of the Plan, the date such coverage item terminates.
2. The last day of the last Plan Month for which the required Member contribution has been paid to the Plan, if the Member is required to make a contribution.
3. The date specified by the Employer that a Subscriber or Family Dependent is no longer eligible for coverage under the terms of the Plan.
4. The date the Employer receives written notice from the Member for termination of coverage, or the date requested by the Member in such notice, if later.
5. The date on which the Member is retired or pensioned, unless a specific coverage classification is specified for retired or pensioned individuals in the Plan.
6. The date of entry into military duty, except temporary duty of thirty (30) days or less.
7. For a Dependent Child, the end of the month when the child no longer qualifies as a Family Dependent.
8. The date the Member or Family Dependent commits any type of fraud or abuse related to the filing of claims or incurring Covered Dental Services.

COBRA CONTINUATION COVERAGE

If coverage under the Plan ceases for you, your eligible spouse and your eligible dependents, under certain circumstances you, your eligible spouse and your eligible dependents may be able to continue coverage under this Plan under a federal law called COBRA. COBRA continuation coverage is a continuation of coverage under the Plan when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose

your coverage under the Plan because either one of the following qualifying events happens:

(1) Your hours of employment are reduced, or

(2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

(1) Your spouse dies;

(2) Your spouse's hours of employment are reduced;

(3) Your spouse's employment ends for any reason other than his or her gross misconduct;

(4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or

(5) You become divorced or legally separated from your spouse.

Your Dependent Children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

(1) The parent-employee dies;

(2) The parent-employee's hours of employment are reduced;

(3) The parent-employee's employment ends for any reason other than his or her gross misconduct;

(4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);

(5) The parents become divorced or legally separated; or

(6) The child stops being eligible for coverage under the Plan as a "Dependent Child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the Employer must notify the Plan Administrator of the qualifying event.

For the other qualifying events (divorce or legal separation of the employee and spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to: The Christ Hospital. In addition, if applicable, you must provide a certified copy of the court order granting the divorce or legal separation.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare (Part A, Part B, or both), your divorce or legal separation, or a Dependent Child's losing eligibility as a Dependent Child, COBRA continuation coverage lasts up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to started at some time before the 60th day of COBRA continuation coverage and last at least until the end of the 18-month period of continuation coverage. You must make sure that the Plan Administrator is notified of the Social Security Administration determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to:

The Christ Hospital
2139 Auburn Avenue
Cincinnati, OH 45219

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and Dependent Children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any Dependent Children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to:

The Christ Hospital
2139 Auburn Avenue
Cincinnati, OH 45219

If You Have Questions About COBRA

Questions concerning your Plan or your COBRA continuation coverage should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health benefits, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Plan Administrator:
The Christ Hospital
2139 Auburn Avenue
Cincinnati, OH 45219
513-585-0895

Claims Administrator:
Dental Care Plus
100 Crowne Point Place
Cincinnati, OH 45241
513-554-1100

RIGHT TO RECOVERY

If any payment is made under this Plan in excess of the amount properly payable to or on behalf of you or your Covered Dependents under the terms and conditions of this Plan, then the Plan has the right to recover such excess payments from you and/or your Covered Dependents or any entity which received such payment or was relieved from payment due to payment by this Plan.

As Participants in the Plan, you and your Covered Dependents hereby agree that you will execute and deliver any and all instruments and papers required by the Plan in order to protect the Plan's rights of recovery, and further, you must do whatever is requested or necessary in order to fully execute and to fully protect all the Plan's rights hereunder.

SUBROGATION AND REIMBURSEMENT

This Plan reserves the right of subrogation. This means that the Plan can recover the cost of benefits paid to you or on your behalf when a third party is or may be liable for or pays any money for an injury, illness or loss covered under the Plan.

A common situation involving subrogation is where someone injures a Plan Participant in an auto accident. The Participant suffers an injury and receives dental treatment which is covered under the Plan and the Plan pays for the treatment. The Plan can then recover the cost of the treatment directly from the driver or his insurance company. Recovery can also be made from a second medical policy, e.g., for medical malpractice; from a homeowner's policy, e.g., for accidents in another's home or property; or from general liability coverage, e.g., for a defective product; where the Plan Participant incurred dental expenses for which the other party was liable. The Plan can recover the cost of benefits paid from any person or organization including, but not limited to, insurance companies that issue liability insurance, uninsured/underinsured insurance and medical payments coverage.

You may be asked to assist the Plan in the process of securing payment for the cost of benefits provided on your behalf. As a Participant in the Plan, you, and your Covered Dependents, agree to execute and deliver any and all instruments, papers or other documents required by the Plan to fully protect the Plan's right to subrogation and to cooperate fully with the Plan to secure such rights. Moreover, you, and your Covered Dependents, shall do nothing which may prejudice the Plan's subrogation rights.

The Plan shall be legally subrogated to all claims, demands, actions and rights of recovery you may have against a third party to the extent of any and all payments of benefits by the Plan. The Plan's right to subrogation takes priority over your right to recover from third parties, even if the third party has insufficient resources to fully compensate you for all losses sustained or alleged.

The Plan also reserves the right of reimbursement. This means that you must

reimburse the Plan for the cost of benefits paid to you or on your behalf for any illness or injury caused by a third party in the event you, or your Covered Dependents, receive any money for the same illness or injury. As a Participant in the Plan, you are required to hold the gross (unreduced by attorney fees, other expenses or costs) proceeds of any third party payment in trust for the benefit of the Plan and you must immediately upon receipt pay the third party payment to the Plan. If the third party pays you before the Plan pays any benefits, then the Plan will not pay benefits for the same injury to the extent of the payment by the third party. If the third party pays you after the Plan pays benefits, then you must repay the Plan for the cost of any and all benefits provided for the same injury or illness. If you fail to repay the Plan for any payment received from a third party, then the Plan will cease paying benefits on your behalf until either you repay the Plan or the Plan receives unrelated claims which, in the aggregate, amount to more than the amount of the third party payment.

You must reimburse the Plan regardless of whether:

- the third party payment is the result of a court judgement, arbitration award, compromise, settlement or any other arrangement; or
- the third party admits liability;
- the medical and dental expenses or loss of income are itemized or included in the third party payment; or
- you have been fully compensated or made whole by the third party payment for all losses sustained or alleged.

Consider, once again, the auto accident example where someone injures you and you receive dental treatment that is covered under the Plan. If the Plan has already paid benefits and the other driver's insurance company sends you a check for damages or you settle a lawsuit concerning the accident, you must first repay the Plan for the cost of any and all benefits paid on your behalf before you pay any other expenses. This is true even if the amount you receive is not sufficient to fully compensate you for all the losses you incurred or if the portion of the settlement payment allocated to pay dental expenses is smaller than the amount which must be repaid to the Plan.

You, and your Covered Dependents, agree to reimburse the Plan in first priority and without any set-off or reduction for attorney fees, other expenses, or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan. You, and your Covered Dependents, also agree, to notify the Plan, in writing, whenever benefits are paid under this Plan that arise out of any injury or illness that provides or may provide the Plan subrogation or reimbursement rights. You, and your Covered Dependents, further agree, when requested by the Plan, to execute and deliver any and all instruments, papers or other documents required by the Plan to fully protect the Plan's right to

reimbursement and to cooperate fully with the Plan to secure such rights. You shall do nothing to prejudice the Plan's right to reimbursement.

Failure to comply fully with the provisions of the Plan regarding subrogation and reimbursement can result in suspension or termination of benefits.

RIGHTS AND LIMITS

This booklet constitutes both the Plan and the Summary Plan Description (SPD). It describes your benefits. It is important to remember that:

- The description of benefits in this booklet replaces and supersedes any other Plan document, Summary Plan Description, summary or description previously issued by The Christ Hospital.
- Nothing in the Plan or in this booklet is intended to provide employees, former employees, or covered dependents with a vested right to any benefits under the Plan and/or any rights for continued employment.
- Your rights, if any, to benefits of the Plan depend upon whether you satisfy the eligibility requirements of the Plan and whether your submitted claims are allowed charges under the Plan.
- Your rights as a participant in this Plan are outlined in the ERISA Information section.

ERISA INFORMATION

This Plan, regulated by the Employee Retirement Income Security Act of 1974 (ERISA), is required to make available to all Plan participants specific information about the Plan. The following sections describe basic Plan information and your rights under ERISA.

Plan Name

The Christ Hospital Employee Dental Plan

Plan Sponsor and Plan Administrator

The Christ Hospital
2139 Auburn Avenue
Cincinnati, Ohio 45219
(513) 585-0895

Employer's Identification number:

31-1435820

The Plan Sponsor is also the Plan’s Agent for the serving of legal process

Plan Type and Number

This is a welfare benefit plan that offers dental benefits. The Plan number is 501.

Plan Effective Date

The effective date of the Plan as described in this booklet is January 1, 2008.

Eligible Participants

Please refer to the Eligibility Information section.

Claims Administrator:

The independent third party administrator who processes all Plan claims is:

Dental Care Plus, Inc.
100 Crowne Point Place
Cincinnati, Ohio 45241

(513) 554-1100
1-800-367-9466 (Toll Free)

PLAN FUNDING

This Plan is self-funded by the Plan Sponsor. Benefits are paid by contributions from the Employer and the Employees. Benefits are paid from the general assets of The Christ Hospital. Employee contributions, if any, are calculated annually and are used to pay claims. Dental Care Plus is the Claim Administrator, and does not insure the benefits paid by the Plan.

Benefit Records - Calendar Year

The benefit records are kept 1/1 to 12/31 for processing claims.

Plan Records - Plan Year

The fiscal records are kept 1/1 to 12/31 for IRS reporting.

Plan Document

You are being provided with a copy of this Plan document. An additional copy of the Plan document is available upon written request to the Plan Administrator who may make a reasonable charge for the copies.

APPEAL PROCEDURE

Each Plan participant has the right to appeal and is entitled to a full and fair review of any denial of a claim, or any pretreatment estimate obtained under the pretreatment review procedure. Appeals must be filed in writing within 180 days following your receipt of notice of the denial and should be sent to the Claims Administrator. If you are appealing a pretreatment estimate which involves treatment of an urgent condition (as defined in the Pretreatment Review section), you may request an appeal by phone. All other appeals must be filed in writing.

You or your dentist may submit written comments, records and other information when you file an appeal. You may also request, free of charge, copies of all records and other information which were relied on or created by Dental Care Plus in the process of reviewing the claim or pretreatment review request. If the claim or estimate was denied, in whole or in part, based on the professional judgment of a dentist that the treatment is experimental, investigational or not dentally necessary or appropriate, Dental Care Plus will notify you of the identity of the dentist who was initially consulted or who reviewed the claim or pretreatment review request. Your appeal and all relevant information, including information you submitted, will be re-reviewed by a different dentist prior to deciding your appeal.

Dental Care Plus will review your appeal to make sure the initial determination was consistent with your Plan benefits. If Dental Care Plus determines that the initial determination was not consistent with your Plan benefits, Dental Care

Plus will reverse the initial determination and pay the claim or modify the pretreatment estimate. If Dental Care Plus determines that the initial determination was consistent with your Plan benefits, Dental Care Plus will forward the complete record to your Plan Administrator for a final determination of your appeal.

Your Plan Administrator will make a final determination on your appeal and you and your dentist will be notified of the final determination as soon as possible taking into account the dental circumstances. If you are appealing a denial of a claim, you will be notified not later than 60 days after Dental Care Plus received the appeal. If you are appealing a pretreatment estimate, you will be notified not later than 30 days after Dental Care Plus received the appeal. If you are appealing a pretreatment estimate which involved urgent treatment, you will be notified as soon as possible, but not later than 72 hours after Dental Care Plus received the appeal.

Dental Care Plus will notify you and your dentist of the Plan Administrators final determination in writing, or orally followed by a written confirmation if the appeal was of a pretreatment estimate involving urgent treatment. If the appeal decision is adverse, the notice will include the specific reason for the determination and the specific plan provisions on which the determination is based, and you will be entitled to request, free of charge, copies of all records and other information which was relied on or obtained in making the adverse determination.
You must file an appeal before bringing a civil action under Section 502(a) of ERISA. If your appeal is denied, you then have the right to file an action under 29 U.S.C. 1132, section 502(a).

STATEMENT OF ERISA RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

- examine, without charge, at the Plan Administrator's office, all documents governing the Plan, including the Summary Plan Description and a copy of the latest annual report.
- obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including the Plan document, Summary Plan Description, and a copy of the latest annual report. The Plan Administrator may make a reasonable charge for copies.
- receive a summary of the Plan's annual financial report. The Christ Hospital is required by law to furnish each Plan Participant with a copy of this summary financial report.

You may have a 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 on the rules governing your COBRA continuation coverage rights.

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 so do prudently and in the interest of you and other Plan Participants and beneficiaries.

No one, including your Employer, 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.

If your claim for a welfare benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claims.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan 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 material 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 most cases, the Plan Sponsor is the Plan's agent for service or legal process. If you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or 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 a federal court. The court decides who should pay the court cost and legal fees. If you are successful, the court may order the person you 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 to be frivolous.

If you have questions about your Plan, you should contact your Human Resources Department or Dental Care Plus. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, 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.

IN THE FUTURE

The Christ Hospital has established this Plan with the intention of it being maintained for an indefinite period of time. However, The Christ Hospital, reserves the right, at its sole discretion:

- to alter, amend, or terminate this Plan, in whole or in part, at any time;
- to alter, amend, or terminate retiree benefits (if any), in whole or in part, at any time;
- to change, increase, or decrease Plan contributions (if any), in whole or in part, at anytime.

All amendments will be made pursuant to written documents.

COMMON DENTAL TERMS

Amalgam	A metal alloy used as a restorative filling material.
Anesthesia	(local) Administration of a specific medication to achieve the absence of pain in a particular area of the body. (general) A medication used to render the patient unconscious.
Crown	An artificial crown is a total restoration of the exposed portion of a tooth.
Denture	A device that is a substitute for missing teeth.
Emergency Palliative Care	To relieve pain, but not cure the disease.
Endodontics	Treatment of disease of the dental pulp.
Fluoride	A solution applied topically to the teeth to help prevent dental decay.
Hygienist	A licensed trained person who cleans teeth and provides information on prevention of oral disease.
Inlay	A restoration usually of cast metal prepared to fit a tooth and cemented in place.
Onlay	A restoration cast to cover the entire chewing surface of a tooth.
Orthodontics	Specialty primarily concerned with the detection, prevention, and correction of abnormalities in the positioning of teeth in their relationship to the jaws (straightening teeth).
Pedodontics	Dentistry for children.
Prophylaxis	The removal of tartar and stains from the teeth. Cleaning of the teeth by either a dentist or dental hygienist.
Restoration	Broad term that applies to repairing or restoring the shape, form, or function of a tooth or group of teeth.
Root Canal	Removal of the pulp tissue of the tooth, and after therapy sterilization, filling the spaces with a sealing material.

DENTAL CARE PLUS, INC.
100 Crowne Point Place
Cincinnati, Ohio 45241
(513) 554-1100 or 1-800-367-9466
Fax (513) 554-3187
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