Dental Summary Plan Description

Church Plan PPO and Core
Effective January 1,2023

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Dental Plan Introduction

In accordance with the heritage of its participating congregations, CommonSpirit Health emphasizes care of the whole person in body, mind, and spirit. This commitment is reflected not only in the care provided to the individuals and communities CommonSpirit Health serves, but also in the benefits the organization provides to You, its employees.

The Dental Plan is administered by Metropolitan Life Insurance Company ("MetLife").

This Plan has been established on a noninsured basis; all liability for payment of benefits is assumed by CommonSpirit Health. While MetLife administers payment of claims, MetLife has no liability for the funding of the Dental Plan.

Claims are administered on behalf of This Plan by MetLife, as the CHI Dental Plan Customer Service Team, pursuant to the terms of an administrative service agreement. MetLife will process claims according to the Plan provisions, and all claims under This Plan are paid by CommonSpirit Health. CommonSpirit Health owns the claim files, and the final decision on any disputed claim may involve review of these files by CommonSpirit Health.

This Plan was established on January 1, 2007 and this Summary Plan Description which provides detailed descriptions of the benefits available to You is effective as of that date. Please read the information in this Summary Plan Description carefully so You will have a full understanding of Your dental benefits. If You want more information or have any questions about Your dental benefits, please contact the CHI Dental Plan Customer Service Team at 1.888.865.6873. Once Your coverage begins, You can access MetLife's website at http://www.metlife.com/dental which provides specific information about the Dental Plan.

CommonSpirit Health reserves the right to amend, modify, or terminate This Plan, in whole or in part, at any time for any reason. This Summary Plan Description also constitutes the Plan document. Nothing in this Summary Plan Description constitutes a promise of continued employment. The Plan described in this Summary Plan Description is not governed by ERISA (the Employee Retirement Income Security Act of 1974) since it is a church plan.

Please note that the terms "You" and "Your" throughout this Summary Plan Description refer to the employee, except where otherwise indicated. Many of the terms that are important in understanding Your benefits are explained in the DEFINITIONS section.

Our Mission

As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Benefits at a Glance

This section provides You with a description of Your benefits. Certain limitations and exclusions may apply to any benefit or benefit amount. It is important to refer to the provisions contained in this Summary Plan Description for details about Your benefits.

PPO OPTION BENEFITS	BENEFIT AMOUNT AND HIGHLIGHTS	
Covered Percentage for:	**In-Network based on the Maximum Allowed Charge**	**Out-of-Network based on the Reasonable and Customary Charge**
Preventive and Diagnostic Services	100%	100%
Basic Restorative Services	90%	80%
Major Restorative Services	60%	50%
Temporomandibular Joint Disorder (TMJ)	50%	50%
Orthodontic Covered Services	50%	50%
Deductibles for:		
Yearly Individual Deductible	$50 for the following Covered Services Combined: Basic Restorative; Major Restorative including Temporomandibular Joint Disorder	
Yearly Family Deductible	$150 for the following Covered Services Combined: Basic Restorative; Major Restorative including Temporomandibular Joint Disorder	
Maximum Benefit:		
Yearly Individual Maximum	$1,500 for the following Covered Services: Preventive and Diagnostic; Basic Restorative; Major Restorative excluding Temporomandibular Joint Disorder	
Lifetime Individual Maximum for Orthodontic Covered Services	$1,500	
Lifetime Individual Maximum for Temporomandibular Joint Disorder (TMJ)	$500	

Benefits at a Glance (continued)

CORE OPTION BENEFITS	BENEFIT AMOUNT AND HIGHLIGHTS
Covered Percentage for:	**In- & Out-of-Network based on Maximum Allowed Charge or Reasonable & Customary Charge**
Preventive and Diagnostic Services	100%
Basic Restorative Services	50%
Major Restorative Services	50%
Temporomandibular Joint Disorder (TMJ)	50%
Orthodontic Covered Services	50%
Deductibles for:	
Yearly Individual Deductible	$50 for the following Covered Services Combined: Basic Restorative; Major Restorative including Temporomandibular Joint Disorder
Yearly Family Deductible	$150 for the following Covered Services Combined: Basic Restorative; Major Restorative including Temporomandibular Joint Disorder
Maximum Benefit:	
Yearly Individual Maximum	$1,000 for the following Covered Services: Preventive and Diagnostic; Basic Restorative; Major Restorative excluding Temporomandibular Joint Disorder
Lifetime Individual Maximum for Orthodontic Covered Services	$1,000
Lifetime Individual Maximum for Temporomandibular Joint Disorder (TMJ)	$500

Definitions

As used in this Summary Plan Description, the terms listed below will have the meanings set forth below. When defined terms are used in this Summary Plan Description, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

Annual Benefit Enrollment Period means the period specified by CommonSpirit Health during which You may elect or change coverage for You and Your eligible Dependents.

Bridge means a combination of abutment and pontic teeth (also called units) that are permanently cemented in the mouth. The pontic is the part of the bridge that replaces missing natural teeth.

Cast Restoration means an inlay, onlay, or crown.

Child means:

- A dependent (within the meaning of Code § 105(b)) child, married or unmarried, of an Eligible Person by birth, marriage, legal adoption, or placement for adoption who is under the age of 26; or
- A dependent (within the meaning of Code § 105(b)) child, married or unmarried, of an Eligible Person by birth, marriage, legal adoption, or placement for adoption who is under the age of 26 for whom the Eligible Person is required by law to provide health coverage; or
- A dependent (within the meaning of Code § 105(b)) child, married or unmarried, of an eligible Legally Domiciled Adult; or
- A dependent (within the meaning of Code § 105(b)) child, married or unmarried, under the age of 26 who resides primarily in the Eligible Person's household and for whom the Eligible Person is the Legal Guardian, such as a court approved foster child; or
- A dependent (within the meaning of Code § 105(b)) unmarried child of the Eligible Person by birth, marriage, legal adoption, or placement for adoption who is age 26 or over, who is dependent upon the Eligible Person for support and maintenance because of a continuous developmental or physical disability that began while the child was covered under this Plan or other group medical insurance coverage as an eligible Dependent of the Eligible Person and for whom coverage under this Plan or other group medical insurance coverage has been continuous since the inception of such child's disability.

CHI Dental Plan Customer Service Team means Metropolitan Life Insurance Company ("MetLife"), New York, New York. The CHI Dental Plan Customer Service Team does not insure the benefits described in this Summary Plan Description.

Contributory Coverage means coverage for which the Employer requires You to pay any part of the cost of the coverage. Contributory Coverage includes dental benefits.

Coverage Date means the date on which You become eligible under the Dental Plan.

Covered Percentage means:

- For a Covered Service performed by an In-Network Dentist, the percentage of the Maximum Allowed Charge that This Plan will pay for such services after any required Deductible is satisfied; or
- For a Covered Service performed by an Out-of-Network Dentist, the percentage of the Reasonable and Customary Charge that This Plan will pay for such services after any required Deductible is satisfied.

Covered Service means a dental service used to treat You or Your Dependent's dental condition which is:

- Prescribed or performed by a Dentist while such person is covered for dental benefits;
- Dentally Necessary to treat the condition; and
- Described in the BENEFITS AT A GLANCE or DENTAL BENEFITS sections of this Summary Plan Description.

Deductible means the amount You or Your Dependents must pay before This Plan will pay for Covered Services.

Dental Hygienist means a person trained to:

- Remove calcareous deposits and stains from the surfaces of teeth; and
- Provide information on the prevention of oral disease.

The term does not include:

- You;
- Your Spouse; or
- Any member of Your immediate family including Your and/or Your Spouse's parents; Children (natural, step or adopted); siblings; grandparents; or grandchildren.

Dentally Necessary means a dental service or treatment performed in accordance with generally accepted dental standards as determined by the CHI Dental Plan Customer Service Team and is:

- Necessary to treat decay, disease or injury of the teeth; or
- Essential for the care of the teeth and/or supporting tissues of the teeth.

Dentist means:

- A person licensed to practice dentistry in the jurisdiction where such services are performed; or
- Any other person whose services, according to applicable law, must be treated as Dentist's services for purposes of This Plan. Each such person must be licensed in the jurisdiction where the services are performed and must act within the scope of that license. The person must also be certified and/or registered if required by such jurisdiction.

For purposes of dental benefits, the term will include a Physician who performs a Covered Service.

Dentures means fixed partial Dentures (bridgework), removable partial Dentures and removable full Dentures.

Dependent(s) means Your Spouse, Legally Domiciled Adult and/or Child(ren) as defined in this section of the Summary Plan Description.

Eligible Employee means an employee of CommonSpirit Health who meets the eligibility requirements for this coverage. He or she must be considered an employee for Form W-2 reporting purposes; the term "employee" does not include leased employees or independent contractors or individuals not treated as employees, even if they are subsequently determined to have been employees.

Employer means CommonSpirit Health and its market-based organizations, hospitals and facilities.

In-Network Dentist means a Dentist who participates in MetLife's Preferred Dentist Program Plus and has a contractual agreement with MetLife to accept the Maximum Allowed Charge as payment in full for a dental service.

Legally Domiciled Adult means an individual over 18 who has, for at least six months, lived in the same principal residence of an employee and remains a member of that employee's household throughout the coverage period; and who either:

- Has an on-going, exclusive and committed relationship with the employee (not a casual roommate or tenant), shares basic living expenses and is financially interdependent with the employee, is neither legally married to anyone else nor legally related to the employee by blood in any way that would prohibit marriage.
- Is the employee's blood adult relative who meets the definition of his or her tax dependent as defined by Section 152 of the Internal Revenue Code during the coverage period, and is not considered a Child as defined in this section of the Summary Plan Description?

Maximum Allowed Charge means the lesser of:

- The amount charged by the Dentist; or
- The maximum amount which the In-Network Dentist has agreed with MetLife to accept as payment in full for the dental service.

Onlays/Inlays means cast fillings constructed by a dental laboratory that may be used instead of silver/white fillings to restore a tooth.

Out-of-Network Dentist means a Dentist who does not participate in the Preferred Dentist Program Plus and is not obligated to accept the Claims Administrator’s Reasonable and Customary payments as payment in full for a dental service.

Physician means:

- A person licensed to practice medicine in the jurisdiction where such services are performed; or
- Any other person whose services, according to applicable law, must be treated as Physician’s services for purposes of the group benefits. Such persons must be licensed in the jurisdiction where they perform the service and must act within the scope of their license. They must also be certified and/or registered if required by such jurisdiction.

The term does not include:

- You;
- Your Spouse; or
- Any member of Your immediate family including Your and/or Your Spouse’s parents, Children (natural, step or adopted), siblings, grandparents, or grandchildren.

Plan Administrator means CommonSpirit Health.

Plan Sponsor means CommonSpirit Health.

Preferred Dentist Program Plus refers to MetLife’s proprietary network of contracted Dentists.

Proof means Written evidence satisfactory to the CHI Dental Plan Customer Service Team that a person has satisfied the conditions and requirements for any benefit described in this Summary Plan Description. When a claim is made for any benefit described in this Summary Plan Description, Proof must establish:

- The nature and extent of the loss or condition;
- This Plan’s obligation to pay the claim; and
- The claimant’s right to receive payment. Proof must be provided at the claimant’s expense.

Reasonable and Customary Charge is the lowest of:

- The Dentist's actual charge for the services or supplies (or, if the provider of the service or supplies is not a Dentist, such other provider's actual charge for the services or supplies);
- The usual charge by the Dentist or other provider of the services or supplies for the same or similar services or supplies; or
- The usual charge of most other Dentists or other providers of similar training or experience in the same geographic area for the same or similar services or supplies.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media which is acceptable to the CHI Dental Plan Customer Service Team and consistent with applicable law.

Spouse means a person who is legally married under the laws of the state where the marriage was celebrated to an employee who is participating in the health care benefits offered by CommonSpirit Health, regardless of where the couple currently resides.

The term does not include any person who:

- Is in the military of any country or subdivision of any country;
- Lives outside of the United States or Canada; or
- Is covered under This Plan as an Eligible Employee.

This Plan or Plan means the noninsured dental benefits plan of the Employer.

Written or Writing means a record which is on or transmitted by paper or electronic media which is acceptable to the CHI Dental Plan Customer Service Team and consistent with applicable law.

Year or Yearly, for dental benefits means the 12 month period that begins January 1.

You and Your means an employee who is eligible for the benefits described in this Summary Plan Description.

Eligibility

This Summary Plan Description contains information about the Dental Plan for persons who meet the description of an Eligible Employee as determined by CommonSpirit Health. If You meet the description of an Eligible Employee and have enrolled for this coverage, then You are entitled to the benefits described in this Summary Plan Description as of Your Coverage Date.

Your Coverage

As an employee of the Employer, You must meet the applicable eligibility requirements. If You choose to only enroll yourself, only Your own dental care expenses, not the dental care expenses of other Dependents, are covered as described in the BENEFITS AT A GLANCE or DENTAL BENEFITS sections of this Summary Plan Description. If you choose to only enroll yourself, the dental care expenses of other Dependents are not covered.

Enrollment

Mechanics of Enrollment

An Eligible Employee enrolls in the Dental Plan by completing the enrollment process established by the MBO. The enrollment process will include an election as to how many and which Dependents, if any, will be covered (i.e., Employee Only; Employee/ Child[ren]; Employee/Legally Domiciled Adult; or Employee/ Spouse/Child[ren]) as well as the Dental Plan option available to You.

You must provide the Social Security number of each person enrolling, as required by the Patient Protection and Affordable Care Act.

Dual Coverage Under This Plan Is Prohibited

No person will be covered as a Dependent of more than one Employee, and no person will be covered as both an Employee and a Dependent.

Your ID Card

After enrolling in the Plan, you will receive a Dental Plan ID Card. This card includes your member identification number and will be very important to you in obtaining Benefits for Dental Care. You will receive one ID card if you have Single Coverage and you will receive two ID cards if you have Family Coverage. Both ID cards will show your name. If you need additional ID cards, please call the CHI Dental Plan Customer Service Team to request them.

Time Limits for Enrollment and Special Enrollment Rights

Enrollment must be completed during the applicable initial waiting period, or during the first 30 days of employment if Your MBO does not have a waiting period, for an Eligible Employee and his or her Dependents unless one of the special enrollment periods described below apply.

If You decline enrollment for yourself or Your Dependents (including Your Spouse) because of other dental insurance coverage, You can enroll yourself and Your Dependents in This Plan mid-Year if You or Your Dependents lose eligibility for that other coverage (or if another employer stops contributing towards You or Your Dependents' other coverage). However, You must request enrollment within 31 days after Your other coverage ends (or after the other employer stops contributing toward the other coverage) for You or Your Dependents.

In addition, if You have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, You can enroll yourself and Your Dependents. However, You must request enrollment within 31 days after the marriage or 60 days after the birth, adoption, or placement for adoption.

The American Academy of Pediatric Dentistry and American Dental Association recommend that a Child's first visit to the dental office occur at approximately six months or when the first tooth erupts. If teeth do not erupt by the end of Your Child's first year, You should see a Dentist. Please take these clinical guidelines into account when planning to enroll Your newborn Child(ren) during This Plan's Annual Enrollment Period which occurs each Year.

In addition, an Eligible Employee or Dependent may also enroll in This Plan within 31 days after a change in status if such enrollment is necessary as a result of and consistent with the change in status. If proper enrollment is not completed during the time periods specified above, enrollment of such an Eligible Employee or Dependent must wait until the next Annual Enrollment Period. Annual Benefit Enrollment Periods will be conducted annually prior to the beginning of the next Year.

Change in Status Events

The following events are changes in status for purposes of this ENROLLMENT section:

- Legal marital status — Events that change Your legal marital status, including the following: marriage, death of Spouse, divorce, legal separation, and annulment;
- Number of Dependents — Events that change Your number of Dependents, including the following: birth, death, adoption, and placement for adoption;
- Employment status — Any of the following events that change the employment status of You, Your Spouse, or Your Dependent: a termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, and a change in worksite. In addition, if the eligibility conditions of This Plan or the benefit plan of the employer of Your Spouse or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under that Plan, then that change constitutes a change in employment (e.g., if a Plan only applies to salaried employees and an employee switches from salaried to hourly-paid with the consequence that the employee ceases to be eligible for the Plan, then that change constitutes a change in employment);
- Dependent satisfies or ceases to satisfy eligibility requirements — Events that cause Your Dependent to satisfy or cease to satisfy eligibility requirements for coverage under the Dental Plan as a Dependent, such as birth, adoption, attainment of age, student status, or any similar circumstances; and
- Consistency rule — An election change satisfies the "change in status" requirements of This Plan only if the election change is on account of and corresponds with a change in status that affects eligibility for coverage under This Plan. A change in status that affects eligibility under This Plan includes a change in status that results in an increase or decrease in the number of Your Dependents who may benefit from coverage under This Plan.

Covering Your Dependents

To be eligible for enrollment as a covered Dependent, an individual must be:

- The Spouse of an Eligible Employee; or
- The Legally Domiciled Adult of an Eligible Employee; or
- A Child of an Eligible Employee or Legally Domiciled Adult

Adding Dependents to Your Coverage

You can add Dependents to Your coverage, because of:

- Marriage;
- The birth, adoption, or placement for adoption of a Child;
- Obtaining legal guardianship of a Child;
- Termination of previous dental insurance coverage which was in effect when You were first eligible to enroll for coverage under the Dental Plan and which is not terminating for failure to pay premiums or for fraudulent cause; or
- A qualified medical Child Support Order (QMCSO). A QMCSO is a legal judgment, decree or order issued under a state domestic relations law by a court or an administrator. A QMCSO creates or recognizes the rights of a Child to coverage for health care benefits, including dental benefits. Under a Child Support Order, the state can require You to provide coverage to a Child under the Dental Plan who otherwise would not have coverage under This Plan. To be a QMCSO, the order must meet specific requirements provided by the Plan Administrator.

If you enroll a new Dependent as a result of a Qualified Life Event, the coverage will be effective the first of the month following your notification to CommonSpirit Health of the Qualified Life Event. However, if the change is due to a birth, adoption, obtaining Legal Guardianship, or interim court order prior to finalization of adoption, the coverage will be effective as of the event date of the Qualified Life Event. For birth, adoption, obtaining Legal Guardianship, or interim court order prior to finalization of adoption, you will be responsible for any back premiums.

If You enroll a new Dependent within 31 days of the termination of previous dental coverage, the Dependent's coverage will be effective from the first of the month following your notification to CommonSpirit Health of the Qualified Life Event.

Dependent Eligibility Audit

To be good stewards of our resources and continue to provide affordable, high-quality benefits to employees and their families, CommonSpirit Health verifies the eligibility of our employees' dependent(s) enrolled in any of the following plans:

- Medical Plan
- Dental Plan
- Vision Plan

When a dependent is added to one of these plans, the employee may receive an audit notice and must return the appropriate documentation by the due date or the dependent(s) will lose coverage. If the employee does not respond to the audit or provide appropriate information the dependent will be dropped from coverage at the end of the month following notification to CommonSpirit Health. Premiums will cease as of the end of the month in which coverage terminates.

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CommonSpirit Health reserves the right to request verification of dependent status at any time and may pursue any fraudulent activity.

Preexisting Condition/Late Enrollee Waiting Period

The Dental Plan does not have a preexisting condition or late enrollee waiting period. You will be entitled to the benefits described in this Summary Plan Description as of Your Coverage Date.

Termination of Coverage

Coverage under This Plan will cease on the last day of the month in which one or more of the following occur:

- You no longer meet the description of an Eligible Employee;
- The Dental Plan terminates; or
- Your Dependent ceases to be eligible for enrollment as a covered Dependent under the rules set out above under the COVERING YOUR DEPENDENTS section.

No benefits are available to You for services or supplies rendered after the date Your coverage terminates under the Dental Plan except as otherwise specifically stated in the CONTINUATION OF COVERAGE provisions of this Summary Plan Description. However, termination of Your coverage under the Dental Plan shall not affect any claim for Covered Services rendered prior to the effective date of such termination.

If one of Your Dependents becomes ineligible, his or her coverage will end as of the last day of the month in which the event occurs which makes him or her ineligible (for example, date of marriage, date of divorce, date the limiting age is reached).

Options available for continuation of coverage are explained in the CONTINUATION OF COVERAGE section of this Summary Plan Description.

Dental Benefits

If You or a Dependent incur a charge for a Covered Service, Proof of such service must be sent to the CHI Dental Plan Customer Service Team. When the CHI Dental Plan Customer Service Team receives such Proof, the CHI Dental Plan Customer Service Team will review the claim and if the CHI Dental Plan Customer Service Team approves it, This Plan will pay the dental benefits in effect on the date that service was completed.

These dental benefits give You access to Dentists through the MetLife Preferred Dentist Program Plus ("PDP Plus"). Dentists participating in the PDP Plus have agreed to limit their charge for a dental service to the Maximum Allowed Charge for such service. This Plan pays benefits for Covered Services performed by either In-Network Dentists or Out-of-Network Dentists. However, You may be able to reduce Your out-of-pocket costs by using an In-Network Dentist because Out-of-Network Dentists have not entered into an agreement with MetLife to limit their charges. **You may always choose to receive services from any Dentist.** You do not need any authorization from This Plan to choose a Dentist.

Whether or not benefits are available for a particular service, does not mean You should or should not receive the service. You and Your Dentist have the right and are responsible at all times for choosing the course of treatment and services to be performed. After services have been performed, the CHI Dental Plan Customer Service Team will determine the extent to which benefits, if any, are payable.

When requesting a Covered Service from an In-Network Dentist, it is recommended that You:

- Identify yourself as covered under the Preferred Dentist Program Plus; and
- Confirm the network status of the Dentist at the time that the Covered Service is performed.

The amount of the benefit will not be affected by whether or not You identify Yourself as an Eligible Employee in the Preferred Dentist Program Plus.

You can obtain a customized listing of MetLife's In-Network Dentists either by calling 1-888-865-6873 or by visiting MetLife's website at http://www.metlife.com/dental.

Benefit Amounts

This Plan will pay benefits in an amount equal to the Covered Percentage for charges incurred by You or a Dependent for a Covered Service as shown in the section entitled BENEFITS AT A GLANCE, subject to the conditions set forth in this Summary Plan Description.

In-Network

If a Covered Service is performed by an In-Network Dentist, This Plan will base the benefit on the Covered Percentage of the Maximum Allowed Charge.

If an In-Network Dentist performs a Covered Service, You will be responsible for paying:

- The Deductible; and
- Any remaining amount of the Maximum Allowed Charge after which This Plan pays the benefits outlined in the BENEFITS AT A GLANCE section (Covered Percentage)

You will not be responsible for any amount in excess of the Maximum Allowed Charge over and above Your Covered Percentage obligations outlined in the BENEFITS AT A GLANCE section.

Out-of-Network

If a Covered Service is performed by an Out-of-Network Dentist, This Plan will base the benefit on the Covered Percentage of the Reasonable and Customary Charge.

Out-of-Network Dentists may charge You more than the Reasonable and Customary Charge. If

an Out-of-Network Dentist performs a Covered Service, You will be responsible for paying:

- The Deductible;
- Any remaining amount of the Reasonable and Customary Charge after which This Plan pays the benefits outlined in the BENEFITS AT A GLANCE section (Covered Percentage); and
- Any amount in excess of the Reasonable and Customary Charge charged by the Out-of-Network Dentist.

Maximum Benefit Amounts

The section entitled BENEFITS AT A GLANCE sets forth the Maximum Benefit Amounts This Plan will pay for Covered Services received from In-Network and Out-of-Network Dentists. This Plan will never pay more than the Maximum Benefit amount specified in the applicable BENEFITS AT A GLANCE section.

Deductibles

The Deductible amounts are shown in the section entitled BENEFITS AT A GLANCE.

The Yearly individual Deductible is the amount that You and each Dependent must pay for Covered Services before This Plan will pay benefits for such Covered Services. The Deductible does not apply to all Covered Services so refer to the BENEFITS AT A GLANCE section for more details.

If applicable, This Plan applies amounts used to satisfy Yearly individual Deductibles to the Yearly family Deductible. Once the Yearly family Deductible is satisfied, no further Yearly individual Deductibles are required to be met.

This Plan will not apply more than the Maximum Allowed Charge in the case of an In-Network Dentist or the Reasonable and Customary Charge in the case of an Out-of-Network Dentist toward satisfying the Deductible.

Alternate Benefit

If the CHI Dental Plan Customer Service Team determines that a less costly service performed by the Dentist could have been performed to treat a dental condition, This Plan will pay benefits based upon the less costly service if such service:

- Would produce a professionally acceptable result under generally accepted dental standards; and
- Would qualify as a Covered Service.

For example:

- When a filling and an inlay are both professionally acceptable methods for treating tooth decay or breakdown, the CHI Dental Plan Customer Service Team may base the benefit determination upon the filling which is the less costly service;
- When a filling and a crown are both professionally acceptable methods for treating tooth decay or breakdown, the CHI Dental Plan Customer Service Team may base the benefit determination upon the filling which is the less costly service; and
- When a partial Denture and fixed bridgework are both professionally acceptable methods for replacing multiple missing teeth in an arch, the CHI Dental Plan Customer Service Team may base the benefit determination upon the partial Denture which is the less costly service.

If This Plan pays benefits based upon a less costly service in accordance with this subsection, the Dentist may charge You or Your Dependent for the difference between the service that was performed and the less costly service. This is the case even if the service is performed by an In-Network Dentist.

Certain comprehensive dental services have multiple steps associated with them. These steps can be completed at one time or during multiple sessions. For benefit purposes under this Summary Plan Description, these separate steps of one service are considered to be part of the more comprehensive service. Even if the Dentist submits separate bills, the total benefit payable for all related charges will be limited by the maximum benefit payable for the more comprehensive service. For example, root canal therapy includes x-rays, opening of the pulp chamber, additional x-rays, and filling of the chamber. Although these services may be performed in multiple sessions, they all constitute root canal therapy.

Orthodontic Covered Services

Eligible adult and Children are eligible for orthodontic benefits.

Orthodontic treatment generally consists of initial placement of an appliance and periodic follow-up visits.

The benefit payable for the initial placement will not exceed 20% of the Maximum Benefit Amount for orthodontia.

The benefit payable for the periodic follow-up visits will be payable on a quarterly basis during the course of the orthodontic treatment if:

- Dental benefits are in effect for the person receiving the orthodontic treatment; and
- Proof is given to the CHI Dental Plan Customer Service Team that the orthodontic treatment is continuing.

If the initial placement was made prior to the Coverage Date of these dental benefits, the benefit payable under This Plan will be reduced by the portion attributable to the initial placement. Additionally, if the periodic follow-up visits commenced prior to the Coverage Date of these dental benefits:

- The number of months for which benefits are payable will be reduced by the number of months of treatment performed before these dental benefits were in effect; and
- The total amount of the benefit payable for the periodic visits will be reduced proportionately;
- If orthodontia treatment starts while eligible for coverage, benefits will be considered through the end of treatment.

The CHI Dental Plan Customer Service team will consider the entire cost of Your treatment plan, as well as the duration of Your treatment plan when calculating the remaining benefit available.

Pretreatment Estimate of Benefits

If a planned dental service is expected to cost more than $300, You have the option of requesting a pretreatment estimate of benefits. The Dentist should submit a claim detailing the services to be performed and the amount to be charged. After the CHI Dental Plan Customer Service Team receives this information, the CHI Dental Plan Customer Service Team will provide You and Your Dentist with an estimate of the dental benefits available for the service. **The estimate is only an estimate of the benefits available for the proposed dental services; it is not a guarantee of the amount This Plan will pay.** Under the Alternate Benefit provision found in this section, benefits may be based on the cost of a service other than the service that You choose. You are required to submit Proof on or after the date the dental service is completed in order for This Plan to pay a benefit for such service.

The pretreatment estimate of benefits is only an estimate of benefits and there are no penalties for not getting a pretreatment estimate of benefits. There are no charges associated with requesting a pretreatment estimate of benefits. As always, You or Your Dependent and the Dentist are responsible for choosing the services to be performed.

Benefits This Plan Will Pay After Coverage Ends

Prosthetic Devices: This Plan will pay benefits for a 31 day period after Your coverage ends for the completion of installation of a **prosthetic device** if:

- The Dentist prepared the abutment teeth or made impressions before Your coverage ends; and
- The device is installed within 31 days after the date the coverage ends.

Cast Restorations: This Plan will pay benefits for a 31 day period after Your coverage ends for the completion of installation of a **Cast Restoration** if:

- The Dentist prepared the tooth for the Cast Restoration before Your coverage ends; and
- The Cast Restoration is installed within 31 days after the date the coverage ends.

Root Canal Therapy: This Plan will pay benefits for a 31 day period after Your coverage ends for completion of **root canal therapy** if:

- The Dentist opened into the pulp chamber before Your coverage ends; and
- The treatment is finished within 31 days after the date the coverage ends.

Dental Benefits: Description of Covered Services

Preventive and Diagnostic Services

This Plan will pay dental benefits for charges incurred for:

1. Oral exams twice in a Year;
2. Cleaning of teeth (oral prophylaxis) twice in a Year;
3. Full mouth or panoramic x-rays once every 60 months;
4. Bitewing x-rays once in a Year;
5. Intraoral-periapical and extraoral x-rays;
6. Pulp vitality and bacteriological studies for determination of bacteriologic agents;
7. Diagnostic casts;
8. Emergency palliative treatment to relieve tooth pain;
9. Topical fluoride treatment for a Child under age 19, once in a Year;
10. Space maintainers for a Child under age 19; and/or
11. Sealants for a Child under age 19, which are applied to non-restored, non-decayed first and second permanent molars, once per tooth every 60 months. Excludes wisdom teeth;
12. Preventive resin fillings once every 60 months on permanent first and second molars.

Basic Covered Services

This Plan will pay dental benefits for charges incurred once in any 24-month period for:

1. Amalgam or resin fillings;
2. Sedative fillings;
3. Oral surgery except as mentioned elsewhere in this Summary Plan Description;
4. Consultations once in a 12 month period;
5. Root canal treatment once in any 24 month period for the same tooth;
6. Periodontal scaling and root planning once per quadrant in any 24 month period;
7. Periodontal surgery, including gingivectomy, gingivoplasty, gingival curettage and osseous surgery; one surgical procedure per quadrant in any 36 month period;
8. Simple extractions;
9. Surgical extractions (including wisdom teeth);
10. Periodontal maintenance where periodontal treatment (including scaling, root planning, and periodontal surgery, such as gingivectomy, gingivoplasty, gingival curettage and osseous surgery) has been performed (periodontal maintenance is limited to four times in any Year combined with oral prophylaxis, which is also known as cleanings);
11. Pulp capping (excluding final restoration) and therapeutic pulpotomy (excluding final restoration);
12. Pulp therapy and apexification/recalcification;
13. Local chemotherapeutic agents;

14. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when the Claims Administrator determines such anesthesia is necessary in accordance with generally accepted dental standards;
15. Injections of therapeutic drugs;
16. Relinings and rebasings of existing removable Dentures:
    - If at least 6 months have passed since the installation of the existing removable Denture; and
    - Only once in any 36 month period;
17. Re-cementing of Cast Restorations or Dentures;
18. Prefabricated stainless steel crown or prefabricated resin crown, but no more than one replacement for the same tooth surface within 84 consecutive months;
19. Repair of Dentures;
20. Adjustments of Dentures, if at least 6 months have passed since the installation of the Denture;
21. Tissue conditioning, once in a 36 month period;
22. Simple repairs of Cast Restorations;
23. Application of desensitizing medications where periodontal treatment (including scaling, root planning, and periodontal surgery such as osseous surgery) has been performed;
24. Occlusal adjustments once in a 12 month period; and/or
25. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards, once in a 60 month period;
26. Debridement, once per lifetime;
27. Addition of teeth to denture, once per lifetime;
28. Repair/reline/adjustment of occlusal guard;
29. Pins loaded as type B, once every 84 months;
30. Pulpal regeneration, once per lifetime.

Major Covered Services

This Plan will pay dental benefits for charges incurred for:

1. Initial installation of full or removable Dentures:
    - When needed to replace congenitally missing teeth; or
    - When needed to replace natural teeth that are lost;
2. Replacement of a non-serviceable Denture if such Denture was installed more than 84 months prior to replacement;
3. Replacement of an immediate, temporary full Denture with a permanent full Denture if the immediate, temporary full Denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary full Denture;
4. Initial installation of Cast Restorations (i.e. crowns);
5. Replacement of any Cast Restoration with the same or a different type of Cast Restoration (only one replacement for the same tooth surface within 84 months of a prior replacement);
6. Core buildup, once per tooth in a period of 84 months;
7. Posts and cores, once per tooth in a period of 84 months;

8. Fixed and removable appliances for correction of harmful habits (covered to age 26);
9. Implants, once for the same tooth position in an 84 month period;
10. Repair of implants, once in a 12 month period;
11. Implant supported prosthetics, once for the same tooth position in an 84 month period;
12. Repair of implant supported prosthetics, once in a 12 month period; and/or
13. Non-surgical treatment of temporomandibular joint disorders. The Aggregate Maximum Benefit for temporomandibular joint disorders is shown in the BENEFITS AT A GLANCE section;
14. Veneers, once every 84 months;
15. Cleaning and inspection of removable appliance, two per year.

Orthodontic Covered Services

Orthodontics includes preventive and corrective treatment for irregularities in the alignment of teeth. Orthodontic coverage includes exams, diagnostic x-rays and all related treatment such as extractions, fixed or removable appliances.

Dental Benefits: Exclusions

This Plan will not pay dental benefits for charges incurred for:

1. Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which the Claims Administrator deems experimental in nature (Experimental procedures would be those that are not described by a current valid Current Dental Terminology (CDT) code and are not recognized by the American Dental Association and the vast majority of dentists. Experimental procedures could also include the administration of drugs that are not approved by the Federal Drug Administration);
2. Services for which You would not be required to pay in the absence of dental benefits;
3. Services or supplies received by You or Your Dependent before the dental benefits starts for that person;
4. Services which are neither performed nor prescribed by a Dentist except for those services of a licensed Dental Hygienist which are supervised and billed by a Dentist and which are for:
   - Scaling and polishing of teeth; or
   - Fluoride treatments;
5. Services which are primarily cosmetic;
6. Services or appliances which restore or alter occlusion or vertical dimension;
7. Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease;
8. Restorations or appliances used for the purpose of periodontal splinting;
9. Counseling or instruction about oral hygiene, plaque control, nutrition and/or tobacco;
10. Personal supplies or devices including, but not limited to, water piks, toothbrushes, or dental floss;
11. Decoration or inscription of any tooth, device, appliance, crown or other dental work;
12. Missed appointments;
13. Services that are:
    - Covered under any workers' compensation or occupational disease law;
    - Covered under any employer liability law;
    - For which the Employer of the person receiving such services is not required to pay; or
    - Received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital;
14. Services covered under other coverage provided by the Employer;
15. Temporary or provisional restorations;
16. Temporary or provisional appliances;
17. Prescription drugs;
18. Services for which the submitted documentation indicates a poor prognosis;

19. Services, to the extent such services, or benefits for such services, are available under a Government Plan. This exclusion will apply whether or not the person receiving the services is enrolled for the Government Plan. This Plan will not exclude payment of benefits for such services if the Government Plan requires that dental benefits under This Plan be paid first;

    Government Plan means any Plan, program, or coverage which is established under the laws or regulations of any government.

    The term does not include:

    - Any plan, program or coverage provided by a government as an employer; or
    - Medicare.
20. The following services when charged by the Dentist on a separate basis:
    - Claim form completion;
    - Infection control such as gloves, masks, and sterilization of supplies; or
    - Local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide;
21. Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
22. Caries susceptibility tests;
23. Precision attachments associated with fixed and removable prostheses, except when the precision attachment is related to implant prosthetics;
24. Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
25. Duplicate prosthetic devices or appliances;
26. Replacement of a lost or stolen appliance, Cast Restoration or Denture;
27. Repair or replacement of an orthodontic device; and/or
28. Intra and extraoral photographic images;
29. Other removable prosthetics and other fixed prosthetics.

Dental Benefits: Coordination of Benefits

When You or a Dependent incur charges for Covered Services, there may be other Plans, as defined below, which also provide benefits for those same charges. In that case, This Plan may reduce what This Plan pays based on what the other Plans pay. This COORDINATION OF BENEFITS section explains how and when This Plan does this.

Definitions

In this section, the terms set forth below have the following meanings:

Allowable Expense means a necessary dental expense for which both of the following are true:

- A covered person must owe it, and
- It is at least partly covered by one or more of the Plans that provide benefits to the covered person. If a Plan provides fixed benefits for specified events or conditions (instead of benefits based on expenses incurred) such benefits are Allowable Expenses.

If a Plan provides benefits in the form of services, This Plan treats the reasonable cash value of each service performed as both an Allowable Expense and a benefit paid by that Plan.

The term does not include:

- Expenses for services performed because of a Job-Related Injury or Sickness;
- Any amount of expenses in excess of the higher Reasonable and Customary Charge for a service, if two or more Plans compute their benefit payments on the basis of Reasonable and Customary Charges;
- Any amount of expenses in excess of the higher negotiated fee for a service, if two or more Plans compute their benefit payments on the basis of negotiated fees; and
- Any amount of benefits that a Primary Plan does not pay because the covered person fails to comply with the Primary Plan's managed care or utilization review provisions, these include provisions requiring:
  - Second surgical opinions;
  - Pre-certification of services;
  - Use of providers in a Plan's network of providers; or
  - Any other similar provisions.

This Plan won't use this provision to refuse to pay benefits because a DMO or HMO member has elected to have dental services provided by a non-DMO or HMO provider and the DMO's or HMO's contract does not require the DMO or HMO to pay for those services provided.

Claim Determination Period means a period that starts on any January 1 and ends on the next December 31. A Claim Determination Period for any covered person will not include periods of time during which that person is not covered under This Plan.

Custodial Parent means a Parent awarded custody, other than joint custody, by a court decree. In the absence of a court decree, it means the Parent with whom the Child resides more than half of the Year without regard to any temporary visitation.

DMO means a Dental Maintenance Organization.

HMO means a Health Maintenance Organization.

Job-Related Injury or Sickness means any injury or sickness:

- For which You are entitled to benefits under a workers' compensation or similar law, or any arrangement that provides for similar compensation; or
- Arising out of employment for wage or profit.

Parent means a person who covers a Child as a Dependent under a Plan.

Plan means any of the following if it provides benefits or services for an Allowable Expense:

- A group insurance Plan;
- A DMO or HMO;
- A blanket Plan;
- Uninsured arrangements of group or group type coverage;
- A group practice Plan;
- A group service Plan;
- A group prepayment Plan;
- Motor vehicle No Fault coverage if the coverage is required by law;
- Any other Plan that covers people as a group; and
- Any other coverage required or provided by any law or any governmental program, except Medicaid.

The term does not include any of the following:

- Individual or family insurance or subscriber contracts;
- Individual or family coverage through closed panel Plans or other prepayment, group practice or individual practice Plans;
- Hospital indemnity coverage;
- A school blanket Plan that only provides accident-type coverage on a 24 hour basis, or a "to and from school basis," to students in a grammar school, high school or college;
- Disability income protection coverage;
- Accident only coverage;
- Specified disease or specified accident coverage;
- Nursing home or long term care coverage; or
- Any government program or coverage if, by state or Federal law, its benefits are excess to those of any private insurance Plan or other non-government Plan.

The provisions of This Plan limit benefits based on benefits or services provided under:

- Government Plans;
- Plans which the Employer (or an affiliate) contributes to or sponsors; or
- Plans that are not be affected by the COORDINATION OF BENEFITS provisions of this section.

Each policy, contract or other arrangement for benefits is a separate Plan. If part of a Plan reserves the right to reduce what it pays based on benefits or services provided by other Plans, that part will be treated separately from any parts which do not. If two people are both covered under This Plan as employees, each person's coverage will be treated as a separate Plan. No person will be covered as a Dependent of more than one employee, and no person will be covered as both an employee and a Dependent.

This Plan means the dental benefits described in this Summary Plan Description, except for any provisions in this Summary Plan Description that limit coverage based on benefits for services provided under government Plans, or Plans which the Employer (or an affiliate) contributes to or sponsors.

Primary Plan means a Plan that pays its benefits first under the RULES TO DECIDE WHICH PLAN IS PRIMARY section. A Primary Plan pays benefits as if the Secondary Plans do not exist.

Secondary Plan means a Plan that is not a Primary Plan. A Secondary Plan may reduce its benefits by amounts payable by the Primary Plan. If there are more than two Plans that provide coverage, a Plan may be Primary to some Plans, and Secondary to others.

Rules to Decide Which Plan Is Primary

When more than one Plan covers the person for whom Allowable Expenses were incurred, the CHI Dental Plan Customer Service Team determines which Plan is primary by applying the rules in this section.

When there is a basis for claim under This Plan and another Plan, This Plan is Secondary unless:

- The other Plan has rules coordinating its benefits with those of This Plan; and
- This Plan is primary under This Plan's rules.

The first rule below which will allow the CHI Dental Plan Customer Service Team to determine which Plan is Primary is the rule that the CHI Dental Plan Customer Service Team will use.

Dependent or Non-Dependent: A Plan that covers a person other than as a Dependent (for example, as an employee) is Primary and shall pay its benefits before a Plan that covers the person as a Dependent; except that if the person is a Medicare beneficiary and, as a result of federal law or regulations, Medicare is:

- Secondary to the Plan covering the person as a Dependent; and
- Primary to the Plan covering the person as other than a Dependent (e.g., a retired employee);

Then the order of benefits between the two Plans is reversed and the Plan that covers the person as a Dependent is Primary.

Child Covered Under More Than One Plan — Court Decree: When This Plan and another Plan cover the same Child as the Dependent of two or more Parents, and the specific terms of a court decree state that one of the Parents must provide health coverage or pay for the Child's health care expenses, that Parent's Plan is Primary if the Plan has actual knowledge of those terms. This rule applies to Claim Determination Periods that start after the Plan is given notice of the court decree.

Child Covered Under More Than One Plan — The Birthday Rule: When This Plan and another Plan cover the same Child as the Dependent of two or more Parents, the Primary Plan is the Plan of the Parent whose birthday falls earlier in the Year if:

- The Parents are married;
- The Parents are not separated (whether or not they have ever married); or
- A court decree awards joint custody without specifying which Parent must provide health coverage. If both Parents have the same birthday, the Plan that covered either of the Parents longer is the Primary Plan.

However, if the other Plan does not have this rule but instead has a rule based on the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

Child Covered Under More than One Plan — Custodial Parent: When This Plan and another Plan cover the same Child as the Dependent of two or more Parents, if the Parents are not married, or are separated (whether or not they ever married), or are divorced, the Primary Plan is:

- The Plan of the Custodial Parent; then
- The Plan of the Spouse of the Custodial Parent; then
- The Plan of the non-custodial Parent; and then
- The Plan of the Spouse of the non-custodial Parent.

Active or Inactive Employee: A Plan that covers a person as an employee who is neither laid off nor retired is Primary to a Plan that covers the person as a laid-off or retired employee (or as that person's Dependent). If the other Plan does not have this rule and, if as a result, the Plans do not agree on the order of benefits, this rule is ignored.

Continuation Coverage: The Plan that covers a person as an Active Employee, member or subscriber (or as that employee's Dependent) is Primary to a Plan that covers that person under a right of continuation pursuant to federal law (e.g., COBRA) or state law. If the Plan that covers the person has not adopted this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule shall not apply.

Longer/Shorter Time Covered: If none of the above rules determine which Plan is Primary, the Plan that has covered the person for the longer time shall be Primary to a Plan that has covered the person for a shorter time.

No Rules Apply: If none of the above rules determine which Plan is Primary, the Allowable Expenses shall be shared equally between all of the Plans. In no event will This Plan pay more than it would if it were Primary.

Effect on Benefits of This Plan

If This Plan is Secondary, when the total Allowable Expenses incurred by a covered person in any Claim Determination Period are less than the sum of:

- The benefits that would be payable under This Plan without applying the COORDINATION OF BENEFITS provisions of this section; and
- The benefits that would be payable under all other Plans without applying the COORDINATION OF BENEFITS provisions of this section or similar provisions;

Then This Plan will reduce the benefits that would otherwise be payable under This Plan. The sum of these reduced benefits plus all benefits payable for such Allowable Expenses under all other Plans will not exceed the total of the Allowable Expenses. Benefits payable under all other Plans include all benefits that would be payable if the proper claims had been made on time.

Right to Receive and Release Needed Information

The CHI Dental Plan Customer Service Team needs certain information to apply the rules of this COORDINATION OF BENEFITS section. The CHI Dental Plan Customer Service Team has the right to decide which facts the CHI Dental Plan Customer Service Team needs. In accordance with the Health Insurance Accountability and Portability Act (HIPAA), the CHI Dental Plan Customer Service Team may get facts from or give them to any other organization or person. The CHI Dental Plan Customer Service Team does not need to tell, or get the consent of, any person or organization to do this. To obtain all benefits available, a covered person who incurs Allowable Expenses should file a claim under each Plan which covers the person. Each person claiming benefits under This Plan must give the CHI Dental Plan Customer Service Team any facts This Plan needs to pay the claim.

Facility of Payment

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, This Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. This Plan will not have to pay that amount again. The term "payment made" includes benefits provided in the form of services, in which case This Plan may pay the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount This Plan pays is more than This Plan should have paid under the COORDINATION OF BENEFITS provisions of this section, This Plan may recover the excess from one or more of:

- The person This Plan has paid or for whom This Plan has paid;
- Insurance companies; and/or
- Other organizations.

The amount of the payment includes the reasonable cash value of any benefits provided in the form of services.

General Provisions

Assignment

Upon receipt of a Covered Service, You may assign dental benefits to the Dentist providing such service.

Who We Will Pay

The Plan will typically pay benefits directly to Your Dentist. In the rare instance where You are required to pay the Dentist for the full cost of services received before the Plan makes payment, This Plan will pay dental benefits to You.

Misstatement of Age

If Your or Your Dependent's age is misstated, the correct age will be used to determine if coverage is in effect and, as appropriate, This Plan will adjust the benefits and/or contributions.

Conformity with Law

If the terms and provisions of this Summary Plan Description do not conform to any applicable law, this Summary Plan Description shall be interpreted to so conform.

Overpayments

Recovery of Dental Benefits Overpayments

This Plan has the right to recover any amount that the CHI Dental Plan Customer Service Team determines to be an overpayment, whether for services received by You or Your Dependents.

An overpayment occurs if the Plan determines that:

- The total amount paid by This Plan on a claim for dental benefits is more than the total of the benefits due to You under this Summary Plan Description; or
- Payment made by This Plan that should have been made by another group Plan.

How Overpayments Are Recovered

If the overpayment results from This Plan having made a payment on Your behalf that should have been made under another group Plan, This Plan may recover such overpayment from one or more of the following:

- Any other insurance company;
- Any other organization; and
- Any person to or for whom payment was made.

This Plan may recover the overpayment from You or Your dependents by:

- Stopping or reducing any future benefits payable for dental benefits;
- Demanding an immediate refund of the overpayment from You; and
- As a last resort, taking legal action.

This Plan may recover such overpayment in accordance with that agreement.

Continuation of Coverage

The purpose of this section of the Summary Plan Description is to explain the options which are required for temporarily continuing Your or Your Dependent's coverage at group rates in certain instances when Your or Your Dependent's coverage would otherwise end.

What Is Continuation of Coverage?

Continuation of coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a qualifying event. Specific qualifying events are listed later in this section. After a qualifying event, continuation of coverage may be offered to each person who is a qualified beneficiary. You, Your Spouse, and Your Dependent Children could become qualified beneficiaries if coverage under This Plan is lost because of the qualifying event. Under This Plan, qualified beneficiaries who elect continuation of coverage must pay for coverage.

If You are an employee, You will become a qualified beneficiary if You lose Your coverage under This Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- 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 lose Your coverage under This Plan because any of the following qualifying events happens:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from Your Spouse.

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The Child stops being eligible for coverage under This Plan as a Dependent Child.

When Is Coverage Available?

This Plan will offer continuation of 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 the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

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 provide this notice to Your local Human Resources Department. Check with Your Human Resources Department for more information.

Notification of a qualifying event must include the following information:

- Name and identification number of the Eligible Employee and each qualified beneficiary;
- Type and date of initial or second qualifying event; and
- The name, address and daytime phone number of the qualified person (or legal representative) that the Plan Administrator may contact if additional information is needed.

How Is Coverage Provided?

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

When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), Your divorce or legal separation, or a Dependent Child's losing eligibility as a Dependent Child, continuation of coverage may last for 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, continuation of 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 eight months before the date on which his employment terminates, continuation of 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, continuation of coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of continuation of coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If You or anyone in Your family covered under This Plan is determined by the Social Security Administration (SSA) to be disabled and You notify the Plan Administrator within 60 days of the Social Security Administration's decision (and before the end of the original 18 month period of continuation of coverage), You and Your entire family may be entitled to receive up to an additional 11 months of continuation of coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of continuation of coverage and must last at least until the end of the 18 month period of continuation coverage.

To request an extension of Your continuation coverage due to disability, send a copy of any letters from the Social Security Administration and the Notice of Determination to Your Plan Administrator:

Your request must also include:

- The name and identification number of the Eligible Employee and each qualified beneficiary;
- The type and date of initial or second qualifying event; and
- Phone number of the qualified person (or legal representative) that the Plan Administrator may contact if additional information is needed.

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

If Your family experiences another qualifying event while receiving 18 months of continuation of coverage, Your Spouse and Dependent Children can get up to 18 additional months of continuation of coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to This 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 This Plan as a Dependent Child, but only if the event would have caused the Spouse or Dependent Child to lose coverage under This Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning Your Plan or Your continuation of coverage rights should be addressed to Your Plan Administrator.

Keep Your Plan Informed of Address Changes

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.

Claims Information

Procedures for Presenting Claims for Dental Benefits

All claim forms needed to file for benefits under the group benefits program can be obtained from the CHI Dental Plan Customer Service Team who can also answer questions about the benefits and assist You or, if applicable, Your beneficiary in filing claims. Dental claim forms can also be downloaded from www.metlife.com/dental.

Routine Questions

If there is any question about a claim payment, an explanation may be requested from the CHI Dental Plan Customer Service Team by dialing 1-888-865-6873.

Claim Submission

For claims for dental benefits, the claimant must complete the appropriate claim form and submit the required Proof as described below:

When a claimant files a claim for Dental Benefits described in this Summary Plan Description, the required Proof should be sent to the CHI Dental Plan Customer Service Team within 90 days of receiving services.

The required Proof may also be given to the CHI Dental Plan Customer Service Team by following the steps set forth below:

Step 1
A claimant may request a claim form by calling the CHI Dental Plan Customer Service Team at 1.888.865.6873.

Step 2
The CHI Dental Plan Customer Service Team will send a claim form to the claimant and explain how to complete it. The claimant should receive the claim form within 15 days of requesting it.

Step 3
When the claimant receives the claim form, the claimant should fill it out as instructed and return it with the required Proof described in the claim form.

If the claimant does not receive a claim form within 15 days, Proof may be sent using any form sufficient to provide the CHI Dental Plan Customer Service Team with the required Proof.

Step 4
The claimant must give the CHI Dental Plan Customer Service Team Proof no later than 90 days after the date of loss.

If Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such Proof is given as soon as is reasonably possible but, in no event, other than for lack of legal capacity, may Proof be given later than one Year after the date it is otherwise required.

Claim forms must be submitted in accordance with the instructions on the claim form. The claim filing limit is one year (12 months) from the date of service.

Initial Determination

After You submit a claim for dental benefits to the CHI Dental Plan Customer Service Team, the CHI Dental Plan Customer Service Team will review Your claim and notify You of its decision to approve or deny Your claim.

Such notification will be provided to You within a 30 day period from the date You submitted Your claim; except for situations requiring an extension of time of up to 15 days because of matters beyond the control of This Plan. If the CHI Dental Plan Customer Service Team needs such an extension, the CHI Dental Plan Customer Service Team will notify You prior to the expiration of the initial 30 day period, state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because You did not provide sufficient information or filed an incomplete claim, the time from the date of the CHI Dental Plan Customer Service Team's notice requesting further information and an extension until the CHI Dental Plan Customer Service Team receives the requested information does not count toward the time period the CHI Dental Plan Customer Service Team is allowed to notify You as to its claim decision. You will have 45 days to provide the requested information from the date You receive the notice from the CHI Dental Plan Customer Service Team requesting further information.

If the CHI Dental Plan Customer Service Team denies Your claim in whole or in part, the notification of the claims decision will state the reason why Your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because the CHI Dental Plan Customer Service Team did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that You may request a copy free of charge. If an extension is needed because You did not provide sufficient information, the time period from the Claims Administrator's notice to You of the need for an extension to when the Claims Administrator receives the requested information does not count toward the time the Claims Administrator is allowed to notify You of its final decision. If an extension is needed because You did not provide sufficient information, the time period from the Claims Administrator's notice to You of the need for an extension to when the Claims Administrator receives the requested information does not count toward the time the Claims Administrator is allowed to notify You of its final decision.

Appeals Process

If You have questions regarding coverage or how a claim will be paid, You should call the CHI Dental Plan Customer Service Team. If, after Your claim is processed, You question the payment of a claim, You may submit an appeal for review. Before beginning the appeals process, You may wish to telephone the CHI Dental Plan Customer Service Team. They may be able to assist You. However, any communication and/or correspondence exchanged with the Customer Service Team will not affect Your appeals deadlines as set forth in this Summary Plan Description.

Step One — Appealing the Initial Determination

If the CHI Dental Plan Customer Service Team denies Your claim, You may appeal the initial determination. Upon Your Written request, the CHI Dental Plan Customer Service Team will provide You free of charge with copies of documents, records and other information relevant to Your claim. You must submit Your appeal to the CHI Dental Plan Customer Service Team at the address indicated on the claim form within 180 days of receiving the CHI Dental Plan Customer Service Team's decision. Your appeal must be in Writing and must include at least the following information:

- Name of employee;
- Name of This Plan;
- Reference to the initial decision; and
- An explanation as to why You are appealing the initial determination.

As part of Your appeal, You may submit any Written comments, documents, records, or other information relating to Your claim.

After the CHI Dental Plan Customer Service Team receives Your Written request appealing the initial determination on Your appeal, the CHI Dental Plan Customer Service Team will conduct a full and fair review of Your claim. Deference will not be given to initial denial, and the CHI Dental Plan Customer Service Team's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that You submit relating to Your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review Your appeal will not be the same person as the person who made the initial decision to deny Your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny Your claim. If the initial denial is based in whole or in part on a clinical judgment, the CHI Dental Plan Customer Service Team will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

The CHI Dental Plan Customer Service Team will notify You in Writing of its final decision within 30 days after the CHI Dental Plan Customer Service Team's receipt of Your Written request for review. Under special circumstances, the CHI Dental Plan Customer Service Team may have up to an additional 30 days to provide Written notification of the final decision. If such an extension is required, the CHI Dental Plan Customer Service Team will notify You prior to the expiration of the initial 30 day period, state the reason(s) why such an extension is needed, and state when it will make its determination.

If the CHI Dental Plan Customer Service Team denies the claim on appeal, the CHI Dental Plan Customer Service Team will send You a final Written decision that states the reason(s) why the claim You appealed is being denied and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final Written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that You may request a copy free of charge. Upon Written request, the CHI Dental Plan Customer Service Team will provide You free of charge with copies of documents, records and other information relevant to Your claim.

The receipt of the CHI Dental Plan Customer Service Team's Written decision marks the end of Your official appeal. If the determination is unfavorable to You, You may submit a voluntary request for review to the CHI Dental Plan Administrator, as discussed in Step Two.

Step Two — Voluntary Request for Review by the CHI Dental Plan Administrator

If You are dissatisfied with the resolution of the appeal to the CHI Dental Plan Customer Service Team, You may submit a voluntary request for review to the CHI Dental Plan Administrator. You may also pursue legal remedies.

The request for review must be in Writing and sent via U.S. mail to the address below.

MetLife Group Claims Review
P.O. Box 14589
Lexington, KY 40512

MetLife will forward the request for review to the CHI Dental Plan Administrator. The request for review must include copies of all Written correspondence in regard to the appeal to the Claims Administrator and must indicate that the request for review is a final voluntary request to the CHI Dental Plan Administrator.

The Plan Administrator will review all claims and related information and will notify the claimant in Writing of the decision within 60 days of the receipt of the Written voluntary request for review.

Urgent Care Claim Submission

A small number of claims for dental benefits may be urgent care claims. Urgent care claims for dental benefits are claims for reimbursement of dental expenses for services which a Dentist familiar with the dental condition determines would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Of course any such claim may always be submitted in accordance with the normal claim procedures. However Your Dentist may also submit such a claim to the CHI Dental Plan Customer Service Team by telephoning the CHI Dental Plan Customer Service Team and informing the CHI Dental Plan Customer Service Team that the claim is an urgent care claim. Urgent care claims are processed according to the procedures set out above, however once a claim for urgent care is submitted, the CHI Dental Plan Customer Service Team will notify You of the determination on the claim as soon as possible, but no later than 72 hours after the claim was filed. If You or Your covered Dependent does not provide the CHI Dental Plan Customer Service Team with enough information to decide the claim, the CHI Dental Plan Customer Service Team will notify You within 24 hours after it receives the claim of the further information that is needed. You will have 48 hours to provide the information. If the needed information is provided, the CHI Dental Plan Customer Service Team will notify You of the claim decision within 48 hours after receiving the information. If the needed information is not provided, the CHI Dental Plan Customer Service Team will notify You or Your covered Dependent of its decision within 120 hours after receiving the claim.

If Your urgent care claim is denied but You receive the care, You may appeal the denial using the normal claim procedures. If Your urgent care claim is denied and You do not receive the care, You can request an expedited appeal of Your claim denial by phone or in Writing. The CHI Dental Plan Customer Service Team will provide You any necessary information to assist You in Your appeal. The CHI Dental Plan Customer Service Team will then notify You of its decision within 72 hours of receiving Your request in Writing. However, the CHI Dental Plan Customer Service Team may notify You by phone within the time frames above and then mail You a Written notice.

Uses and Disclosure of Protected Health Information

Definitions

For purposes of this Section and Section entitled "Administrative Requirements Relating to Protected Health Information" below, the following terms shall have the meanings ascribed below:

Business Associate means any third-party, other than the Plan Sponsor or Plan Sponsor personnel, who receives, uses or discloses Protected Health Information in connection with the performance of an administrative function on behalf of This Plan or the Organized Health Care Arrangement, or in connection with the provision of legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation or financial services to or on behalf of This Plan or the Organized Health Care Arrangement, within the meaning of the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996, 21 CFR Parts 160 and 164 ("HHS Reg."), §160.103.

Covered Entity means a health Plan, health care clearinghouse, or a health care Provider who transmits Protected Health Information in electronic form.

Organized Health Care Arrangement means This Plan and each other health Plan maintained by the Plan Sponsor, including the insurers that provide benefits under any such Plan.

Permitted Disclosures means any disclosure for purpose of payment, treatment or health care operations of a Plan or its Organized Health Care Arrangement as defined in HHS Reg. §164.501.

Permitted Uses means any payment, treatment or health care operation of This Plan or its Organized Health Care Arrangement as defined in HHS Reg. §164.501.

Plan Administration Functions means administration functions performed by Plan Sponsor personnel on behalf of a Plan and excludes functions performed by the Plan Sponsor in connection with any other benefit or benefit Plan of the Plan Sponsor.

Privacy Officer means the CommonSpirit Health Privacy Officer.

Protected Health Information means information, including demographic information collected from an individual, that is created or received by a Plan and that is transmitted or maintained in any medium (including orally) that (1) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual; and (2) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. Protected Health Information shall not include information that is de-identified in accordance with HHS Reg. §164.514(a).

Summary Health Information means information that summarizes the claims history, claims expenses or types of claims experienced by an individual for whom benefits are or were provided under This Plan, provided that individual identifying information has been deleted.

Permitted Uses and Permitted Disclosures by Plan. This Plan may use Protected Health Information of an individual for any Permitted Use. This Plan may disclose Protected Health Information of an individual for any Permitted Disclosure.

Disclosure to Providers; Other Covered Entities; Organized Health Care Arrangements

This Plan may disclose Protected Health Information (1) to a health care Provider or other Covered Entity for the purpose of treatment or payment activities of such Provider or entity, or (2) to a Covered Entity if that entity has a relationship with the individual who is the subject of the disclosure and the disclosure is for the purpose of the receiving entity's health care operations (within the meaning of HHS §164.501, subsections (1) and (2) only) or for the purpose of health care fraud and abuse detection or compliance, or (3) to another Covered Entity that participates in the Organized Health Care Arrangement for health care operations activities (within the meaning of HHS §164.501) of such arrangement.

Use and Disclosure of Protected Health Information to Plan Sponsor

This Plan shall transfer Protected Health Information to the Plan Sponsor in order for the Plan Sponsor to carry out Plan Administration Functions and This Plan shall permit the Plan Sponsor to use or further disclose Protected Health Information for purposes of carrying out Plan Administration Functions, as well as for any Permitted Use, or for any use or further disclosure which is otherwise permitted or required under HIPAA and the regulations promulgated there under. This Plan will disclose Protected Health Information to the Plan Sponsor only after receiving a certification from the Plan Sponsor that the Plan Sponsor agrees:

1. Not to use or further disclose the Protected Health Information other than as permitted or required herein or as required by law;
2. To ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from This Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
3. Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit Plan of the Plan Sponsor;
4. Report to This Plan any use or disclosure of information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
5. Make available Protected Health Information in accordance with HHS Reg. §164.524;
6. Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with HHS Reg. §164.526;
7. Make available the information required to provide an accounting of disclosures in accordance with HHS Reg. §164.528;
8. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of HHS for purposes of determining compliance by the Plan with the HIPAA privacy regulations;
9. If feasible, return or destroy all Protected Health Information received from This Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made; except that if such return or destruction is not feasible, the Plan Sponsor shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
10. Ensure that only those employees of the Plan Sponsor will use or further disclose the Protected Health Information, and ensure that such use or further disclosure will be limited to the Permitted Uses, Permitted Disclosures or other uses authorized herein and by the HHS regulations.

This Plan will disclose Protected Health Information only to those employees under the control of the Plan Sponsor and who are employed as either employees in the Plan Sponsor's corporate benefits department who are responsible for Plan administration or local MBO officials who are responsible for participant advocacy/ facilitation functions in connection with This Plan. Such persons may use the Protected Health Information solely for a Permitted Use, Permitted Disclosure or for any other disclosure or use that would be permissible by This Plan under the provisions hereof and the applicable HHS Regulations.

Notwithstanding the foregoing, This Plan may disclose (1) Summary Health Information to This Plan Sponsor for purposes of obtaining premiums bids from dental Plans for providing dental insurance coverage under This Plan or modifying, amending or terminating This Plan, or (2) information on whether an individual is participating in This Plan or is enrolled or has disenrolled from a dental insurance issuer or HMO offered by This Plan without requiring the certification described in this subsection.

Disclosures to Business Associates

This Plan may disclose Protected Health Information to, and permit the use of Protected Health Information by, any Business Associate pursuant to the terms of a business associate contract or similar Written arrangement that limits the Business Associate's use or further disclosure of the Protected Health Information to a Permitted Use, Permitted Disclosure or to any other disclosure or use that would be permissible by This Plan under the provisions hereof and the applicable HHS regulations.

Disclosures to Individuals

This Plan may disclose the Protected Health Information of an individual to such individual, or to the personal representative of such individual; provided that This Plan shall comply with any reasonable Written instructions provided by the individual requesting that such information be provided to an alternative location or by an alternative means. This Plan may disclose the Protected Health Information of an individual to the individual's family member or other person involved in the individual's treatment or payment for health care; provided that, where feasible, the individual who is the subject of such disclosure has been given the opportunity to agree to such disclosure.

Disclosures Required by Law

This Plan may disclose Protected Health Information to the extent required by law, including but not limited to pursuant to: court orders and court-ordered warrants, subpoenas or summons issued by a court, grand jury or governmental or tribal inspector general or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care Providers participating in any program with respect to This Plan; statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits; and to comply with laws relating to workers' compensation or other similar programs established by law that provide benefits for work-related illness or injuries. In addition, This Plan shall disclose Protected Health Information to the Secretary of HHS for the purpose of determining This Plan's compliance with the provisions hereof and the HHS regulations.

Disclosure Permitted by Authorization

This Plan may disclose Protected Health Information pursuant to a valid authorization of an individual that meets the requirements of HHS Reg. §164.508.

Miscellaneous Uses and Disclosures

This Plan may use and/or disclose Protected Health Information as required or permitted by, and pursuant to, any other provisions of the HHS regulations.

Administrative Requirements Relating to Protected Health Information

General

This Plan Administrator shall be responsible for administering the privacy provisions of This Plan, and may delegate some or all of its responsibilities to third-parties. Notwithstanding the foregoing, the Plan Administrator shall be subject to the supervision and direction of the Privacy Officer concerning application of the HIPAA privacy rules to This Plan and This Plan's compliance therewith.

Minimum Disclosure Necessary

When requesting Protected Health Information from another Covered Entity, or when using or disclosing Protected Health Information, This Plan shall make reasonable efforts to limit such request, use or disclosure of the Protected Health Information to the minimum necessary to accomplish the intended purpose of the request, use, or disclosure; provided that this requirement shall not apply with respect to disclosures to the individual of his or her own Protected Health Information; disclosures made pursuant to an authorization under HHS Reg. §164.508; disclosures to a health care Provider for the treatment of an individual; disclosures to the Secretary of HHS; uses and disclosures as required by law or uses and disclosures required for compliance with the HHS Regulations.

Privacy Notice

This Plan shall provide to each participant a notice regarding the uses and disclosures of Protected Health Information as described herein. The notice shall be provided:

- To all individuals covered by This Plan as of April 14, 2003;
- To all new participants at the time of enrollment in This Plan; and
- To all participants within 60 days after a material revision to the notice is made.

To the extent benefits under This Plan are provided by an insurer or HMO, the insurer or HMO shall be responsible for providing the notice. At least once every three Years, This Plan (or HMO or insurer, as applicable) will notify participants then covered under This Plan of the availability of the notice and how to obtain the notice.

Restrictions

Each individual for whom This Plan receives or maintains Protected Health Information may request that This Plan restricts the uses or disclosures of the Protected Health Information; provided that This Plan shall not be obligated to agree to any requested restriction on the receipt, use or disclosure of Protected Health Information made by an individual.

Access to and Amendment of Protected Health Information

- Any individual for whom This Plan maintains Protected Health Information shall have the right to inspect or obtain a copy of such Protected Health Information upon Written notice to the contact person identified in the Privacy Notice. The Plan Administrator may charge a reasonable fee for copies of Protected Health Information.
- Any individual for whom This Plan maintains Protected Health Information shall have the right to request an amendment of such Protected Health Information upon Written notice to the contact person identified in the Privacy Notice. If This Plan approves the request, This Plan must amend the Protected Health Information, and make reasonable efforts to provide the amended information to those persons identified by the individual as having such Protected Health Information and those persons, including Business Associates, which the Plan Administrator knows have copies of such Protected Health Information and that may rely on the Protected Health Information to the detriment of the individual.

Procedures

The Plan Administrator shall adopt and maintain policies and procedures (as approved by the Privacy Officer) to comply with the requirements specified herein and as otherwise required by the HHS Regulations.

Noncompliance by Plan Sponsor Personnel

The Privacy Officer and Plan Administrator shall establish a mechanism by which the failure of Plan Sponsor personnel to comply with the restrictions described herein shall be resolved. Such mechanism shall be included as part of This Plan's policies and procedures.

Plan Information

Plan Sponsor

Catholic Health Initiatives
3900 Olympic Boulevard, Suite 300
Erlanger, KY 41018-1099

Employer Identification Number

47-0617373

Plan Administrator

Catholic Health Initiatives
3900 Olympic Boulevard, Suite 300
Erlanger, KY 41018-1099

Plan Administrator's Authority

The Plan Administrator shall control and manage the operation and administration of This Plan. The Plan Administrator shall have the exclusive right and power to interpret This Plan and to decide all matters arising under This Plan, including eligibility for benefits and the right to remedy possible ambiguities, inconsistencies, or omissions. All determinations of the Plan Administrator with respect to any matter relating to the administration of This Plan shall be conclusive and binding on all persons.

The Plan Administrator shall have the following additional powers and duties:

- To require any person to furnish such reasonable information as it may request for the proper administration of This Plan as a condition to receiving any benefits under This Plan;
- To make and enforce such rules and regulations and prescribe the use of such forms as it shall deem necessary for the efficient administration of This Plan;
- To decide on questions concerning This Plan and the eligibility of any employee to participate in This Plan, in accordance with the provisions of This Plan;
- To determine the amount of benefits which shall be payable to any person in accordance with the provisions of This Plan, and to provide a full and fair review to any Participant whose claim for benefits has been denied in whole or in part;
- To designate other persons to carry out any duty or power which would otherwise be a responsibility of the Plan Administrator under the terms of This Plan; and
- To interpret Plan terms and provisions.

Delegation by the Plan Administrator

The Plan Administrator may employ the services of such persons as it may deem necessary or desirable in connection with the administration of claims or other operations of This Plan. The Plan Administrator and any person to whom any duty or power in connection with the operation of This Plan is delegated may rely upon all tables, valuations, certificates, reports, and opinions furnished by any duly appointed actuary, accountant (including employees who are actuaries or accountants), consultant (internal medical director, ombudsman with clinical background, etc.), third party administration service provider, legal counsel, or other specialist.

Funding Arrangements

General assets

Plan Year

The twelve month period from January 1 to December 31.

Future of This Plan

Although CommonSpirit Health intends to continue This Plan indefinitely, CommonSpirit Health reserves the right to amend or end This Plan at any time for any reason. Changes may be made retroactively, if necessary, to qualify or maintain the benefits under the Internal Revenue Code. If This Plan is amended or ends, You and other Eligible Employees may not receive benefits as described in this booklet. However, You may be entitled to receive different benefits, or benefits under different conditions. In no event will You become entitled to any vested rights under This Plan.

3900 Olympic Boulevard Suite
300
Erlanger, KY 41018
www.commonspirit.org

Effective January 1, 2023