CARILION CLINIC

SUMMARY PLAN DESCRIPTION (SPD)

Dental Care Plan

Effective as of January 1, 2007

ADDITIONAL INFORMATION ABOUT YOUR PLAN

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). Your Plan Administrator has determined that this information, together with the information contained in your Evidence of Coverage booklet and benefit summaries from Delta Dental is the Summary Plan Description (SPD) required by ERISA.

DEFINITION OF AN ELIGIBLE EMPLOYEE

Employees must be working at least 48 hours per two week pay period.

YOUR BENEFITS UNDER THE PLAN

For details on your dental benefit coverage, please refer to the *Evidence of Coverage (EOC)* or booklet provided by Delta Dental of Virginia (Delta Dental) in whose plan you are enrolled.

Benefits under this plan will be paid only if the Plan Administrator decides in his/her discretion that the applicant is entitled to them.

Eligibility for a benefit or the right to a benefit under this Plan is not a contract of employment or a guarantee of employment with Carilion or other certain entities affiliated with Carilion participating under this Plan.

BENEFIT CLAIMS AND APPEALS PROCEDURE

For details on the benefit claims and appeals adjudication procedures, please refer to the *Evidence of Coverage (EOC)* or booklet provided by the carrier in whose plan you are enrolled.

Under the ERISA procedures, the plan must make a determination on initial "urgent" claims within 72 hours of receipt, claimants have 180 days to appeal denied claims, and the plan must make a determination on appeals of denied "urgent" claims within 72 hours of receipt. For non-urgent "pre-service" claims, the plan must make a determination within 15 days of receipt, claimants have 180 days to appeal denied claims, and the plan must make a determination on appeals within 30 days of receipt. For non-urgent "post-service" claims, the plan must make a determination within 30 days of receipt, claimants have 180 days to appeal denied claims, and the plan must make a determination on appeals within 60 days of receipt. Additional timeframes and details are in your *Evidence of Coverage* or the booklet provided by Delta Dental.

PREEXISTING CONDITIONS LIMITATIONS AND SPECIAL ENROLLMENT PERIODS

Federal law (The Health Insurance Portability and Accountability Act of 1996, known as "HIPAA") limits the circumstances under which a group health plan may exclude coverage for medical conditions present before an individual enrolled. HIPAA applies to all plans, insured or self-funded. (However Preexisting Condition Limitations do not apply to HMOs.) For details on the preexisting conditions, if any, which may apply to you, see the *Evidence of Coverage (EOC)* or booklet provided by the carrier or issuer in whose plan you are enrolled. The EOC or booklet will also explain the procedure for documenting that you had prior health coverage and will define "special enrollment events" and the ramifications of such events, and will define "late enrollee" and the ramifications of that status.

HIPAA

This plan will comply with applicable requirements of the Heath Insurance Portability and Accountability Act (HIPAA).

Non-Discrimination Rule

This Plan will not deny group health benefits (e. g. dental benefits) otherwise provided for treatment of the injury if the injury results from an act of domestic violence or medical condition (including both physical and mental health conditions). For example, the group health benefits will not exclude coverage for self-inflicted injuries due to a suicide attempt by a person who suffers from depression.

Privacy Practices

Participants will not be intimidated or retaliated against for exercising their privacy rights or filing a complaint with U. S. Department of Health and Human Services. Participants will not be required to waive their privacy rights as a condition of treatment, payment, and enrollment in the plan or eligibility for benefits.

BENEFITS DURING FAMILY AND MEDICAL LEAVE or PREGNANCY DISABILITY LEAVE

If you are on a leave of absence approved by your employer and your leave is protected under the federal Family and Medical Leave Act (FMLA), you may continue dental benefits during such leave of absence. Contact the Human Resources Service Center for details on eligibility for, and terms and conditions of, an approved leave of absence.

While you are on FMLA leave, Carilion will continue to pay its regular share of the health insurance premium (for individual or dependent coverage) up to a maximum of 12 weeks within a 12-month period. If FMLA leave continues longer than 12 weeks, you must elect and pay for COBRA to continue medical or dental coverage. Benefits that are not continued during FMLA leave will be reinstated, with no waiting period or preexisting condition limitation, when you return from FMLA leave.

Contact the Human Resources Service Center for additional information on the family/medical or pregnancy disability leave policy or if you want to request leave under one of these statutes. You may also have certain rights under other state family leave laws.

CONTINUING BENEFITS DURING MILITARY LEAVE

If you go on active duty in the U.S. armed forces, you will cease to be covered under the regular group health plan as of the last day of the month in which you enter active military service. However, you have the following rights to continue coverage:

1. If your military leave period is for 30 days or less, you have the right to continue dental coverage for yourself and dependents who were covered under our group dental plan for up to 30 days, at a cost of not more than the cost for a similarly situated active employee.
2. If the military leave period is for 31 days or more, you have the right to elect COBRA-like continuation coverage for yourself and your dependents who were covered under the group dental plan. [See the "COBRA - INITIAL NOTICE" section at the end of this booklet for details on your COBRA rights.]

COBRA CONTINUATION RIGHTS

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that allows plan participants to continue medical and dental coverage under specified circumstances where such group coverage would otherwise be lost. To continue coverage, you or your covered dependents must apply

for continuation coverage and pay the required premium before the deadline for payment. COBRA coverage can be extended for 18, 29, or 36 months, depending on the particular "qualifying event" that gave rise to COBRA. You will receive a COBRA - INITIAL NOTICE from our COBRA vendor once you are enrolled in the dental plan with details on your COBRA rights.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOs)

A Qualified Medical Child Support Order (QMCSO) is a state court or administrative agency order that requires an employer's medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer's plan. QMCSOs usually apply to a child who is born out of wedlock or whose parents get divorced. When the Employer, as plan sponsor, receives a QMCSO, we must promptly notify the employee and the child that the order has been received and what procedures we will use to determine if the order is "qualified." If we determine the order is qualified and the employee must provide coverage for his/her child pursuant to the QMCSO, we will deduct from the employee's paycheck the amount necessary to pay for such coverage. We will notify the affected employee once we determine whether or not the order is qualified. Participants and beneficiaries can obtain a copy of the procedures governing QMCSO determinations from the Plan Administrator without charge.

SECTION 125 PLAN

Carilion has established a "cafeteria plan" under Internal Revenue Code Section 125, which allows you to pay for Medical, Dental, and Vision coverages on a pretax basis.

If you elect to enroll in the cafeteria plan, you must sign an enrollment form agreeing to have your salary reduced by an amount equal to your share of the premiums for the coverages you elect. The employer pays your salary reduction amount toward the benefits you elect. Thus, your salary reduction amount is not included in taxable income for purposes of federal and most state and local income taxes. You also do not pay Social Security tax on this money, which means your contributions may reduce your wages reported for Social Security purposes and could ultimately reduce your Social Security benefit amount.

If you enroll in the cafeteria plan, your salary reduction election will be effective for the entire plan year. You cannot change your salary reduction election during the plan year unless you have an allowable change event, as defined in the IRS regulations. This includes events such as marriage, divorce, birth or adoption of a child, death of a spouse or child, commencement or termination of employment, change from part-time to full-time employment or vice-versa, other employment changes, or changes in cost or coverage.

Contact the Human Resources Service Center you want additional information about how the cafeteria plan works.

STATEMENT OF ERISA RIGHTS

As a participant in the plan**,** you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependent if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

If you have creditable coverage from another plan, any exclusionary periods may be reduced or eliminated for preexisting conditions under your group health. You should be provided a certificate of creditable coverage, free of charge, from your group heath plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees).

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

SUMMARY OF PLAN INFORMATION

NAME OF PLAN:	Carilion Dental Care Plan; this Plan is also referred to as the Dental Care Plan
PLAN SPONSOR and PLAN ADMINISTRATOR:	Carilion 1212 Third Street Roanoke VA 24016 (540) 983-3600 In addition to Carilion employees, certain entities affiliated with Carilion are participating employers in the Plan. When you read this SPD and the EOC, you should treat any reference to "Group" as a reference to Carilion and the participating employers, unless the specific context requires otherwise. A complete list of the employers sponsoring the Plan is available for your examination at the office of the Plan Administrator. You may obtain a copy of the complete list of the employers sponsoring the Plan upon written request to the Plan Administrator. Further, upon written request, you may receive from the Plan Administrator information as to whether a particular employer is a sponsor of the Plan and, if the employer is a Plan Sponsor, the sponsor's address and phone number.

AGENT FOR SERVICE OF LEGAL PROCESS: [include address & telephone number(s)]	Office of General Counsel Carilion Suite 720 213 South Jefferson Street Roanoke VA 24011
EMPLOYER IDENTIFICATION NUMBER:	54-1190771
PLAN NUMBER:	502
TYPE OF PLAN:	This plan is a benefit program under the Group's Dental Care Plan. The information in this summary plan description only describes the dental benefits that are provided under the Dental Care Plan.
END OF PLAN YEAR:	December 31
TYPE OF ADMINISTRATION:	The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable group plan.
HEALTH INSURANCE ISSUERS: These benefits are guaranteed under a contract and/or policy of insurance issued by the issuer. The issuers provide various administrative services including claims administration.	**Delta Dental of Virginia**
PLAN CONTRIBUTIONS:	The Employer and Employee contribute to the Plan
ELIGIBILITY FOR PLAN PARTICIPATION:	Full-time and Regular part-time employees
LOSS OF BENEFITS:	Circumstances under which you may be disqualified from the plan, ineligible for benefits, or have benefits denied, forfeited, suspended are outlined in the *Evidence of Coverage (EOC)* or benefits booklet provided by the carrier of the plan in which you are enrolled.
PROCEDURE FOR AMENDING THE PLAN:	The Employer reserves the right to discontinue or change the plan at any time, subject to any applicable legal requirements for prior notice.
CLAIMS PROCEDURE:	For details on the claims and appeals procedure, please refer to the *Evidence of Coverage (EOC)* or benefit booklet provided by the carrier in whose contract you are enrolled. You also may obtain claim forms from the Human Resources Service Center.

If your claim is denied in whole or in part, you will receive a written notice of the denial. The notice will explain the reason for the denial and the review procedures. You may request a review of the denied claim. Specify, in writing, your reasons for requesting the review of the denied claim. For additional details, including how much time you have to submit your request and where to submit your request, refer to your *Evidence of Coverage* (EOC) or booklet provided by the carrier for the coverage in which you are enrolled.