DIGNITY HEALTH
CENTRAL COAST DENTAL PLAN

January 1, 2021

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INTRODUCTION

The purpose of this document is to provide you and your covered dependents, if any, with summary information on benefits available under this Plan as well as with information on a Covered Person's rights and obligations under the DIGNITY HEALTH Welfare Benefit Plan (the "Plan"), which is commonly known as Flex*Ability*. You are a valued Employee of DIGNITY HEALTH, and your Employer is pleased to sponsor this Plan to provide benefits that can help meet your health care needs.

PLAN DESCRIPTION / NETWORK INFORMATION

Members may select any licensed Dentist to receive dental services; however, a group of local Dentists has agreed to discount the remaining balance (after deductible and insurance payment) up to 20%. Visit http://www.brmsonline.com/dignityhealth/central-coast/preferredproviderlist.pdf for a list of Preferred Dental Providers. The Plan has a Calendar Year deductible of $50 per person, with a family deductible of $150. The Plan pays a specific amount per procedure as listed in the Schedule of Plan Benefits beginning on page 3. Plan participants are required to pay the difference between the Dentist's charge and the plan payments, once the deductibles are met. There is a maximum benefit of $1,200 per participant per year. The plan will pay 100% of one (1) annual exam (up to $50) and one (1) prophylaxis (up to $75) per year.

VERIFICATION OF ELIGIBILITY

As a member covered under this Plan you will receive an identification card that you may present to providers whenever you receive services. Call the CommonSpirit Health Benefits Contact Center at 1.855.475.4747 and press option 1.

BENEFITS INFORMATION

For benefits information contact Benefit & Risk Management Services (BRMS) at 1.866.755.6974.

SUMMARY OF BENEFITS

Dignity Health Central Coast Dental	
PLAN HIGHLIGHTS	
Claims Administrator	Benefit & Risk Management Services (BRMS)
Network	Any dental provider in the United States
Calendar Year Deductible	$50 per person/$150 per family
Calendar Year Maximum Benefit	$1,200 per person
Diagnostic and Preventive Services	100% up to $50 for first dental exam per Calendar Year; 100% up to $75 for first prophylaxis per Calendar Year
Fillings, Extractions and Oral Surgery	Plan pays per a fee schedule after deductible
OTHER DENTAL SERVICES	
Crowns, Jackets and Cast Restorations	Plan pays per a fee schedule after deductible
Prosthodontic	Plan pays per a fee schedule after deductible
Orthodontics	Not covered

SCHEDULE OF PLAN BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described on page 7 of this document.

Procedure #	Procedure	Plan Payment
Exams (First exam paid at 100%, up to $50.00)		
100	Yearly Exam	$31.20
110	Initial Exam	$8.40
120	Periodic Exam	$12.00
130	Emergency Exam	$30.00
140	Limited Oral Eval Problem	$30.00
150	Comprehensive	$31.20
180	Comprehensive perio evaluation	$31.20
Prophylaxis (First prophylaxis paid at 100%, up to $75)		
1110	Prophylaxis 14 years old and older	$28.80
1120	Prophylaxis Child	$21.60
1201	Top App Fluoride/prophylaxis	$24.00
1203	Topical Fluoride 14 years old and older	$18.00
1204	Topical Fluoride Child	$18.00
1205	Topical Fluoride/Prophylaxis	$30.00
1206	Top Fluoride Varnish	$18.00
4910	Periodontal Maintenance	$36.00
Diagnostics X-Rays		
210	Full Mouth X-Rays	$54.00
220	Single Film	$18.00
230	Additional Films – up to 12	$7.20
240	Intraoral Occlusal View	$18.00
250	Lateral Jaw – One Film	$19.20
260	Lateral Jaw – wo Films	$28.80
270	Bitewing X-ray	$10.80
272	Bitewing – 2 Films	$21.60
274	Bitewing – 4 Films	$30.00
330	Panographic Films	$45.60
340	Cephalometric Film	$24.00
470	Diagnostics Study Model Only	$48.00
Sealants		
1351	Sealant – Per Tooth	$9.60

SCHEDULE OF PLAN BENEFITS (Continued)

Procedure #	Procedure	Plan Payment
Space Maintainers		
1510	Space Maintainer/Fixed	$120.00
1515	Fixed Lingual/Palatal	$96.00
Restorative		
2110	Amalgam 1 Primary Surface	$36.00
2120	Amalgam 2 Primary Surface	$42.00
2130	Amalgam 3+ Primary Surface	$48.00
2140	Amalgam 1 Surface Permanent	$42.00
2150	Amalgam 2 Surface Permanent	$60.00
2160	Amalgam 3+ Surface Permanent	$72.00
2161	Amalgam Restoration	$40.00
2330	ResBased Comp 1 Surface Anter	$54.00
2331	Res Based Comp 2 Surface Anter	$60.00
2332	Res Based Comp 3 Surface Anter	$66.00
2335	Res Based Comp 4 Surface Anter	$78.00
2337	Res Based Comp Crown Anter Per	$78.00
2380	Res Based Comp 1 Surface Post Primary	$36.00
2381	Res Based Comp 2 Surface Post Primary	$72.00
2382	Res Based Comp 3+ Surface Post Primary	$108.00
2385	Res Based Comp 1 Surface Post Permanent	$48.00
2386	Res Based Comp 2 Surface Post Permanent	$96.00
2387	Res Based Comp 3+ Surface Post Permanent	$144.00
2391	Res Based Comp 1 Surface Post	$48.00
2392	Res Based Comp 2 Surface Post Permanent	$96.00
2393	Res Based Comp 3+ Surface Post Permanent	$144.00
2510	Inlay-Metallic 1 Surface	$114.00
2520	Inlay-Metallic 2 Surface	$222.00
2530	Inlay-Metallic 3+ Surface	$240.00
2644	Porcelain onlay/inlay-4 surface	$240.00
Crowns		
2710	Crown Resin (laboratory)	$210.00
2720	Crown Resin High Noble Metal	$300.00
2721	Crown Resin Pred Base Metal	$300.00
2722	Crown Resin with Noble Metal	$300.00
2740	Crown Porcelain	$300.00
2750	Crown Porcelain – High Nobel Metal	$300.00
2751	Crown Porcelain Predom base metal	$300.00
2752	Crown Fused to Noble Metal	$300.00
2780	Crown ¾ Cast	$300.00
2790	Crown Cast High Noble	$300.00

SCHEDULE OF PLAN BENEFITS (Continued)

Procedure #	Procedure	Plan Payment
Crowns (continued)		
2791	Crown Cast Pred Base Metal	$300.00
2792	Crown Cast Noble Metal	$300.00
2910	Recement Inlay	$36.00
2930	Stainless Steel Crown Prim	$54.00
2931	Stainless Steel Crown Perm	$54.00
2940	Dental sedative filling	$35.00
2950	Core Build Up, Including any Pins	$72.00
2951	Pin Retention	$20.00
2952	Cast Post and Core	$120.00
2954	Prefab Post and Core	$100.00
2970	Temporary Tooth	$24.00
Endodontics		
3110	Direct Pulp Capping	$30.00
3120	Indirect Pulp Capping	$37.20
3220	Therapeutic Pulpotomy	$30.00
3310	Root Canal –Anterior	$216.00
3320	Root Canal – Bicuspid	$300.00
3330	Root Canal – Molar	$300.00
3410	Apicoetomy surgery Anterior	$252.00
3420	Apicoetomy Molar/Bicuspid surgery	$300.00
Periodontics		
4210	Gingiverctomy Per Quad	$180.00
4211	Gingiverctomy Per Tooth	$30.00
4220	Gingival Curettage Surgery	$72.00
4260	Osseous Surgery per Quadrant	$48.00
4341	Periodontal Scaling	$72.00
4342	Periodontal Scaling	$72.00
4355	Full Mouth Deridement	$72.00
4910	Perio Maint Procedure	$36.00
Dentures		
5110	Complete Denture Maxillary	$480.00
5120	Complete Denture Mandibular	$480.00
5211	Partial Denture – Maxi Res	$480.00
5212	Partial Denture – Mand Based	$300.00
5213	Partial Denture – Metal Maxillary	$480.00
5214	Partial Denture – Metal Mand	$480.00
5510	Denture Repair Broken Comp	$60.00
5610	Repair Broken Denture	$60.00
5620	Repair Cast Framework	$42.00
5640	Replace Broken Tooth Each	$36.00
5650	Add Tooth Partial Denture	$84.00

SCHEDULE OF PLAN BENEFITS (Continued)

Procedure #	Procedure	Plan Payment
Dentures (continued)		
5660	Add Clasp Existing Denture	$88.80
5730	Reline Maxillary Denture	$60.00
5750	Reline Maxillary Denture (lab)	$120.00
5761	Reline Mandibular Denture	$120.00
5820	Temporization	$120.00
Oral and Maxillofacial Surgery		
7110	Extractions Uncomplicated	$50.40
7120	Extractions Each Additional Tooth	$42.00
7210	Extractions Removal Erupt Tooth	$74.40
7220	Remove Impact Tooth Soft	$112.80
7230	Remove Impact Tooth Part Bony	$148.80
7240	Remove Impact Tooth Comp Bony	$184.80
7270	Tooth Reimplantation	$60.00
7310	Alveoloplasty Per Quadrant	$60.00
7320	Alveoloplasty No Ext Per Quadrant	$98.40
7450	Excise Lesion up to 1.25 cm	$144.00
7451	Excise Lesion > 1.25 cm	$276.00
7510	I & D Abscess Intraoral	$60.00
7520	I & D Abscess Extra oral	$60.00
7530	Removal of Foreign Body	$48.00
7960	Frenectomy	$108.00
Other Services		
9110	Emergency Treatment	$30.00
9220	Anesthesia (1/2) Hour	$74.40
9221	General Anesthesia (15 min)	$24.00
9230	Nitrous Oxide	$30.00
9241	IV Sedation	$75.00
9242	IV Sedation Each Additional 30 Minutes	$40.00
9310	Professional Consultation	$36.00
9430	Office visit Regular Hours	$24.00
9440	Office Visit After Hours	$30.00
999	OSHA	$10.80

LIMITATIONS AND EXCLUSIONS

LIMITATIONS

1. Prophylaxis – 2 per Calendar Year (see schedule of payments).
2. Full mouth X-rays – 1 set per 12 month period.
3. Gold restorations are covered only if tooth cannot be restored with a lesser material.
4. Porcelain backed to gold crowns or facings are not eligible if placed on teeth posterior to second bicuspid.
5. Placement of initial prosthetics only for teeth which are extracted while covered under this Plan.
6. Replacement of any prosthetics is not covered until 4 years of continuous dental coverage under this Plan and after each subsequent 4 year period.

EXCLUSIONS

For benefits shown in the Schedule of Benefits beginning on Page 3, a charge for the following is not covered:

1. Orthodontics of malocclusion – including congenital malocclusion.
2. Disease covered by Worker's Compensation or injuries arising out of any employment for wage or profit.
3. Services supplied by a governmental agency.
4. Loss or theft of dentures or bridgework.
5. Services rendered by a member of your immediate family.
6. Any procedure which is not listed in the Schedule of Plan Benefits.
7. Any procedure which was started prior to the effective date of the individual's coverage (e.g., impressions, preparation of tooth for crown, root canal therapy if pulp chamber open).
8. For which payment is made under the terms of this Plan other than this dental expense benefit.
9. Cosmetic dentistry unless as a result of an accidental injury to natural teeth occurring while covered and restorations must be accomplished within 180 days.

Dental expenses are subject to coordination of benefits.

Dental benefits terminate for the covered individual and his/her Dependents on the last day of the month in which the individual terminates employment.

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

You are responsible for enrolling in the manner and form prescribed by your Employer. Specific information, shown below, can be found on MyBenefits at home.commonspirit.org/employeecentral/mybenefits.

- Who is eligible for the plans?
- Who are your eligible Dependents?
- Selecting your family coverage categories.
- Enrolling in *FlexAbility*.
- Qualified life events affecting your coverage.
- If You do not enroll, and
- Special enrollment rules.

If you have questions about your Dignity Health benefits, call the CommonSpirit Health Benefits Contact Center at 1.855.475.4747 and press option 1.

HOW TO FILE A CLAIM

SUBMITTING CLAIMS

The Dignity Health Central Coast Dental Plan requires all Dentists to be licensed practitioners in the United States except for emergency procedures. Members may select any licensed Dentist, however a group of local Dentists have agreed to be preferred providers.

Employees selecting a Preferred Dental Provider will receive a 20% discount on the unpaid balance after the Dignity Health Central Coast Dental Plan has paid all benefits due and the deductible has been satisfied. Most Dentists will submit the claims for payment. Be certain to present your ID card at the time of service. If your Dentist will not submit a bill on your behalf, you may submit your claim directly to Benefits & Risk Management Services (BRMS) by using the bill received from your Dentist indicating payment made and procedures performed. Claim forms are available at www.brmsonline.com/dignityhealth/centralcoast.

Your claim may be submitted to the following address:

Benefits & Risk Management Services (BRMS)
P.O. Box 2140
Folsom, CA 95673

CLAIMS PROCEDURE

BRMS, the Claims Administrator shall, within ninety (90) days after receipt of a claim, either allow or deny the claim in writing. A denial of a claim shall include:

1. The specific reason or reasons for the denial;

2. Specific reference to pertinent Plan provisions on which the denial is based;

3. A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary; and

4. An explanation of the Plan's claim review procedure.

If within ninety (90) days of filing a claim the Claimant does not receive either a notice of denial or a notice explaining why additional time is required to process the claim, the claim is deemed denied and the Claimant may initiate the review procedure described on page 10.

HOW TO APPEAL A CLAIM

If your claim for dental benefits is wholly or partially denied, you, or someone on your behalf, are entitled to file a request for review with the Claims Administrator for your benefit plan. The steps in the review process are outlined below:

First Appeal. Within 180 days after receiving a notice that your claim has been denied (or within 180 days of the date you were entitled to consider your request denied, if you do not receive a denial notice), you or your authorized representative may submit a written request for review of the denial to:

Benefits & Risk Management Services (BRMS)
P.O. Box 2140
Folsom, CA 95673
1.866.755.6974

You must submit all of the issues, comments, additional information, and relevant documents that you want considered with your request for review.

The Claims Administrator will make a full and fair review of your request and may ask for additional information. Your request for review of the denial will be conducted by an appropriate named fiduciary of the Plan, who is neither the individual who made the initial benefit determination nor a subordinate of such individual. The review of the denied claim will not afford that denial any deference.

You will receive written notification of the decision on your appeal within:

- 72 hours, for urgent health care claims
- 30 days for all other claims (those that are not urgent or do not require prior approval)

If your appeal is denied, the notice will explain:

- The reason(s) for the denial;
- The Plan provisions on which it is based;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim; and
- A statement that "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Second Appeal. Within 180 days of receiving a notice from the Claims Administrator (or within 180 days of the date you were entitled to consider your request denied, if you do not receive a denial notice from the Claims Administrator) that your claim has been denied, you or your authorized representative may submit a written request for review of the denial to the CommonSpirit Health Benefits Contact Center, 3033 N. 3rd Avenue, Phoenix, AZ 85013.

The CommonSpirit Health Benefits Center will perform a second full and fair review of your request and may ask for additional information. You will receive written notification of the decision on your appeal, within:

- 72 hours, for urgent health care claims
- 30 days for all other claims (those that are not urgent or do not require prior approval)

If your appeal is denied, the notice will explain:

- The reason(s) for the denial;
- The Plan provisions on which it is based;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim;
- A statement that "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency"; and
- A statement of your right to bring a civil action following a claim denial on review.

PAYMENT OF BENEFITS

Benefits are payable to the Covered Person whose Illness or Injury is the basis of her claim under this Plan, except when an application for benefits does not include satisfactory proof that charges made by providers of health care services for which this Plan's benefits are payable have been paid by or on behalf of the Covered Person, all or a portion of any benefits provided by the Plan may, at Dignity Health's option, be paid directly to the provider of health services.

RIGHT OF RECOVERY

Where benefit payments have been made by the Plan for expenses in an amount in excess of the amount of payment necessary at that time to satisfy the intent of the Plan's provision, Dignity Health or its designated agent shall have the right to recover these payments, to the extent of the excess, from the individual to whom, or for whom, or with respect to whom these payments have been made or from any other person who is legally or equitably accountable to Dignity Health with respect to the excess.

ASSIGNMENT

No benefit payable under the Plan shall be subject in any way to alienation, sale, transfer, assignment, pledge, attachment, garnishment, execution, or encumbrance of any kind and any attempt to accomplish the same shall be void.

No Covered Person entitled to benefits under the Plan shall have power to transfer, assign, mortgage or otherwise encumber any interest he may have herein, or to anticipate in any manner by assignment, agreement (including, but not limited to, any agreement to pay alimony, separate maintenance or child support, whether or not said agreement is pursuant to, or embodied in, a court order), or otherwise, the payment of any benefit or any other sum herein provided for him to be made; nor shall the interest of any Covered Person under this Plan or in any benefit provided hereunder be subject to attachment, garnishment, seizure or sequestration for the payment of any debits, judgments, decrees or obligations of any kind owed by such person (including, but not

limited to, any obligation to pay alimony, separate maintenance or child support for which said person shall be obligated by virtue of a court order or decree of any court of any jurisdiction or by virtue of any agreement whether or not embodied in such a court order or decree), or by transferable by operation of law in event of bankruptcy, insolvency or otherwise.

Notwithstanding any provision of the Assignment Section and subject to any written direction of the Covered Person, all or a portion of any benefits provided by the Plan on account of any medical services may, at the Plan's option, be paid directly to the provider of such services.

FACILITY OF PAYMENT

Whenever and as often as any person entitled to payments shall be determined to be a minor or under other legal disability or otherwise incapacitated in any way so as to be unable to manage his financial affairs, Dignity Health in its discretion, may direct that all or any portion of the benefit payments be made: (a) to such person; (b) to such person's legal guardian or conservator; or (c) to such person's spouse or to any other person. The decision of Dignity Health shall, in each case, be final and binding upon all persons. Any payment made pursuant to the authority herein conferred shall operate as a complete discharge of the obligations of Dignity Health under the Plan in respect hereof.

DEFINITIONS

The following terms have special meanings and when used in this Plan will be capitalized.

Calendar Year – The period of time commencing at 12:01 A.M. on January 1 of each year and ending at 12:01 A.M. on the next succeeding January 1.

Claimant – Any Covered Person for whom a claim is submitted for benefits under the Plan;

Claims Administrator is Benefit & Risk Management Services (BRMS).

Contract Administrator – A company which performs all functions reasonably related to the general management, supervision and administration of the Plan in accordance with the terms and conditions of an administration agreement between the Contract Administrator and the Plan Sponsor.

Covered Person – A covered Employee, a covered Dependent, and a Qualified Beneficiary (COBRA). See Extended Coverage Provisions Section for further information.

Dentist – An individual who is duly licensed to practice dentistry or perform oral surgery on the state where the dental service is performed and who is operating within the scope of his license. A physician (M.D.) will be considered to be a Dentist when he performs any dental services within the scope of his license.

Dependent means an eligible Dependent from one of the following categories:

(1) One adult from the following categories:

- Spouse – legally married spouse, as defined by the law of the jurisdiction where the marriage was performed.
- Registered domestic partner – (California Only) – an individual who is a same-sex or opposite sex partner with whom you have registered with any state or local government domestic partner registry.

(2) Dependent Child:

- An eligible Employee's biological Children, step Children, legally adopted Children who are under age 26, Under age 26 Children under the Employee's legal guardianship and/or Children of Registered Domestic Partners (if coverage for Legally Domiciled Adults and Adult Tax Dependents is offered then their Children who are under age 26 are also Eligible Dependents for medical, dental and vision). A Child becomes a legally adopted Child as soon as he or she is placed for adoption. Being placed for adoption means the earlier of either the assumption and retention of the legal obligation to support the Child in anticipation of adoption, or the actual date of adoption. The Child's placement for adoption status terminates upon the termination of this legal obligation.
- Disabled Child Age 26 and Older - Employee's unmarried biological, adopted, step, legal guardianship Child(ren) and/or Child(ren) of a Registered Domestic Partner who became mentally or physically disabled prior to age 26, who are incapable of self-sustaining employment and chiefly dependent upon the Employee for support (Social Security disability determination or physician documented incapability of self-support).

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is Dignity Health.

Plan means the Dignity Health Central Coast Dental, which is a benefits plan for certain active Employees of Dignity Health and is described in this booklet.

EXTENDED COVERAGE PROVISIONS

In accordance with the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), your Employer, as sponsor of the Plan is required to comply with the health care continuation coverage rues of ERISA and the Internal Revenue Code. Please refer to the Dignity Health *FlexAbility* Summary Plan Description (SPD) located on MyBenefits on EmployeeCentral or log on to home.commonspirit.org/employeecentral/mybenefits for detailed information on all aspects related to continuation coverage.

Information regarding the following topics is also covered under the Continuation Coverage section in the Dignity Health *FlexAbility* Summary Plan Description (SPD).

- Continuation of coverage.
- Your right to covert coverage.
- Family and Medical Leave Act (FMLA) coverage.
- USERRA.

For questions about Continuation Coverage, call the CommonSpirit Health Benefits Contact Center at 1.855.475.4747 and press option 1.

PLAN ADMINISTRATION INFORMATION

DIGNITY HEALTH is named the Plan Administrator for this Plan. The Plan Administrator has retained the services of Benefit & Risk Management Services (BRMS), an independent Third Party Administrator to process claims and handle other duties for this self-funded Plan. The Third Party Administrator does not assume liability for benefits payable under this Plan, since they are solely claims-paying agents for the Plan Administrator.

The Employer assumes the sole responsibility for funding the Plan benefits out of general assets; however, Employees help cover some of the costs of covered benefits through contributions, Deductibles, out-of-pocket amounts, and Plan Participation amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the Employer and there is no separate fund that is used to pay promised benefits. As a self-insured welfare plan and one that is covered by the Employee Retirement Income Security Act of 1974 ("ERISA"), the Plan constitutes an "employee welfare benefit plan" within the meaning of Section 3(1) of ERISA.

NAME OF PLAN

Dignity Health Central Coast Dental Plan

EMPLOYER

Dignity Health
185 Berry Street, Suite 300
San Francisco, CA 94107

PLAN SPONSOR/ PLAN ADMINISTRATOR

Dignity Health
185 Berry Street, Suite 300
San Francisco, CA 94107

CLAIMS ADMINISTRATOR

Benefits & Risk Management Services (BRMS)
P.O. Box 2140
Folsom, CA 95673

PLAN RECORDS

The records of the Plan are kept on a plan year basis commencing on each January 1st, and ending as of the following December 31st.

TYPE OF PLAN

The Plan is a self-funded group dental Plan and the administration is provided through a Third Party Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN BENEFITS

To receive benefits under this Plan:

1. You must be covered under the Plan,
2. You must incur an expense for which a benefit is payable,
3. The expense must be incurred during the period of time and under the conditions specified by the Plan, and
4. A claim must be filed for any benefit payable.