Summary Plan Document
Scripps Coastal Medical Group Dental Plan

Restated January 1, 2021

Introduction

This booklet is the Plan Document and Summary Plan Description of the Scripps Coastal Medical Group Dental Plan. Please review this summary booklet thoroughly. It is important that you understand your Plan and the services it will and will not cover.

This Plan Document and Summary Plan Description sets forth the Plan's services and procedures. The information in this booklet is effective January 1, 2021. From time to time, it may be necessary to amend portions of this booklet. Amendments are formal changes to the Plan and must be taken into consideration when the time comes to use your benefits. If an amendment to the Plan is made, you will be notified in writing.

This Plan Document and Summary Plan Description is available on MyScrippsHR.org, Scripps.org/HRBenefits and at www.MyScrippsHealthPlan.com.

Sincerely,

Scripps Coastal Medical Group

Contents

General Information

Who is eligible?

Employees

As a Scripps Coastal Medical Group employee, you are eligible to participate in the Plan if you meet one of the following conditions:

- You are a regular (non-temporary) full-time employee classified as .75 FTE and above; or
- You are a regular (non-temporary) part-time employee classified as .5 to .74 FTE.
- Per Affordable Care Act (ACA) regulations, any Scripps Coastal Medical Group employee that worked an average of 30 hours per week between the period ending with the last pay period in October of the preceding calendar year and beginning with the first pay period in November of the calendar year preceding that, will qualify for full time dental insurance in the next calendar year. Employees hired after November 1st of the preceding calendar year will be assessed based upon hire date.

Part-time non-benefit eligible, casual, temporary/limited tenure, or registry employees are not eligible for coverage under the Plan, except as may be required for Scripps Coastal Medical Group to be in compliance with the provisions of the Affordable Care Act (ACA).

Eligible Dependents

If you are eligible for coverage as an employee, you may also elect coverage for eligible dependents. ***Verification of dependent eligibility is required upon enrollment.***

Eligible dependents include your:

- Spouse:
  - Husband or wife as defined by applicable law.
- Children:
  - A child under age 26, or
  - Disabled, dependent child incapable of self-support due to mental or physical disability, if the child becomes disabled prior to reaching age 26. Social Security documentation is required.
- Registered Domestic Partner:

- A same sex partner or opposite sex partner, as declared on a Declaration of Domestic Partnership filed with the California Secretary of State.

Your eligible children include:

1. Natural born child
2. Stepchild, legally adopted (or placed for adoption) child who has not attained the age of 18 or a child for whom you have been appointed legal guardianship by a court of law
3. Child for whom the Plan has received a Qualified Medical Child Support Order
4. Child of a covered spouse or covered registered domestic partner (as defined above)

Only you, your dependent children, and one other adult dependent (either your spouse or a registered domestic partner) can be covered under the Plan.

If any one of the individuals you cover is not your legal spouse or child, the cost per pay period for *all* dependents is taxable (or post-tax), in accordance with applicable law. For example, if you cover a registered domestic partner and your legal children, the portion of the premium attributable to the adult *and* the children will be taxable. In this example, the portion related to your coverage will be deducted before taxes are calculated (or "pre-tax"). Your paycheck stub will show two deductions—a pre-tax deduction for your coverage and a post-tax deduction for your dependent coverage.

If You and an Eligible Dependent Both Work for Scripps

If both you and your spouse, registered domestic partner or child are employees of any Scripps business unit, you may not be covered as both a dependent and an employee under the Scripps Dental Plans. Employees may cover one qualifying adult and dependent children, but no dependent(s) may be covered by more than one employee under the Plan.

When does coverage begin?

Coverage begins on January 1st if you are adding coverage or adding a new Dependent during the annual open enrollment. For new hires (except for those hired at the level of a Department Director or above, Fellow or Resident), coverage begins on the first of the month following or coinciding with 60 days of employment with Scripps. If you are at the level of a Department Director and above, Fellow or Resident, coverage begins on your first date of assignment, provided you enroll within 31 days of your date of hire.

Status change employees are eligible for benefits the 1st day of the month following the status change, provided they have met the 60 days of employment requirement (including time in the non-benefit eligible position).

For special enrollment events, coverage begins on the first of the month following the date of the qualifying event. A special enrollment due to birth, adoption, or placement for adoption is retroactive to the date of birth, adoption, or placement for adoption.

If you have a qualified status change (as described on page 3), you have 31 days from the date of the event to make changes to your benefit election. Your benefit changes will take effect retroactively and will date back to the change in status if due to birth, adoption, or placement for adoption. Otherwise, the change is effective on the first of the month following the election change.

Changing Your Elections Due to a Qualified Status Change

Your benefit elections remain in effect until the next Plan year begins. The IRS allows you to change your benefit elections during the Plan year *only* if you have a qualified status change (a "qualifying change") as defined by law. If you satisfy the requirements for a status change, you must contact your Scripps HR Service Center *within 31 days* of the date you experience an event that allows you to make an election change. This time frame is extended to 60 days in some circumstances, as noted below.

Qualified status changes, with respect to coverage changes under the Plan, include:

- ***Marital status****:* Your legal marital status changes because of marriage, divorce, legal separation, annulment or death of a spouse.
- ***Dependents****:* Your number of dependents changes for reasons such as birth, adoption (or placement for adoption), or death.
- ***Employment status****:* You, your spouse or your dependent child experiences a change in employment (or employment status) including:
  - Termination or commencement of employment
  - Strike or lockout
  - Commencement or return from an unpaid leave
  - A change from part-time benefit eligible to full-time benefit eligible, or full-time benefit eligible to part-time benefit eligible, or
  - Any other change in employment status that affects benefits eligibility
- ***Change in coverage of spouse or dependent****:* Your spouse or dependent child makes a change to coverage under his or her employer's plan due to a permitted election change or during his or her plan's annual enrollment period (if different from your annual open enrollment period). You may make a permitted election change that is due to, and corresponds with, the change made by your spouse or dependent.
- ***Overall reduction in benefits****:* You experience a significant overall reduction or termination of benefits provided under the Company's health care Plan, as determined by the Plan Administrator. In general, a significant overall reduction

includes a significant increase in the **deductible** or **copay**, but does not include your provider ceasing to be a **network provider**.

- ***Addition of benefit options****:* The Company adds a benefit package option or coverage option under its benefit Plan that affects you.
- ***Medicare or Medicaid eligibility****:* You, your spouse, or your child gain or lose eligibility for Medicare or Medicaid.
- ***Loss of Medicare or Medicaid coverage****:* You, your spouse, or your child loses Medicaid or CHIP coverage as a result of loss of eligibility. You must request coverage under the Plan within 60 days after the termination.
- ***Eligibility for premium assistance subsidy under Medicaid or CHIP***: You, your spouse, or your child becomes eligible for a premium assistance subsidy under Medicaid or CHIP. You must request coverage under the Plan within 60 days after eligibility is determined.

Consistency Rule

You can only change your benefits election if the requested change is due to, and corresponds with, the permitted election change event you experience. Generally, the event has to affect your eligibility or your family member's eligibility for coverage for that benefit. Please contact the Scripps HR Service Center at 1-858-678-MyHR (6947) if you have questions about a specific change in status.

When does coverage end?

Your coverage ends on the earliest of the following dates:

- The last day of the month in which you leave the Company or change your employment status to an ineligible class
- The date the Plan is terminated
- The last day of the month in which you last paid required contributions
- The date coverage ends for any employee class or group to which you belong
- The date you waive coverage
- The last day of the month in which you retire, or
- The date you die. Coverage for your eligible dependents will terminate at the end of the month in which your death occurs

Coverage for your dependents, if applicable, ends on the earliest of the following dates:

- On the date your coverage ends
- The last day of the month in which they are 25

- The last day of the month in which you do not make the required contributions for dependent coverage, or

- The date in which a dependent is covered by the Plan as an employee

Coverage for your dependents, if applicable, ends on the date that the Plan no longer covers dependents.

Coverage for a registered domestic partner ends the last day of the month in which the domestic partnership ends

Reinstatement

If your coverage ends due to termination of employment, it will be reinstated on the first of the month following the date you return to work with Scripps if you return to work with Scripps within one year of your termination date. Reinstatement terms and conditions are defined by Human Resources policy. On the first of the month following the date you return to work, coverage for you and your eligible dependents will be on the same basis as provided for any other active employee and his or her dependents on that date. Any restrictions on your coverage that were in effect before your reinstatement will apply.

Coverage for a Military Reservist who returns from active duty will be reinstated as required under the Uniformed Services Employment and Reemployment Rights Act.

Leaves of Absence

Family and Medical Leave Act (FMLA)

If you cease active employment due to an employer-approved leave of absence that qualifies as a family or medical leave under the Family Medical Leave Act of 1993 (an “FMLA leave”) (or in accordance with any state or local law which provides a more generous medical or family leave and requires continuation of coverage during the leave), to the extent required by law, coverage will be continued under the same terms and conditions which would have applied had you continued in active employment, provided you continue to pay your contribution share toward the cost of coverage, if any contribution is required. Contributions will remain at the same employer/employee levels as were in effect on the date immediately prior to the leave of absence (unless contribution levels change for other employees in the same classification). Please contact your Site Human Resources office for more information and refer to the Scripps Leave of Absence policies, as modified by Scripps from time to time, for terms and conditions.

Uniformed Services Employment and Reemployment Rights Act of 1994

If you take a leave of absence that qualifies as a leave under the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”), also referred to as a “military leave,” you are entitled to continue coverage for up to 24 months, as long as you give Scripps advance notice (with certain exceptions) of the leave, in accordance with applicable law. If the entire length of the leave is 30 days or less, you will not be required to pay any more than the portion you paid before the leave. If the entire length

of the leave is 31 days or longer, you may be required to pay up to 102% of the entire amount necessary to cover an employee who does not go on military leave. If you take military leave and your coverage under the Plan is terminated – for instance, because you do not elect the extended coverage – you will be treated as if you had not taken a military leave upon reemployment when determining whether an exclusion or waiting period applies upon your reinstatement into the Plan.

Under circumstances in which COBRA continuation coverage rights also apply (see the section entitled *COBRA Continuation Coverage*), an election to continue coverage during a military leave will be an election to take COBRA, and the two will run concurrently.

Please contact your Scripps HR Service Center office for more information and refer to the Scripps Coastal Medical Group Leave of Absence policies for terms and conditions.

All Other Leaves

Certain situations may qualify you for an approved Leave of Absence. Please refer to Scripps policies S-FW-HR-0700, 0701, 0702, 0703 and 0704. Scripps Coastal Medical Group, in its discretion, will continue to provide the employer's contribution for benefits coverage for employees on an approved leave of absence in accordance with HR policy and applicable federal and state laws. Please contact your Site Human Resources office for more information and refer to the Scripps Leave of Absence policies for terms and conditions.

Disclosure of Protected Health Information (PHI) Compliance with HIPAA

This section contains information on the use of certain health information, known as "protected health information" (PHI), for administration of the Plan, as well as the rights you are entitled to as a member.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) places restrictions on when an employer may have access to such health information. Scripps Coastal Medical Group (the "Employer") may use or disclose such health information for "Plan administration" functions—those activities the Employer performs to assist in administering The Scripps Dental Plan.

These activities include the following:

- Scripps Coastal Medical Group, such as the Plan Administrator or another person in the employee Benefits Office or Human Resources Department, might assist with enrollment and general questions about benefits.
- Scripps Coastal Medical Group might review an appeal of a claims denial under the voluntary Committee Review process.

Scripps Coastal Medical Group agrees not to use or disclose such health information for purposes other than Plan administration functions, as required or permitted by law, or as authorized by you, where such authorization is legally required. Scripps Coastal Medical Group will not use or disclose such health information for employment-related actions and decisions, or in connection with any other benefit or Employee benefit Plan. Scripps Coastal Medical Group will report to the Plan's HIPAA Privacy Officer if it makes any use or disclosure that is inconsistent with these restrictions. If Scripps Coastal Medical Group gives such health information to any agents or subcontractors that support or provide Plan administrative functions, those agents or subcontractors also will agree to these same restrictions. For example, such health information may be disclosed to facilitate the processing of claims for benefits as described in Section Two.

To ensure that Scripps Coastal Medical Group is using and disclosing such health information only for Plan administration functions, Scripps Coastal Medical Group has established separation between those Employees that perform Plan administration functions and other functions at Scripps Coastal Medical Group. Only designated Employees in the Benefits Office, the Human Resources Department, Scripps Coastal Medical Group Plan Services, Scripps Coastal Medical Group Legal Department or their supervisors and managers may access such health information to perform Plan administration functions. These Employees will use that information only for Plan administration functions. Scripps Coastal Medical Group has in place internal disciplinary mechanisms for resolving any noncompliance.

Scripps Coastal Medical Group also agrees to return or destroy all of such health information when it no longer needs such information to perform Plan administration functions. If this return or destruction is not feasible (such as where the employer is required to retain such health information for its legal obligations), the Scripps Coastal Medical Group will limit further uses or disclosures of such health information to those purposes that make the return or destruction infeasible.

You also have certain rights with regard to such health information about you held by Scripps Coastal Medical Group to perform Plan administration functions.

First, Scripps Coastal Medical Group will make such health information it holds about you available to you for inspection and copying.

Second, if you believe that such health information held by Scripps Coastal Medical Group is erroneous or incomplete, you have the right to request Scripps Coastal Medical Group to amend that information.

Third, if Scripps Coastal Medical Group makes certain disclosures of such health information for purposes other than Plan administration, Scripps Coastal Medical Group will give you a list of those disclosures.

Finally, Scripps Coastal Medical Group will open its internal practices, books and records relating to the use and disclosure of such health information available to the Secretary of the Department of Health and Human Services to determine Scripps Coastal Medical Group's compliance with HIPAA.

Electronic Protected Health Information

If the Plan Administrator handles electronic protected health information, the Plan Administrator also agrees to:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protects the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the plan;
- Ensure that the separation between those employees that perform plan administration functions and other functions is supported by reasonable and appropriate security measures;
- Ensure that any agent or subcontractor to whom it provides electronic protected health information agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the plan any security incident (as defined by HIPAA) of which it becomes aware.

The Preferred Provider (PPO) Dental Plans

Pre-Authorization

If you are planning extensive dental work (in excess of $300), the Plan recommends that a pre-authorization be obtained prior to the work being performed. A pre-authorization is obtained by having your dentist complete a statement (including procedures, services and supplies), outlining the proposed dental work and related charges.

This serves two purposes, as follows:

- First, it gives both you and your dentist a good idea of the benefit levels and Plan maximums that will apply to the proposed treatment; and

- Secondly, it provides you with an opportunity to consider other methods of restorative care, which may be equally effective and less costly.

Deductibles

The deductible is the amount which must be incurred by you before dental benefits become payable. The deductible is waived for Preventive and Diagnostic services.

The individual deductible is $50 per person, per calendar year, for services by Network Providers and $100 per person, per calendar year, for services by all other Providers. Any covered benefits used to meet the deductible during the last three (3) months of the calendar year, will be applied toward the deductible for the following year.

Coinsurance

Coinsurance is the percentage of eligible dental expenses which the Plan will pay, once your deductible requirements have been satisfied.

Schedule of Benefits – PPO Dental

If you use an Anthem Blue Cross Dental Complete Network provider, your benefits will be based on the **negotiated fee** structure in effect at the time services are rendered. If you use Non-Network providers, your benefits will be based on the **recognized charge**. All benefits are subject to dental review.

DEDUCTIBLE (CALENDAR YEAR) Network and All Other Providers deductibles are separate.	**Network Providers**	**All Other Providers**
Individual (Waived for Preventive and Diagnostic Services)	$50	$100
COINSURANCE		
Preventive Care/Diagnostic Services ▪ periodic oral exams ▪ cleaning ▪ bite-wing and full-mouth x-rays ▪ fluoride treatment (children < age 16) ▪ sealants (children age 6-14) ▪ space maintainers (children < age 16) ▪ periapical x-rays ▪ palliative care	100%	90%
Basic Care ▪ anesthesia ▪ fillings (other than gold) ▪ injections ▪ simple extractions ▪ basic periodontics (including scaling) ▪ oral surgery ▪ endodontics ▪ periodontics ▪ recementing of inlays, onlays and crowns ▪ pathology ▪ consultation ▪ occlusal guards	80%	70%
Major Care ▪ bridges & dentures ▪ crowns and gold restorations ▪ gold post and core ▪ replacement of damaged appliances ▪ prosthetic appliance repair	50%	40%
Orthodontia	50%	50%
MAXIMUMS		
▪ orthodontia	$1,800/covered person/lifetime	
▪ all other services(excluding orthodontia)	$1,800/covered person/calendar year	

Schedule of Benefits – Buy-Up PPO Dental

If you use an Anthem Blue Cross Dental Complete Network provider, your benefits will be based on the **negotiated fee** structure in effect at the time services are rendered. If you use Non-Network providers, your benefits will be based on the **recognized charge**. All benefits are subject to dental review.

DEDUCTIBLE (CALENDAR YEAR) Network and All Other Providers deductibles are separate.	**Network Providers**	**All Other Providers**
Individual (Waived for Preventive and Diagnostic Services)	$50	$100
COINSURANCE		
Preventive Care/Diagnostic Services ▪ periodic oral exams ▪ cleaning ▪ bite-wing and full-mouth x-rays ▪ fluoride treatment (children < age 16) ▪ sealants (children age 6-14) ▪ space maintainers (children < age 16) ▪ periapical x-rays ▪ palliative care	100%	90%
Basic Care ▪ anesthesia ▪ fillings (other than gold) ▪ injections ▪ simple extractions ▪ basic periodontics (including scaling) ▪ oral surgery ▪ endodontics ▪ periodontics ▪ recementing of inlays, onlays and crowns ▪ pathology ▪ consultation ▪ occlusal guards	80%	70%
Major Care ▪ bridges & dentures ▪ crowns and gold restorations ▪ gold post and core ▪ implants ▪ replacement of damaged appliances ▪ prosthetic appliance repair	60%	50%
Orthodontia	50%	50%
MAXIMUMS		
▪ orthodontia	$2,000/covered person/lifetime	
▪ all other services (excluding orthodontia)	$2,200/covered person/calendar year	

How do I file a claim?

When you file a claim, you are, in effect, asking the Plan to make payment based on the information on the claim form. Therefore, it is very important to fill out the form properly.

Follow these guidelines in submitting your claim:

- use a separate claim form for each family member,
- provide the employee's identification number as listed on ID card,
- submit copies of the **itemized** bill, and
- if your spouse is covered under another group plan, file your spouse's claim under his or her plan first.

Using these guidelines will speed up the claims paying process. Once you have completed the form, submit it along with your bills and any correspondence to the address indicated on your ID card, or:

Anthem Blue Cross
PO Box 1115
Minneapolis, MN 55440 -1115

When your claim has been verified and approved, benefits will be paid directly to you or your provider, whichever is appropriate.

Claim forms are available online at www.myscrippshealthplan.com or by contacting the Claims Administrator at (844) 852-1561.

What is covered under the Dental Plan?

The Plan covers the services outlined below. In general, services and supplies must be approved by a dentist and be necessary for the care and treatment of a non-occupational dental disease, defect, or injury or in connection with preventive dental care. All claims are reviewed to determine if the services and supplies are necessary. If there is more than one method of professionally adequate treatment, this Plan will determine its benefits based upon the least expensive covered service or supply, which is professionally adequate. For benefit purposes, dental expenses shall be deemed incurred as follows:

- for an appliance or modification of an appliance, on the date the final impression is taken;
- for a crown, bridge or gold restoration, on the date the tooth is prepared;
- for root canal therapy, the date the pulp chamber is opened; or
- for all other services, on the date the service is rendered.

Note: Only charges made for items shown below will be covered dental expenses.

Preventive/Diagnostic Services and Supplies

(i) Exams: Periodic oral examinations, but not more than twice in a calendar year.

(ii) Fluoride Treatments: Application of fluoride for a covered person under 16 years of age, limited to two (2) applications per calendar year.

(iii) Prophylaxis: Cleaning and scaling of teeth, but not more than twice in a calendar year.

(iv) X-rays: Bitewing x-rays, but not more than once in any period of six (6) consecutive months. A panoral radiograph or a full mouth series of x-rays, including supplementary bitewing x-rays if necessary, shall be covered once in each period of 36 consecutive months.

(v) Sealants: Application of sealants (topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in teeth for the purpose of preventing dental decay) on permanent posterior molar teeth with no caries (decay), no restorations and the occlusal surface intact, for covered children age 6-14. This does not include the repair or replacement of a sealant on any tooth within 36 consecutive months of its application.

Basic Services and Supplies

(i) Amalgam: silicate, plastic, porcelain and composite restorations anterior to molars; amalgam on molars.

(ii) Anesthetics: General anesthesia, including intravenous sedation, is only covered when administered in connection with covered oral surgery or periodontal surgery. Charges for general anesthesia, in connection with any other procedure, are excluded.

(iii) Drugs: Injectable antibiotics administered by a dentist.

(iv) Endodontics:

1. Root canal therapy.
2. Pulp capping and pulpotomy.
3. Apical surgery, retrograde fitting, apicoectomy, and root amputation.
4. Hemisection and apexification.

(v) Extractions and Oral Surgery:

1. The extraction of one or more teeth.
2. The extraction of a tooth root.
3. Alveolectomy, alveoplasty and frenectomy.
4. Excision of pericoronal gingiva, exostosis, or hyperplastic tissue, and excision of oral tissue for biopsy.
5. Excision of a tooth generated cyst of less than ¼ inch and incision and drainage of an abscess.
6. Reduction of tuberosity.
7. Vestibuloplasty, submucosal resection.

8. Removal of palatal and/or mandibular tori.
9. Sequestrectomy for osteomyelitis or abscess.
10. Incision and removal of foreign body from soft tissue.
11. Suture of soft tissue wound or injury.
12. Crown exposure to aid eruption.

(vi) Periodontics:

1. Periodontal scaling, with or without root planing, provided 24 consecutive months have passed since the last such periodontal scaling for which benefits were payable by this Plan.
2. Gingivectomy, provided 36 consecutive months have passed since the last such gingivectomy for the same tooth or quadrant for which benefits were payable by this Plan.
3. Osseous or muco-gingival surgery.
4. Provisional periodontal splinting.

(vii) Pin retention of fillings.

(viii) Pathology: Diagnostic laboratory services performed to assist in the diagnosis of oral disease.

Major Services and Supplies

(i) Crowns and gold restorations, except that:

1. The charge for a crown or gold restoration will be limited to the charge for an amalgam, silicate, plastic or composite restoration unless the tooth structure cannot be restored with such other material;
2. Replacement of a crown or gold restoration will be included only if the crown or restoration is over 5 years old; and
3. Precision attachments, personalization or characterization, or specialized techniques, are not covered services or supplies.

(ii) Dentures and Bridges:

1. Full denture, upper or lower.
2. Partial removable denture.
3. Fixed bridges, including crowns and inlays which form a part thereof.
4. Adding teeth to an existing prosthesis.

However, the replacement of such denture, bridge or tooth will be covered under this Plan only if the existing prosthesis is at least 5 years old.

(iii) Gold Post and Core.

(iv) Inlays and Onlays - cast restorations. Replacement of an inlay or onlay will be included only if the inlay or onlay is over 5 years old.

(v) Implants (allowed on the Buy-Up Plan only).

Orthodontic Services and Supplies

(i) Initial consultation, models, x-rays and other diagnostic services.

(ii) Initial banding or placement of orthodontic appliance(s).

(iii) Periodic adjustments.

(iv) Retainers.

Extended Dental Benefits

Benefits will be extended for 30 days beyond a covered person's termination date for the following services and supplies, provided such services would have been covered under the Plan if the coverage had remained in force:

- an appliance, or modification of one, for which an impression was taken prior to the date of termination;
- a crown, bridge or gold restoration for which the tooth was prepared prior to the date of termination; and
- root canal therapy, if the pulp chamber was opened prior to the date coverage ended.

What is not covered under the Dental Plan?

Acid Etch - Other than acid etch for metal bridge retainers.

Analgesia - Separate charges for pre-medication, local anesthesia, analgesia, or conscious sedation.

Broken Appointments

Characterizations

Charges in Excess of Recognized Charge - Any charge or portion of a charge which is in excess of the recognized charge.

Cleft Palate Treatment

Congenital or Developmental Conditions - The treatment of congenital (hereditary) or developmental (following birth) malformations.

Cosmetic Treatment - Charges for services or supplies partially or wholly cosmetic in nature, except for repair or damage to sound natural teeth caused by an accidental injury sustained while covered under this Plan. Charges for repair of such damage must be incurred within 90 days of the accidental injury.

Dental Implants - Materials planted into or on bone or soft tissue, or benefit procedures related to the placement or removal of implants are not covered benefits under this contract. However, if implants are provided or removed, the Plan will allow the cost of standard complete or partial denture toward the cost of the implant.
This exclusion does not apply to the Buy-Up PPO Dental Plan.

Dentally Unnecessary Services - Any services or supplies which are not dentally necessary and not incurred on the advice of a dentist, except as expressly included herein.

Discoloration Treatment

Drugs and Medicines - Other than charges for injectable antibiotics administered by a dentist.

Education or Training - Charges for education or training in, and supplies used for, dietary or nutritional counseling, personal oral hygiene, or dental plaque control.

Employment Related Services or Supplies - Any services or supplies for which benefits may be claimed under the Workers' Compensation Act, Jones Act or similar employee benefit legislation, or which are due to the treatment of an illness or injury arising out of, or in the course of, any occupation or employment for wage or profit.

Experimental or Investigative Treatment or Medication - Any charges for experimental or investigative therapy, treatment or drugs which are not approved by the American/Canadian Dental Association.

Facings - Facings on pontics or crowns posterior to the second bicuspid.

Government-Operated Facilities - Services furnished to the covered person in any veteran’s hospital, military hospital, institution or facility operated by the United States government (except for treatment of non-service related disabilities), or by any state government or any agency or instrumentality of such government, for which the covered person has no legal obligation to pay.

Grafting - Extra oral grafts (grafting of tissue from outside the mouth to oral tissues).

Hospital Charges

Illegal Acts or War Injuries - Charges for services and supplies furnished in connection with injury or other loss sustained as a result of being engaged in an illegal occupation, commission of, or attempted commission of, an assault or an illegal act, or duty as a member of the armed forces of any state or country or war or act of war, declared or undeclared.

Late Submission of Claims - Charges for services or supplies, otherwise covered, which were provided more than 12 months prior to the date the charges are submitted to this Plan for payment.

Lost or Stolen Prosthetics or Appliances - Replacement of a prosthetic or any other type of appliance which has been lost, misplaced or stolen.

Maxillo-facial Surgery

Myofunctional Therapy - Muscle training therapy or training to correct or control harmful habits.

Occlusal Restoration - Charges for procedures, restoration and appliances to alter, restore or maintain occlusion (i.e. the way the teeth mesh), including:

- increasing the vertical dimension;
- replacing or stabilizing tooth structure lost by attrition;
- realignment of teeth;
- gnathological recording or bite registration or bite analysis;
- occlusal equilibration.

Oral Hygiene Counseling/Instruction - Education or training in, and supplies used for, dietary or nutritional counseling, personal oral hygiene instruction or plaque control. Charges for supplies normally used at home including, but not limited to, toothpaste, toothbrushes, waterpiks and mouthwashes.

Orthognathic Surgery

Personalizations

Precision Attachments

Prescription Drugs – See “Drugs and Medicines”.

Replacement of Existing Full or Partial Dentures - Replacement of existing full or partial dentures, unless:

1. The denture is over five (5) years old and cannot be made serviceable. This exclusion will not apply if replacement is made necessary by the extraction of functioning natural teeth.; or
2. The denture was placed more than 12 months after an immediate denture was placed.

Replacement of Lost or Stolen Prosthetic Devices

Self-Inflicted Injuries - Any charges for services or supplies related to the treatment of intentionally self-inflicted injuries.

Services Rendered by Relatives - Any charges for services rendered by a person related to the patient by either blood or marriage, or by any person residing in the same household as the patient.

Specialized Techniques

Splinting - Appliances and restorations of splinting teeth.

Temporo-mandibular Joint Syndrome or Dysfunction - Any charges for jaw (mandibular) augmentation or reduction procedures; or procedures, restorations or appliances for the treatment or prevention of temporomandibular joint dysfunction syndrome, including the correction of abnormal positioning and relationship of teeth.

Travel – Charges incurred outside the United States if the member traveled to the location for the purpose of receiving dental care. However, charges incurred outside of the United States for emergency dental care or when the employee is required to be on temporary work assignment in a foreign country are allowed.

Treatment by someone other than a Dentist - Charges for treatment by someone other than a Dentist, except charges for treatment performed under the supervision and direction of a dentist by any person duly licensed to perform such treatment under applicable professional statutes and regulations.

Treatment of Micrognathia or Macrognathia

Vertical Dimension - Charges for procedures, restoration and appliances to increase vertical dimension.

Definitions

Accidental Injury - A sudden and unforeseen event which:

- causes injury to the physical structure of the body; and
- results from an external agent or trauma; and
- is definite as to time and place; and
- happens involuntarily or, if it is the result of a voluntary act, entails unforeseen consequences.

It does not include harm resulting from disease.

Covered Person - means you and those of your dependents who are covered under this plan.

Dentist - A Dentist or Oral Surgeon is a person appropriately licensed to practice dentistry.

Diagnostic Services - Diagnostic laboratory and x-ray expense, including charges for electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests or similar diagnostic tests generally approved by physicians throughout the United States.

Doctor - A person licensed to practice medicine or osteopathy. Doctor also includes any other practitioner of the healing arts if:

- he performs a service;
    - within the scope of his license; and
    - for which this Plan Document provides coverage.

Emergency Services - Treatment in a hospital emergency room or other emergency care facility for a condition that can be classified as a dental emergency.

A dental emergency is a sickness or accidental injury which occurs suddenly and unexpectedly, requiring immediate dental care.

Employee - A person in the service of the employer.

Dental Necessity - Any services and supplies provided for the diagnosis and treatment of a specific dental condition must be:

- ordered by a doctor or dentist; and
- required for the treatment or management of a dental symptom or condition; and
- the most efficient and economical service which can be safely provided to such person; and
- provided in accordance with approved and generally accepted medical or surgical practice.

The Plan may require, in proof satisfactory to us, that any type of treatment, service or supply received is necessary. Dental necessity will be determined solely by the Plan.

The fact that a doctor or dentist may prescribe, order, recommend or approve a service does not, in itself, make such service or supply necessary.

Dental necessity does not include: (a) any repeated test which is not necessary; or (b) experimental treatment, service, or supplies.

Recognized Charge – Is the lower of:

- the provider's usual charge to provide a service or supply, or
- the charge the Claims Administrator determines to be the recognized charge percentage for the service or supply, or
- the charge the Claims Administrator determines to be appropriate, based on factors such as:
    - the cost of supplying the same or similar service or supply, and
    - the manner in which the charges for the service or supply are made.
    - the complexity of the service or supply,
    - the Degree of skill needed to provide it,
    - the provider's specialty, and
    - the Recognized Charge in other areas.

Totally Disabled - Being under the care of a doctor, and prevented by illness:

- in your case, from performing your regular work, and
- in the case of your dependent, from engaging in substantially all of the normal activities of a person of the same age and sex who is in good health.

Claims and Coordination of Benefits

What if my claim for benefits is denied?

If your claim is not paid, or if you do not understand, or do not agree with, the handling of your claim, there are several things that you can do to appeal the decision. Most of your questions can be answered quickly and efficiently by either calling or writing the Claims Administrator.

If your claim for a plan of benefits is denied or reduced, you will be notified in writing within 30 days unless special circumstances require a time extension of processing. If this extension is necessary, you will receive written notice before the end of 45 days. This notice will tell you why additional time is needed and the date you can expect a final decision.

If you receive a denial, the form will include:

- The specific reason for the denial.
- Specific reference to pertinent Plan provisions on which the denial is based.
- An explanation of the Plan's claim review procedure.

The Claims Administrator intends to respond to claims promptly; however, if you do not receive a response in 60 days, allowing reasonable time for mailing, contact the Claims Administrator immediately.

Within 180 days after receiving notice that your claim has been denied, you or your authorized representative may submit a written request for claim review to the Claims Administrator. In your request, state the reasons you believe the claim denial was improper, and submit any additional information, materials or comments you consider appropriate.

The claim will then be reviewed by the Claims Administrator within 60 days after receiving your request.

Coordination of Benefits

Like most group medical and dental plans, this Plan includes a coordination of benefits (COB) provision. If you or any of your dependents are eligible to receive benefits under more than one group medical and/or dental plan, your benefits will be coordinated so that the total amount paid by all plans will not exceed 100% of the allowable expenses incurred.

The plan that is primary pays first and usually pays full regular benefits. The plan that is secondary pays second and usually pays the balance of your eligible expenses.

Rules for Determining the Primary Plan

A plan which does not reserve the right to consider the benefits of other plans will be considered the primary plan; otherwise the rules which follow will be used to determine which of any two plans is the primary plan. The first rule that describes one, but not both, of the plans will identify the primary plan:

1. The plan covers the person as an employee, rather than as a dependent.
2. The plan covers the person as an active employee, rather than as a laid-off or retired employee.
3. The plan covers a child as the dependent of the parent whose birthday is earlier in the year. If both parents have the same birthday, the plan that covered the parent the longest determines its benefits and pays first. But if the other plan does not have this "parent birthday" rule, the other plan's COB rule applies.

Exception to Rule 3: If the person is a dependent child of parents who are divorced or separated, then the following rules will be used in place of Rule 3:

a. The plan is the plan of the parent who has been assigned the financial duty for the child's health by a court decree.
b. The plan is the plan of the parent who has custody of the child.
c. The plan is the plan of the step-parent who is married to the parent with custody of the child.

Recovery from Third Parties

If you receive proceeds of any settlement or judgment as a result of another party (including your employer) being legally responsible for an injury for which this Plan pays benefits, the Plan is entitled to a refund for the benefits paid. If you sue the responsible party or accept a settlement, the Plan still has the right to pursue recovery.

In addition, the Plan is not obligated to pay benefits for any medical or dental expenses incurred in connection with an injury or condition unless you, or someone legally qualified and authorized to represent you, agree in writing to the following:

- to include such expenses in any claim you or your dependents make against a third party for the injury or conditions;
- to sign an agreement to reimburse the Plan an amount equal to the value of benefits provided under this Plan, on account of such injury or illness, (including a job-related injury or illness);
- in the event of financial recovery from a third party on account of illness or injury (including your employer in the event of a job-related injury or illness), to reimburse the Plan an amount equal to the value of benefits provided under this Plan on account of such injury or illness;
- to instruct your attorney, if one is retained, to reimburse the Plan from such financial recovery in a form satisfactory to the Plan; and

- to cooperate fully with the Plan in asserting its subrogation rights and supply the Plan with any and all information and execute any and all forms the Plan may need for this purpose.

In the event of an accident which may give rise to your right to financial recovery from a third party (including your employer in the event of a job-related illness or injury), the right to receive benefits under this Plan shall be conditioned upon you, or your personal representative, agreeing to pay an amount equal to the value of benefits provided under this Plan on account of such illness or injury.

Financial recovery includes any amount received, whether by judgment, settlement, arbitration, compromise and release, or otherwise. For purposes of this provision, the value of the benefits provided under this Plan shall be conclusively presumed to be the cost to this Plan of providing such benefits. The payment to this Plan required under this paragraph shall not be an amount which exceeds the proceeds of any such recovery.

In determining the amount of any attorneys' fees or costs payable by the Plan, the incremental and total amount of time and effort expended by attorneys retained by you, or on behalf of you, shall be considered in determining any reduction in the Plan's recovery. The Plan shall not be bound by, nor is it obligated to honor, any fee agreement between you and your attorneys.

All reimbursement to the Plan must occur within 30 days of the receipt of financial settlement by you and/or your attorney(s).

Should you, or your personal representative, fail to comply with the foregoing provisions, in addition to any other legal remedies available to the Plan, the Plan may deduct, at its discretion, an amount up to or equal to the value of benefits provided under this Plan on account of such injury or illness (including job-related illness or injury) from future benefits you would otherwise be entitled to.

In the event you or your dependents fail or refuse to execute whatever lien, assignment, form or document requested by the Claims Administrator on behalf of the Plan, the Plan shall be relieved of any and all legal, equitable, or contractual obligation contained in this Plan for any benefits or covered expense incurred by you or your dependents.

The Plan is also entitled to a refund from benefits available under underinsured or uninsured motorist provisions of automobile insurance policies.

COBRA

COBRA Continuation Coverage

A federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA) gives you and your covered dependents rights in certain circumstances to temporarily extend group health coverage beyond the date it would normally end. You are eligible to elect COBRA coverage if you were participating in any Company-sponsored group health Plan at the time of the qualifying event (unless your employment was terminated for gross misconduct, as determined by the Plan Administrator in its sole discretion), as described in the following section. Your COBRA coverage is identical to the coverage available to an eligible active employee.

Qualifying Events for COBRA

The following chart shows each qualifying event for you and your covered dependents.

	Qualifying Event
You, the employee:	Voluntary or involuntary termination of employment, except for gross misconduct
	Reduction in hours resulting in loss of coverage
	Retirement
	Leave of absence or layoffs/strikes resulting in loss of coverage
Covered dependents:	Their loss of coverage due to any of the events listed above
	Your death
	Your entitlement to Medicare (but only if it causes covered dependents to lose coverage)
	Divorce, legal separation or annulment
	Dependent no longer meets the Plan's eligibility requirements

Second Qualifying Events

If you have a second qualifying event after your employment ends or a reduction in hours that affects your benefit eligibility, your covered dependent(s) can be eligible for an additional period of coverage. The total coverage period under COBRA is limited to 36 months from the date of the first qualifying event.

For example, assume you end your employment with the Company and you and your spouse choose to continue coverage for 18 months under COBRA. If you and your spouse divorce during the 18-month COBRA coverage period, your spouse can receive up to an additional 18 months of COBRA coverage. COBRA coverage for your spouse may never exceed a total of 36 months.

Medicare

If you become entitled to Medicare and coverage under the Plan is later lost due to your termination of employment or reduction in hours of employment, your spouse or dependent will be entitled to continuation coverage until the later of the date that is:

- 36 months from the date you became entitled to Medicare, or
- 18 months from the date of your termination of employment or reduction in hours of employment

COBRA Coverage Periods

The following chart shows each qualifying event and the maximum COBRA continuation coverage period.

COBRA Qualifying Event	You	Dependents
Your employment ends(except for gross misconduct), you retire or you lose coverage due to a reduction in hours	18 months (up to a total of 29 months of extended coverage, if you are determined to be disabled under the Social Security Act (SSA) on the date of the original qualifying event or during the first 60 days of continuation coverage and notice of that SSA disability award is given to the Plan Administrator within 60 days of the award and before the end of the 18 months of COBRA continuation)	18 months (up to a total of 29 months of extended coverage, if you or a covered dependent is determined to be disabled under the Social Security Act (SSA) on the date of the original qualifying event or during the first 60 days of continuation coverage and notice of that SSA disability award is given to the Plan Administrator within 60 days of the award and before the end of the 18 months of COBRA continuation)
You die	N/A	36 months
You become entitled to Medicare	N/A	36 months (but only if it causes a loss of coverage)
You and your spouse divorce or legally separate	N/A	36 months
Your child is no longer eligible	N/A	36 months

To qualify for the 11-month extension due to a disability under the Social Security Act, you or your qualified beneficiary must satisfy the following requirements:

- The disability (as determined by the Social Security Administration) exists on the date of the original qualifying event or within the first 60 days of continuation coverage, and
- You or your qualified beneficiary must file for disability with the Social Security Administration and then forward a copy of a letter of determination of disability by the Social

Security Administration to the Plan Administrator within 60 days of receipt and within the initial 18-month coverage period

- The member or employee must notify the Plan Administrator within 30 days if Social Security makes a final determination that you or your qualified beneficiary is no longer disabled

Applying for COBRA Coverage

By law, you or a family member must notify the Plan Administrator of a divorce, legal separation, annulment or a child losing dependent status within 60 days of whichever is later—the date of the event or the date that coverage would be lost because of the event. If such notice is not provided within the required 60-day period, continuation coverage will not be offered.

Scripps Coastal Medical Group must notify the Plan Administrator of the employee's death, termination of employment, reduction in hours, or Medicare entitlement within 30 days of the event or date of receiving notice.

When the Plan Administrator is notified that a qualifying event has occurred, you will be sent information regarding your right to choose continuation coverage, the cost of the coverage and when payment is due. By law, you have at least 60 days from the date you receive the notice or from the date you would lose coverage because of a qualifying event (whichever is later) to inform the Plan Administrator that you want continuation coverage. If the election forms are not completed and sent within the 60-day period, you will lose the right of continuation coverage and will have no further rights to elect such coverage. You do not have to provide proof of good health to choose continuation coverage.

Coverage During the Election Period

As of the date coverage is terminated, you and your covered dependents will not have any coverage until continuation coverage is properly elected (and claims may be pended until the required COBRA premiums have been paid). This means no benefits or expenses will be paid during the election period, until the COBRA premiums have been paid. To receive uninterrupted coverage of covered benefits, it is important to elect continuation coverage and make the required premium payments as soon as possible after receiving the COBRA notice. Once a completed election form is received and all required premiums are paid, coverage becomes retroactive to the date coverage was terminated.

Cost of COBRA Coverage

If you elect to continue coverage under the Plan, you must pay 102% of the full cost of the Plan for active employees (on a monthly basis) for the first 18 or 36 months of coverage (depending on the qualifying event).

If you or your eligible dependents are disabled under the Social Security Act at the time you become eligible for COBRA coverage (or become Social Security disabled within the first 60 days after COBRA coverage begins), and qualify for the 11-month extension of coverage, your cost for continued coverage for months 19 through 29 is 150% of the cost of the Plan for active

employees. However, if the Social Security disabled qualified beneficiary does not continue coverage past the initial 18-month period, but other qualified beneficiaries associated with the Social Security disabled qualified beneficiary continue coverage, the cost remains at 102% of the cost of the Plan for active employees.

If you or your covered dependents elect COBRA, you will have 45 days from the date of your election to pay the initial cost for continuation coverage. All continuation coverage payments will be made on an after-tax basis. After this initial 45-day grace period you or your covered dependents must pay the monthly premiums for the cost continuation coverage by the first day of the month.

If these subsequent payments are not received within 30 days of the first day of the month, continuation coverage will be terminated, and you or your covered dependents will have no further rights to elect continuation coverage. Even if continuation coverage is elected, benefits will not be paid until all payments that are due have been paid, without regard to any grace period.

Changing Coverage While on COBRA

During annual open enrollment, you will have the same rights as similarly situated active employees to change your elected coverage option. You may also have special enrollment rights for newly acquired dependents.

To enroll a new dependent as a result of a special enrollment event, you must follow the process for special enrollment. If the addition of a dependent will result in a higher applicable premium, COBRA rates will reflect the higher amount.

Newborn Child, Adopted Child, Legal Guardianship, or Child Placed for Adoption

If, during the period of continuation coverage, a child is born to you, the child is under age 18 and adopted by you, you are appointed legal guardian or a child who has not attained the age of 18 is placed for adoption with you, the child is considered a qualified beneficiary. You have the right to elect continuation coverage for that child, provided the child satisfies the otherwise applicable eligibility requirements. To enroll the child on COBRA, you must notify the COBRA administrator within 60 days of the date of the birth, adoption, legal guardianship, or placement for adoption and pay the required cost, at which time coverage will be effective back to the date of the birth, adoption, legal guardianship, or placement. If you fail to do so, you will not be offered the option to elect COBRA coverage until the next Open Enrollment period.

Address Changes

If continuation coverage is elected, you or your covered dependents must notify the COBRA administrator if your address changes.

When COBRA Coverage Ends

COBRA continued coverage ends when the earliest of the following occurs:

- The relevant continuation period of 18, 29 or 36 months ends
- The covered individual becomes covered by another group dental plan that does not restrict coverage of a pre-existing condition of the covered individual
- The covered individual becomes entitled to Medicare
- The covered individual fails to pay the required payments for continued coverage in a timely manner
- The first day of the month beginning 30 days after the Social Security Administration determines that the individual initially determined to have been disabled under the Social Security Act is no longer disabled, or
- Scripps stops providing dental coverage to all active employees

Senior Cal-COBRA

Senior Cal-COBRA Qualifications

A former employee who was at least 60 years old at the time employment ended, and who had worked for the Company for at least 5 years, and participated in a Scripps Dental Plan for at least one year immediately preceding retirement may be eligible for Senior Cal-COBRA. The former employee's spouse may also continue coverage.

Who May Not Enroll in Senior Cal-COBRA

You are not eligible for Senior Cal-COBRA if you are:

- A former employee whose employment ended because of gross misconduct
- Eligible for Medicare
- Sixty-five years old or older, or
- Covered by another group health plan

Benefits under Senior Cal-COBRA

Anyone covered under Senior Cal-COBRA continues the same basic health care benefits as were available under federal COBRA. No restrictions based on pre-existing conditions are allowed.

Payment of Premiums under Senior Cal-COBRA

Payments are due the first of each month for the month's Senior Cal-COBRA coverage. There is, however, a grace period for late payments, which expires on the 30th day after the first of the month. Failure to pay the full premium by premium due dates, or within the 30-day grace period, will result in cancellation of your Senior Cal-COBRA coverage retroactively to the last good payment. If, for any reason, any qualified beneficiary receives any benefits under the Plan during a month for which the premium was not timely paid, you will be required to reimburse the Plan for the benefits received.

Time Period for Continuing Coverage under Senior Cal-COBRA

Benefits may last up to five years or until one of the following events occur:

- The individual turns 65
- The individual becomes Medicare-eligible
- The individual does not pay premiums in a timely manner, or
- The employer no longer offers health coverage to any active employees

COBRA Qualifying Event	You	Dependents
Your employment ends (except for gross misconduct), you retire or you lose coverage due to a reduction in hours	18 months (up to a total of 29 months of extended coverage, if you are determined to be disabled under the Social Security Act on the date of the original qualifying event or during the first 60 days of continuation coverage) and notice of that SSA disability award is given to the Plan Administrator within 60 days of the award and before the end of the 18 months of COBRA continuation)	18 months (up to a total of 29 months of extended coverage, if a covered dependent is determined to be disabled under the Social Security Act on the date of the original qualifying event or during the first 60 days of continuation coverage) and notice of that SSA disability award is given to the Plan Administrator within 60 days of the award and before the end of the 18 months of COBRA continuation)
You die	N/A	36 months
You become entitled to Medicare	N/A	36 months (but only if it causes a loss of coverage)
You and your spouse divorce or legally separate	N/A	36 months
Your child is no longer eligible	N/A	36 months

RIGHTS & RESPONSIBILITIES

If you are covered by this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that you shall be entitled to:

- Examine without charge, at the Employer's office, all plan documents, including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Continue health care coverage for yourself, your Spouse, or your other dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage.

If your claim for a 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 the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan 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 to pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in state or federal court.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.
In addition to creating rights for you, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan members and their beneficiaries. No one, including the Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining benefits under the Plan or from exercising your rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan member is discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or 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 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 the claim or suit to be frivolous.

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group

health plans, you should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Plan

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact 1-800-Scripps.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Gerry Soderstrom, Corporate VP, Chief Audit & Compliance Executive. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Gerry Soderstrom, Corporate VP, Chief Audit & Compliance Executive is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20211
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

In fulfillment of the requirements of Section 504(f)(2) of the privacy rule found in 45 C.F.R. Part 164 (the Privacy Rule) promulgated pursuant to the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA) the Plan provides (and the Plan Sponsor certifies its agreement) :

1. Persons holding positions with Scripps Coastal Medical Group and who have access to individually identifiable health information deemed “protected health information” (PHI) under the Privacy Rule are identified below, and are restricted (without further authorization) to using and disclosing PHI for Plan administrative purposes such as those described as “payment” and “health care operations” under the Privacy Rule. More particularly, such uses and disclosures may include: evaluating the Plan’s claims experience; seeking proposals for insurance or reinsurance of Plan benefits; reporting to stop-loss carriers; administering case, quality and utilization management programs (including, but not limited to, care management performed, coordinated or supervised by the Plan Sponsor’s Case Management Department); determining the application of Plan provisions to particular claims; and assisting participants and beneficiaries with the filing of claims.

2. The classes of positions within the workforce of the Plan Sponsor that may receive, use or disclose PHI for the purposes set forth in item 1 above:

    a) Corporate Human Resources and those executives or managers of the Plan Sponsor to whom Corporate Human Resources reports in connection with the administration of the Plan;

    b) Finance Department personnel assigned to support or supervise Corporate Human Resources Administration;

    c) Legal counsel assigned to support Corporate Human Resources or to advise the Plan Sponsor in connection with the administration of the Plan;

    d) Personnel assigned to or supervising the operations of the Case Management Department in connection with care management under the Plan; and;

    e) Such other employees or classes of employees to whom the Plan Sponsor may from time to time delegate responsibility for the administration and operation of the Plan.

3. Employees in the job functions or classes described above will have access to Plan participants’ PHI only for the purposes described in item 1 (i.e., administrative functions performed for the Plan) and only as permitted by HIPAA and the Privacy Rule.

4. In accordance with the certification requirement of the 45 C.F.R. §164.504(f)(2)(ii), the Plan Sponsor hereby certifies that it will comply with the above relating to HIPAA and also:

    a) Not use or further disclose individually identifiable health information created in connection with the Plan except as required by law or for Plan administrative purposes as described in item 1, above, as such administrative purposes may be amended from time to time;

b) Arrange for any agents or subcontractors of the Plan Sponsor that receive PHI to use and disclose PHI consistent with this certification;

c) Not use or disclose the PHI for employment related actions or in connection with any other benefits or benefit plans;

d) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for in item 1, which it becomes aware of;

e) Make available to the Plan any PHI in any "designated record set" (as such term is defined in the Privacy Rule) related to Plan participants or beneficiaries that the Plan Sponsor has control of in accordance with the access requirements of the Privacy Rule;

f) Make available for amendment, to the extent required by the Privacy Rule, the PHI in a designated record set which is related to Plan participants or beneficiaries and incorporate any amendment as required by the Privacy Rule;

g) Make information available to the Plan for, or provide the Plan with, an accounting of PHI disclosures (to the extent required by the Privacy Rule, e.g., other than for treatment, payment, health care operations or other exempt purposes) related to Plan participants or beneficiaries in response to such person's exercise of his/her rights under such section;

h) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the Department of Health and Human Services to assist the Secretary in determining the Plan's compliance with the Privacy Rule;

i) Where feasible, return to the Plan or destroy any PHI received from the Plan when such PHI is no longer needed by the Plan Sponsor for the purpose which permitted the Plan to make the disclosure and, where such return or destruction of PHI is not feasible, to limit its future use of the PHI to the situations that make the return or destruction of the PHI not feasible; and

j) Limit access of its employees to the Plan's PHI (other than as subjects of the PHI or subscribers to the coverage), except where such employees are in job classifications which have been designated above as assisting in Plan administration and thus engaging in the use or disclosure of PHI for treatment, payment and health care operations purposes.

5. The Plan Sponsor shall also:

a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
b) Ensure that the adequate separation required by 45 C.F.R. §164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
c) Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and
d) Report to the Plan any security incident of which it becomes aware.

6. Following the discovery of a breach of unsecured PHI, the Plan shall provide any required notification:

    a) to individuals in accordance with HIPAA and the Privacy Rule;

    b) to media outlets in accordance with HIPAA and the Privacy Rule; and

    c) to the Secretary of HHS in accordance with HIPAA and the Privacy Rule.

7. To the extent the Plan fails to comply with HIPAA, the Plan shall be deemed to be automatically amended to so comply and the Plan shall in any event be administered in accordance with any and all such deemed automatic amendments.

Your Rights – Legal Notices

If you are covered by this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that you shall be entitled to:

- Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Continue health care coverage for yourself, your Spouse, or your other dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage.
- Review this plan document and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

Plan Information

The following information applies to the Scripps Coastal Medical Group Dental Plan, as described in this handbook.

The preceding sections of this handbook constitute a summary plan description for the Scripps Coastal Medical Group Dental Plan.

Scripps Coastal Medical Group may modify, alter, amend or terminate this Plan at any time.

Plan Sponsor/Administrator

Scripps Coastal Medical Group
c/o Scripps Health, Inc.
4275 Campus Point Court
San Diego, CA 92121

Claims Administrator

Anthem Blue Cross
PO Box 1115
Minneapolis, MN 55440 -1115
(844) 852-1561

COBRA Administrator

HealthComp Administrators
P. O. Box 45018
Fresno, CA 93718-5018
(877) 552-7247

Agent for Service of Legal Process

General Counsel
Scripps Coastal Medical Group
c/o Scripps Health
10140 Campus Point Drive, CPA 415
San Diego, CA 92121

Plan Identification Number

33-0776371

IRS Plan Number

501

Plan Year

January 1 through December 31

Fiduciaries

Board of Directors

Scripps Coastal Medical Group
c/o Scripps Health, Inc.
4275 Campus Point Court
San Diego, CA 92121

Type of Plan

This is a welfare benefit Plan providing certain dental benefits for employees and their eligible dependents and qualified beneficiaries under COBRA.

Type of Administration

The Plan is sponsored and administered by Scripps Coastal Medical Group. As Plan Sponsor and Plan Administrator, Scripps Coastal Medical Group is responsible for seeing that information regarding the Plan is reported to government agencies and disclosed to Plan participants and beneficiaries.

The Plan Administrator has the final authority and responsibility to review and make final decisions on Plan matters such as benefit determination, eligibility for coverage and Plan interpretation.

Funding

Covered persons must make contributions for any coverage and benefits during such periods, in such amounts and in such manner, as Scripps Coastal Medical Group, in its discretion, may from time to time require. Scripps Coastal Medical Group may, at any time, require increased contributions by Covered Persons and may, in its discretion, require Covered Persons to pay the full cost of the coverage and benefits without any contribution by Scripps Coastal Medical Group. Employee contributions are held in, and are part of, Scripps Coastal Medical Group's general assets (in accordance with DOL Technical Release 92-01) and are not segregated in any separate fund, bank account or trust. Such contributions are used solely for the payment of Plan benefits and reasonable administrative expenses (e.g. Claims Administrator fees) of the Plan. For purposes of general asset accounting/bookkeeping, Scripps Coastal Medical Group has the discretion to determine those Plan benefit costs and reasonable Plan administrative expenses to which amounts of employee contributions are from time to time allocated. To the fullest extent permitted by law, any dividends, premium refunds, demutualization payments, class action settlements, or like adjustments or amounts, paid or payable, under, or in connection with, any coverage or benefits under the Plan, shall remain the exclusive property of Scripps Coastal Medical Group.

No Vested Rights: Right to Amend or Terminate the Plan

Covered Persons have no vested rights to the benefits provided under the Plan. Scripps Coastal Medical Group reserves the right to change, modify, amend, suspend, or terminate any or all of the benefits provided here in whole or in part at any time by a written instrument signed or approved by a duly authorized officer of Scripps Coastal Medical Group. Scripps Coastal Medical Group's authority to modify the Plan includes the right to alter the mix of the benefits provided by the Plan. No member has a vested right to the continuation of any particular benefit provided by the Plan.

This Plan Document is intended to comply with all applicable Federal and State laws and regulations. In the event of non-compliance with any such law or regulation, the Plan Document will be automatically amended to comply with said law or regulation as of its effective date, and the remainder of the Plan Document will remain in full force and effect. Similarly, in the event a law or regulation applicable to this Plan becomes effective after the effective date of this Plan Document, said law or regulation will be deemed included in this Plan Document as of such law's or regulation's effective date and without the necessity of an amendment to this Plan Document.

To the extent any provision of the Plan conflicts with the Affordable Care Act (ACA) or other applicable law, as determined by Scripps Coastal Medical Group, the Plan shall be automatically amended to so comply. Any dollar limitations under the Plan on essential health benefits under the ACA shall be benchmarked for ACA purposes against a benchmark plan of any state permitting those limitations as selected by Scripps Coastal Medical Group, in its sole discretion from time to time, but nothing herein shall be interpreted as requiring the Plan to provide essential health benefits (and Scripps Coastal Medical Group may treat certain brand drugs as non-essential health benefits in accordance with applicable law) or any benefits other than as expressly stated in the Plan. Scripps Coastal Medical Group, in its sole discretion, may modify such benchmarking from time to time in any manner it sees fit.

Discretionary Authority of Plan Administrator, Claims Administrator and Designees

In carrying out their respective responsibilities under the Plan, the Claims Administrators, Plan Administrator, Claim Fiduciaries, Plan fiduciaries, and individuals to whom responsibility for the administration of the Plan has been delegated have all full and unrestricted discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown, by clear and convincing evidence, that the interpretation or determination was arbitrary and capricious.