Summary Plan Description/Plan Document for the SCL Health Dental Plan

Core Plan Option
Group #11127

(Effective January 1, 2022)

Visit Delta Dental's Website:
www.deltadentalco.com

You can search for a Provider, download a claim form or access other personal account information.

Delta Dental of Colorado
4582 South Ulster Street, Suite 800
Denver, CO 80237

Customer Service: 1-800-610-0201

Delta Dental PPO
Schedule of Benefits
For Group #11127

SCL HEALTH DENTAL PLAN - CORE PLAN

In the event that you seek treatment from a non-participating provider, you may have more out-of-pocket costs.

Benefit Year - January 1st to December 31st

	PPO Provider	Delta Dental Premier Provider	*Non-Participating Provider
Covered Services	**Plan Pays**	**Plan Pays**	**Plan Pays**
Diagnostic & Preventive Services			
Oral Exams and Cleanings	100%	100%	100%
X-Rays	100%	100%	100%
Sealants	100%	100%	100%
Fluoride Treatment	100%	100%	100%
Basic Services			
Basic Restorative (Fillings)	85%	85%	75%
Oral Surgery	85%	85%	75%
Endodontics (Root Canal Therapy)	85%	85%	75%
Periodontics (Gum Disease Treatment)	85%	85%	75%
Major Services – Not a Benefit			
Orthodontia - Not a Benefit			

*** Important: Non-Participating Providers are allowed to balance bill. Employees and/or Dependents are responsible for the difference between the non-participating Maximum Plan Allowance and the full fee charged by the Provider.**

Deductible – None

Maximum (January 1st - December 31st)

Class	Type	Network	Amount
All Covered Classes Except D&P	Individual coverage amount	PPO and Non-PPO	$1500

Under the Plan, you may visit any Provider of your choice. There are three levels of Providers to choose from who are located nationwide:

PPO Participating Provider

Advantages of seeing a PPO Provider include:

- Payment is based upon the PPO Provider's Allowable fee, or the fee actually charged, whichever is less.
- Claim forms are submitted directly to Delta Dental by the Providers.
- You are responsible for any applicable deductible and coinsurance for covered procedures.

You will receive the best benefits available on the Plan by choosing a PPO Provider.

Premier Participating Provider (Non-PPO)

You have the option of seeing a Premier Provider, but you may incur additional costs:

- Payment is based upon the Premier Maximum Plan Allowance, or the fee actually charged, whichever is less.
- Claim forms are submitted directly to Delta Dental by the Providers. You are only responsible for any applicable deductible and coinsurance for covered procedures.

Non-Participating Provider (Non-PPO)

- You have the option of seeing a non-participating Provider, but you may incur additional out-of- pocket costs.
- You may be responsible for payment in full to the Provider and for filing your claim with Delta Dental for reimbursement.
- You are responsible for the difference between the non-participating Maximum Plan Allowance and the full fee charged by the Provider.

Covered Amount means

- For PPO Providers, the lesser of the PPO Provider's Allowable fee or the fee actually charged.
- For Premier Participating Providers, the lesser of the Premier Maximum Plan Allowance, or the fee actually charged.
- For all other Providers, the lesser of the Non-Participating Maximum Plan Allowance, or the fee actually charged.

Please note that PPO Providers and Premier Participating Providers are not available in all locations.

TABLE OF CONTENTS

ELIGIBILITY 3

HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS (Applicable to Managed Care Plans) 4

BENEFITS/COVERAGE (What is Covered) 5

LIMITATIONS/EXCLUSIONS (What Is Not Covered) 8

PARTICIPANT PAYMENT RESPONSIBILITY 9

CLAIM PROCEDURES (How to File a Claim) 9

GENERAL PROVISIONS 9

TERMINATION/NONRENEWAL/ CONTINUATION 10

APPEALS AND COMPLAINTS 11

DEFINITIONS 12

SCL Health ("Plan Sponsor") sponsors the SCL Health Dental Plan (the "Plan") for the benefit of its eligible employees and the eligible employees of its participating employers (collectively, "Employer" or "Employers").

The Plan Sponsor has selected Delta Dental of Colorado ("Delta Dental") to administer the Plan. Delta Dental does not insure any benefit under the Plan. All benefits are paid from the general assets of the Employers.

This document has been written so that it is not just a summary of Plan benefits, but also the legal plan document written so that it can be used by you or the Plan Sponsor in understanding and administering the benefits provided under the Plan. This document is effective as of January 1, 2022 and replaces all prior versions. This document and the SCL Health Associate Health Benefit Plan constitute the formal plan document for the Plan.

Note that capitalized terms used in this booklet are defined the first time they are used or are defined in the Definitions section of this booklet.

ELIGIBILITY

ASSOCIATE ELIGIBILITY

Except as specifically noted, all associates of an Employer with a payroll status of Full Time Equivalency (FTE) of 0.5 or above or, with respect to the University of Saint Mary, employees who are regularly scheduled to work 30 or more hours per week, full-time faculty while covered by an active contract, and coaches who are expected to regularly work 30 hours or more per week while fall and spring semesters are in session so long as they remain employed, are eligible to participate in the Plan. These individuals are called "Eligible Associates." The following associates are not eligible to participate in the Plan: individuals classified as "PRN," "Per Diem," "Temporary," student interns, volunteers, or any person classified as an independent contractor or a leased employee, regardless of whether such individual is subsequently determined by a court of competent jurisdiction or governmental agency or authority to have been a common law employee.

DEPENDENT ELIGIBILITY

An eligible Associate who has enrolled in the Plan may also enroll his or her eligible Dependents, as defined in the Definitions section of this booklet.

No one may be covered as a Dependent and also as an Associate under the Plan. If both parents are covered as Associates, children may be covered as Dependents of one parent only. A child under age 26 may be covered as either an Associate or as a Dependent child. An individual cannot be covered as an Associate while also covered as a Dependent of an Associate.

EFFECTIVE DATE OF COVERAGE

Coverage under the Plan becomes effective the first day of the month following the eligible Associate's date of hire (or, if later, the date he or she becomes eligible to participate) or, with respect to resident physicians, on the date of hire as an eligible Associate, provided the Associate makes an election for such coverage in accordance with the Plan Administrator's procedures within 31 days of his or her date of hire.

Before the beginning of each Plan Year, the eligible Associate will have the opportunity to add or drop coverage under the Plan, or change coverage options for himself or herself and his or her eligible Dependents. Elections made during annual open enrollment will be effective as of the first day of the following Plan Year (January 1st).

Generally, an eligible Associate cannot make changes to his or her coverage, such as dropping his or her coverage or adding a dependent to coverage, during the Plan Year. Most coverage changes may be made only during the annual open enrollment period. There are some circumstances, however, such as marriage or the birth of a new dependent, in which mid-year changes to coverage under the Plan may be permitted, provided you request a change within 31 days of the event. These are explained in the SCL Health Flexible Benefits Plan. You may obtain a copy of the SCL Health Flexible Benefits Plan from the SCL Health Human Resources Department or by calling (855) 412-3701.

If an eligible Associate is required to provide dental coverage for a dependent child as a result of a divorce, legal separation, annulment, or change in legal custody, the Plan may change his or her election during a Plan Year to comply with the legal instrument mandating coverage. The eligible Associate may elect to cancel any such coverage for a dependent child if the order requires your spouse, former spouse, or other individual to provide coverage for the child, and that coverage is, in fact, provided. The eligible Associate may obtain from the Plan Administrator a copy, free of charge, of the Plan's procedures for reviewing these orders, called "qualified medical child support orders" or QMCSOs.

HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS
(Applicable to Managed Care Plans)

How to Find a Provider
There are two easy ways to find out if your Provider is a Delta Dental PPO Network Provider.

1. **Visit our website at www.deltadentalco.com** or
2. **Phone our automated call center** at 1-800-610-0201.

The network is subject to change. Please check on the status of your Provider before your next appointment.

You need not obtain approval before being receiving services. Before starting dental treatment that may cost $400 or more, however, you may request an estimate from Delta Dental of what may be covered. Pre-treatment estimates are not required.

BENEFITS/COVERAGE (What is Covered)

COVERED DENTAL SERVICES

DIAGNOSTIC & PREVENTIVE SERVICES

Diagnostic: Certain Services performed to assist the Provider in evaluating the existing conditions and determining the dental care required.

Preventive: Certain Services performed to prevent the occurrence of dental abnormalities or disease.

Adjunctive: Certain additional Services, including Emergency palliative treatment, performed as a temporary measure that does not affect a definitive cure.

PROCEDURE	BENEFIT DESCRIPTION
Oral Exam (All exam types)	Three exams in calendar year are covered. There is no separate benefit for diagnosis, treatment planning or consultation by the treating provider.
Dental Cleaning	Two cleanings in calendar year are covered. For those with defined periodontal history, two additional cleanings may be provided during a calendar year. Periodontal maintenance procedures or any combination of periodontal maintenance procedures and prophylaxis (adult and child cleanings) are limited to 4 per any calendar year. An adult cleaning is not covered for persons under age 14. For those with any conditions listed below, two additional cleanings, not to exceed 4 per calendar year, (or any procedure that requires cleaning) will be provided during the calendar year: • Diabetes with documented gum conditions, • Pregnancy with documented gum conditions, • Cardiovascular disease with documented gum conditions, • Kidney failure with dialysis, and Suppressed immune system due to chemotherapy or radiation treatment, HIV Positive status, Organ transplant or stem cell (bone marrow) transplant.
Bitewing X-rays	Covered two times in a calendar year for dependents under age 18 and one time in a calendar year for all others.
Full Mouth Survey or Panoramic X-ray	Covered one time in a 60 month period.
Individual Periapical X-rays Intraoral Occlusal X-rays Extraoral X-rays	Limited to the allowance for a full mouth survey or panoramic x-ray. If the fee meets or exceeds the allowance for a full mouth survey, it will be processed as a full mouth survey.
Sealants	Covered one time per tooth in a 36 month period. Allowed for the occlusal (chewing) surface of decay-free unrestored permanent molars. Covered for children under the age of 19. There is no separate benefit for preparation of the tooth or any other procedure associated with the sealant application.
Preventive Resin Restoration	Covered as a sealant above.
Fluoride Treatment	Covered up to two times in a calendar year for children under the age of 19.
Space Maintainer	Covered for children under the age of 14 to maintain space left by prematurely lost baby back teeth.
Adjunctive Services	Services related to another category of covered services will be covered at the same percentage as the related category of covered services.
Palliative Treatment	Covered as a separate benefit only if no other service is provided during the visit except an exam and/or x-rays.
Oral Pathology Lab Procedures	Covered with a pathology report.

BASIC SERVICES

Basic Restorative: Fillings and preformed shell crowns, for treatment of tooth decay which results in visible destruction of hard tooth structure or loss of tooth structure due to fracture.

Oral Surgery: Extractions and certain other surgical Services and associated covered anesthesia and/or related Covered Services.

Endodontic: Certain Services for treatment of non-vital tooth pulp resulting from disease or trauma.

Periodontic: Certain Services for treatment of gum tissue and bone supporting teeth.

PROCEDURE	BENEFIT DESCRIPTION
Amalgam Fillings (silver fillings)	Multiple fillings on one surface will be paid as a single filling. Replacement of an existing amalgam filling is allowed if at least 12 months have passed since the existing amalgam was placed.
Composite Resin (white plastic) Fillings	Multiple fillings on one surface will be paid as a single filling. Replacement of an existing composite resin filling is allowed if at least 12 months have passed since the filling was placed.
Stainless Steel Crowns **Resin Crowns**	Covered when the tooth cannot be restored by a filling and then 1 time in a 12 month period.
Protective Filling	Covered if no other restorative service is performed on the same tooth on the same date. Not covered during a course of endodontic therapy.
Pin Retention	Covered with a basic (amalgam or composite) filling. A benefit one time per filling.
Extraction - Coronal Remnants **Deciduous Tooth**	Includes local anesthesia and routine post-operative care, which are not covered separately.
Extraction - Erupted Tooth or Exposed Root	Includes local anesthesia and routine post-operative care, which are not covered separately.
Therapeutic Pulpotomy	Covered for baby teeth.
Root Canal Therapy	Covered once per tooth. X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Repeat Root Canal therapy	Covered if the first root canal procedure on the same tooth was performed at least 24 months earlier.
Apexification/Recalcification (apical closure/calcific repair of perforations, root resorption, etc.)	Covered once per tooth. A course of treatment includes initial, interim and final visits. X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Apicoectomy	Covered once per root each 24 months. X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Retrograde Filling (per root)	Covered once per root each 24 months. X-rays, cultures, tests, local anesthesia and routine follow-up care are not covered separately.
Root Amputation (per root)	X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.

PROCEDURE	BENEFIT DESCRIPTION
Hemisection **(includes any root removal)**	X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Periodontal Scaling and Root Planing - Per Quadrant	Covered one time per quadrant of the mouth in any 24 month period.
Gingivectomy	One periodontal surgical procedure is covered per quadrant in any 36 month period. If less than a full quadrant is treated, benefits will be based on the fee for a partial quadrant. Local anesthesia and routine post-operative care are not separately allowed as benefits.
Gingival Flap Procedure	One periodontal surgical procedure is covered per quadrant in any 36 month period. If less than a full quadrant is treated, benefits will be based on the fee for a partial quadrant. Root planing, local anesthesia and routine post-operative care are not separately covered.
Crown Lengthening - Hard **Tissue, by Report**	Not covered if performed on the same date as surgery to bone structures, crown preparation or other restoration.
Osseous Surgery, Guided **Tissue Regeneration (includes surgery and re-entry), Pedicle Soft Tissue Graft, Free Soft Tissue Graft (including donor site)**	One periodontal surgical procedure is covered per quadrant in any 36 month period. If less than a full quadrant is treated, benefits will be based on the fee for a partial quadrant. Local anesthesia and routine post-operative care are not separately allowed as benefits.
Surgical Extractions **of Teeth or Tooth Roots**	Local anesthesia and routine post-operative care are not separately allowed as benefits.
Oral Surgery Services	Covered one time in a 36 month period. Includes fistula closure, sinus perforation closure, tooth reimplantation, surgical access to expose teeth, biopsies, soft-tissue lesion removal, excision of bone tissue, excision of hyperplastic gum tissue, surgical incisions, and cyst removal. Local anesthesia and routine post-operative care are not separately allowed as benefits.
General Anesthesia Analgesia (Nitrous Oxide) **I.V. Sedation**	Only one type of anesthesia procedure per date of service is allowed as a separate benefit when provided for covered oral surgical procedures.
Alveoloplasty	Not allowed as a separate benefit when performed on the same date as extractions. Includes local anesthesia and routine post-operative care.

MAJOR SERVICES – NOT A COVERED BENEFIT

ORTHODONTIA - NOT A COVERED BENEFIT

LIMITATIONS/EXCLUSIONS
(What Is Not Covered)

GENERAL LIMITATIONS – ALL SERVICES

a) Alternate Benefits - Often more than one service or supply can be used for treatment. In deciding the amount allowed on a claim, Plan will consider other materials and methods of treatment. Payment will be limited to the Covered Amount for the least costly Covered Service that meets accepted standards of dental care as determined by Delta Dental. The covered person and his Provider may decide on a more costly treatment. Delta Dental will pay toward the cost of the selected procedure at the Coinsurance level shown on the Schedule of Benefits. Payment will be limited to the Covered Amount for the least costly treatment. **Only covered services will receive Alternate Benefits.**

b) Temporary services will be covered as part of the final service. The benefit allowed for such service and the final service is limited to the benefit allowed for the final service.

c) Plan will pay Procedures performed at the same time and as part of a primary procedure at the amount allowed for the primary procedure.

d) Services are covered when provided by a person legally permitted to perform such Services and are determined to be Necessary and appropriate. Benefits will be based on the terms of this plan and Delta Dental's Processing Policies, even if no monies are paid.

e) Pre- and post-operative procedures are considered part of any associated Covered Service. Benefit will be limited to the Covered Amount for the Covered Service.

f) Local anesthesia is considered part of any associated Covered Service. Benefit will be limited to the Covered Amount for the Covered Service.

g) The Covered Amount for a Covered Service Started but not Completed will be limited to the amount determined by Delta Dental.

h) Allowance for an assistant surgeon, when determined by Delta Dental to be a Covered Service, will not exceed 20% of the surgeon's fee for the same Covered Service.

i) Services related to another category of Covered Services will be covered at the same percentage as the related category of Covered Services.

EXCLUSIONS

a) Services for injuries or conditions which are covered under Worker's Compensation or employer's liability laws. Services provided by any federal or state agency. Services provided without cost by any city, county or other political subdivision. Any Services for which the person would not have to pay if not insured, except if such exclusion may be prohibited by law.

b) Any Service Started when the person was not covered under this Plan. This includes any Service Started during an applicable Waiting Period.

c) Services for treatment of birth or developmental defects, ***except*** Services within the mouth for treatment of a condition related to cleft lip and/or cleft palate

d) Any treatment provided primarily for cosmetic purposes. Veneers on teeth and facings or veneers placed on crowns or bridge units for teeth after the first molar will always be considered cosmetic. Delta Dental will limit their allowance to a Covered Service without facings or veneers and the patient is responsible for the remainder of the Provider's approved fee.

e) Services to treat tooth structure lost from wear, erosion, attrition, abrasion or abfraction.

f) Services resulting from improper alignment, occlusion or contour.

g) Services related to periodontal stabilization of teeth (splinting).

h) Habit appliances, night guards, occlusal guards, athletic mouth guards and jaw function services, bite registration or analysis, or any related services.

i) Patient management services (except covered anesthetic services).

j) Charges for prescribed drugs.

k) Any Experimental or Investigational treatment.

l) Services that may otherwise be covered, but due to the patient's condition would not prove successful to improve the patient's oral health.

m) Any treatment done in anticipation of future need (except covered preventive services).

n) Hospital costs or any charges for use of any facility.

o) Any anesthesia service not included in Covered Services.

p) Grafts done in the mouth where teeth are not present.

q) Grafts of tissues from outside the mouth into the mouth.

r) Therapy for speech or the function of the tongue or face.

s) Orthodontic Services unless shown as covered on the Schedule of Benefits.

t) Implant Services unless shown as covered on the Schedule of Benefits.

u) Major Services such as crowns, bridges and dentures.

v) Treatment of any temporomandibular joint (TMJ) problems, including facial pain, or any related conditions. Any related diagnostic, preventive or treatment Services.

w) Services not performed in accordance with Colorado state law. Services by any person other than a person licensed to perform them. Services to treat any condition, other than an oral or dental disease, abnormality or condition.

x) Teaching services.

y) Completion of forms. Providing diagnostic information. Copying of other records.

z) Replacement of lost, stolen or damaged items.

aa) Repair of items altered by someone other than a Provider.
bb) Any Services not included in Covered Services.
cc) Services for which charges would not have been made but for this coverage, except for Services as provided under Medicaid.
dd) Missed appointment charges.
ee) Preventive control programs, including home care items.
ff) Plaque control programs.
gg) Self-injury.
hh) Provisional splinting.

PARTICIPANT PAYMENT RESPONSIBILITY

Some things that may affect the amount you will pay include your specific plan provisions and if your Provider participates (and at what level) with Delta Dental. You are responsible for deductibles, amounts above the maximum allowed, and your coinsurance. You must pay charges for Services not covered under the Plan. You may be responsible for some part of the premium.

CLAIM PROCEDURES (How to File a Claim)

If your Provider participates with Delta Dental, the claim form will be filed by your Dentist. The patient must sign the form to permit release of the information to Delta Dental.

If you elect treatment from a Provider who does not participate with Delta Dental, you may need to file your own claim.

If you are covered by more than one dental plan, you should file all of your claims with each plan.

The Plan will not pay claims submitted more than 12 months after the date the service was provided.

Delta Dental will furnish notice of its decision on your claim within 30 days after receipt of the claim, unless special circumstances require an extension of time for processing the claim. No extension will be more than 15 days after the end of the initial 30 day period. If an extension of time for processing is required, written notice of the extension shall be furnished to you before the end of the initial 30-day period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which a final decision is expected to be made. If an extension is necessary due to your failure to submit the information necessary to decide the claim, the extension notice will specifically describe the required information and you will be afforded 45 days from your receipt of the notice within which to provide the specified information.

If your claim is wholly or partially denied, you will be furnished a written notice setting forth:

a. The specific reasons for the adverse benefit determination;
b. A specific reference to pertinent Plan provisions on which the determination was based;
c. A description of any additional material or information necessary to process your claim and an explanation of why such material or information is necessary;
d. A description of the Plan's review procedures and the time limits applicable to such procedures, including, if applicable, a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review; and
e. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

PRE-TREATMENT ESTIMATE

Before starting treatment that may cost $400 or more, you may request an estimate of what is covered. Pre-treatment estimates are not required.

GENERAL PROVISIONS

Double Coverage
Family members may be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one group health plan, state law permits your carriers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The aim is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of benefits (COB) covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, contact your group plan administrator or your state insurance department for a full review of coordination of benefits requirements.

Primary or Secondary?
You will be asked to identify all the plans that cover family members. We need this information to determine whether we

are “primary” or “secondary.” The primary plan always pays first.

Any plan which does not contain your state’s coordination of benefits rules will always be primary.

When This Plan is Primary

If you or a family member ae covered under another plan in addition to this one, this Plan will be primary when:

Your Own Expenses

- The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired.

Your Spouse’s Expenses

- The claim is for your spouse, who is covered by Medicare, and you are not both retired.

Your Child’s Expenses

- The claim is for the health care expenses of your child who is covered by this plan and

- you are married and your birthday is earlier in the year than your spouse’s or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual’s birthday. This is known as the “birthday rule”; or

- you are separated or divorced and you have informed us of a court decree that makes you responsible for the child’s health care expenses; or

- there is no court decree, but you have primary custody of the child.

Other Situations

This Plan will be primary when any other provisions of state or federal law require it to be.

How The Plan Pays Claims When It is Primary

When this Plan is the primary plan, the Plan will pay the benefits provided by your contract, just as if you had no other coverage.

How the Plan Pays Claims When It is Secondary

The Plan will be secondary whenever the rules do not require it to be primary.

When the Plan is the secondary plan, the Plan does not pay until after the primary plan has paid its benefits. The Plan will then pay part or all of the allowable expenses left unpaid. An “allowable expense” is a health care service or expense covered by one of the plans, including copayments and deductibles.

If there is a difference between the amount the plans allow, this Plan will base its payment on the higher amount. However, if the primary plan has a contract with the Provider, our combined payments will not be more than the contract calls for Health maintenance organizations (HMO) and preferred Provider organizations (PPO) usually have contracts with their Providers.

The Plan will determine its payment by subtracting the amount the primary plan paid from the amount the Plan would have paid if it had been primary. The Plan will use any savings to pay the balance of any unpaid allowable expenses covered by either plan.

If the primary plan covers similar kinds of health care, but allows expenses that this Plan does not cover, this Plan may pay for those expenses. The Plan will not pay an amount the primary plan did not cover because you didn’t follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain pre-certification, this Plan will not pay the amount of the reduction, because it is not an allowable expense.

SUBROGATION

The Plan has the right to enforce on its own, or with a covered person, a claim against a third party up to the amount paid by the Plan. If the Plan pays a claim for injuries to a covered person and the covered person settles with a third party for an amount that includes such costs, the covered person must refund the Plan the amount equal to the benefit payment made to, or on behalf of, the covered person.

TERMINATION/NONRENEWAL/ CONTINUATION

Coverage under the Plan will terminate at the earliest of:

- For the Associate and her or her covered Dependents, the effective date of any Associate request to cancel coverage;
- For the Associate and his or her covered Dependents, the last day of the month in which the Associate becomes ineligible for coverage;
- For the Associate and his or her covered Dependents, the date the Plan terminates;
- For the Associate and his or her covered Dependents, the end of the period for which any required premium is paid;
- For the Associate and his or her covered Dependents, the date the Plan is amended such that the Associate is no longer eligible to participate in the Plan.
- As to any covered Dependent, the date the person no longer qualifies as a Dependent. Loss of Dependent

status can occur for many different reasons. Your Employer may not know when this happens. Therefore, you are required to notify your Employer within 31 days of the event or the loss of coverage, whichever is later.

Coverage may continue during any approved leave of absence in accordance with the Employer's leave of absence policy. To the extent coverage is extended, the Associate may be required to continue paying premiums for coverage while on such leave.

EXTENDED COVERAGE

Plan benefits will end if this Plan is terminated or if your coverage is cancelled. The Plan will cover no further Services except as described below.

If a Covered Service Started before coverage ends, but the Covered Service is completed after coverage ends, the Plan will pay Benefits for the Covered Service as follows:

- Benefits will be paid in the amount that would have been paid and subject to the same terms as would have applied if the Person's coverage were still in effect.
- Benefits will be paid only if the Covered Service is completed within 60 days after the date the Person's coverage ended.

No benefit will be paid if the Covered Service is Started after coverage ends.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)

Covered persons may be able to continue coverage through COBRA. The benefits will be the same as the benefits active Employees receive. The Covered person must pay the entire Premium, which cannot exceed 102% of the cost for an active employee with the same Plan. See the notice at the end of this booklet for more information regarding your COBRA rights.

APPEALS AND COMPLAINTS

A covered person may appeal an adverse claim decision within 180 days of the date of the original Explanation of Benefits by writing to:

Delta Dental of Colorado
Appeals Analyst
P.O. Box 172528
Denver, CO 80217-2528

A covered person may submit additional information in support of the appeal.

Appeals are reviewed by an impartial Provider of the same or similar specialty as would typically manage the case being reviewed. The reviewing provider will not have been involved in the initial decision.

The decision will be sent to the covered person with the rationale for the decision. The decision will be made within 15 calendar days for pre-service denials. Post-service decisions will be made within 30 calendar days.

Internal Appeal Process - Expedited Appeals:
Covered persons may request an expedited appeal when the time for a standard review would seriously jeopardize the life or health of the covered person, would jeopardize the covered person's ability to regain maximum function, or, for persons with a disability, create an imminent and substantial limitation on their existing ability to live independently.

Expedited review decisions will be issued within 72 hours.

As a result of the national emergency related to the COVID-19 outbreak, the time periods in which covered persons may file a claim and file a request for an appeal of a denied claim have been extended to the extent required by law. Generally, covered persons have up to 60 days after the announced end of the national emergency related to the COVID-19 outbreak to file a claim or request an appeal of a denied claim.

DEFINITIONS

ALLOWABLE FEE means the maximum fee a provider is allowed to charge for a given service in accordance with the fee schedule associated with the Provider's Participating Provider Agreement.

ALTERNATE BENEFIT means the benefit allowed for the least costly, commonly accepted Service or supply that could be used to treat a dental problem for which there are other, more costly treatment options that the covered person selects.

ASSOCIATE means an individual who is a common law employee of an Employer.

BENEFITS means those Services and supplies covered pursuant to the terms of this plan. Benefits for all Covered Services are subject to the limitations and exclusions noted in this Benefit Booklet.

COINSURANCE means the percentage of a Covered Amount which is payable by the Plan. The Coinsurance for each type of Covered Service is shown on the Schedule of Benefits. The Coinsurance applicable will vary depending upon the type of dental Service.

COMPLETED means:

- For Root Canal Therapy: The date the canals are permanently filled.
- For Fixed bridges (fixed partial dentures), Crowns, Inlays, Onlays, and other laboratory prepared restorations: On the date the restoration is cemented in place, regardless of the type of cement used.
- For Dentures and Partial Dentures (removable partial dentures): On the date that the final appliance is first inserted in the mouth.
- For all other Services, on the date the procedure is Started.

For claim payment purposes, the date Completed will be the date when a claim is incurred.

DEDUCTIBLE means the amount that must be paid by the covered person before the Plan will make payment. The amount of the Deductible is shown on the Schedule of Benefits. If there is a limit to the deductible amount that a family must pay, that will also be shown.

DEPENDENT means:

- The eligible Associate's lawful spouse
- The eligible Associate's Legally Domiciled Adult or LDA (LDA coverage is not offered at the University of Saint Mary or Cristo Rey.)
- The eligible Associate's or covered LDA A's child who is:
  - under the age of 26.
  - 26 or more years old, unmarried and primarily supported by the Associate and incapable of self-sustaining employment by a reason of mental or physical disability, which has been determined to be a disability by the Social Security Administration (SSA) and which arose while the child was covered as a dependent under this Plan, or while covered as a dependent under a prior plan, with no break in coverage.
    - You must provide your child's SSA Certificate of Disability from time to time, but not more frequently than once a year, and you may be required to provide proof of the continuation of such condition and dependence.

The term "child" as used above means the Associate's or covered LDA A's natural or legally adopted child. It also includes a stepchild or a child for whom the Associate or LDA A is the legal guardian. A child of the Associate's LDA B is not eligible to participate in the Plan.

EFFECTIVE DATE is the date coverage begins.

EMERGENCY TREATMENT or EMERGENCY SERVICE means any required Service that is provided as the direct result of an unforeseen occurrence that requires immediate, urgent action.

EMPLOYER means SCL Health and any related entity that has adopted this Plan, with the consent of SCL Health, for the benefit of its eligible Associates.

EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES means those services or supplies that are not generally accepted in the dental community as being safe and effective, as defined by Delta Dental.

LEGALLY DOMICILED ADULT OR "LDA" means an individual over 18 who shares the same principal residence as the Associate, remains a member of the Associate's household throughout the coverage period, and meets one of the following definitions:

- **Category A LDA (LDA A)** – (1) has lived with the associate continuously for at least 12 months, (2) has an on-going, exclusive and committed relationship with the associate similar to marriage (e.g., is not a casual roommate or tenant), (3) shares basic living expenses and is financially interdependent with the associate, and (4) is neither legally married to (or legally separated from) or in a civil union with anyone else, nor legally related to the associate by blood in any way that would prohibit marriage in the state of his or her residence.

- **Category B LDA (LDA B)** – (1) is the associate's adult child, sibling or parent by blood, adoption, or marriage (e.g., a step-child), (2) the associate claimed the individual as a dependent on his or her federal income tax return for the preceding year, and (3) has lived with the associate continuously for at least 6 months.

An Associate may cover a maximum of two adults under the Plan, including himself or herself, in addition to any dependent children under age 26 or disabled. For instance, an Associate who is married and covers his or her spouse cannot also cover an LDA B.

MAXIMUM PLAN ALLOWANCE means the maximum allowable amount for a procedure as determined by Delta Dental.

NECESSARY means a Service that is required by, and appropriate for treatment of, the Covered person's dental condition according to generally accepted standards of dental care as determined by Delta Dental.

OUT-OF-POCKET MAXIMUM means the maximum amount you will have to pay for allowable covered expenses under this plan.

PLAN SPONSOR means SCL Health.

PLAN YEAR means the twelve consecutive month period beginning each January 1 and ending on the following December 31.

PROVIDER means a person licensed to practice dentistry.

STARTED means:

- For Full Dentures or Partial Dentures (removable partial dentures): The date the final impression is taken.
- For Fixed Bridges (fixed partial dentures), Crowns, Inlays, Onlays and other laboratory prepared restorations: The date the teeth are first prepared (i.e., drilled down) to receive the restoration.
- For Root Canal Therapy: The date the pulp chamber is first opened.
- For Periodontal Surgery: The date the surgery is actually performed.
- For All Other Services: The date the Service is performed.

FACTS YOU SHOULD KNOW ABOUT THIS PLAN

1. Name of Plan: SCL Health Dental Plan

   The SCL Health Dental Plan is part of the SCL Health Associate Health Benefit Plan.

2. Name and address of Plan Sponsor and ERISA Plan Administrator:

   SCL Health
   500 Eldorado Blvd., Suite 4300
   Broomfield, CO 80021
   303-813-5250

3. Employer Identification No. (EIN) of the Plan Sponsor: 23-7379161

4. Participating Employers as of January 1, 2022:

   Brighton Community Hospital Association (d/b/a Platte Valley Medical Center)
   Caritas Clinics, Inc.
   Holy Rosary Healthcare
   Marian Clinic, Inc.
   Mount St. Vincent Home, Inc.
   Platte Valley Medical Group, LLC
   SCL Front Range Home Health, LLC
   SCL Health-Front Range, Inc.
   SCL Health Medical Group - Billings, LLC
   SCL Health Medical Group - Butte, LLC
   SCL Health Medical Group - Denver, LLC
   SCL Health Medical Group - Grand Junction, LLC
   SCL Health Medical Group Miles City
   SCL Health - Montana
   St. James Healthcare
   St. Mary's Hospital and Medical Center, Inc.
   Mother House of the Sisters of Charity of Leavenworth, Kansas
   University of Saint Mary
   Cristo Rey Kansas City, a Sisters of Charity of Leavenworth High School

5. Type of Plan: Welfare benefit plan providing dental benefits

6. Plan No.: 521

7. Type of Administration: Contract Administration

8. Name and Address of Contract Administrator:

   Delta Dental of Colorado
   4582 S. Ulster St., Suite 800
   Denver, CO 80237
   1-800-610-0201

Delta Dental does not insure any benefit under the Plan. All benefits are paid from the general assets of the Employers.

9. The name and address of the person designated as agent for service of legal process and address at which process may be served.

SCL Health
c/o Senior Vice President, Chief Human Resources Officer
500 Eldorado Blvd., Suite 4300
Broomfield, CO 80021

Service may also be made upon the Plan Administrator.

10. Sources of Contributions: Employer & Employee. Benefits are paid from the general assets of the Employer.

11. Plan Year: January 1st – December 31st

12. Amendment of the Plan: The Plan Sponsor reserves the right at any time and from time to time to modify or amend, in whole or in part, any or all of the provisions of the Plan, as follows:

- The Board of Directors of the Plan Sponsor, in its sole discretion, may amend or modify the Plan, in whole or in part, at any time.
- The President/Chief Executive Officer of the Plan Sponsor, in his or her sole discretion, may amend or modify the Plan to the extent such amendment or modification would not constitute a material change in the benefits design or philosophy of the Plan Sponsor or result in a material increase in costs to the Sponsoring Employer; provided, however, that the President/Chief Executive Officer of the Sponsoring Employer shall make any Plan amendment reasonably requested by the Mother House of the Sisters of Charity of Leavenworth, the University of Saint Mary, Mount St. Vincent Home, Inc. or Cristo Rey Kansas City solely with respect to its Participants, to the extent such amendment is permitted by law, does not result in adverse tax consequences and is administratively practicable. In determining whether an amendment constitutes a material change or would result in a material cost increase for this purpose, the determination of the President/Chief Executive Officer will be binding on the Plan Sponsor and the Plan.
- The Senior Vice President, Chief Human Resources Officer, of the Plan Sponsor, or the person from time to time performing such function, may amend or modify the Plan at any time to the extent such amendment or modification is routine, required by law or where circumstances make it impracticable for action by the President/ Chief Executive Officer of the Plan Sponsor.

RIGHTS AND PROTECTIONS UNDER ERISA

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

Receive Information About Your Plan and Benefits

ERISA provides that all Plan participants will be entitled to:

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

  Send written requests to:

  HR Benefits Department
  500 Eldorado Blvd., Suite 4600
  Broomfield, CO 80021

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Assistance with Your Questions

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

COBRA INFORMATION

This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

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

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

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

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

NOTE: Although Legally Domiciled Adults and children of Legally Domiciled Adults are not eligible for COBRA coverage, the Plan makes available continuation coverage similar to COBRA to these individuals.

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The Employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the associate; or
- The associate's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the associate and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 31 days after the qualifying event occurs. You must provide this notice in writing to:

SCL Health
HR Service Center
500 Eldorado Blvd., Ste. 4200
Broomfield, CO 80021

Notice forms may be obtained by calling the Human Resources Department at (855) 412-3701 or online at so-hrsupport@sclhealth.org. If you do not provide notice within the time period above or if you do not provide any additional documentation or information (if requested) in a timely manner, your notice will be rejected and COBRA coverage will not be offered.

Note: As a result of the national emergency related to the COVID-19 outbreak, the time period you have to notify the Plan Administrator of a qualifying event has been extended to the extent required by law. Generally, you have up to 60 days after the announced end of the national emergency related to the COVID-19 outbreak to provide this notification.

How is COBRA continuation coverage provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Notice must be provided in writing to:

Discovery Benefits, Inc.
P.O. Box 869
Fargo, ND 58107-0869
Phone: (866) 451-3399
Fax: (888) 408-7224
cobraforms@discoverybenefits.com

If the above notification is not timely made, or if you do not provide the additional documentation or information (if requested) in a timely manner, your notification will be rejected and any additional COBRA/continuation coverage beyond the original 18-month period will not be offered.

The affected individual must also notify the Discovery Benefits, Inc. within 30 days of any final determination by the Social Security Administration that the individual is no longer disabled.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the associate or former associate dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

SCL Health
500 Eldorado Blvd., Ste. 4300
Broomfield, CO 80021

SCL Health Human Resources Department may be reached by phone at (855) 412-3701

Visit Delta Dental's Website at:

www.deltadentalco.com

You can search for a Provider, download a claim form or access other personal account information.

Delta Dental of Colorado
4582 South Ulster Street, Suite 800
Denver, CO 80237

Customer Service:
1-800-610-0201