PARTNERSHIP HEALTHPLAN OF CALIFORNIA

SELF FUNDED DENTAL PLAN

SUMMARY PLAN DESCRIPTION

Effective: January 1, 2016

Revised: January 1, 2022

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PLAN INFORMATION

Plan Name:	PARTNERSHIP HEALTHPLAN OF CALIFORNIA Self Funded Dental Plan
Plan Information:	The information contained in this Summary Plan Description ("SPD") is only a general discussion of the relevant provisions of the Plan found in the official Plan Document. In all events, the provisions of the official Plan Document concerning the administration and operation of the Plan are contained in such official Plan Document. The official Plan Document is available for your review at Direct Dental Administrators, LLC.
Type of Plan:	Welfare Benefit Plan
Plan Year:	January 1 through December 31 of the same year
Plan Number:	502PHP0116
Effective Date of Plan:	January 1, 2016. Revised January 1, 2022.
Funding Method:	Funded through Employer and Employee contributions, if required
Source of Contributions:	From PARTNERSHIP HEALTHPLAN OF CALIFORNIA'S general assets
Plan Sponsor and Plan Administrator:	PARTNERSHIP HEALTHPLAN OF CALIFORNIA 4665 Business Center Drive Fairfield, CA 94534 (707) 863-4226
Plan Sponsor's Employer Identification Number:	68-0301406
Agent for Service of Legal Process:	PARTNERSHIP HEALTHPLAN OF CALIFORNIA 4665 Business Center Drive Fairfield, CA 94534 (707) 863-4226
Contract Administrator for Plan:	Direct Dental Administrators, LLC 7510 Shoreline Drive Stockton, CA 95219 (844) 213-8140

INTRODUCTION

PARTNERSHIP HEALTHPLAN OF CALIFORNIA maintains PARTNERSHIP HEALTHPLAN OF CALIFORNIA Self-Funded Dental Plan (the "Plan") for the exclusive benefit of, and to provide health benefits to, its eligible employees, their spouses and eligible dependents.

This document, together with the Plan document, constitutes the Summary Plan Description for the Plan. If the terms of this Summary Plan Description conflict with the terms of the Plan Document, the terms of the Plan Document will control, unless superseded by applicable law.

This Plan is a health plan and thereby subject to the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) including regulations affecting the maintenance, creation or use of Protected Health Information (PHI) (as that term is defined under HIPAA). Please refer to the Notice of Privacy Practices issued by the Plan for a description of how your medical information may be used and disclosed and how you can get access to this information.

SPECIFIC PLAN INFORMATION

Schedule of Benefits

Effective for those meeting the eligibility and waiting period requirements identified below.

Annual Maximum Benefits

Annual Maximum Reimbursement for Dental Expenses per Plan Year is **$3,000.00 per person.**

Plan Year Deductible

Plan Year Deductible is: **$50 per person/$150 per family (waived for Preventive).**

Dental Expense Coverage (In and Out of Network Benefits)

100% In and Out of Network for Preventive Services: Two (2) Exams, Two (2) Bitewing X-rays, and three (3) Cleanings allowed every 12 months, Full Mouth X-rays allowed every 36 months, Two (2) Topical Fluoride Applications every Plan Year to age 16, Space Maintainers for dependents to age 12.

90% In Network and 80% Out of Network for Basic Services: Basic Fillings, Periodontal Procedures, Root Canal Treatment, Sealants up to age 16 once per permanent molar every 36 months, Re-cementing of bridges, crowns and inlays, General Anesthesia and Oral Surgery, Emergency Palliative Treatment, Repair of crowns, bridges and removable dentures.

60% In Network and 50% Out of Network for Major Services: Crowns, Inlays, Bridges, Post and Cores, Prosthodontics, Implant Services, Partial and Full Dentures.

50% In Network and Out of Network for Orthodontic Services: Lifetime maximum of $1500 per person for all participants including benefits paid by prior Partnership HealthPlan of California dental plans.

You may see any dentist. If you use a PPO Provider you may receive discounts of up to 30%. Find a DHA PPO Provider at: **www.directdentalplans.com** and select "Find a DHA provider" and click on the DHA logo.

Out of Network Benefits are paid according to the 90% Usual, Customary and Reasonable Fees for the treating dental office zip code.

Members may access plan information and claim status by registering on the Member Web Portal at www.directdentalplans.com.

*The anniversary date of this plan is **January 1** of each year.*

Annual enrollment Period is held each year. Only during this period employees may add existing dependents to the plan. Existing dependents added to the plan will be eligible for dental benefits the following ***January 1***. Newly acquired dependents may be enrolled within 31 days of becoming eligible (ie, marriage, domestic partner, birth, adoption, etc.) and will be eligible for all benefits described herein as of the date of eligibility.

Please consult this booklet for further information regarding the specifics of plan eligibility, dependent coverage and expense reimbursement.

Eligibility for Benefits

Eligible Employee: A regular full-time employee of the Employer. A full-time employee is considered to be an individual who is regularly scheduled to work 30 or more hours a week.

Eligible Dependents: Eligible dependents include:

(a) Legal Spouse or Domestic Partner of an Eligible Employee;

(b) Dependent Children of an Eligible Employee. Group health plans must make dependent coverage available to adult children until they turn age 26. For plan years beginning on or after January 1, 2014, the mandate to provide coverage for adult children through age 26 will apply to all group health plans, even if the adult child is eligible for coverage under some other employer-sponsored group health plan. Adult children shall include those who are a child of the participant, whether or not they are:

- Married or not married;
- Live at home;
- Are a dependent on the employee's tax return; or,
- Are a student.

(c) Children of an Eligible Employee who have attained the age specified in item B above who are incapable of self-sustained employment due to handicap or disability and are still dependent on the employee are covered with no age limit.

Waiting Period: You are eligible to participate in the Plan with PARTNERSHIP HEALTHPLAN OF CALIFORNIA on the first day of the month following 30 days from your hire date.

Effective Date of Coverage

You will commence participation in the Plan on the first day of the month following 30 days from your hire date.

Filing Claims

(a) Submit your Dental claim, paid receipt or bill, along with a completed claim form to:

Direct Dental
Dental Claims
P.O. Box 497
Milwaukee, WI 53201

The fastest way to submit a claim and find patient information: Providers may also submit claims via Provider Web Portal at www.directdentalplans.com and selecting LogIn-Provider Web Portal.

Providers may also submit claims electronically to payer ID: SDCOM.

(b) Claims must be filed within ninety (90) days of the date charges were incurred or, in the case of dual coverage, date of payment from other plan, to be eligible for reimbursement.

(c) Please refer to the Claims and Appeals Procedures later in this SPD for further information.

Eligible Expenses

For charges incurred to be eligible for reimbursement, they must be the result of services provided by a properly licensed individual who is a dentist or individual acting under his/her supervision as a technician, and treatment is within the scope of his/her licensure and training.

Individual Termination of Coverage

Your eligibility for the Plan benefits terminates on the last day of the month in which (i) you terminate employment with PARTNERSHIP HEALTHPLAN OF CALIFORNIA, (ii) you cease (because of layoff, reduction of hours, or any other reason) to be an employee eligible to participate in the Plan, or (iii) the Plan terminates.

If your participation terminates, you will receive reimbursement for covered expenses incurred prior to your termination of participation if you apply for reimbursement within 90 days of the date the charges were incurred.

Termination of Coverage

The coverage of any Plan participant shall terminate on any of the following dates:

(a) The date of termination of the Plan; or,

(b) The date all or certain benefits are terminated for his/her particular class of employee by modification of the Plan; or,

(c) The date he/she fails to make the required contribution, if applicable.

Dental Expense Benefits

After the Employee submits a valid receipt along with a completed claim form, as proof that a Covered Person has incurred covered expenses for care or treatment by a dentist, the Plan will pay up to the Maximum Reimbursement specified in the Schedule of Benefits for the service(s) provided. Claims must be submitted within ninety (90) days of the date on which charges were incurred. Amount payable is subject to Coordination of Benefits as applicable.

Exclusions

The Dental Plan does not cover:

(a) Expenses covered under Workers' Compensation or employer liability laws;

(b) Expenses covered by any governmental agency or under any governmental program or law, except as to charges that the person is legally obligated to pay;

(c) Expenses incurred prior to the date the person became covered under this Plan;

(d) Cosmetic services as defined by IRS regulations;

(e) Crowns/Jackets/Inlays/Onlays/Cast Restorations/Partial and Full Dentures/Implants that are replaced in less than 5 years from placement;

(f) Occlusal Repositioning Devices, Night guards and athletic mouth pieces;

(g) Initial replacement of teeth that were extracted prior to eligibility for any Partnership HealthPlan of California dental plan.

Covered expenses do not include expenses for cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease. "Cosmetic surgery" means any procedure, which is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease. The "medical necessity" of any treatment will be the basis for coverage consideration.

Questions

If you have a question about whether a particular expense is or is not reimbursable under the Plan, you should contact the Plan Administrator. The Plan Administrator has the discretionary authority to determine what expenses are reimbursable, taking into account the terms of this Plan, and rules contained in the applicable sections of the Code, and regulations and other IRS guidance thereunder.

One cautionary note: Benefits for which you receive reimbursement cannot be deducted as a medical expense on your Federal income tax return.

Coordination of Benefits

The purpose of this Plan is to help you meet the cost of needed dental care or treatment. It is not intended that anyone receive benefits greater than actual expenses incurred. Benefits payable by this Plan and any other group dental or medical plan may be coordinated so that the total benefits allowed will not exceed the amount which would have been allowed if no other plan were involved. All benefits provided hereunder are subject to this provision.

This Plan will always pay its regular benefit in full when it is the employee's primary plan. As a secondary Plan, this Plan may provide a reduced amount which, when added to the benefits payable by the other plan, will equal an amount not greater than 100 percent of the fee charged.

If the patient is eligible for benefits under more than one group dental plan, benefits will be calculated using the birthday rule to determine which Plan is primary and which is secondary. The following rules are used in order to make this decision:

(a) If you are the patient, then this Plan is the primary plan. If your spouse is the patient and covered under a plan of his or her own, then that plan is the primary plan.

(b) If a dependent child is the patient and is covered under both parents' plans, the following rules will apply:

- The benefits of the program of the parent whose birthday (according to the month and day) falls earlier in the year as determined before those of the program of the parent whose birthday falls later in that year; but,
- If both parents have the same birthday, the benefits of the program which covered the parent longer are determined before those of the program which covered the other parent for a shorter period of time. However, if the other benefit program does not have the rule described in item A above, then the rule in the other benefit program will determine the order of benefits.

(c) If two or more plans cover a person as a dependent child of separated or divorced parents, benefits for the dependent child will be determined in the following order:

- The plan of the parent with custody will be primary;
- The plan of the spouse of the parent with custody of the child;
- The plan of the parent not having custody of the child;
- However, if it has been established by court decree that one parent has responsibility for the child's health care expenses, then the plan of that parent is primary.

(d) If none of the rules determines the order of benefits, the plan that has covered the patient for a longer period is the primary plan.

Right to Receive and Release Necessary Information

In order to determine this Plan's responsibility, the Employer or Administrator may, with or without notice to you, or without your consent, give to or get from any other plan, company or person any information need to coordinate benefits. When you file a claim with this Plan, you agree to provide, and give the Employer and Administrator your permission to give or get, any additional information needed to coordinate benefits.

ADDITIONAL HEALTH PLAN PROVISIONS

FMLA: Family and Medical Leave Act of 1993. In the event PARTNERSHIP HEALTHPLAN OF CALIFORNIA employs 50 or more individuals within a 75 mile radius, PARTNERSHIP HEALTHPLAN OF CALIFORNIA will be subject to FMLA. As such, notwithstanding the above rule regarding termination of participation or any other provision to the contrary in this Plan, if you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), the following rules will apply. Only to the extent required by FMLA (among other things, this means only for the duration of a qualifying leave), PARTNERSHIP HEALTHPLAN OF CALIFORNIA will continue to maintain your benefits on the same terms and conditions as though you were still an active employee. Except as otherwise provided by FMLA, your Plan participation will cease when the Plan Administrator learns that you do not intend to return to work after your leave. If earlier, your Plan participation will immediately cease upon expiration of your FMLA leave, if you fail to return to work at such time. Except as otherwise provided in FMLA, if you fail to return to work after the FMLA leave, you will be required to reimburse PARTNERSHIP HEALTHPLAN OF CALIFORNIA for the cost of the coverage PARTNERSHIP HEALTHPLAN OF CALIFORNIA provided you while you were on FMLA leave (the cost equals the COBRA premium, without a 2% add-on).

FMLA: Military Family Leave. FMLA includes the following additional leave rights:

- Eligible employees are entitled to up to 12 weeks of leave because of “any qualifying exigency” arising out of the fact that the spouse, son, daughter, or parent of the employee is on active military duty or a reservist being called to active military duty in the Armed Forces and is deployed to a foreign country (service member).
- An eligible employee who is the spouse, son, daughter, parent, or next of kin of an eligible covered service member as defined below is entitled to up to 26 work weeks of leave in a single 12-month period to care for the service member. For purposes of this subparagraph, “eligible covered service member” shall mean a veteran who was a member of the Armed Forces (including a member of the National Guard or a military reservist) who is undergoing medical treatment, recuperation, or therapy for a serious illness or injury. A “serious illness or injury” includes illnesses or injuries that either (i) occurred during the service member’s active duty, or (ii) existed prior to the service member’s active duty and which were aggravated by service in the line of duty. The military service of the eligible covered service member must have ended within 5 years of the first date the eligible employee takes leave.
- An eligible employee who is the spouse, son, daughter, or parent of a service member may take “rest and recuperation” leave of up to 15 days to spend time with the service member who is on a short-term, temporary, rest and recuperation leave during the period of the service member’s deployment. The eligible employee may be required to provide a copy of the service member’s orders that indicate the dates of the service member’s rest and recuperation leave.

USERRA: Employees on Military Leave. Employees going into or returning from military service will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights include up to 24 months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee and immediate coverage with no preexisting conditions exclusions applied in the Plan upon return from service. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

Special Open Enrollment Rights for Certain Individuals under Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself and your dependents in one of the health care options offered by the Plan Sponsor, provided that you request enrollment within 30 days after your other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you otherwise decline to enroll, you may be required to wait until the group's next open enrollment to do so. You also may be subject to additional limitations on the coverage available at that time.

Any requests for special enrollment or to obtain more information should be directed to:

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
attn: Human Resources Department
4665 Business Center Drive
Fairfield, CA 94534
(707) 863-4226

Certificate of Creditable Coverage. A certificate of creditable coverage (certificate) is a written certification of the period of your creditable coverage under this Plan including COBRA continuation coverage, if applicable. If a certificate is automatically provided at the end of your coverage, the period included on the certificate is the last period of continuous coverage ending on the date the coverage ceased. If you request a certificate from the Plan Administrator, a certificate must be provided for each period of continuous coverage ending within the 24-month period prior to the date of the request. A separate certificate may be provided for each period of continuous coverage. The certificate also certifies the length of any waiting periods you served for coverage under the Plan.

The certificate enables you to provide proof to a new employer or insurance plan that you had health coverage through your employment with PARTNERSHIP HEALTHPLAN OF CALIFORNIA. The certificate may help you avoid or reduce the preexisting condition limitation or exclusion period under another plan.

You can request a certificate at any time within 24 months after you lose coverage under the Plan or you lose COBRA continuation coverage, whichever is later. You may submit your written request to the Plan Administrator or you may call PARTNERSHIP HEALTHPLAN OF CALIFORNIA at:

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
attn: Human Resources Department
4665 Business Center Drive
Fairfield, CA 94534
(707) 863-4226

After your request is received, the certificate will be provided to you by the earliest date that the Plan Administrator, acting in a reasonable and prompt manner, can provide it. The certificate is required to be provided to you even if you have already received an automatic certificate when your coverage otherwise ended.

Qualified Medical Child Support Orders. This Plan will also provide benefits as required by any qualified medical child support order, as defined in ERISA § 609(a) or National Medical Support Notice, and provide benefits to dependent children placed with Plan participants or beneficiaries for adoption under the same terms and conditions as apply in the case of dependent children who are your natural children or children of your beneficiaries, in accordance with ERISA § 609(c). For a copy of PARTNERSHIP HEALTHPLAN OF CALIFORNIA's procedures applicable to such notices, please contact the Plan Administrator.

Genetic Information Nondiscrimination Act of 2008 (GINA). GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we ask that you not provide any genetic information when responding to any request for medical information. 'Genetic information' as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus

carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assisted reproductive services.

NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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 to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional 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 health Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this 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 either one of the following qualifying events happens:

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

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

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

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;

- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (under 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 a "dependent child."

When is COBRA 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Your notice must provide the type of qualifying event, the date of the qualifying event, and the name and address of the employee, spouse or dependent who underwent the qualifying event.

You must provide this notice to:

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
4665 Business Center Drive
Fairfield, CA 94534
(707) 863-4226

How is COBRA 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employees lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months. Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and

your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 for continuation coverage. You must provide notice to us of receipt of a determination by the Social Security Administration of total disability within 60 days of the date of the notice, the name of the qualified beneficiary who has become disabled, a copy of the determination letter, and the original date of disability.

You must provide this notice to:

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
attn: Human Resources Department
4665 Business Center Drive
Fairfield, CA 94534
(707) 863-4226

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

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

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 ERISA, including COBRA, HIPAA, 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 the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website).

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the address of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Self Funded Dental Plan
attn: Human Resources Department
4665 Business Center Drive
Fairfield, CA 94534
(707) 863-4226

Continuation of Coverage under California Group Health Policies

COBRA Qualified Beneficiaries under federal law who are covered under a group health policy issued in California are eligible to receive up to 18 months of additional COBRA coverage for medical care upon completion of the 18 months received under federal COBRA. This provision does not apply to self-funded medical plans. *The combination of federal and state COBRA coverage may not exceed 36 months in any event.* The 36 month period dates back to the original qualifying event. The additional COBRA period of coverage terminates the earliest of:

- The date the maximum period of coverage expires;
- The date coverage ceases because a premium payment is not made on time;
- The date the employer no longer provides any group health plan; or,
- The date the employee or qualified beneficiary moves out of insurer's services area.

PLAN ADMINISTRATION

In General

PARTNERSHIP HEALTHPLAN OF CALIFORNIA is the Plan Administrator of the Plan and a Named Fiduciary within the meaning of such terms as used in the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). PARTNERSHIP HEALTHPLAN OF CALIFORNIA is the Plan's agent for service of legal process.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA has the duty and authority to interpret and construe the Plan in regard to all questions of eligibility, the status and rights of any Plan participant under the Plan, and the manner, time, and amount of payment of any benefits under the Plan. Each Employee shall, from time to time, upon request of PARTNERSHIP HEALTHPLAN OF CALIFORNIA furnish to PARTNERSHIP HEALTHPLAN OF CALIFORNIA such data and information as PARTNERSHIP HEALTHPLAN OF CALIFORNIA shall require in the performance of its duties under the Plan.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA may designate any individual, partnership or corporation as the Administrator to carry out its duties and responsibilities with respect to the administration of the Plan. Such designation shall be in writing and such writing shall be kept with the records of the Plan.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA may adopt such rules and procedures as it deems desirable for the administration of the Plan, provided that any such rules and procedures shall be consistent with provisions of the Plan and ERISA.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA will discharge its duties with respect to the Plan (i) solely in the interest of persons eligible to receive benefits under the Plan, (ii) for the exclusive purpose of providing benefits to persons eligible to receive benefits under the Plan and of defraying reasonable expenses of administering the Plan, and (iii) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims.

Amendment and Termination

PARTNERSHIP HEALTHPLAN OF CALIFORNIA intends to maintain the Plan indefinitely, but is under no obligation to continue the Plan and can amend or terminate the Plan by providing written notice to the Plan participants. In terminating or amending the Plan, PARTNERSHIP HEALTHPLAN OF CALIFORNIA cannot retroactively reduce the benefits to which a participant is entitled prior to the termination or amendment.

PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)

Effective Date

The following provisions in this Section are effective as of September 23, 2010 unless otherwise stated.

Coverage for Dependents Up to Age 26

Group health plans must make dependent coverage to adult children available until they turn age 26. The mandate applies to any adult child whether or not he or she is eligible to enroll in some other employer-sponsored group health plan. Adult children shall include those who are a child of the Plan participant, whether or not they are:

- married or not married;
- Live at home;
- A dependent on the employee's tax return; or,
- A student.

Preventive Care

Group health plans subject to the preventive services coverage mandate must provide coverage for all of the following preventive services without imposing any co-payments, co-insurance, deductibles, or other cost-sharing requirements:

- Evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force;
- Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents; and,
- Other evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.

Claims Appeal Process

In addition to the claims appeals procedures described in this Plan and the Summary Plan Description, a group health plan shall implement an effective appeals process for appeals of coverage determinations and claims, under which the Plan or issuer shall, at a minimum:

- Have in effect an internal claims appeal process;
- Provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman to assist such enrollees with the appeals processes; and
- Allow enrollees to review their files, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

A group health plan shall also:

- Comply with the applicable state external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans; or,
- Implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to the process applicable to the internal claims process:

- o if the applicable state has not established an external review process that meets the requirements applicable to the internal claims process; or
- o if the plan is a self-insured plan that is not subject to state insurance regulation (including a state law that establishes an external review process whose terms are similar to the process applicable to the internal claims process.

Continuing Effect of This Section 4

The provisions of PPACA described in this Section 4 shall continue in effect, for the Component Health Plans contained herein, as modified by further legislation and regulatory guidance.

CLAIMS AND APPEAL PROCEDURES

Insofar as these procedures are consistent with the provisions of PPACA, the procedures outlined below must be followed by Plan participants ("claimants") to obtain payment of benefits under this Plan.

Health Claims

For purposes of the Health Claims and Claims Appeal Procedure contained in this Summary Plan Description, the term "Administrator" will mean either the issuer or the Plan Administrator depending upon the policy or plan under which the claim has been filed.

You must follow the procedures outlined below to obtain payment of health benefits under this Plan.

You should direct all claims and questions regarding health claims to the Administrator. The Administrator shall have final authority for adjudicating all claims and a full review of the decision on such claims in accordance with the following provisions and with ERISA.

As an individual claiming benefits under the Plan, you shall be responsible for supplying, at such times and in such manner as the Administrator in its sole discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Administrator in its sole discretion shall determine that you have not incurred a covered expense or that the benefit is not covered under the Plan, or if you have failed to furnish such proof as is requested, no benefits shall be payable to you under the Plan.

Under the Plan, there are four types of claims: Urgent Pre-Service, Non-urgent Pre-Service, Concurrent, and Post-Service.

(a) **Pre-Service Claims**. A "Pre-Service Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A "Pre-Service Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

It is important to remember that, if you need medical care for a condition which could seriously jeopardize your life, there is no need to contact the Plan for prior approval. You should obtain such care without delay.

Further, if the Plan does not require you to obtain approval of a medical service prior to getting treatment, then there is no "Pre-Service Claim." You simply follow the Plan's procedures with respect to any notice which may be required after receipt of treatment, and file the claim as a Post-Service Claim.

(b) **Concurrent Claims:** A "Concurrent Claim" arises when the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, and either (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) you request an extension of the course of treatment beyond that which the Plan has approved.

If the Plan does not require you to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Administrator to request an extension of a course of treatment. You simply follow the Plan's procedures with respect to any notice which may be required after receipt of treatment, and file the claim as a Post-Service Claim.

(c) **Post-Service Claims:** A "Post-Service Claim" is a claim for a benefit under the Plan after the services have been rendered.

When Health Claims Must Be Filed

Health claims must be filed with the Administrator within 90 days of the date charges for the service were incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. Charges are considered incurred when treatment or care is given or supplies are provided. Claims filed later than that date shall be denied, unless it is shown that it was not reasonably possible to file within 90 days, but in no event later than twelve (12) months from the date on which covered charges were incurred.

The Plan, upon receipt of a written notice of a claim, will furnish you a form for filing proof of loss. If such forms are not furnished within 15 days after notice is given, you will be considered to have complied with the requirement of the Plan with respect to proof of loss and written proof covering the occurrence, the character, and the extent of the loss for which the claim is made.

A Pre-Service Claim (including a Concurrent Claim that also is a Pre-Service Claim) is considered to be filed when the request for approval of treatment or services is made and received by the Administrator in accordance with the Plan's procedures. However, a Post-Service Claim is considered to be filed when the following information is received by the Administrator:

- The date of service;
- The name, address, telephone number and tax identification number of the provider of the services or supplies;
- The place where the services were rendered;
- The diagnosis and procedure codes;
- The amount of charges;
- The name of the Plan;
- The name of the Covered Employee; and,
- The name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Administrator will determine if enough information has been submitted to adjudicate the claim. If not, the Administrator may request more information. The Administrator must receive the additional information within 45 days (48 hours in the case of Pre-Service Urgent Care Claims) from your receipt of the request for additional information. Failure to do so may result in claims being declined or benefits reduced.

Timing of Claim Decisions

The Administrator shall notify you, in accordance with the provisions set forth below, of a denial (and, in the case of Pre-Service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following time frames:

(a) **Pre-Service Urgent Care Claims.** If you have provided all of the necessary information, the Administrator will notify you of its decision as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.

If you have not provided all of the information needed to process the claim, then the Administrator will notify you as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim. The Administrator will notify you of its determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earlier of (i) the Plan's receipt of the specified information, or (ii) the end of the period afforded you to provide the information.

(b) **Pre-Service Non-urgent Care Claims.** If you have provided all of the information needed to process the claim, the Administrator will notify you of its decision within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after

receipt of the claim. If an extension has been requested, the Administrator will notify you of its decision prior to the end of the 15-day extension period.

If you have not provided all of the information needed to process the claim, the Administrator will notify you as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. You will be given at least 45 days from receipt of the notice within which to provide the specified information.

(c) **Concurrent Claims:**

- **Plan Notice of Reduction or Termination.** If the Administrator is notifying you of a reduction or termination of a course of treatment (other than by Plan amendment or termination), the Administrator will notify you of its decision sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
- **Request by Claimant Involving Urgent Care.** If the Administrator receives a request from you to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care, the Administrator will notify you of its decision as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as you make the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If you submit the request less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving Urgent Care and decided within the Urgent Care time frame.
- **Request by Claimant Involving Non-urgent Care**. If the Administrator receives a request from you to extend the course of treatment beyond the period of time or number of treatments and the claim does not involve Urgent Care, the request will be treated as a new benefit claim and will be decided within the time frame appropriate to the type of claim (either as a Pre-Service Non-urgent Claim or a Post-Service Claim).

(d) **Post-Service Claims.** If you have provided all of the information needed to process the claim, the Administrator will notify you of its decision within a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

If the extension described above is necessary because you failed to submit the information necessary to decide the claim, the notice of extension must describe specifically the required information. You shall be afforded at least 45 days from the receipt of such notice within which to provide the specified information.

(e) **Extensions – Pre-Service Urgent Care Claims**. No extensions are available in connection with Pre-Service Urgent Care Claims.

(f) **Extensions – Pre-Service Non-urgent Care Claims.** This period may be extended by the Plan for up to 15 days, provided that the Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

(g) **Extensions – Post-Service Claims**. This period may be extended by the Plan for up to 15 days, provided that the Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

(h) **Calculating Time Periods.** The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Claims Appeal Procedure

Nature of Denial. The notice of a denial of a claim shall be written or in electronic form (in compliance with ERISA regulations), or oral in the case of a Pre-Service Urgent Care claim, as long as a written or electronic notice is furnished to you within 3 days of the oral notice, and shall set forth:

(a) The specific reason for the denial;

(b) Specific references to the pertinent Plan provisions on which the denial is based including a copy of any internal guideline used in the benefit determination or notice of where and how you can obtain a copy free of charge;

(c) A description of any additional material or information necessary for you to perfect the claim and an explanation as to why such information is necessary;

(d) An explanation of the Plan's claims appeals procedures;

(e) Your right to bring a civil action under ERISA Section 502(a);

(f) If your claim is denied based on medical necessity, experimental treatment, or similar exclusion or limitation, an explanation of the scientific or clinical judgment applied in the benefit determination, or notice of where and how you can obtain a copy free of charge; and,

(g) For purposes of Pre-Service Urgent Care Claims, a description of the expedited review process.

Timing of an Appeal

(a) **Pre-Service Claims:** Special Rule

For Pre-Service Urgent Care Claims, if you choose to appeal, please refer to Page 1 for a listing of names, addresses and phone numbers for each issuer.

(b) **All Other Claims**

Within 180 days after the receipt of the above material, you shall have a reasonable opportunity to appeal the claim denial to the Administrator for a full and fair review. You or your duly authorized representative may:

- Request a review by providing written notice to the Administrator;
- Submit written comments, documents, records and other information relating to the claim; and,
- Upon request, have reasonable access to and copies of all documents, records, and other information relevant to the claim.

Timing of Notification of Benefit Determination on Review

The Administrator shall notify you of the Plan's benefit determination on review within the following time frames:

(a) **Pre-Service Urgent Care Claims.** As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.

(b) **Pre-Service Non-urgent Care Claims.** Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

(c) **Concurrent Claims.** The response will be made in the appropriate time period based upon the type of claim: Pre-Service Urgent, Pre-Service Non-urgent or Post-Service.

(d) **Post-Service Claims.** Within a reasonable period of time, but not later than 60 days after receipt of the appeal**.**

(e) **Calculating Time Periods.** The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Review and Decision

(a) **Full and Fair Review.** The Plan Administrator, as Plan Fiduciary, shall take into account all comments, documents, and other information submitted by you without regard to whether the information was submitted with the original claim and without deference to the original determination. The decision shall be based in whole or in part on a medical judgment, with consultation with the appropriate independent health care professionals, if the claim involves investigational or experimental treatment, or issues of medical necessity, and shall identify such professionals.

(b) **Decision.** The decision of the Plan Administrator shall be written and shall include specific reasons for the decision, with specific references and copies of the pertinent Plan provisions or internal guideline on which the decision is based. You also have a right to bring a civil action under ERISA Section 502(a) following the denial of your appeal. If your appeal is denied based on medical necessity, experimental treatment, or similar exclusion or limitation, you will receive an explanation of the scientific or clinical judgment applied on the benefit determination, or notice of where and how you can obtain a copy. If your health plan is subject to California law, you have a right to a voluntary independent medical review of denials for medical necessity or experimental/investigational services through the Department of Managed Care and/or the Department of Insurance. Please refer to your health plan booklet or evidence of coverage for details.

(c) **Second Appeal**. Should you receive an adverse determination of the appeal, you have the right to file a second appeal. The second appeal must be filed no later than 30 days from the date indicated on the response letter to the first appeal. The timing of response to the second appeal shall be made in accordance with the same time guidelines as those outlined for the first appeal.

STATEMENT OF ERISA RIGHTS

As a participant in the PARTNERSHIP HEALTHPLAN OF CALIFORNIASelf Funded Dental Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to the following.

Receive Information About Your Plan and Benefits

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 US. Department of Labor and available at the Public Disclosure Room of the Employee Benefit 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.

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or 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 your COBRA continuation coverage rights.

Reduction or Elimination of Exclusionary Periods

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Assistance with Your Questions

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

OTHER IMPORTANT INFORMATION

Privacy of Information

In the administration of this Plan, PARTNERSHIP HEALTHPLAN OF CALIFORNIA or of one of its Business Associates may be required to use or disclose protected information for purposes of paying or causing to be paid benefits under this Plan. PARTNERSHIP HEALTHPLAN OF CALIFORNIA has established the following policy regarding the use and disclosure of protected information. PARTNERSHIP HEALTHPLAN OF CALIFORNIA hereby agrees to:

- Not use or disclose protected health information other than as permitted or required by the Plan document or by law;
- Ensure that any agents to whom it provides protected health information agrees to the same restrictions and conditions that apply to the Plan Sponsor (i.e. PARTNERSHIP HEALTHPLAN OF CALIFORNIA).
- Not use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit Plan of the Plan Sponsor;
- Report to the group health plan any use or disclosure of protected health information inconsistent with Plan provisions;
- Make protected health information available as required under other privacy rules provisions;
- Make internal practices and records regarding protected health information available to the HHS Secretary; and,
- Where feasible, return or destroy all protected health information received from the group health plan then no longer needed for the purpose for which disclosure was made.

Please refer to the Plan's Notice of Privacy Practices for details.

Controlling Documents

The information contained in this Summary Plan Description is only a general discussion of the relevant provisions of the Plan found in the official Plan Document. In all events, the provisions of the official Plan Document shall control with regard to all matters concerning the administration and operation of the Plan. The official Plan Document is available for your review at PARTNERSHIP HEALTHPLAN OF CALIFORNIA.

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