

**SUBMITTAL TO THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA**

613A



FROM: Human Resources Department

SUBMITTAL DATE:
October 08, 2009

SUBJECT: 2010 Freedom Dental Plan Revised Summary Plan Document

RECOMMENDED MOTION: That the Board 1) approve the revised Freedom Dental Plan Summary Plan Document (SPD) (Attachment "A"); 2) authorize the chairperson to sign four (4) copies of the document; and 3) retain one (1) copy of the signed document and return three (3) copies to Human Resources for distribution.

BACKGROUND: The Freedom Dental plan is one of the County's self-insured dental plan options administered by American Dental Professional Services (ADPS). The Freedom Dental plan was originally contracted with the County in March 2003 and is a competitive alternative to the County's other dental plan options. The 2010 SPD (Attachment "A") was revised to clarify the definition of Surgical Implants, update contact information and provide additional guidance to employees and their covered dependents regarding plan benefits. There are no changes to provider services or fees. There is no direct cost to the County associated with the recommended action, employees and retirees pay premiums for the services.

Ronald W. Komers
Asst. County Executive Officer/Human Resources Dir.

FINANCIAL DATA	Current F.Y. Total Cost:	\$ 0	In Current Year Budget:	Yes
	Current F.Y. Net County Cost:	\$ 0	Budget Adjustment:	No
	Annual Net County Cost:	\$ 0	For Fiscal Year:	2009/10

SOURCE OF FUNDS: Employee and Retiree Dental Insurance Premiums	Positions To Be Deleted Per A-30	<input type="checkbox"/>
	Requires 4/5 Vote	<input type="checkbox"/>

C.E.O. RECOMMENDATION:

APPROVE

BY:
Karen L. Johnson

County Executive Office Signature

FORM APPROVED COUNTY COUNSEL
BY:
TAWNY V. VIEU
DATE: 10/13/09
Departmental Concurrence

- Consent
- Policy
- Consent
- Policy

Dep't Recomm.:
Per Exec. Ofc.:

Prev. Agn. Ref.:

District:

Agenda Number:

3.36

SUMMARY PLAN DOCUMENT

**THE COUNTY OF RIVERSIDE
FREEDOM DENTAL PLAN**

January 2010

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OVERVIEW OF THE PLAN

The County of Riverside Freedom Dental Plan

A dental plan underwritten by the County of Riverside and one of the optional benefit plans included in the County's portfolio of health care plans available to certain employees.

If you have a question about your eligibility to participate in this plan, please contact the County of Riverside Human Resources Department.

Plan Overview

You may receive services from any licensed dental provider. The plan will pay according to the plan benefits, and based upon the fee charged by your dentist. As fees for dental services will vary from dentist to dentist, the plan will pay up to the 90th percentile of usual fees in the area for each service.

Annual Maximum Benefit	\$1,500
Additional Lifetime Orthodontic Benefit	\$1,000

NO DEDUCTIBLES

Diagnostic and Preventive Services	Covered at 100%
Restorative, Endodontic, Periodontic, and Oral Surgery Services	Covered at 80%
Orthodontics	Covered at 50%
All other services*	Covered at 60%

*Except limitations and exclusions

PLAN ADMINISTRATION

American Dental Professional Services (ADPS) ...

ADPS is a third party administrator that has contracted with the County of Riverside to provide certain administrative services for the Dental Plan.

- ADPS maintains the eligibility files on enrolled members and provides customer service to members who have questions or need assistance in obtaining benefits.
- ADPS can answer questions about benefits available under this plan.
- ADPS pays any claims for covered services incurred under the plan.
- ADPS administers the Grievance and Appeals process available to members who have a complaint about benefits or administration of the Dental Plan.
- Calls and claims should be directed to:

**American Dental Professional Services
9054 North Deerbrook Trail
Milwaukee, WI 53223-2474
1-888-540-9488**

- Customer Service lines are open Monday through Friday from 8:00am to 6:00pm Central Time.

This Summary Plan Document will be the primary governing document for all plan coverage decisions and will be the basis for final determination for the provision of benefits. This plan is intended to comply with all laws and regulations that are applicable whether or not specifically described in this Summary Plan Document.

Enrollment Process

You can obtain an Enrollment Form from the County of Riverside Human Resources Department. Please complete this form and return it to Human Resources. Human Resources will notify the plan administrator (ADPS) of your eligibility.

Once enrolled, ADPS will send an ID card to you, including the names of any dependents that are eligible under the plan. If you or your eligible family member requires dental services prior to your receipt of an ID card, ADPS can verify eligibility for your dental office. Please instruct the dental office to call American Dental Professional Services at: 1-888-540-9488.

If you would like to add or delete your spouse or a dependent from the plan once they have been enrolled, please contact the County of Riverside Benefits Division at:

Benefits Information Line (951) 955-4981

Website: <http://benefits.rc-hr.com>

Email: Benefits@rc-hr.com

Eligibility

You, your spouse and your eligible dependents may enroll in the dental plan.

Dependents are considered eligible if they are under the age of 23 prior to your effective date. A dependent is also considered eligible if incapable of self-sustaining employment because of mental or physical handicap. Proof of dependency is required upon request from the dental plan or its administrator.

Claim Processing

You or your dentist must submit a claim to the plan administrator to receive payment for covered services. A pre-determination of benefits is not necessary. However, your dentist may submit a pre-determination if you or your dentist would like clarification of benefits available. Within 90 days after services are performed, a standard American Dental Association claim form should be submitted to:

American Dental Professional Services

9054 North Deerbrook Trail

Milwaukee, WI 53223-2474

COVERED DENTAL PROCEDURES

You may receive services from any licensed dental provider. The plan will pay according to the plan benefits detailed below, based upon the fee charged by your dentist. As fees for dental services will vary from dentist to dentist, the plan will pay up to the 90th percentile of usual fees in the geographic area for each service. If your dentist's fee is above the 90th percentile, he/she may charge you the difference between his/her fee and the benefit paid by the plan.

Calendar Year Maximum Benefit

The calendar year (annual) maximum benefit is the accumulated dollar amount paid by the plan for covered services rendered to each covered person during a calendar year. The annual maximum accumulates on an individual basis for each covered person. There is no family maximum benefit.

After you reach the annual maximum benefit, your dentist may charge you his/her usual and customary charge for services provided to you. No benefits will be paid under the contract in excess of the annual maximum benefit per covered person, per calendar year.

Charges for covered orthodontic treatment do not apply to the calendar year maximum benefit. There is a separate lifetime orthodontic maximum benefit per covered person.

Payment Arrangements

You will be responsible for payment of any non-covered services, and a portion of covered services that are not paid 100% by the Freedom Dental Plan. The payment policy and payment arrangements made are solely a matter of contract between the member and the dental office.

Schedule Of Benefits

I. Diagnostic and Preventive Benefits – 100%

Diagnostic: Oral examination, x-rays, diagnostic casts, biopsy/tissue, examination, emergency treatment, consultation by a specialist.

Preventive: Prophylaxis (cleaning), fluoride treatments, space maintainers.

Limitations:

- a) Oral examinations are benefits twice in a calendar year while you are eligible under this plan.
- b) Prophylaxes (cleanings), fluoride treatments or procedures that include cleanings are benefits twice in a calendar year while you are eligible under this plan.
- c) Unless special need is shown, full-mouth x-rays are benefits once in a three-year period while you are eligible under this plan.
- d) Bitewing x-rays are benefits twice in a calendar year for children to age 18 or once in a calendar year for adults age 18 and over while you are eligible under this plan.

II. Basic Benefits – 80%

Oral Surgery: Extractions and certain other surgical procedures, including pre- and post-operative care.

Restorative: Amalgam, synthetic, plastic or resin restorations (fillings) for treatment of cavities (decay).

Endodontic: Treatment of the tooth pulp.

Periodontic: Treatment of gums and bones that support the teeth.

Sealants: Topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in teeth for the purpose of preventing dental decay.

Limitations:

- a) Periodontal procedures that include cleanings are subject to the same limitations as other cleanings (i.e., cleanings of any kind are benefit no more than twice in any calendar year while you are eligible under this plan).
- b) Sealant benefits are available to eligible dependent children under the age of 14. Sealant benefits include the application of sealants only to permanent posterior molar teeth without caries (decay), without restorations and with the occlusal surface intact. Sealant benefits do not include the repair or replacement of a sealant on any tooth within three years of its application.

III. Crowns, Jackets, Inlays, Onlays and Cast Restoration Benefits – 60%

Crowns, jackets, inlays, onlays and cast restorations are benefits only if they are provided to treat cavities that cannot be directly restored with amalgam, synthetic, plastic or resin fillings.

Limitation: a) Crowns, jackets, inlays, onlays and cast restorations are benefits on the same tooth only once every three years while you are eligible under this plan.

IV. Prosthodontic Benefits – 60%

Construction or repair of fixed bridges, partial dentures and complete dentures are benefits if provided to replace missing, natural teeth.

- Limitations:
- a) All Prosthodontic appliances are a covered benefit only once every three years, while you are eligible under this plan unless the Administrator determines that there has been such an extensive loss of remaining teeth or a change in supporting tissues that the existing appliance cannot be made satisfactory.
 - b) The Administrator will pay the above percentage of the dentist's fee for a standard partial or complete denture up to a maximum fee allowance. This fee allowance is set at the 90th percentile of UCR. A standard partial or complete denture is one made from accepted materials and by conventional methods. For a partial or complete denture that is higher than this maximum allowance, you must pay that portion of the fee that exceeds the allowance in addition to your portion of the allowance.
 - c) Implants and any associated abutments (appliances inserted into bone or soft tissue in the jaw, usually to anchor a crown, fixed bridge, partial denture) are not covered by your plan. However, if implants are provided along with a covered prosthodontic appliance (examples noted above), the Administrator will allow the benefit for the covered standard prosthodontic appliance supported by the implant in conjunction with all other provisions, exclusions and limitations of the plan. You are responsible for the remainder of the dentist's fees less the plan's benefits.

General Limitation

This limitation applies to all Benefits as set forth in section I., II., III., and IV., above. If an Enrollee selects a more expensive plan of treatment than is customarily provided, or specialized techniques, rather than standard procedures, this plan will pay the applicable percentage of the lesser fee for the customary or standard treatment and the patient is responsible for the remainder of the dentist's fee.

For example: a crown where an alloy/amalgam filling would restore the tooth; a composite (white) filling on a back tooth where an alloy/amalgam filling would restore the tooth; a gold crown where one constructed of semi-precious materials would restore the tooth; or a precision denture where a standard denture would suffice.

V. Orthodontic Benefits – 50%

Procedures using appliances or surgery to straighten or realign teeth, which otherwise would not function properly.

- Limitations:
- a) Payment is limited to treatment of eligible adults and dependent children.
 - b) If orthodontic treatment is begun before you become eligible for coverage, this plan's payments will begin with the first payment due to the dentist following your eligibility date.
 - c) This plan's payments will stop when the first payment is due to the dentist following either a loss of eligibility, or if treatment is ended for any reason before it is completed.
 - d) X-rays and extractions that might be necessary for orthodontic treatment are not covered by orthodontic benefits, but are covered under diagnostic and preventive or basic benefits.

VI. MPD-TMJ Benefits – 50%

Certain intraoral procedures for the treatment of acute dental symptoms associated with myofascial pain dysfunction (MPD) or malfunction of the temporomandibular (jaw) joint (TMJ). These procedures are:

- Temporary repositioning appliance
- Occlusal guard
- Occlusal adjustment – complete
- Removable metal overlay stabilizing appliance

- Limitations:
- a) Dental services that may be associated with treatment of MPD-TMJ but are not listed as MPD-TMJ Benefits. Still other non-intraoral services may be provided under your medical care coverage, such as medications.

- b) This plan will pay only those MPD-TMJ Benefits which are predetermined in advance by the Administrator based upon the treating dentist's documentation of the treatment plan and the necessity of proposed treatment as the Administrator deems adequate.
- c) This Plan will not pay for the repair or replacement of any appliance furnished in whole or part as MPD-TMJ Benefits.

Exclusions

This plan covers a wide variety of dental care expenses, but there are some services for which the plan does not provide benefits. It is important for you to know what these services are before you visit your dentist. This plan does not provide benefits for:

1. Services for injuries covered by Workers' Compensation or Employer's Liability Laws or services which are paid by any federal, state or local government agency, except Medi-Cal benefits.
2. Services for cosmetic purposes or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.
3. Treatment which restores tooth structure that is worn; treatment which rebuilds or maintains chewing surfaces that are damaged because the teeth are out of alignment or occlusion; or treatment which stabilizes the teeth. Examples of such treatment are equilibration and periodontal splinting.
4. Any single procedure bridge, denture or other prosthodontic service, which was started before you were covered by this plan.
5. Prescribed drugs, premedication or analgesia.
6. Experimental procedures.
7. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dentist for treatment in any such facility.
8. Anesthesia, except for general anesthesia given by a dentist for covered oral surgery procedures.
9. Grafting tissues from outside the mouth to tissue inside the mouth ("extraoral grafts"), implants (materials implanted into bone or soft tissue) or the removal of implants.
10. Charges for replacement or repair of an orthodontic appliance paid in part or in full by this plan.

GENERAL PROVISIONS

Appeals Process

If you have a question or complaint about the service that you received from your dentist, we recommend that you promptly discuss your concern with your dentist.

If you have a question or complaint regarding the denial of a claim payment, eligibility or other plan administration issue please contact ADPS, the plan administrator, at 1-888-540-9488. Most concerns can be taken care of quickly in this manner.

If you wish to file a formal appeal of a claim payment denial, you must do so within 60 days of receiving the denial notice. It is important that you include all pertinent information including the name of the member, social security number or other identifying number, birth date, your telephone number and address. Also include a complete description of your complaint. Forward this information to the plan administrator at:

American Dental Professional Services
9054 North Deerbrook Trail
Milwaukee, WI 53223-2474

Within 30 days of ADPS' receipt of the appeal, you will receive a response or a request for more information in order to make a decision.

Arbitration

Arbitration is a vehicle for the resolution of any disputes concerning dental care services or benefits, or contract interpretation (except disputes concerning eligibility for enrollment, effective date of coverage, and malpractice or bad faith).

Arbitration resolves differences pertaining to any personal liability, tort claims, or contract disputes (excluding claims for professional malpractice or bad faith) originating from this agreement.

Pursuant to California law, any claim of up to \$200,000 must be decided by a single neutral arbitrator who shall be chosen by the parties and who shall have no jurisdiction to award more than \$200,000. However, The County of Riverside Freedom Dental Plan and the Member may agree in writing to waive the requirement to use a single arbitrator and instead use a tripartite arbitration panel that includes the two-party appointed arbitrators or a panel of three neutral arbitrators, or another multiple arbitrator system mutually agreeable to the parties. The Member shall have three business days to rescind the waiver agreement unless the agreement has also been signed by the Member's attorney, in which case the waiver cannot be rescinded. In cases of extreme hardship, The County of Riverside Freedom Dental Plan may assume all or part of a Member's share of the fees and expenses of the neutral arbitrator, provided the Member has submitted a hardship

application with the American Arbitration Association. The approval or denial of a hardship application shall be determined by the American Arbitration Association. Members may obtain a hardship application by contacting the American Arbitration Association in Los Angeles or Orange County.

BY ENROLLING IN THIS PLAN YOU ARE AGREEING TO HAVE CERTAIN DISPUTES (MENTIONED ABOVE) DECIDED BY NEUTRAL BINDING ARBITRATION. BOTH THE COUNTY OF RIVERSIDE FREEDOM DENTAL PLAN AND MEMBERS WAIVE THEIR RIGHT TO A JURY OR COURT TRIAL FOR THESE DISPUTES.

The California Department of Insurance is responsible for regulating public agency self-funded health care service plans. The Department has a toll-free telephone number (1-800-927-4357) to receive complaints regarding health plans. If you have a grievance against The County of Riverside Freedom Dental Plan, you should contact the plan and use the plan's grievance process. If you need the Department's help with a complaint involving an emergency grievance or with a grievance that has not been satisfactorily resolved by the plan, you may call the Department's toll-free telephone number.

Termination of Coverage

If you wish to cancel coverage for yourself, your spouse or a dependent, please contact your Human Resources Department.

Benefits cease as of the effective date of termination. If the County of Riverside no longer offers its Freedom Dental Plan, coverage will cease as of the effective termination date of the Plan.

Continuation of Coverage through COBRA

You have the option to continue your dental insurance benefits by paying a monthly premium according to the provisions of COBRA (Consolidated Omnibus Reconciliation Act of 1985). Benefits may be continued for your dependents that were covered under the plans even if you do not wish to continue your own benefits.

If you elect continued coverage for yourself and/or your covered dependents, the applicable dental benefits will continue until whichever of the following events occurs first:

- * You become covered under any group dental plan, which does not deny or exclude benefits to you or your dependents due to a pre-existing condition;
- * The expiration of the 18-month continuation period;
- * You or a dependent become entitled to Medicare benefits (coverage ends for entitled person only);

- * You fail to pay the monthly premium on time; or
- * The company no longer offers group dental coverage to any employee.

The 18-month coverage period may be extended for the following reasons:

- * Death of employee, divorce, legal separation, or change in dependency status; or
- * Employee becomes entitled to Medicare benefits.

In these instances, coverage may be extended for an additional 18 months. In order to receive the extension, the County of Riverside must be notified within 60 days of the occurrence of the event.

If you or a covered dependent are disabled on the date your coverage ends, or when another qualifying event occurs and you are certified as being disabled under the Social Security Act before the end of the 18-month COBRA period, and you or the dependent notifies the County of Riverside of the certification within 60 days following the date of certification and within the 18-month continuation period and submits a copy of it, you or the covered dependent will be able to elect up to 11 additional months of continued coverage.

Your first payment will be for the period beginning the first of the month after your coverage ends plus any subsequent months prior to the signing of the election form. If your first payment or any subsequent monthly payment is not received by the first day of the covered month, your insurance will be discontinued.

To be sure that you receive the necessary information concerning your rights, you should keep the County of Riverside informed of any address changes.

Please contact your Human Resources Department for any questions and other information.

Non-Assignment of Benefits

The benefits of this plan are not assignable. You may not assign or transfer the rights to receive any portion of your benefits to any person or entity, either through power of attorney or outright assignment.

Payments Made in Error

If the County of Riverside or the plan administrator erroneously makes a payment or over-payment to you or on your behalf, the County of Riverside or the plan administrator may obtain reimbursement from you or the provider of services or may

offset the amount owed against a future claim arising from covered services provided under this plan.

Coordination of Benefits

If you are eligible for dental benefits under another insurance plan, are eligible for dental benefits under Workers' Compensation or through any other third party, please notify the plan administrator and your dental provider of all sources that may provide benefits for dental services. The County of Riverside Freedom Dental Plan will coordinate benefits with other plans, based on standard Order of Benefit Determination rules and guidelines.

The purpose of the coordination of benefits is to maximize benefit for allowable expenses and to prevent duplication of benefit payments.

Please contact the plan administrator, American Dental Professional Services, if you have any questions about your plan benefits.

1-888-540-9488

This document has been reviewed and approved by the County of Riverside's Board of Supervisors, and is the official plan document.

COUNTY OF RIVERSIDE:

By: _____
Chairman, Board of Supervisors

Date: _____