426

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

FROM: Human Resources Department

SUBMITTAL DATE:
April 23, 2014

SUBJECT: First Dental Health Network Lease and Marketing Agreements for the period of January 1 - April 30, 2014 and May 1, 2014 - December 31, 2019 [District-ALL] [Total Cost - $63,500] [SOURCE OF FUNDS: Employee and Retiree Dental Insurance Premiums]

RECOMMENDED MOTION: That the Board of Supervisors:

1. Ratify and approve the renewal agreement with First Dental Health Network for the period of January 1, 2014 through April 30, 2014 (Attachment A);
2. Ratify and approve the agreement with First Dental Health Network for the period of May 1, 2014 through December 31, 2019 (Attachment B);
3. Authorize the Chairperson to sign four (4) copies of each agreement, retain one (1) copy of each agreement, and return three (3) copies to Human Resources for distribution.

BACKGROUND:

Summary

Since 2004, the County has partnered with First Dental Health (FDH) to perform network management services for the County's self-funded Local Advantage dental HMO plans. The Local Advantage Plus and Blythe plans are located throughout Riverside and San Bernardino Counties and utilized American Dental

Michael T. Stock
Asst. County Executive Officer/
Human Resources Director

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost:	POLICY/CONSENT (per Exec. Office)
COST	$ 10,800	$ 23,000	$ 115,000	$	Consent ☐ Policy ☐
NET COUNTY COST	$	$	$	$	

SOURCE OF FUNDS: Employee and Retiree Dental Insurance Premiums

Budget Adjustment: No

For Fiscal Year: 13/14-19/20

C.E.O. RECOMMENDATION:

APPROVE

BY: Ivan M. Chand 4/29/2014

County Executive Office Signature

MINUTES OF THE BOARD OF SUPERVISORS

FORM APPROVED COUNTY COUNSEL
BY: NEAL R. KIPNIS DATE 4/24/14

☐ Positions Added ☐ Change Order
☐ A-30 ☐ 4/5 Vote

Prev. Agn. Ref.: 02/03/2009, 3.18 | **District:** All | **Agenda Number:** 3-10

BACKGROUND:

Summary (continued)

Professional Services (ADPS) to administer the claims and the FDH network management services to expand dental provider access for employees and retirees.

In December 2013, ADPS notified Human Resources of their plan to exit its Third Party Administrative line of business. In an effort for Human Resources to address the official notice of termination from ADPS and conduct a Request for Proposal (RFP) to find a new plan administrator, Human Resources elected to delay the January 1, 2014 FDH renewal agreement.

On April 8, 2014, Item 3-13, the Board approved Capitol Administrators as the new dental plan administrator. As a result, Human Resources was able to negotiate new terms and fee structures with FDH. The FDH agreement (Attachment A), includes services in conjunction with ADPS and the FDH agreement for the period January 1 through April 30, 2014. The FDH agreement (Attachment B) for May 1, 2014 through December 31, 2019 (Attachment B), includes services in conjunction with Capitol Administrators.

Impact on Residents and Businesses

There is no direct impact to residents or businesses.

SUPPLEMENTAL:

Additional Fiscal Information

For the period of January 1 through April 30, 2014, FDH was compensated for its network management services based on our prior agreement approved by the Board on February 3, 2009, Item 3.18. The compensation structure consisted of a 25% shared savings. The total cost of shared savings in the 2013 plan year was $25,442.

If approved by the Board, effective May 1, 2014, the compensation structure for the FDH network management services will change from a shared savings to a flat rate of $1.80 per employee per month. The term of the new agreement will extend for a five (5) year period. The estimated cost under the new fee structure for the 2014 plan year is $15,300 and rates are guaranteed through December 31, 2019. All fees are paid through employee and retiree dental insurance premiums. There is no direct cost to the County.

Contract History and Price Reasonableness

Since January 1, 2004, the FDH network management services have provided County of Riverside employees and retirees an expanded network of dental provider options at a low-cost.

According to Aon Hewitt, the County's Health Benefits Consultant, the new compensation structure of $1.80 PEPM is a fair rate for the exclusive network that is used for the Local Advantage plans. There is no additional cost to the County for this recommendation.

ATTACHMENTS:

A. First Dental Health Network Lease and Marketing Agreement (January 1 - April 30, 2014).
B. First Dental Health Network Lease and Marketing Agreement (May 1, 2014 – December 31, 2019)

Attachment A

FIRST DENTAL HEALTH NETWORK LEASE AND MARKETING AGREEMENT

January 1 – April 30, 2014

FIRST DENTAL HEALTH
NETWORK LEASE and MARKETING AGREEMENT

This network lease and marketing agreement ("Agreement") is made and entered into as of January 1, 2014 by and between FIRST DENTAL HEALTH ("FDH") and the COUNTY OF RIVERSIDE, State of California ("Payer"), a political subdivision of the State of California, and hereby individually referred to as "Party" and collectively as "Parties", with reference to the following facts:

RECITALS

A. WHEREAS, FDH has established and maintains networks of dental care Providers who have agreed to provide dental care Services at certain Fee Schedule Amounts and other guidelines as set forth and administered by FDH as set forth in this Agreement;

B. WHEREAS, Payer is an Employer that offers a self-insured dental plan administered by a third-party administrator to its employees and retirees; and

C. WHEREAS, Payer wishes to lease such networks as FDH has established and maintains for the purposes of marketing and providing access to those networks to its clients and Members;

I. AGREEMENT

NOW, THEREFORE, the Parties do hereby enter into this Agreement to set forth the terms and conditions pursuant to which the Payer will lease, market, and provide access to the FDH networks to its clients and Members, and do hereby agree as follows:

II. DEFINITIONS

The following terms shall have the meanings set forth below unless the context in which they are used clearly indicates otherwise:

A. "Covered Services" mean all necessary dental care services rendered to Members by Providers that are pursuant to and covered under a written Dental Plan and that Providers are licensed to and customarily provide.

B. "Dental Plan" means a written plan of dental insurance underwritten, administered, and/or otherwise sponsored by Payer that dictates coverage (reimbursement) for Covered Services rendered to Members by Providers.

C. "Fee Schedule Amounts" mean the maximum allowable amounts payable for Covered and Non-Covered Services rendered to Members by Participating Providers as set forth in their Provider Agreements.

D. "Members" mean eligible employees, or retirees (and their eligible dependants) of a Dental Plan whose dental care or dental care benefits are underwritten, administered, and/or otherwise sponsored by Payer.

E. "Non-Covered Services" mean all dental care services rendered to Members by Providers that are not pursuant to or covered under a written Dental Plan but that Providers are licensed to and customarily provide.

F. "Provider Agreements" mean the written agreements by and between FDH and individual dental care Providers that set forth the Fee Schedule Amounts and other terms and conditions upon which Participating Providers are to render Covered and Non-Covered Services to Members.

G. "Providers", namely "Participating Providers", are dentists and other dental care providers, including but not limited to ancillary service providers, with whom FDH enters into agreements to set forth the Fee Schedule Amounts and other terms and conditions upon which Providers are to render Covered and Non-Covered Services to Members.

III. RELATIONSHIP BETWEEN PAYER AND PROVIDERS

A. Upon this Agreement, FDH shall deliver to Payer a list of Participating Providers, which shall be updated periodically, as determined by FDH, to ensure proper administration and utilization of its networks. Upon this Agreement, Participating Providers shall provide both Covered and Non-Covered Services to Members according to the terms and conditions set forth in their Provider Agreements.

B. Payer and Providers shall at all times remain independent entities, and neither Payer nor Providers shall at any time act as or consider themselves an agent of the other. No relationship or joint venture between Payer and Providers or their respective agents, affiliates, employees, representatives, or successors is created by this Agreement, and neither party shall have nor exercise any control or direction over the business or performance of the other. Nothing in this Agreement shall create any rights or remedies in any third party, except that Providers shall be third party beneficiaries of obligations undertaken by Payer to reimburse Providers for Covered Services as set forth in the Dental Plan and as required by law. None of FDH, Payer, and Providers or their respective agents, affiliates, employees, representatives, or successors shall be liable to any third party for any act or omission of any other Party (or its respective agents, affiliates, employees, representatives, or successors).

IV. FDH OBLIGATIONS

FDH hereby agrees to perform the following functions, duties, and services:

A. Establish and maintain networks of Providers by entering into Provider Agreements to set forth the Fee Schedule Amounts, Exhibit A and other terms and conditions pursuant to which Providers are to render Services to Members;

B. Work directly with Payer's contracted Third Party Administrator to provide services mutually determined by FDH and Payer so as to facilitate the administration and utilization of the FDH networks consistent with the terms and conditions of this Agreement.

V. PAYER OBLIGATIONS

Payer hereby agrees to perform the following functions, duties, and services:

A. Provide Members a way to identify themselves to Participating Providers as network participants, such as identification cards to obtain in-network Services from Participating Providers, such as reduced co-payments and/or deductibles;

B. Provide the names, addresses, and telephone numbers of Participating Providers to Members in the form of a directory, which shall be updated periodically and/or information on how to obtain such information. Each Provider shall have the right to identify him or herself as a Participating Provider in the Dental Plan;

C. Compensate Providers for Covered Services rendered to Members by Providers pursuant to the Fee Schedule Amounts set forth in their Provider Agreements:

D. Furnish Providers (and if applicable, FDH) with verification of eligibility and coverage of Members when requested and as set forth in this Agreement, and provide FDH complete information on any and all Dental Plans being administered and the benefits available thereunder;

E. Authorize Members to assign to Providers providing Covered Services the Members' rights to payment from Payer for such Covered Services. Such assignment shall not, however, be a prerequisite for payment to Providers by Payer; and

F. Maintain adequate claims reserves to satisfy obligations to Providers as set forth in the Dental Plan and upon request provide FDH with financial data to substantiate the ability to compensate Providers for Covered Services rendered to Members as set forth in this Agreement.

G. Provide FDH all data regarding eligibility required by FDH to perform its services and to determine the amount of compensation (network leasing fees) due FDH.

VI. COMPENSATION OF PROVIDERS

A. Payer shall compensate Providers for Covered Services rendered to Members pursuant to the Fee Schedule Amounts set forth in their Provider Agreements and in accordance with the Dental Plan. Payer shall advise Providers of the involvement of the network in the Dental Plan when verification of eligibility and coverage is requested. Providers have agreed not to waive any co-payments or deductibles as part of their Provider Agreements. FDH may modify the Fee Schedule Amounts upon one hundred eighty (180)-days prior written notice to Payer. Payer shall adjudicate all dental claims for Covered Services and reimburse Providers within thirty (30) days of

receipt, or as required by law. Should Payer reasonably dispute any claim, Payer shall notify Providers of the dispute and the nature and basis thereof within thirty (30) days of receipt, or as required by law.

B. Providers may bill Members direct for both Covered and Non-Covered Services at the Fee Schedule Amounts. Members shall have the sole responsibility of verifying eligibility and coverage under their Dental Plan, and have final financial responsibility for all Services rendered by Providers.

C. Providers have agreed to accept the Fee Schedule Amounts set forth in their Provider Agreements as payment in full, except however as determined and dictated through coordination of benefits, so long as Payer complies with all other terms of this Agreement.

D. Payer acknowledges and agrees that in the event of default on payment of any accurate and complete claims which are not the subject of reasonable dispute, Payer must provide written notice to FDH of such breach within ten (10) days of receipt. Provider may bill (and Payer shall pay) for Covered Services at Provider's usual and customary rates. Further, Provider may notify FDH and FDH may terminate this Agreement upon ten (10)-days prior written notice to Payer unless all such bills are paid in full within said ten (10)-day period.

E. Providers shall endeavor to submit claims to Payer (or if requested by Payer, to FDH) not later than sixty (60) days after the rendering of services. Each claim shall describe the services rendered to Member by Providers with sufficient particularity so that the services rendered may be reasonably identified.

F. Providers are not precluded from seeking reimbursement under coordination of benefits from third parties other than Payer; however, the liability of Payer to Providers for Covered Services provided to Members shall in no event exceed the Fee Schedule Amounts. Except as otherwise provided in the applicable Dental Plan, if Payer is the primary carrier Payer will pay Providers the Fee Schedule Amounts, and if Payer is not the primary carrier Payer shall pay the difference between the Fee Schedule Amounts and the amounts received from other third parties (less applicable co-payments and/or deductibles).

VII. COMPENSATION OF FDH

A. Payer shall compensate FDH for lease of its networks and services hereunder on a monthly basis in accordance with the schedule set forth in Exhibit B of this Agreement, attached hereto and incorporated herein by this reference. Overdue invoices shall accrue interest at the rate of 18% per annum, not to exceed highest amount permitted by law.

B. FDH may adjust its compensation schedule following the first anniversary date of this Agreement by one hundred eighty (180)-days prior written notice to Payer by incorporating a revised Exhibit B.

VIII. ELIGIBILITY AND COVERAGE VERIFICATION PROCEDURE

A. Payer shall provide FDH a copy of the Dental Plan Summary Plan Document, Exhibit C, under which Payer provides dental care benefits to Members that specifies the benefits, co-payments and/or deductibles and other pertinent terms and conditions of the Plan. Payer shall also provide FDH with all amendments thereto no less than thirty (30)-days notice in advance of the effective date.

B. Payer shall provide all Members with an identification card or other information effectively identifying them as Members of the Dental Plan and as FDH network participants. Payer shall provide FDH and Providers with a telephone number operating during normal business hours through which Providers may verify whether a person seeking services pursuant to this Agreement is a Member, coverage of such services, and amounts for which the Member is responsible, including co-payments and/or deductibles.

IX. DENTAL RECORDS

To the extent required for Payer to process payment, FDH shall provide or use its best efforts to cause each Provider to provide, upon reasonable notice from Payer, copies of all records relating to Covered Services provided by the Provider subject to applicable law governing the release of such records. Payer shall maintain the confidentiality of all Members' dental records as required by law.

X. PROTECTION OF PROPRIETARY RIGHTS

A. Payer acknowledges that FDH has, at substantial expense, compiled, designed, and developed certain logos, symbols, service marks, data, processes, plans and procedures, all of which are proprietary to and trade secrets of FDH (hereby referred to as "Proprietary Information"). This Proprietary Information includes, without limitation, FDH Fee Schedule Amounts and the names, addresses, and all other information pertaining to FDH Participating Providers. Beginning on the effective date and ending twenty-four (24) months after termination of this Agreement, neither Payer nor any of its agents, affiliates, employees, representatives, or successors shall use this Proprietary Information except as expressly set forth in this Agreement without the prior written consent of FDH. This includes direct or indirect contact with or attempts to contact other FDH clients and Participating Providers.

B. FDH acknowledges that Payer has, at substantial expense, compiled, designed, and developed certain logos, symbols, service marks, data, processes, plans and procedures, all of which are proprietary to and trade secrets of Payer. FDH shall not use the Proprietary Information, except as expressly set forth in this Agreement, without the prior written consent of FDH. Beginning on the effective date and ending twenty-four (24) months after termination of this Agreement, neither FDH nor any of its agents, affiliates, employees, representatives, or successors shall use this Proprietary Information except as expressly set forth in this Agreement, without the prior written consent of Payer. This includes direct or indirect contact with or attempts to contact other Payer clients and Members.

XI. DISPUTE RESOLUTION

Any dispute arising under this Agreement or arising out of the relationship or activities of the Parties under this Agreement shall be resolved by and pursuant to the rules and procedures of the American Arbitration Association in Riverside County, California. The prevailing Party in those proceedings, or in any legal action concerning arbitration proceedings regarding this Agreement, shall be entitled to recover reasonable attorney's fees and costs from the other Party. Judgment on the award may be entered in any court having jurisdiction and shall be fully binding on the Parties. This provision shall not require arbitration of any malpractice, negligence, or other third party claims, other than disputes with Providers over claims and billings.

XII. TERM AND TERMINATION

A. The term of this Agreement shall become effective on January 1, 2014, and shall continue in effect until April 30, 2014, unless and until either Party gives the other Party written notice of its desire to terminate this Agreement at least 60 days prior to the end of the term.

B. Either Party shall have the right to terminate this Agreement upon at least sixty (60)-days prior written notice to the other Party as set forth in this Agreement, with or without cause.

C. Either Party shall have the right to terminate this Agreement forthwith due to cessation of the other Party's business, including through bankruptcy, judicial administration, arrangement by or for the benefit of creditors, dissolution, etc.

D. Payer shall notify FDH in writing in the event of failure to substantially comply with the financial solvency, net equity, or similar requirements of any regulatory body or rating organization, in which case FDH shall have the option to terminate this Agreement forthwith.

E. Upon termination of this Agreement for any reason, Payer shall continue to be responsible for Covered Services rendered to Members by Participating Providers in the event that a Member is receiving such Services as part of a course of treatment entered into prior to the termination date of this Agreement until the course is completed or the Member discontinues receiving Services from the Provider.

XIII. ASSIGNMENT

Neither Party shall, without prior written consent of the other Party, assign any duties or rights under this Agreement. Any assignment in contravention of this paragraph shall constitute a material breach of this Agreement and shall be void. The foregoing shall not prohibit the Payer from entering into a contract with a third party to assist with the adjudication and processing of claims, provided that third party be required to abide by the terms and provisions of this Agreement.

XIV. AMENDMENTS

No amendment or modification to this Agreement shall be valid, binding or effective unless in writing and signed by both Parties.

XV. SUCCESSORS

Subject to the prohibitions of assignment hereunder, this Agreement shall be binding upon the successors, assignees, and personal representatives of the Parties hereto.

XVI. NOTICES

Any and all notices or other correspondence permitted or required by this Agreement shall be in writing and shall be delivered in person or by United States Postal Service First Class Mail (Certified, Registered, and Return Receipt requested and postage paid) addressed as follows:

FDH: First Dental Health
5771 Copley Drive Suite 101
San Diego, CA 92111

Payer: County of Riverside, Human Resources
4080 Lemon Street, First Floor
Riverside, CA 92501
Attn: Stacey M. Beale, Human Resources Division Manager

Such notices shall be effective on the date of delivery or on the date indicated in the notice, whichever is later. Either Party may change notice address by giving written notice of the change to the other Party.

XVIII. WAIVER OF BREACH; GOVERNING LAW; ENTIRE AGREEMENT

The waiver of any breach of this Agreement shall not be deemed to be a waiver of any other breach of either the same or any different provision. This Agreement shall be construed and enforced in accordance with the laws of the State of California. This Agreement supersedes any and all other agreements, negotiations, or representations, whether oral or written, between FDH and Payer with respect to the subject matter of this Agreement, and contains the entire agreement between the parties relating to the subject matter hereof.

XIX. SEVERABILITY; REFORMATION

In the event that any provision of this Agreement, or the performance thereof, is rendered unlawful, invalid, or unenforceable by the enactment of an applicable statute, ordinance, or regulation, or is so deemed by any court or governmental agency of competent jurisdiction, the Parties shall meet and confer in good faith to amend that provision or this Agreement to preserve the essential business purposes hereof. However, if the effect of such an amendment would impose unreasonable financial burden on one of the Parties, the Party so affected may terminate this Agreement upon written notice. In the event of termination, FDH shall be compensated for all services rendered prior to termination.

XX. VENUE

All actions and proceedings arising in connection with this Agreement shall be tried and litigated exclusively in the state and federal (if permitted by law and a party elects to file an action in federal court) courts located in the County of Riverside, State of California.

XXI. DISPUTES

Payor and FDH agree to meet and confer in good faith to resolve any problems or disputes that may arise under this Agreement, prior to the filing of a claim under the Government Claims Act (Government Code section 900 et. seq.) and prior to the initiation of any litigation by either party.

XXII. TIME IS OF THE ESSENCE

Time shall be of the essence of each and every term, obligation, and condition of this Agreement.

XXIII. CONFLICT OF INTEREST

The parties hereto and their respective employees or agents shall have no interest, and shall not acquire any interest, direct or indirect, which shall conflict in any manner or degree with the performance of services required under this Agreement.

XXIV. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Under this Agreement, FDH is subject to all relevant requirements contained in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, enacted August 21, 1996, and the laws and regulations promulgated subsequent thereto. FDH hereto agrees to cooperate in accordance with the terms and intent of this Agreement for implementation of relevant law(s) and/or regulation(s) promulgated under this Law. FDH further agrees that it shall be in compliance, and shall remain in compliance with the requirement of HIPAA, and the laws and regulations promulgated subsequent hereto, as may be amended from time to time.

XXV. FORCE MAJEURE

Neither party shall be liable to the other party or be deemed to have breached this Agreement for any failure or delay in the performance of all or any porting of its obligations under this Agreement if such failure or delay is due to any contingency beyond its reasonable control (a 'force majeure"). Without limiting the generality of the foregoing, such contingency includes, but is not limited to, acts of God, fires, floods, pandemics, storms, earthquakes, riots, boycotts, strikes, lock-outs, acts of terror, wars and war operations, restraints of government, power or communication line failure or other circumstance beyond such party's reasonable control, or by reason of a judgment, ruling or order of any court or agency of competent jurisdiction or change of law or regulation subsequent to the execution of this Agreement. Both parties are obligated to

provide reasonable back-up capability to avoid the potential interruptions described above. If a force majeure occurs, the party delayed or unable to perform shall give immediate notice to the other party. Payor acknowledges that the foregoing provision does not apply to Payor's obligation to make timely payment of any fees due FDH, and that FDH shall be entitled to all remedies set forth in this Agreement and those allowed by law for Payor's failure to timely pay such fees.

XXVI. CERTIFICATION OF AUTHORITY TO EXECUTE THIS AGREEMENT

FDH certifies that the individual signing herein has authority to execute this Agreement on behalf of FDH, and may legally bind FDH to the terms and conditions of this Agreement, and any attachments hereto.

[Remainder of the page was intentionally left blank]

IN WITNESS WHEREOF, the parties hereto have caused their duly appointed representatives to execute this Agreement:

ATTEST:
Clerk of the Board
Kaia Harper-Ihem

By: _____

Deputy

Date: _____

COUNTY OF RIVERSIDE:

By: _____

Chairman, Board of Supervisors

Date: _____

Approved as to form and content:

Pamela J Walls
County Counsel

By: _____
Deputy County Counsel

FIRST DENTAL HEALTH

By: Jeannie Kemper

Printed Name: Jeannie Kemper

Title: Director, Operations

Date: 4/21/2014

EXHIBIT "A"

FEE SCHEDULE AMOUNTS

By accepting this data, Payer acknowledges this information is proprietary to FDH under Section X and shall not be used except as expressly set forth in this Agreement. Furthermore, Payer shall not use this information for business (individuals, groups, etc.) except for that which is reported to FDH as compensation under Section VII and Exhibit B, and shall not share this information with any third party without the prior written consent of FDH. Violation of these terms shall constitute material breach of this Agreement.

[ATTACHED AS A SEPARATE DOCUMENT UNDER "EXHIBIT A" FIRST DENTAL HEALTH 2014 LOCAL ADVANTAGE FEE SCHEDULE]

EXHIBIT "B"

FDH COMPENSATION

NETWORK ACCESS FEES

Local Advantage Network (Customized)	25% Shared Savings of Network Claims

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1) Shared savings percentage to be paid to FDH monthly.

2) Shared Savings percentage to be determined by calculating 25% of the total money saved in-network compared to costs out-of-network.

3) Calculation of in-network savings is based upon the difference between (a) the Participating Provider's billed amount and the FDH discounted amount; or if the dentist bills the FDH discounted fee, the difference between the 80th percentile of FairHealth and the FDH discounted fee.

4) FDH shared savings apply to all claims savings realized through the Local Advantage network (excluding the offices of Riverside Dental Group and Hospitality Dental).

EXHIBIT "C"

LOCAL ADVANTAGE SUMMARY PLAN DOCUMENT

LOCAL ADVANTAGE PLUS
LOCAL ADVANTAGE BLYTHE
DENTAL PLANS

SUMMARY PLAN DOCUMENT

APPROVED FOR PLAN YEAR 2011 - 2014

TABLE OF CONTENTS

INTRODUCTION

The plan is specifically designed by the County of Riverside for County of Riverside employees and their eligible dependents. This Dental Plan provides dental care services through a network of participating dentists and dental groups throughout the County of Riverside. The plan benefits include extensive coverage to meet your dental care needs such as preventative care, restorative services, specialty services, and orthodontia. This Summary Plan Document provides a detailed description of how this plan works and the coverage provided to you. Detailed benefit explanations are included along with an explanation of your responsibilities as a member of this plan.

The plan provides certain services at no charge to you. For other procedures, you pay a co-payment at the time the services are received.

Benefits/Coverage/Claims Questions

If you have any questions about your benefits under this plan, or how the plan works, a representative is available to answer your questions at the office of the plan's Claims Administrator. This office can be reached at: **888-540-9488**

Dental Provider/Network Questions

If you require information about a specific network dentist, or you wish to speak to someone about your network dentist, or you have questions about the network in general, a representative is available to answer your questions at the office of the plan's Claims Administrator. This office can be reached at: **1-888-540-9488.**

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.

DENTAL PLAN ADDRESSES AND TELEPHONE NUMBERS

Dental Plan Claims Administrator/Member Services:
American Dental Professional Services
9054 N. Deerbrook Trail
Milwaukee, WI 53223
888-540-9488

DEFINITIONS

Annual Enrollment - a period of time established by County of Riverside during which eligible employees and retirees may enroll in a dental plan.

Benefits (Covered Services) - those services which a member is entitled to receive pursuant to the terms of the Dental Plan.

Calendar Year - a period beginning at 12:01 a.m. on January 1 and ending at 12:01 a.m. January 1 of the following year.

Categories of Benefits:

- Diagnostic - procedures to help the dentist evaluate your dental health to determine necessary treatment.
- Preventative - procedures to prevent dental disease (cleanings, for example).
- Restorative - procedures necessary to restore the teeth (other than crowns or cast restorations)
- Minor Restorative - oral surgery, endodontic (root canals), and periodontic (gum) procedures.
- Major Restorative - crowns and cast restorations (caps, veneers, inlays and onlays).
- Prosthodontic - procedures involving bridges and dentures to replace missing teeth.
- Orthodontic - procedures involving appliances (such as braces) or surgery to realign teeth and/or jaws which otherwise do not function properly.

Co-payment - the member's share of the costs to be paid at the time services are received.

Covered Services - those dental services to which the Plan will apply benefit payments, according to the Summary Plan Document.

Dental Plan - Local Advantage Dental Plan.

Eligible Dependent - any of the dependents of an eligible employee who are eligible to enroll for benefits in accordance with the conditions of eligibility outlined in this booklet.

Eligible Employee - any group member or employee who is eligible to enroll for benefits in accordance with the conditions of eligibility outlined in this booklet.

Employer - County of Riverside.

Exclusion - any dental or other treatment for a condition for which the Plan provides no coverage.

Experimental or Investigational - any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized as being in accordance with generally accepted professional dental standards, or if safety and efficacy have not been determined for use in the treatment of a particular illness, injury or dental condition for which it is recommended or prescribed.

Maximum - the greatest dollar amount the Plan will pay for covered procedures in any calendar year, or lifetime orthodontic benefits.

Medicare - the programs of medical care coverage set forth in Title XVIII of the Social Security Act, as amended by Public Law 89-97, or as thereafter amended.

Member - an employee, retiree or family member enrolled under this Dental Plan.

Network - the dentists and dental groups which are contracting with the Plan to provide its members with treatment and services.

Participating Dentist/Dental Group - an independent provider who has an agreement to provide Plan benefits to Members.

Specialist - a dentist other than a network general dentist who has an agreement with the Plan to provide specialty services to members according to an authorized referral by a network general dentist.

Summary Plan Document - the approved summary description of entire benefits available, including Exclusions and Limitations, under this benefit program.

Services - dental care services and supplies.

ELIGIBILITY

Employee Eligibility

You are eligible to participate in the benefits program if you are a regular County employee scheduled to work at least 20 hours per week. Your bargaining unit determines which plan options are available to you. For more information about your benefit options, please review the information provided in the County of Riverside annual enrollment guide.

Dependent Eligibility

You may enroll your eligible dependents in your dental coverage. Your eligible dependents* include:

- Your legal spouse/registered domestic partner, Your and/or your spouse/domestic partner's dependent natural children, adopted children, foster children, and stepchildren under age 26.
    - An otherwise eligible child past age 26 if the child is incapable of self support because of a mental or physical handicap and you continue to claim the child as a dependent on your federal income tax return.

** Important notes about dependent eligibility:*

1. It is against the law to enroll ineligible family members. If you do, you may have to pay for all costs incurred by the ineligible dependent from the date the coverage began.
2. If you do not add newly eligible family members to your plan within the 60-day period of eligibility, you may enroll them during any future annual enrollment period.
3. Your former spouse, parents, parents-in-law, other relatives, and non-disabled children age 26 and over, are not eligible for coverage under this plan.
4. You must drop coverage for your enrolled spouse/domestic partner or dependent child when he/she loses eligibility (e.g., divorce, your child attains age 26).

ENROLLMENT

If you are a newly hired or newly eligible employee, you may elect to enroll within 60-days of your hire date or eligibility. All coverage will be effective the first day of the following month after County of Riverside receives and processes your election.

Making Mid-Year Changes

Each year your elections stay in effect from January 1 through December 31, as long as you remain eligible for benefits. During annual enrollment, you have the opportunity to change your coverage elections for the following plan year. However, after the close of annual enrollment you can make benefit changes ONLY if you have a qualified status change. Qualified status changes include:

- Marriage, or gaining a domestic partner
- Divorce, or separation from domestic partner
- Birth or adoption of a child
- Death of a spouse or a child
- Change in spouse's employment
- Significant changes in your spouse's employer's medical coverage
- Child's loss of eligibility due to age, student status, or marital status

- Full-time/part-time employment status change that results in an insurance eligibility change
- Commencement of or return from an unpaid leave of absence

If one of the above events occurs, and you want to make a benefit change consistent with the specific event, you must submit a new Election Form indicating your new coverage elections within 60-days of the event to the County of Riverside.

Remember, it is your responsibility to stay informed about your coverage. If you have any questions, or need additional information, please contact the County of Riverside Benefits Division.

Benefits Information Line (951) 955-4981
Website: http://benefits.rc-hr.com
Email: Benefits@rc-hr.com

CHOOSING YOUR DENTIST

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS DENTAL CARE MAY BE OBTAINED.

The plan provides easy access to dental care services and there is virtually no paperwork. Members have access to a network of licensed dentists in your local community. The network dental provider listing is available by contacting County of Riverside Benefits Information Line or via the County's website. As a Member of this plan, you are entitled to visit any of these dental providers in the plan network when you need dental care services. You may switch to another network provider without pre-approval at any time.

YOU ARE NOT REQUIRED TO PRE-SELECT A DENTIST AT ENROLLMENT

ALWAYS CALL THE PROVIDER YOU CHOOSE TO VERIFY THE PROVIDER'S PARTICIPATION STATUS

SERVICES PROVIDED BY DENTISTS NOT AUTHORIZED BY LOCAL ADVANTAGE DENTAL PLAN ARE NOT COVERED BY THIS DENTAL PLAN.

Selection of Different Dentists by Enrolled Dependents

As a Member of the plan, you and each enrolled family member may choose to use different dentists within the plan's dental provider network.

Scheduling Appointments

Once you have selected your dentist from the list of participating dentists, simply call the dental office and make an appointment.

Broken Appointment Fees
Broken appointment fees may apply for short cancellation notice.

Referrals To Specialists
The dentist that you select to provide your dental care will refer you to a specialist when treatment by a specialist is appropriate. If the plan dentist refers you to a network specialist (e.g. Periodontist), the plan will pay benefits according to a separate specialist network fee schedule. Please call the plan administrator at **1-888-540-9488** for more information. In the event a referral to a specialist outside the network is necessary, a pre-authorization is required before the plan will coordinate the referral.

NOTE: Reimbursement to a non-network Specialist is limited to the amount the plan would have paid to a network Specialist. Any amount billed over this amount will be your financial responsibility, including any applicable co-payment.

Payment For Dental Services
The plan contracts with individual dentists and dental groups to provide dental services to Plan members. Participating dentists are paid on a discounted fee-for-service basis for each procedure. You are responsible for co-payments. For any services that are not covered under this Dental Plan, payment to the dentist for these services will be your financial responsibility.

For questions regarding covered procedures, please call:
American Dental Professional Services
9054 N. Deerbrook Trail
Milwaukee, WI 53223
1-888-540-9488

NOTE: *Be sure to ask your dentist for a Pre-Treatment Estimate and/or a copy of the proposed treatment plan if extensive dental work is going to be undertaken. This will assist you in making your treatment decisions, and understanding what is covered and not covered under the plan.*

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SUMMARY OF COVERED SERVICES

THE FOLLOWING SUMMARY IS ONLY A BRIEF DESCRIPTION. PLEASE REFER TO THE BENEFIT LIMITATIONS AND EXCLUSIONS SECTION OF THIS SUMMARY PLAN DOCUMENT FOR FURTHER INFORMATION.

Benefit Maximum:	**$1,500 each Member per Calendar Year**
Preventative	**100%** Initial exam - twice per 12 months Full mouth x-ray - once every 3 years Bitewing x-ray - twice per calendar year Cleanings - twice per calendar year **Sealants** – Under age 14 to permanent posterior molars with no decay, restorations, and with occlusal surface intact. Does not include replacement or repair of any sealant on any tooth within 3 years of application.
Restorative	**90% (1)** **Restorative** - Amalgam, synthetic, plastic, resin restorations for treatment of cavities. Posterior composite treatments.
Minor Restorative	**Periodontics (2)** - Treatment of gums and bones that support the teeth – periodontal cleanings are covered at twice per calendar year. **Extractions (2)** - Pre and post operative care **Endodontics (2)**- Treatment of tooth pulp
Major Restorative	**65% (3) (*)** **Crowns, jackets, inlays, onlays, cast restorations -** Are benefits on the same tooth only once every 5 years. **Prosthodontics –** Once every 5 years unless there is such extensive loss of remaining teeth that the existing appliance cannot be made satisfactory.
Orthodontic Treatment	**Standard Case (4)** $120.00 Down payment, $120.00 per month for 24 months Lab fees are not included
Cosmetic Dentistry	**50%** Whitening, bonding, bleaching, veneers

1. Upgrade fee formula for posterior composite fillings are addressed elsewhere in the SPD.
2. These benefits apply for procedures provided by a General Dentist. Specialist referrals are addressed elsewhere in the SPD.
3. Precious metal costs are not included.
4. This discount applies for Orthodontic Services provided by a Network Specialist.

(*) Additional fee charges for porcelain on molar teeth.

DENTAL LIMITATIONS AND EXCLUSIONS

Limitations

The following limitations apply to certain procedures (identified below) under this Dental Plan:

1. You are responsible for any charges made by a non-network provider, including specialists, unless preauthorization is obtained and approved by the plan network service department or plan administrator (ADPS).

2. Cleanings of any kind are benefits no more than twice in any calendar year.

3. Periodontal scaling and root planning is limited to four (4) separate quadrants every 2 years.

4. Sealant benefits are limited to eligible dependent children up to age fourteen (14). Sealant benefits include the application of sealants only to permanent posterior molars 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. Sealants are limited to one (1) each tooth every three (3) years through age ten (10) on permanent first molars and up to age fourteen (14) on permanent molars.

5. Crowns, jackets, inlays, onlays and cast restorations are benefits on the same tooth only once every five (5) years while you are a patient under the plan unless the plan determines that replacement is required because restoration is unsatisfactory as a result of poor quality of care, or because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissue since the replacement of the restoration.

6. Full cast crowns, porcelain crowns, porcelain fused to metal or plastic processed to metal type crowns are not a benefit for children under 16 years of age. The plan covers an acrylic or stainless steel crown.

7. Referral for specialty care is limited to orthodontics, oral surgery, periodontics, and endodontics. Referral to an out-of-network pediatric dentist is specfically excluded. Oral surgery, periodontic and endodontic procedures performed by a specialist are covered at 50%.

8. Full mouth x-rays – one (1) set every three (3) years.

9. Two (2) sets of bitewing x-rays twice per calendar year.

10. Prosthodontic appliances are benefits only once every five (5) years, while you are eligible under this plan, unless the plan 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. Replacement of a prosthodontic appliance not provided under the plan will be made if it is unsatisfactory and cannot be made satisfactory. Full or partial denture relines or rebasing are limited to one per arch per 12 consecutive months.

11. Optional treatment provisions: If you select a more expensive plan of treatment than is customarily provided, or specialized techniques, an allowance will be made for the least expensive, professionally acceptable, alternative treatment plan. The plan will pay the applicable percentage of the lesser fee for the customary or standard treatment and you are responsible for the remainder of the dentist's fee. *An example would be: When an enrollee receives a composite (white) filling in place of an alloy/amalgam filling when decay is present on a back tooth, the plan makes an allowance toward its cost. The allowance is based on the plan's fee for the equivalent alloy/amalgam filling and the enrollee pays the difference to the posterior composite fee. For cosmetic purposes to replace an alloy/amalgam filling, the plan coverage is 50%.*

12. You must remain on the plan during the period of time you or your eligible dependent(s) is/are undergoing orthodontic treatment. Any early termination will result in pro-rated charges for all unfinished work according to the Orthodontic contract signed at the start of treatment.

13. Implants and any associated abutments (appliances inserted into bone or soft tissue in the jaw, usually to anchor a crown, fixed bridge, partial or denture) are not covered by the plan. However, if implants are provided along with a covered prosthodontic appliance (examples noted above), the plan 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

Exclusions – Services The Plan Does Not Cover
No benefits will be covered for expenses incurred:

1. For any procedure not specifically listed as a covered benefit.

2. For procedures that are (a) in the opinion of the dentist are not clinically necessary for your health; (b) services or charges which are necessitated as a result of you failing to follow a documented prescribed course of treatment; (c) services which are obtained outside the Plan network and services which are not pre-authorized by the plan (including specialty services); (d) services or supplies that do not meet accepted standards of dental practice, and/or which are experimental in nature.

3. Grafting tissue - from outside the mouth to tissue inside the mouth ("extraoral grafts"), implants (materials implanted into bone or soft tissue) or the removal of implants.

4. Services for any disturbances of the jaw joints (temporomandibular joints or 'TMJ") or associated muscles, nerves or tissues.

5. For treatment that was started by any dentist prior to your eligibility under the plan, including, but not limited to, orthodontics, endodontics, crowns, bridges, inlays, onlays, dentures, and prior extractions.

6. Charges for replacement or repair of an orthodontic appliance paid in part or in full by the plan. See the Orthodontic contract for specific information on repairs and broken appliances.

7. Extractions of over-retained teeth are not covered.

8. Surgery necessary to correct skeletal imbalances and/or malformations (e.g., orthognathic surgery).

9. Procedures requiring appliances or restorations (except dentures) that are necessary for adult or pediatric full mouth rehabilitation or to alter, restore or maintain occlusion, a change of vertical dimension, restorative equilibration, kinesiology, or consultation for and/or treatment of disturbances of the temporomandibular joint (TMJ).

10. The following are not included as orthodontic benefits: replacement or repair of appliances, orthodontic extractions, special appliances (e.g., Herbst appliances, rapid palatal expanders), retreatment of orthodontic cases, changes in treatment necessitated by patient neglect, and treatment in excess of twenty-four (24) months. See the Orthodontic contract for specific information.

11. For consultation by a specialist for non-covered benefits.

12. Hospitalization costs (and associated fees) for any dental procedures.

13. The plan will not be financially responsible for services determined to be the responsibility of Workers' Compensation or Employees Liability, services for which benefits are payable under any Federal Government or any state program, or for services for treatment of any automobile related injury in which you are entitled to payment under an automobile insurance policy.

14. Prescriptions and medications not normally supplied or dispensed by a dental office (this includes home care items such as rotodents, peridex, tetracycline rinses, etc.).

15. Administration of general anesthesia (other than when administered for a covered oral surgery procedure), intravenous sedation, oral sedation, or the services of an Anesthesiologist.

16. Treatment of bone fractures or dislocations.

17. Treatment of cysts, malignancies, or neoplasms.

18. Treatment of congenital or developmental malformations NOT including deciduous teeth and supernumerary teeth.

19. Implants and associated services (e.g. abutments).

20. Replacement of dentures, appliances, crowns, or bridgework, due to loss or theft or any duplicate prosthetic device or appliance.

21. Precision attachments or stress breakers.

GENERAL PROVISIONS

Reimbursement Provisions

The plan is designed to eliminate claim forms and expenses other than required co-payments. In some circumstances, you may incur expenses for covered services (such as out-of-area emergency care). If this happens, any amount billed over this amount will be your financial responsibility, including any applicable co-payment.

If you receive a bill for covered services, please provide the plan with a copy of the bill within 90 days of the date the service was rendered. Please submit the bill to:

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

In the event such a claim is denied, you may resubmit within 90 days of the initial denial, explaining in writing why you believe your claim should be approved.

Complaint And Claims Appeal Procedures

If you have a question or concerns regarding eligibility, you may call the County of Riverside Benefits Information Line: **1-951-955-4981.**

If you have any questions about the services you receive from a plan dentist, we recommend that you first discuss the matter with your dentist. If you continue to have concerns, call the plan's claims administrator: **1-888-540-9488.**

If you have a question or complaint regarding the denial of dental services or claims, the policies, procedures and operations of the quality of dental services performed by a plan dentist, you may call: **1-888-540-9488.**

You have 60 days after you receive notice of denial to appeal. If you write, you must include the name of the patient, the group name and social security number or identification number, and your telephone number on all correspondence. You should also include a copy of the treatment form, notice of payment and any other relevant information. Clearly explain your complaint and send it to the plan's claim administrator:

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

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 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 *Local Advantage Dental* plan may assume all or part of your share of the fees and expenses of the neutral arbitrator, provided you have submitted a hardship application to the American Arbitration Association. The approval or denial of a hardship application shall be determined by the American Arbitration Association. You 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. THE LOCAL ADVANTAGE 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 dental plans. If you have a grievance against the 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.

Eligibility Issues

These issues must be referred directly to the County of Riverside Human Resources Department, Benefits Division.

TERMINATION OF GROUP MEMBERSHIP - CONTINUATION OF COVERAGE

Termination of Benefits and Re-Enrollment

Coverage may be terminated for individual members if any of the following events occur:

- An employee, retiree or dependent ceases to be eligible for coverage.
- Voluntary cancellation of coverage by an employee, retiree or dependent.

All rights to coverage and care stop on the date you are no longer eligible. If for any reason the County of Riverside terminates the plan, your coverage will end on the day the plan terminates.

The plan will not terminate or refuse to renew the enrollment of any person because of his or her dental health status or need for dental care services.

Continuation of Coverage (COBRA)

The Federal Consolidated Omibus Budget Reconciliation Act (COBRA) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You or your dependents may be entitled to continue coverage under this program, at the "Qualified Beneficiary's" expense, if certain conditions are met. The period of continued coverage depends on the "Qualifying Event." Coverage will be extended 18 months for the Subscriber and eligible family members. A dependent can be eligble for up-to 36 months depending on the qualified event.

The benefits of the continuation of coverage are identical to those provided by the plan and the cost of coverage may not exceed 102% of the applicable current group premium. This coverage may be extended for up to an additional eleven (11) months if you are recognized as disabled by Social Security. This extension of coverage is available at a cost not to exceed 150% of the applicable current group premium. An eligible employee or family member is entitled to elect this coverage provided an election is made within sixty (60) days of notification of eligibility and the premium is paid. No employer contribution is available to cover the premium required.

PAYMENT BY THIRD PARTIES

Third Party Recovery Process and Your Responsibilities

If you are ever injured through the actions of another (a third party) and receive compensation for your dental care, you will be required to reimburse the plan, or its nominee, for the reasonable value of dental services and benefits provided. The amount of reimbursement shall not exceed the amount of compensation you receive from the third party.

- You must obtain the plan's written consent prior to settling any claim or releasing any third party from liability, if such a release would limit the plan's right to reimbursement.

- Should you settle your claim against a third party and compromise the plan's **reimbursement** rights, the plan reserves the right to initiate legal action. Attorney fees will be awarded to the prevailing party.

- You are required to cooperate in protecting the interest of the plan by providing the *plan* with all liens, assignments or other documents. Failure to cooperate with the plan in this regard could result in membership termination.

Coordination of Benefits

If you or an eligible dependent are covered by the plan and another group dental plan, the plan will coordinate its benefits with those of the other plan only when the patient is seen by a provider within the Plan's provider network. The goal of this kind of coordination is to maximize coverage for allowable expenses, minimize out-of-pocket costs, and to prevent any payment duplication.

- In order to ensure proper coordination, you must inform the plan of any other dental coverage for which you or your dependent (s) may be eligible.

- If the plan pays more benefits than appropriate, the plan may recover excess benefit payments from you, the plan with primary responsibility, or any other person or entity that benefited from the overpayment.

Workers' Compensation
If you are receiving benefits because of Workers' Compensation, the plan will not duplicate those benefits. It is your responsibility to take whatever action is necessary to receive payment under Workers' Compensation laws, when such payments can reasonably be expected.

If the plan happens, for whatever reason, to duplicate benefits to which you are entitled under Workers' Compensation law, you are required to reimburse the plan, at prevailing rates, immediately after receiving monetary award, whether by settlement or judgment.

In the event of a dispute arising between you and your Workers' Compensation filing, the plan will provide the benefits described in this agreement until the dispute is resolved.

If you receive a settlement of Worker's Compensation that includes payment of future medical costs, you may be liable to reimburse the plan for those costs.

PRIVACY PRACTICES

County of Riverside and American Dental Professional Services, LLC (ADPS) is committed to respecting the privacy of our employees, retirees and customers. We are required by applicable federal and state law to maintain the privacy of your health information.

The Type of Information We May Collect

We collect nonpublic personal information about you from the following sources:

- Eligibility from your Employer
- Transactions with us or our affiliated companies
- Claims submission from dental providers

Information We May Disclose

We do not disclose any nonpublic personal information about our members or former members to anyone, except as permitted by law, unless you specifically request that we do so. We only make those disclosures needed to administer your dental program and as necessary to effect transactions in the ordinary course of business. Any disclosures are only made to our affiliates, agents, or third parties that perform services on our behalf such as account administration or marketing our services or products.

Confidentiality and Security of Your Nonpublic Personal Information

We restrict access to nonpublic personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

Any questions or concerns regarding this privacy notice should be directed to our Customer Services Department at 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: 8-23-12

ATTEST:
KECIA HARPER-IHEM, Clerk

By _____
DEPUTY

Attachment B

FIRST DENTAL HEALTH NETWORK LEASE AND MARKETING AGREEMENT

May 1 – December 31, 2019

FIRST DENTAL HEALTH
NETWORK LEASE and MARKETING AGREEMENT

This network lease and marketing agreement ("Agreement") is made and entered into as of May 1, 2014 by and between FIRST DENTAL HEALTH ("FDH") and the COUNTY OF RIVERSIDE, State of California ("Payer"), a political subdivision of the State of California, and hereby individually referred to as "Party" and collectively as "Parties", with reference to the following facts:

RECITALS

A. WHEREAS, FDH has established and maintains networks of dental care Providers who have agreed to provide dental care Services at certain Fee Schedule Amounts and other guidelines as set forth and administered by FDH as set forth in this Agreement;

B. WHEREAS, Payer is an Employer that offers a self-insured dental plan administered by a third-party administrator to its employees and retirees; and

C. WHEREAS, Payer wishes to lease such networks as FDH has established and maintains for the purposes of marketing and providing access to those networks to its clients and Members;

I. AGREEMENT

NOW, THEREFORE, the Parties do hereby enter into this Agreement to set forth the terms and conditions pursuant to which the Payer will lease, market, and provide access to the FDH networks to its clients and Members, and do hereby agree as follows:

II. DEFINITIONS

The following terms shall have the meanings set forth below unless the context in which they are used clearly indicates otherwise:

A. "Covered Services" mean all necessary dental care services rendered to Members by Providers that are pursuant to and covered under a written Dental Plan and that Providers are licensed to and customarily provide.

B. "Dental Plan" means a written plan of dental insurance underwritten, administered, and/or otherwise sponsored by Payer that dictates coverage (reimbursement) for Covered Services rendered to Members by Providers.

C. "Local Advantage Fee Schedule Amounts" mean the maximum allowable amounts payable for Covered and Non-Covered Services rendered to Members by Participating Providers as set forth in their Provider Agreements.

D. "Members" mean eligible employees, or retirees (and their eligible dependants) of a Dental Plan whose dental care or dental care benefits are underwritten, administered, and/or otherwise sponsored by Payer.

E. "Non-Covered Services" mean all dental care services rendered to Members by Providers that are not pursuant to or covered under a written Dental Plan but that Providers are licensed to and customarily provide.

F. "Provider Agreements" mean the written agreements by and between FDH and individual dental care Providers that set forth the Local Advantage Fee Schedule Amounts and other terms and conditions upon which Participating Providers are to render Covered and Non-Covered Services to Members.

G. "Providers", namely "Participating Providers", are dentists and other dental care providers, including but not limited to ancillary service providers, with whom FDH enters into agreements to set forth the Local Advantage Fee Schedule Amounts and other terms and conditions upon which Providers are to render Covered and Non-Covered Services to Members.

III. RELATIONSHIP BETWEEN PAYER AND PROVIDERS

A. Upon this Agreement, FDH shall deliver to Payer a list of Participating Providers, which shall be updated periodically, as determined by FDH, to ensure proper administration and utilization of its networks. Upon this Agreement, Participating Providers shall provide both Covered and Non-Covered Services to Members according to the terms and conditions set forth in their Provider Agreements.

B. Payer and Providers shall at all times remain independent entities, and neither Payer nor Providers shall at any time act as or consider themselves an agent of the other. No relationship or joint venture between Payer and Providers or their respective agents, affiliates, employees, representatives, or successors is created by this Agreement, and neither party shall have nor exercise any control or direction over the business or performance of the other. Nothing in this Agreement shall create any rights or remedies in any third party, except that Providers shall be third party beneficiaries of obligations undertaken by Payer to reimburse Providers for Covered Services as set forth in the Dental Plan and as required by law. None of FDH, Payer, and Providers or their respective agents, affiliates, employees, representatives, or successors shall be liable to any third party for any act or omission of any other Party (or its respective agents, affiliates, employees, representatives, or successors).

IV. FDH OBLIGATIONS

FDH hereby agrees to perform the following functions, duties, and services:

A. Establish and maintain networks of Providers by entering into Provider Agreements to set forth the Local Advantage Fee Schedule Amounts, Exhibit A and other terms and conditions pursuant to which Providers are to render Services to Members;

B. Work directly with Payer's contracted Third Party Administrator to provide services mutually determined by FDH and Payer so as to facilitate the administration and utilization of the FDH networks consistent with the terms and conditions of this Agreement.

V. PAYER OBLIGATIONS

Payer hereby agrees to perform the following functions, duties, and services:

A. Provide Members a way to identify themselves to Participating Providers as network participants, such as identification cards to obtain in-network Services from Participating Providers, such as reduced co-payments and/or deductibles;

B. Provide the names, addresses, and telephone numbers of Participating Providers to Members in the form of a directory, which shall be updated periodically and/or information on how to obtain such information. Each Provider shall have the right to identify him or herself as a Participating Provider in the Dental Plan;

C. Compensate Providers for Covered Services rendered to Members by Providers pursuant to the Local Advantage Fee Schedule Amounts set forth in their Provider Agreements:

D. Furnish Providers (and if applicable, FDH) with verification of eligibility and coverage of Members when requested and as set forth in this Agreement, and provide FDH complete information on any and all Dental Plans being administered and the benefits available thereunder;

E. Authorize Members to assign to Providers providing Covered Services the Members' rights to payment from Payer for such Covered Services. Such assignment shall not, however, be a prerequisite for payment to Providers by Payer; and

F. Maintain adequate claims reserves to satisfy obligations to Providers as set forth in the Dental Plan and upon request provide FDH with financial data to substantiate the ability to compensate Providers for Covered Services rendered to Members as set forth in this Agreement.

G. Provide FDH all data regarding eligibility required by FDH to perform its services and to determine the amount of compensation (network leasing fees) due FDH.

VI. COMPENSATION OF PROVIDERS

A. Payer shall compensate Providers for Covered Services rendered to Members pursuant to the Local Advantage Fee Schedule Amounts set forth in their Provider Agreements and in accordance with the Dental Plan. Payer shall advise Providers of the involvement of the network in the Dental Plan when verification of eligibility and coverage is requested. Providers have agreed not to waive any co-payments or deductibles as part of their Provider Agreements. FDH may modify the Local Advantage Fee Schedule Amounts upon one hundred twenty (120)-days prior written notice to Payer. Payer shall adjudicate all dental claims for Covered Services and reimburse Providers within thirty (30) days of receipt, or as required by law. Should Payer reasonably dispute any claim, Payer shall notify Providers of the dispute and the nature and basis thereof within thirty (30) days of receipt, or as required by law.

B. Providers may bill Members direct for both Covered and Non-Covered Services at the Local Advantage Fee Schedule Amounts. Members shall have the sole responsibility of verifying eligibility and coverage under their Dental Plan, and have final financial responsibility for all Services rendered by Providers.

C. Providers have agreed to accept the Local Advantage Fee Schedule Amounts set forth in their Provider Agreements as payment in full, except however as determined and dictated through coordination of benefits, so long as Payer complies with all other terms of this Agreement.

D. Payer acknowledges and agrees that in the event of default on payment of any accurate and complete claims which are not the subject of reasonable dispute, Payer must provide written notice to FDH of such breach within ten (10) days of receipt. Provider may bill (and Payer shall pay) for Covered Services at Provider's usual and customary rates. Further, Provider may notify FDH and FDH may terminate this Agreement upon ten (10)-days prior written notice to Payer unless all such bills are paid in full within said ten (10)-day period.

E. Providers shall endeavor to submit claims to Payer (or if requested by Payer, to FDH) not later than sixty (60) days after the rendering of services. Each claim shall describe the services rendered to Member by Providers with sufficient particularity so that the services rendered may be reasonably identified.

F. Providers are not precluded from seeking reimbursement under coordination of benefits from third parties other than Payer; however, the liability of Payer to Providers for Covered Services provided to Members shall in no event exceed the Local Advantage Fee Schedule Amounts. Except as otherwise provided in the applicable Dental Plan, if Payer is the primary carrier Payer will pay Providers the Local Advantage Fee Schedule Amounts, and if Payer is not the primary carrier Payer shall pay the difference between the Local Advantage Fee Schedule Amounts and the amounts received from other third parties (less applicable co-payments and/or deductibles).

VII. COMPENSATION OF FDH

Payer shall compensate FDH for lease of its networks and services hereunder on a monthly basis in accordance with the schedule set forth in Exhibit B of this Agreement, attached hereto and incorporated herein by this reference and listed below:

Network Access Fees

- Local Advantage Network Access (includes General Dentists and Specialists) - $1.00 Per Employee Per Month (PEPM). PEPM includes all dependents and rates are guaranteed for five (5) years to December 31, 2019.

Network Service Options

- Service Option fees are charged in addition to the Network Access Fee.
- Claims re-pricing only - $0.40 PEPM, rates are guaranteed for five (5) years to December 31, 2019.
- Claims Utilization Review in-network - $0.40 PEPM, rates are guaranteed for five (5) years to December 31, 2019.
- Claims Utilization Review of in-network claims is contractually binding.

VIII. ELIGIBILITY AND COVERAGE VERIFICATION PROCEDURE

A. Payer shall provide FDH a copy of the Dental Plan Summary Plan Document, Exhibit C, under which Payer provides dental care benefits to Members that specifies the benefits, co-payments and/or deductibles and other pertinent terms and conditions of the Plan. Payer shall also provide FDH with all amendments thereto no less than thirty (30)-days notice in advance of the effective date.

B. Payer shall provide all Members with an identification card or other information effectively identifying them as Members of the Dental Plan and as FDH Local Advantage network participants. Payer shall provide FDH and Providers with a telephone number operating during normal business hours through which Providers may verify whether a person seeking services pursuant to this Agreement is a Member, coverage of such services, and amounts for which the Member is responsible, including co-payments and/or deductibles.

IX. DENTAL RECORDS

To the extent required for Payer to process payment, FDH shall provide or use its best efforts to cause each Provider to provide, upon reasonable notice from Payer, copies of all records relating to Covered Services provided by the Provider subject to applicable law governing the release of such records. Payer shall maintain the confidentiality of all Members' dental records as required by law.

X. PROTECTION OF PROPRIETARY RIGHTS

A. Payer acknowledges that FDH has, at substantial expense, compiled, designed, and developed certain logos, symbols, service marks, data, processes, plans and procedures, all of which are proprietary to and trade secrets of FDH (hereby referred to as "Proprietary Information"). This Proprietary Information includes, without limitation, FDH Local Advantage Fee Schedule Amounts and the names, addresses, and all other information pertaining to FDH Participating Providers. Beginning on the effective date and ending twenty-four (24) months after termination of this Agreement, neither Payer nor any of its agents, affiliates, employees, representatives, or successors shall use this Proprietary Information except as expressly set forth in this Agreement without the prior written consent of FDH. This includes direct or indirect contact with or attempts to contact other FDH clients and Participating Providers.

B. FDH acknowledges that Payer has, at substantial expense, compiled, designed, and developed certain logos, symbols, service marks, data, processes, plans and procedures, all of which

are proprietary to and trade secrets of Payer. . Beginning on the effective date and ending twenty-four (24) months after termination of this Agreement, neither FDH nor any of its agents, affiliates, employees, representatives, or successors shall use this Proprietary Information except as expressly set forth in this Agreement, without the prior written consent of Payer. This includes direct or indirect contact with or attempts to contact other Payer clients and Members.

XI. DISPUTE RESOLUTION

Any dispute arising under this Agreement or arising out of the relationship or activities of the Parties under this Agreement shall be resolved by and pursuant to the rules and procedures of the American Arbitration Association in Riverside County, California. The prevailing Party in those proceedings, or in any legal action concerning arbitration proceedings regarding this Agreement, shall be entitled to recover reasonable attorney's fees and costs from the other Party. Judgment on the award may be entered in any court having jurisdiction and shall be fully binding on the Parties. This provision shall not require arbitration of any malpractice, negligence, or other third party claims, other than disputes with Providers over claims and billings.

XII. TERM AND TERMINATION

A. The term of this Agreement shall become effective May 1, 2014, and shall continue in effect for through December 31, 2019, unless terminated as provided herein.

B. Either Party shall have the right to terminate this Agreement upon at least ninety (90)-days prior written notice to the other Party as set forth in this Agreement, with or without cause.

C. Either Party shall have the right to terminate this Agreement forthwith due to cessation of the other Party's business, including through bankruptcy, judicial administration, arrangement by or for the benefit of creditors, dissolution, etc.

D. Payer shall notify FDH in writing in the event of failure to substantially comply with the financial solvency, net equity, or similar requirements of any regulatory body or rating organization, in which case FDH shall have the option to terminate this Agreement forthwith.

E. Upon termination of this Agreement for any reason, Payer shall continue to be responsible for Covered Services rendered to Members by Participating Providers in the event that a Member is receiving such Services as part of a course of treatment entered into prior to the termination date of this Agreement until the course is completed or the Member discontinues receiving Services from the Provider.

XIII. ASSIGNMENT

Neither Party shall, without prior written consent of the other Party, assign any duties or rights under this Agreement. Any assignment in contravention of this paragraph shall constitute a material breach of this Agreement and shall be void. The foregoing shall not prohibit the Payer from entering into a contract with a third party to assist with the adjudication and processing of claims, provided that third party be required to abide by the terms and provisions of this Agreement.

XIV. AMENDMENTS

No amendment or modification to this Agreement shall be valid, binding or effective unless in writing and signed by both Parties.

XV. SUCCESSORS

Subject to the prohibitions of assignment hereunder, this Agreement shall be binding upon the successors, assignees, and personal representatives of the Parties hereto.

XVI. NOTICES

Any and all notices or other correspondence permitted or required by this Agreement shall be in writing and shall be delivered in person or by United States Postal Service First Class Mail (Certified, Registered, and Return Receipt requested and postage paid) addressed as follows:

FDH: First Dental Health
5771 Copley Drive Suite 101
San Diego, CA 92111

Payer: County of Riverside, Human Resources
4080 Lemon Street, First Floor
Riverside, CA 92501
Attn: Stacey M. Beale, Human Resources Division Manager

Such notices shall be effective on the date of delivery or on the date indicated in the notice, whichever is later. Either Party may change notice address by giving written notice of the change to the other Party.

XVIII. WAIVER OF BREACH; GOVERNING LAW; ENTIRE AGREEMENT

The waiver of any breach of this Agreement shall not be deemed to be a waiver of any other breach of either the same or any different provision. This Agreement shall be construed and enforced in accordance with the laws of the State of California. This Agreement supersedes any and all other agreements, negotiations, or representations, whether oral or written, between FDH and Payer with respect to the subject matter of this Agreement, and contains the entire agreement between the parties relating to the subject matter hereof.

XIX. SEVERABILITY; REFORMATION

In the event that any provision of this Agreement, or the performance thereof, is rendered unlawful, invalid, or unenforceable by the enactment of an applicable statute, ordinance, or regulation, or is so deemed by any court or governmental agency of competent jurisdiction, the Parties shall meet and confer in good faith to amend that provision or this Agreement to preserve the essential business purposes hereof. However, if the effect of such an amendment would impose unreasonable financial burden on one of the Parties, the Party so affected may terminate this Agreement upon written notice. In the event of termination, FDH shall be compensated for all services rendered prior to termination.

XX. VENUE

All actions and proceedings arising in connection with this Agreement shall be tried and litigated exclusively in the state and federal (if permitted by law and a party elects to file an action in federal court) courts located in the County of Riverside, State of California.

XXI. DISPUTES

Payor and FDH agree to meet and confer in good faith to resolve any problems or disputes that may arise under this Agreement, prior to the filing of a claim under the Government Claims Act (Government Code section 900 et. seq.) and prior to the initiation of any litigation by either party.

XXII. TIME IS OF THE ESSENCE

Time shall be of the essence of each and every term, obligation, and condition of this Agreement.

XXIII. CONFLICT OF INTEREST

The parties hereto and their respective employees or agents shall have no interest, and shall not acquire any interest, direct or indirect, which shall conflict in any manner or degree with the performance of services required under this Agreement.

XXIV. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Under this Agreement, FDH is subject to all relevant requirements contained in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, enacted August 21, 1996, and the laws and regulations promulgated subsequent thereto. FDH hereto agrees to cooperate in accordance with the terms and intent of this Agreement for implementation of relevant law(s) and/or regulation(s) promulgated under this Law. FDH further agrees that it shall be in compliance, and shall remain in compliance with the requirement of HIPAA, and the laws and regulations promulgated subsequent hereto, as may be amended from time to time.

Under this Agreement, Payer is subject to all relevant requirements contained in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, enacted August

21, 1996, and the laws and regulations promulgated subsequent thereto. Payer hereto agrees to cooperate in accordance with the terms and intent of this Agreement for implementation of relevant law(s) and/or regulation(s) promulgated under this Law. Payer further agrees that it shall be in compliance, and shall remain in compliance with the requirement of HIPAA, and the laws and regulations promulgated subsequent hereto, as may be amended from time to time.

XXV. FORCE MAJEURE

Neither party shall be liable to the other party or be deemed to have breached this Agreement for any failure or delay in the performance of all or any porting of its obligations under this Agreement if such failure or delay is due to any contingency beyond its reasonable control (a 'force majeure"). Without limiting the generality of the foregoing, such contingency includes, but is not limited to, acts of God, fires, floods, pandemics, storms, earthquakes, riots, boycotts, strikes, lock-outs, acts of terror, wars and war operations, restraints of government, power or communication line failure or other circumstance beyond such party's reasonable control, or by reason of a judgment, ruling or order of any court or agency of competent jurisdiction or change of law or regulation subsequent to the execution of this Agreement. Both parties are obligated to provide reasonable back-up capability to avoid the potential interruptions described above. If a force majeure occurs, the party delayed or unable to perform shall give immediate notice to the other party. Payor acknowledges that the foregoing provision does not apply to Payor's obligation to make timely payment of any fees due FDH, and that FDH shall be entitled to all remedies set forth in this Agreement and those allowed by law for Payor's failure to timely pay such fees.

XXVI. CERTIFICATION OF AUTHORITY TO EXECUTE THIS AGREEMENT

FDH certifies that the individual signing herein has authority to execute this Agreement on behalf of FDH, and may legally bind FDH to the terms and conditions of this Agreement, and any attachments hereto.

[Remainder of this page was intentionally left blank]

IN WITNESS WHEREOF, the parties hereto have caused their duly appointed representatives to execute this Agreement:

ATTEST:
Clerk of the Board
Kecia Harper-Ihem

By: _____
Deputy

Date: _____

COUNTY OF RIVERSIDE:

By: _____
Chairman, Board of Supervisors

Date: _____

Approved as to form and content:

Pamela J Walls
County Counsel

By: _____
Deputy County Counsel

FIRST DENTAL HEALTH

By: Jeannie Kemper

Printed Name: Jeannie Kemper

Title: Director, Operations

Date: 4/23/2014

EXHIBIT "A"

LOCAL ADVANTAGE FEE SCHEDULE AMOUNTS

By accepting this data, Payer acknowledges this information is proprietary to FDH under Section X and shall not be used except as expressly set forth in this Agreement. Furthermore, Payer shall not use this information for business (individuals, groups, etc.) except for that which is reported to FDH as compensation under Section VII, and shall not share this information with any third party without the prior written consent of FDH. Violation of these terms shall constitute material breach of this Agreement.

[ATTACHED AS A SEPARATE DOCUMENT UNDER "EXHIBIT A" FIRST DENTAL HEALTH LOCAL ADVANTAGE 2014 FEE SCHEDULE]

EXHIBIT "B"

FIRST DENTAL HEALTH (FDH) COMPENSATION

NETWORK ACCESS FEES [1]

Local Advantage Network Access	$1.00 Per Employee Per Month (PEPM) 2, 5

NETWORK SERVICE OPTIONS 3

Claims re-pricing only	$0.40 PEPM 5
Claims Utilization Review In - Network 4	$0.40 PEPM 5

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1) Includes General Dentists and Specialists

2) PEPM includes all dependents

3) Service Option fees are charged in addition to the Network Access Fee.

4) Utilization Review of in-network claims is contractually binding.

5) 5 year fee guarantee to 12/31/2019.

EXHIBIT "C"

LOCAL ADVANTAGE SUMMARY PLAN DOCUMENT

LOCAL ADVANTAGE PLUS
LOCAL ADVANTAGE BLYTHE
DENTAL PLANS

SUMMARY PLAN DOCUMENT

Approved for May 1, 2014 – December 31, 2019

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INTRODUCTION

The plan is specifically designed by the County of Riverside for County of Riverside employees and their eligible dependents. This Dental Plan provides dental care services through a network of participating dentists and dental groups throughout the County of Riverside. The plan benefits include extensive coverage to meet your dental care needs such as preventative care, restorative services, specialty services, and orthodontia. This Summary Plan Document provides a detailed description of how this plan works and the coverage provided to you. Detailed benefit explanations are included along with an explanation of your responsibilities as a member of this plan.

The plan provides certain services at no charge to you. For other procedures, you pay a co-insurance or co-payment at the time the services are received.

Benefits/Coverage/Claims Questions
If you have any questions about your benefits under this plan, or how the plan works, a representative is available to answer your questions at the office of the plan's Claims Administrator. This office can be reached at: **(800) 331-5301**

Dental Provider/Network Questions
If you require information about a specific network dentist, or you wish to speak to someone about your network dentist, or you have questions about the network in general, a representative is available to answer your questions at the office of the plan's Claims Administrator. This office can be reached at: **(800) 331-5301.**

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.

DENTAL PLAN ADDRESSES AND TELEPHONE NUMBERS

Dental Plan Claims Administrator/Member Services:
Capitol Administrators, Inc.
P.O. Box 2318
Rancho Cordova, CA 95741-2318
(800) 331-5301

DEFINITIONS

Annual Enrollment - a period of time established by County of Riverside during which eligible employees and retirees may enroll in a dental plan.

Benefits (Covered Services) - those services which a member is entitled to receive pursuant to the terms of the Dental Plan.

Calendar Year - a period beginning at 12:01 a.m. on January 1 and ending at 12:01 a.m. January 1 of the following year.

Categories of Benefits:

- Diagnostic - procedures to help the dentist evaluate your dental health to determine necessary treatment.
- Preventative - procedures to prevent dental disease (cleanings, for example).
- Restorative - procedures necessary to restore the teeth (other than crowns or cast restorations)
- Minor Restorative - oral surgery, endodontic (root canals), and periodontic (gum) procedures.
- Major Restorative - crowns and cast restorations (caps, veneers, inlays and onlays).
- Prosthodontic - procedures involving bridges and dentures to replace missing teeth.
- Orthodontic - procedures involving appliances (such as braces) or surgery to realign teeth and/or jaws which otherwise do not function properly.

Co-insurance – the percentage of the member's share of the cost to be paid at the time dental services are received.

Co-payment - the member's share of the costs to be paid for orthodontic benefits at the time services are received, in relation to the Plans Summary of Covered Services.

Covered Services - those dental services to which the Plan will apply benefit payments, according to the Summary Plan Document.

Dental Plan - Local Advantage Dental Plan.

Eligible Dependent - any of the dependents of an eligible employee who are eligible to enroll for benefits in accordance with the conditions of eligibility outlined in this booklet.

Eligible Employee - any group member or employee who is eligible to enroll for benefits in accordance with the conditions of eligibility outlined in this booklet.

Employer - County of Riverside.

Exclusion - any dental or other treatment for a condition for which the Plan provides no coverage.

Experimental or Investigational - any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized as being in accordance with generally accepted professional dental standards, or if safety and efficacy have not been determined for use in the treatment of a particular illness, injury or dental condition for which it is recommended or prescribed.

Maximum - the greatest dollar amount the Plan will pay for covered procedures in any calendar year, or lifetime orthodontic benefits.

Medicare - the programs of medical care coverage set forth in Title XVIII of the Social Security Act, as amended by Public Law 89-97, or as thereafter amended.

Member - an employee, retiree or family member enrolled under this Dental Plan.

Network - the dentists and dental groups which are contracting with the Plan to provide its members with treatment and services.

Participating Dentist/Dental Group - an independent provider who has an agreement to provide Plan benefits to Members.

Specialist - a dentist other than a network general dentist who has an agreement with the Plan to provide specialty services to members according to an authorized referral by a network general dentist.

Summary Plan Document - the approved summary description of entire benefits available, including Exclusions and Limitations, under this benefit program.

Services - dental care services and supplies.

ELIGIBILITY

Employee Eligibility

You are eligible to participate in the benefits program if you are a regular County employee scheduled to work at least 20 hours per week. Your bargaining unit determines which plan options are available to you. For more information about your benefit options, please review the information provided in the County of Riverside annual enrollment guide.

Dependent Eligibility

You may enroll your eligible dependents in your dental coverage. Your eligible dependents* include:

- Your legal spouse/registered domestic partner (as defined by the State of California), Your and/or your spouse/domestic partner's dependent natural children, adopted children, foster children, and stepchildren under age 26.

- An otherwise eligible child past age 26 if the child is incapable of self support because of a mental or physical handicap and you continue to claim the child as a dependent on your federal income tax return.

** Important notes about dependent eligibility:*

1. It is against the law to enroll ineligible family members. If you do, you may have to pay for all costs incurred by the ineligible dependent from the date the coverage began.
2. If you do not add newly eligible family members to your plan within the 60-day period of eligibility, you may enroll them during any future annual enrollment period.
3. Your former spouse, foster children, parents, parents-in-law, other relatives, and non-disabled children age 26 and over, are not eligible for coverage under this plan.
4. You must drop coverage for your enrolled spouse/domestic partner or dependent child when he/she loses eligibility (e.g., divorce, your child attains age 26).

ENROLLMENT

If you are a newly hired or newly eligible employee, you may elect to enroll within 60-days of your hire date or eligibility. All coverage will be effective the first day of the following month after County of Riverside receives and processes your election.

Making Mid-Year Changes

Each year your elections stay in effect from January 1 through December 31, as long as you remain eligible for benefits. During annual enrollment, you have the opportunity to change your coverage elections for the following plan year. However, after the close of

annual enrollment you can make benefit changes ONLY if you have a qualified status change. Qualified status changes include:

- Marriage, or gaining a domestic partner
- Divorce, or separation from domestic partner
- Birth or adoption of a child
- Death of a spouse or a child
- Change in spouse's employment
- Significant changes in your spouse's employer's medical coverage
- Child's loss of eligibility due to age, student status, or marital status
- Full-time/part-time employment status change that results in an insurance eligibility change
- Commencement of or return from an unpaid leave of absence

If one of the above events occurs, and you want to make a benefit change consistent with the specific event, you must submit a new Election Form indicating your new coverage elections within 60-days of the event to the County of Riverside.

Remember, it is your responsibility to stay informed about your coverage. If you have any questions, or need additional information, please contact the County of Riverside Benefits Division.

Benefits Information Line (951) 955-4981, select option 1
Website: http://benefits.rc-hr.com
Email: Benefits@rc-hr.com

CHOOSING YOUR DENTIST

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS DENTAL CARE MAY BE OBTAINED.

The plan provides easy access to dental care services and there is virtually no paperwork. Members have access to a network of licensed dentists in your local community. The network dental provider listing is available by contacting County of Riverside Benefits Information Line or via the County's website. As a Member of this plan, you are entitled to visit any of these dental providers in the plan network when you need dental care services. You may switch to another network provider without pre-approval at any time.

You are not required to pre-select a dentist at enrollment. However, it is your responsibility to call the provider you choose to verify the provider's participation status. Services provided by dentist not authorized by the Local Advantage Dental Plan are not covered by this dental plan.

Selection of Different Dentists by Enrolled Dependents

As a Member of the plan, you and each enrolled family member may choose to use different dentists within the plan's dental provider network.

Scheduling Appointments
Once you have selected your dentist from the list of participating dentists, simply call the dental office and make an appointment.

Broken Appointment Fees
Broken appointment fees may apply for short cancellation notice.

Referrals To Specialists
The dentist that you select to provide your dental care will refer you to a specialist when treatment by a specialist is appropriate. If the plan dentist refers you to a network specialist (e.g. Periodontist), the plan will pay benefits according to a separate specialist network fee schedule. Please call the plan administrator at **(800) 331-5301** for more information. In the event a referral to a specialist outside the network is necessary, a pre-authorization is required before the plan will coordinate the referral.

NOTE: Reimbursement to a non-network Specialist is limited to the amount the plan would have paid to a network Specialist. Any amount billed over this amount will be your financial responsibility, including any applicable co-payment.

Payment for Dental Services
The plan contracts with individual dentists and dental groups to provide dental services to Plan members. Participating dentists are paid on a discounted fee-for-service basis for each procedure. You are responsible for co-insurance and/or co-payments. For any services that are not covered under this Dental Plan, payment to the dentist for these services will be your financial responsibility.

For questions regarding covered procedures, please call:
Capitol Administrators, Inc.
P.O. Box 2318
Rancho Cordova, CA 95741-2318
(800) 331-5301

NOTE: *Be sure to ask your dentist for a Pre-Treatment Estimate and/or a copy of the proposed treatment plan if extensive dental work is going to be undertaken. This will assist you in making your treatment decisions, and understanding what is covered and not covered under the plan.*

LOCAL ADVANTAGE PLUS
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SUMMARY OF COVERED SERVICES

THE FOLLOWING SUMMARY IS ONLY A BRIEF DESCRIPTION. PLEASE REFER TO THE BENEFIT LIMITATIONS AND EXCLUSIONS SECTION OF THIS SUMMARY PLAN DOCUMENT FOR FURTHER INFORMATION.

Benefit Maximum:	**$1,500 each Member per Calendar Year**
Preventative	**100%** Initial exam - twice per 12 months Full mouth x-ray - once every 3 years Bitewing x-ray - twice per calendar year Cleanings - twice per calendar year **Sealants** – Under age 14 to permanent posterior molars with no decay, restorations, and with occlusal surface intact. Does not include replacement or repair of any sealant on any tooth within 3 years of application.
Restorative	**90% (1)** **Restorative** - Amalgam, synthetic, plastic, resin restorations for treatment of cavities. Posterior composite treatments. **Minor Restorative 90% (2)** **Periodontics (2)** - Treatment of gums and bones that support the teeth – periodontal cleanings are covered at twice per calendar year. **Extractions (2)** - Pre and post-operative care **Endodontics (2)** - Treatment of tooth pulp
Major Restorative	**65% (3) (*)** **Crowns, jackets, inlays, onlays, cast restorations -** Are benefits on the same tooth only once every 5 years. **Prosthodontics –** Once every 5 years unless there is such extensive loss of remaining teeth that the existing appliance cannot be made satisfactory
Orthodontic Treatment	**Standard Case (4)** $120.00 down payment, $120.00 per month for 24 months Lab fees are not included

Cosmetic Dentistry **50%**
Whitening, bonding, bleaching, veneers

1. Upgrade fee formula for posterior composite fillings is addressed elsewhere in the SPD.
2. These benefits apply for procedures provided by a General Dentist. Specialist referrals are addressed elsewhere in the SPD.
3. Precious metal costs are not included.
4. This discount applies for Orthodontic Services provided by a Network Specialist.

(*) Additional fee charges for porcelain on molar teeth.

DENTAL LIMITATIONS AND EXCLUSIONS

Limitations

The following limitations apply to certain procedures (identified below) under this Dental Plan:

1. You are responsible for any charges made by a non-network provider, including specialists, unless preauthorization is obtained and approved by the plan network service department or plan administrator (Capitol).

2. Cleanings of any kind are benefits no more than twice in any calendar year.

3. Periodontal scaling and root planning is limited to four (4) separate quadrants every two (2) years.

4. Sealant benefits are limited to eligible dependent children up to age fourteen (14). Sealant benefits include the application of sealants only to permanent posterior molars 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. Sealants are limited to one (1) each tooth every three (3) years through age ten (10) on permanent first molars and up to age fourteen (14) on permanent molars.

5. Crowns, jackets, inlays, onlays and cast restorations are benefits on the same tooth only once every five (5) years while you are a patient under the plan unless the plan determines that replacement is required because restoration is unsatisfactory as a result of poor quality of care, or because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissue since the replacement of the restoration.

6. Full cast crowns, porcelain crowns, porcelain fused to metal or plastic processed to metal type crowns are not a benefit for children under 16 years of age. The plan covers an acrylic or stainless steel crown.

7. Referral for specialty care is limited to orthodontics, oral surgery, periodontics, and endodontics. Referral to an out-of-network pediatric dentist is specifically excluded. Oral surgery, periodontic and endodontic procedures performed by a specialist are covered at 50%.

8. Full mouth x-rays – one (1) set every three (3) years.

9. Two (2) sets of bitewing x-rays twice per calendar year.

10. Prosthodontic appliances are benefits only once every five (5) years, while you are eligible under this plan, unless the plan 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. Replacement of a prosthodontic appliance not provided under the plan will be made if it is unsatisfactory and cannot be made satisfactory. Full or partial denture relines or rebasing is limited to one per arch per 12 consecutive months.

11. Optional treatment provisions: If you select a more expensive plan of treatment than is customarily provided, or specialized techniques, an allowance will be made for the least expensive, professionally acceptable, alternative treatment plan. The plan will pay the applicable percentage of the lesser fee for the customary or standard treatment and you are responsible for the remainder of the dentist's fee. *An example would be: When an enrollee receives a composite (white) filling in place of an alloy/amalgam filling when decay is present on a back tooth, the plan makes an allowance toward its cost. The allowance is based on the plan's fee for the equivalent alloy/amalgam filling and the enrollee pays the difference to the posterior composite fee. For cosmetic purposes to replace an alloy/amalgam filling, the plan coverage is 50%.*

12. You must remain on the plan during the period of time you or your eligible dependent(s) is/are undergoing orthodontic treatment. Any early termination will result in pro-rated charges for all unfinished work according to the Orthodontic contract signed at the start of treatment.

13. Implants and any associated abutments (appliances inserted into bone or soft tissue in the jaw, usually to anchor a crown, fixed bridge, partial or denture) are not covered by the plan. However, if implants are provided along with a covered prosthodontic appliance (examples noted above), the plan 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

Exclusions – Services The Plan Does Not Cover
No benefits will be covered for expenses incurred:

1. For any procedure not specifically listed as a covered benefit.

2. For procedures that are (a) in the opinion of the dentist are not clinically necessary for your health; (b) services or charges which are necessitated as a result of you failing to follow a documented prescribed course of treatment; (c) services which are obtained outside the Plan network and services which are not pre-authorized by the plan (including specialty services); (d) services or supplies that do not meet accepted standards of dental practice, and/or which are experimental in nature.

3. Grafting tissue - from outside the mouth to tissue inside the mouth ("extraoral grafts"), implants (materials implanted into bone or soft tissue) or the removal of implants.

4. Services for any disturbances of the jaw joints (temporomandibular joints or 'TMJ") or associated muscles, nerves or tissues.

5. For treatment that was started by any dentist prior to your eligibility under the plan, including, but not limited to, orthodontics, endodontics, crowns, bridges, inlays, onlays, dentures, and prior extractions.

6. Charges for replacement or repair of an orthodontic appliance paid in part or in full by the plan. See the Orthodontic contract for specific information on repairs and broken appliances.

7. Extractions of over-retained teeth are not covered.

8. Surgery necessary to correct skeletal imbalances and/or malformations (e.g., orthognathic surgery).

9. Procedures requiring appliances or restorations (except dentures) that are necessary for adult or pediatric full mouth rehabilitation or to alter, restore or maintain occlusion, a change of vertical dimension, restorative equilibration, kinesiology, or consultation for and/or treatment of disturbances of the temporomandibular joint (TMJ).

10. The following are not included as orthodontic benefits: replacement or repair of appliances, orthodontic extractions, special appliances (e.g., Herbst appliances, rapid palatal expanders), retreatment of orthodontic cases, changes in treatment necessitated by patient neglect, and treatment in excess of twenty-four (24) months. See the Orthodontic contract for specific information.

11. For consultation by a specialist for non-covered benefits.

12. Hospitalization costs (and associated fees) for any dental procedures.

13. The plan will not be financially responsible for services determined to be the responsibility of Workers' Compensation or Employees Liability, services for which benefits are payable under any Federal Government or any state program, or for services for treatment of any automobile related injury in which you are entitled to payment under an automobile insurance policy.

14. Prescriptions and medications not normally supplied or dispensed by a dental office (this includes home care items such as rotodents, peridex, tetracycline rinses, etc.).

15. Administration of general anesthesia (other than when administered for a covered oral surgery procedure), intravenous sedation, oral sedation, or the services of an Anesthesiologist.

16. Treatment of bone fractures or dislocations.

17. Treatment of cysts, malignancies, or neoplasms.

18. Treatment of congenital or developmental malformations NOT including deciduous teeth and supernumerary teeth.

19. Implants and associated services (e.g. abutments).

20. Replacement of dentures, appliances, crowns, or bridgework, due to loss or theft or any duplicate prosthetic device or appliance.

21. Precision attachments or stress breakers.

GENERAL PROVISIONS

Reimbursement Provisions

The plan is designed to eliminate claim forms and expenses other than required co-insurance and/or co-payments. In some circumstances, you may incur expenses for covered services (such as out-of-area emergency care). If this happens, any amount billed over this amount will be your financial responsibility, including any applicable co-insurance and/or co-payment.

If you receive a bill for covered services, please provide the plan with a copy of the bill within 90 days of the date the service was rendered.
Please submit the bill to:

Capitol Administrators, Inc.
P.O. Box 2318
Rancho Cordova, CA 95741-2318

In the event such a claim is denied, you may resubmit within 90 days of the initial denial, explaining in writing why you believe your claim should be approved.

Complaint And Claims Appeal Procedures
If you have a question or concerns regarding eligibility, you may call the County of Riverside Benefits Information Line: **(951) 955-4981**, select option 1.

If you have any questions about the services you receive from a plan dentist, we recommend that you first discuss the matter with your dentist. If you continue to have concerns, call the plan's claims administrator: (**800) 331-5301.**

If you have a question or complaint regarding the denial of dental services or claims, the policies, procedures and operations of the quality of dental services performed by a plan dentist, you may call: **(800) 331-5301.**

You have 60 days after you receive notice of denial to appeal. If you write, you must include the name of the patient, the group name and social security number or identification number, and your telephone number on all correspondence. You should also include a copy of the treatment form, notice of payment and any other relevant information.

Clearly explain your complaint and send it to the plan's claim administrator:

Capitol Administrators, Inc.
P.O. Box 2318
Rancho Cordova, CA 95741-2318

Arbitration
Arbitration is a vehicle for the resolution of any disputes concerning dental care services, 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 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 (3) 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 *Local Advantage Dental* plan may assume all or part of your share of the fees and expenses of the neutral arbitrator, provided you have submitted a hardship application to the American Arbitration Association. The approval or denial of a hardship application shall be determined by the American Arbitration Association. You 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. THE LOCAL ADVANTAGE DENTAL PLAN AND MEMBERSWAIVE 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 (800-927-4357) to receive complaints regarding dental plans. If you have a grievance against the 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.

Eligibility Issues
These issues must be referred directly to the County of Riverside Human Resources Department, Benefits Division.

Benefits Information Line (951) 955-4981, select option 1
Website: http://benefits.rc-hr.com
Email: Benefits@rc-hr.com

TERMINATION OF GROUP MEMBERSHIP - CONTINUATION OF COVERAGE

Termination of Benefits and Re-Enrollment
Coverage may be terminated for individual members if any of the following events occur:

- An employee, retiree or dependent ceases to be eligible for coverage.
- Voluntary cancellation of coverage by an employee, retiree or dependent.

All rights to coverage and care stop on the date you are no longer eligible. If for any reason the County of Riverside terminates the plan, your coverage will end on the day the plan terminates.

The plan will not terminate or refuse to renew the enrollment of any person because of his or her dental health status or need for dental care services.

Continuation of Coverage (COBRA)

The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You or your dependents may be entitled to continue coverage under this program, at the "Qualified Beneficiary's" expense, if certain conditions are met. The period of continued coverage depends on the "Qualifying Event." Coverage will be extended 18 months for the Subscriber and eligible family members. A dependent can be eligible for up-to 36 months depending on the qualified event.

The benefits of the continuation of coverage are identical to those provided by the plan and the cost of coverage may not exceed 102% of the applicable current group premium. This coverage may be extended for up to an additional eleven (11) months if you are recognized as disabled by Social Security. This extension of coverage is available at a cost not to exceed 150% of the applicable current group premium. An eligible employee or family member is entitled to elect this coverage provided an election is made within sixty (60) days of notification of eligibility and the premium is paid. No employer contribution is available to cover the premium required.

PAYMENT BY THIRD PARTIES

Third Party Recovery Process and Your Responsibilities
If you are ever injured through the actions of another (a third party) and receive compensation for your dental care, you will be required to reimburse the plan, or its nominee, for the reasonable value of dental services and benefits provided. The amount of reimbursement shall not exceed the amount of compensation you receive from the third party.

- You must obtain the plan's written consent prior to settling any claim or releasing any third party from liability, if such a release would limit the plan's right to reimbursement.

- Should you settle your claim against a third party and compromise the plan's **reimbursement** rights, the plan reserves the right to initiate legal action. Attorney fees will be awarded to the prevailing party.

- You are required to cooperate in protecting the interest of the plan by providing the *plan* with all liens, assignments or other documents. Failure to cooperate with the plan in this regard could result in membership termination.

Coordination of Benefits
If you or an eligible dependent are covered by the plan and another group dental plan, the plan will coordinate its benefits with those of the other plan only when the patient is seen by a provider within the Plan's provider network. The goal of this kind of coordination is to maximize coverage for allowable expenses, minimize out-of-pocket costs, and to prevent any payment duplication.

- In order to ensure proper coordination, you must inform the plan of any other dental coverage for which you or your dependent (s) may be eligible.

- If the plan pays more benefits than appropriate, the plan may recover excess benefit payments from you, the plan with primary responsibility, or any other person or entity that benefited from the overpayment.

Workers' Compensation
If you are receiving benefits because of Workers' Compensation, the plan will not duplicate those benefits. It is your responsibility to take whatever action is necessary to receive payment under Workers' Compensation laws, when such payments can reasonably be expected.

If the plan happens, for whatever reason, to duplicate benefits to which you are entitled under Workers' Compensation law, you are required to reimburse the plan, at prevailing rates, immediately after receiving monetary award, whether by settlement or judgment.

In the event of a dispute arising between you and your Workers' Compensation filing, the plan will provide the benefits described in this agreement until the dispute is resolved.

If you receive a settlement of Worker's Compensation that includes payment of future medical costs, you may be liable to reimburse the plan for those costs.

PRIVACY PRACTICES

County of Riverside and Capitol Administrator's (Capitol) is committed to respecting the privacy of our employees, retirees and customers. We are required by applicable federal and state law to maintain the privacy of your health information.

The Type of Information We May Collect

We collect nonpublic personal information about you from the following sources:

- Eligibility from your Employer
- Transactions with us or our affiliated companies
- Claims submission from dental providers

Information We May Disclose

We do not disclose any nonpublic personal information about our members or former members to anyone, except as permitted by law, unless you specifically request that we do so. We only make those disclosures needed to administer your dental program and as necessary to effect transactions in the ordinary course of business. Any disclosures are only made to our affiliates, agents, or third parties that perform services on our behalf such as account administration or marketing our services or products.

Confidentiality and Security of Your Nonpublic Personal Information

We restrict access to nonpublic personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

Any questions or concerns regarding this privacy notice should be directed to our Customer Services Department at (800) 331-5301.

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: _____