

LOCAL ADVANTAGE DENTAL BENEFIT PLAN SUMMARY PLAN DOCUMENT

January 2011

Table of Contents

Introduction	3
Definitions	4
Eligibility	5
Enrollment	5
Choosing Your Dentist	6
▪ Selection of Different Dentists by Family Members	
▪ Scheduling Appointments	
▪ Referrals to Specialists	
▪ Payment for Dental Services	
Summary of Covered Benefits	8
Dental Limitations and Exclusions	9
General Provisions	13
▪ Reimbursement Provisions	
▪ Complaint and Claims Appeal Procedures	
▪ Arbitration	
Termination of Group Membership – Continuation of Coverage	15
▪ Termination of Benefits and Re-enrollment	
▪ Continuation of Coverage (COBRA)	
Payment by Third Parties	16
▪ Third Party Recovery Process and Your Responsibilities	
▪ Coordination of Benefits	
▪ Workers Compensation	

INTRODUCTION

The Local Advantage Dental Plan is specifically designed by the City of Riverside for City 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 Inland Empire. 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 (SPD) provides a detailed description of how this Dental Plan works and the coverage provided to you. Detailed benefit explanations are included along with an explanation of your responsibilities as a member of the Dental Plan.

The Local Advantage Dental Plan provides certain services at not 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: 1/ 888-540-9488

DENTAL PROVIDER/NETWORK QUESTIONS

If you require information about a specific network dentist, or 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

THERE IS NO OUT OF NETWORK COVERAGE FOR THE LOCAL ADVANTAGE PLAN.

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

Toll Free: 1/ 888 540 9488 8A.M. – 5 P.M. CST

DEFINITIONS

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 – City 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.

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

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 written agreement between your employer and the plan to provide dental benefits.

Services - dental care services and supplies.

ELIGIBILITY

Covering Your Family Members - You and your dependents are eligible to enroll in the plan if you meet the eligibility requirements for Health Plan coverage defined by the City of Riverside.

Dependent Child Age Limit - You may enroll your eligible child (ren) to age 26 regardless of student or marital status.

Remember, it is your responsibility to stay informed about your coverage. If you have any questions, call the **City of Riverside Benefits Information Line at 951-826-5639**.

ENROLLMENT

To enroll in the plan, complete an enrollment form. Your Human Resources department can provide both the form and assistance in completing it.

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 you with easy access to dental care services and there is virtually no paperwork. The plan provides members with access to a network of licensed dentists in your local community. The network dental provider listing is available by request from your Human Resource management team. 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.

Benefit
Maximum **\$2000.00 each member per calendar year**

For questions regarding covered procedures please call:

**American Dental Professional Services
9054 N. Deerbrook Trail
Milwaukee, WI 53223
1-888-540-9488 extension 150**

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 PLAN
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.

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%
	Restorative – Amalgam, synthetic, plastic, resin restorations for treatment of cavities.
Minor Restorative	90%
	Periodontics - Treatment of gums and bones that support the teeth
	Periodontal cleanings are covered twice per calendar year.
	Extractions, pre and post operative care
	Endodontics - Treatment of tooth pulp
Major Restorative	65%
	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 - provided by a Network Orthodontist
	\$1250.00 Discount from UCF
	\$130.00 Down payment, \$130.00 per month for 24 months
	Lab fees are \$220.00
Cosmetic Dentistry	50%
	Whitening, Bonding , Bleaching, Veneers

DENTAL LIMITATIONS AND EXCLUSIONS

** Please refer to the Summary Plan Document (SPD) for limitations and exclusions on these benefits. Some examples of limitations on services are the number of cleanings and oral exams covered in a calendar year, time limitations on crown replacements, precious metal costs and porcelain fillings. Orthodontic preferred payment option is available. Referrals to Local Advantage Specialists are explained in this document.*

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 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 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. E.g.: 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.

**Questions? Call Toll Free (888) 540-9488
8:00 A.M. - 5:00 P.M.
Central Standard Time**

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.

**Questions? Call Toll Free (888) 540-9488
8:00 A.M. - 5:00 P.M.
Central Standard Time**

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 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 eligibility, 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 N. Deerbrook Trail
Milwaukee, WI 53223
1-888-540-9488**

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 you 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 City.

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) 8:00 a.m. to 6:00 p.m. M-F and a WEB address: www.insurance.ca.gov 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 City of Riverside Human Resources Department.

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 City 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.”

The benefits of the continuation of coverage are identical to those provided by the plan and the cost of coverage may not exceed 102 percent 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.

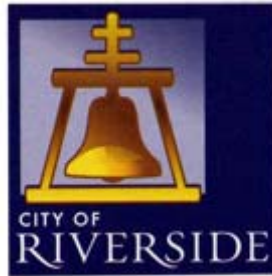
Workers' Compensation

If you are receiving benefits as a result 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 which includes payment of future medical costs, you may be liable to reimburse the plan for those costs.



LOCAL ADVANTAGE DENTAL PLAN

**Questions? Call Toll Free (888) 540-9488
8:00 A.M. - 5:00 P.M.
Central Standard Time**