



***LOCAL ADVANTAGE PLUS
LOCAL ADVANTAGE BLYTHE
DENTAL PLANS***

SUMMARY PLAN DOCUMENT



APPROVED FOR PLAN YEARS 2009 - 2010

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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-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

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.

Open Enrollment - a period of time established by County 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 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 23 and who has never been married
 - Any child, who is under age 23 and has never been married, for whom you have legal custody, have been required to cover under your dental plan as part of a qualified child support order or who resides with you (generally in the absence of the natural or adoptive parent) and who is economically dependent upon you
 - An otherwise eligible child past age 23 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 23 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 23, or marries).

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 month following 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 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 plan 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 - Treatment of gums and bones that support the teeth – periodontal cleanings are covered at twice per calendar year.

Extractions, pre and post operative care

Endodontics - 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.
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 (appliances inserted into bone or soft tissue in the jaw, usually to anchor a crown, fixed bridge or denture) are not covered by the plan. However, if implants are provided along with a covered prosthodontic appliance, the plan will allow the cost of a standard partial or complete denture toward the cost of the implants. If the plan makes such an allowance, the plan will not pay for any replacement for five (5) years following the completion of the service. 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, kinesiologly, 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. Anesthesia, except for general anesthesia given by a dentist for covered oral surgery. Administration of 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.
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 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 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 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 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 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 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.