COUNTY OF KERN
HEALTH BENEFITS DIVISION

INDEPENDENCE PPO PLAN

JANUARY 1, 2020

SUMMARY PLAN DESCRIPTION

BENEFITS ADMINISTERED BY
LIBERTY DENTAL PLAN OF CALIFORNIA, INC.

Dear Plan Beneficiary:

This Summary Plan Description provides a complete explanation of your benefits, limitations, and other plan provisions.

Employees and covered dependents are referred to in this Summary Plan Description as “you” and “your”.

Please read this Summary Plan Description carefully so that you understand all the benefits your plan offers. Keep this Summary Plan Description handy in case you have any questions about your coverage.

TABLE OF CONTENTS

TYPES OF PROVIDERS

You are free to choose any dentist for treatment, but it is to your advantage to choose a PPO dentist. Please read the differences below.

PPO Participating Dentists have agreed to accept a specific dollar amount per covered procedure. You will be responsible for your co-insurance percentage (see Summary of Benefits) of the agreed upon amount, deductibles, non-covered services and any amount over the annual maximum payable by the plan.

We will provide you with a directory of PPO Participating Dentists upon request.

Non-Participating Dentists have no agreement. You will be responsible for your co-insurance percentage (see Summary of Benefits) of the regional customary fee plus any amount the dentist charges above the regional customary fee, deductibles, non-covered services and any amount over the annual maximum payable by the plan.

SUMMARY OF BENEFITS

THE BENEFITS OF THIS PLAN ARE PROVIDED ONLY FOR THOSE SERVICES THAT ARE DETERMINED TO BE "ACCEPTABLE SERVICES". THE FACT THAT YOUR DENTIST PRESCRIBES OR ORDERS A SERVICES DOES NOT, IN ITSELF, MEAN THAT THE SERVICE IS AN ACCEPTABLE SERVICE OR THAT THE SERVICE IS A COVERED DENTAL EXPENSE.

This summary provides a brief outline of your benefits. You need to refer to this entire plan description for complete information about the benefits, conditions, limitations and exclusions of your plan.

Second Opinions. If you have a question about your dental condition or about a plan of treatment which your dentist has recommended, you may receive a second dental opinion from another dentist. This second opinion visit will be provided according to the benefits, limitations and exclusions of this plan. If you wish to receive a second dental opinion, remember that greater benefits are provided when you choose a participating PPO dentist. You may also ask your dentist to refer you to a participating dentist to receive a second opinion.

All benefits are subject to coordination with benefits under certain other plans.

The benefits of this plan may be subject to the REIMBURSEMENT FOR ACTS OF THIRD PARTIES section.

DENTAL BENEFITS

DENTAL DEDUCTIBLES (per calendar year)

- Individual Deductible..... **$50**
- Family Deductible..... **$150**

Exception: The Dental Deductible does not apply to Diagnostic and Preventive Services.

PAYMENT RATES

After the Dental Deductible has been satisfied, the plan will pay the percentage of covered dental expenses shown below, for the type of services received, up to the Dental Benefit Maximum:

PPO Participating Dentists

- Diagnostic & Preventative Services..... **100%**
- Restorative Services..... **90%**
- Prosthodontic Services (Fixed & Removable)..... **90%**
- Endodontic Services..... **90%**
- Periodontic Services..... **90%**
- Implant Services..... **90%**
- Oral Surgery..... **90%**

Non-Participating Dentists

- Diagnostic & Preventative Services..... **70%**
- Restorative Services..... **70%**
- Prosthodontic Services (Fixed & Removable)..... **70%**
- Endodontic Services..... **70%**
- Periodontic Services..... **70%**
- Implant Services..... **70%**

- Oral Surgery..... **70%**

DENTAL BENEFIT MAXIMUM

- Calendar Year Maximum..... **$2,500**
- **Orthodontic Lifetime Maximum……$1,500**

YOUR DENTAL BENEFITS

The plan will pay for covered dental expenses you incur while covered under this plan, subject to all terms, conditions, limitations and exclusions specified in this plan description.

HOW COVERED DENTAL EXPENSE IS DETERMINED

Covered dental expense is based on a maximum charge for each covered service that will be accepted for each provider. It is not necessarily the amount a dentist bills for the service.

Covered dental expense will always be the lesser of the billed charge or the amount shown below.

Type of Dentist	Maximum Covered Dental Expense
PPO Participating Dentists	**Negotiated Rate**
Non-Participating Dentists	**Regional Customary Charge**

PPO Participating Dentists have agreed not to charge you more than the dental negotiated rate. When you choose a PPO Participating Dentist, you will not be responsible for any amount in excess of the negotiated rate for the covered services.

You will be responsible for any billed charge that exceeds the regional customary charge for services provided by a Non-Participating Dentist.

DENTAL DEDUCTIBLES AND BENEFIT MAXIMUMS

After the Dental Deductible is subtracted from the total amount of covered dental expense, benefits will be paid at the Payment Rate which applies to such expense, up to the applicable Dental Benefit Maximums. The Deductible amounts, Payment Rates, and Dental Benefit Maximums can be found in the SUMMARY OF BENEFITS.

DENTAL DEDUCTIBLES

Only charges that are considered covered dental expense will apply toward satisfaction of the Dental Deductible.

Individual Deductible. Each calendar year, you will be responsible for satisfying the Individual Deductible before benefits are payable under the plan.

You are not required to satisfy your Dental Deductible before the plan will pay dental benefits for Diagnostic and Preventive Services.

Family Deductible. If enrolled members of a family pay Deductible expense during a calendar year, equal to the Family Deductible amount shown in the SUMMARY OF BENEFITS, then the Dental Deductible for all dependents is considered to have been met. No further Dental Deductible is required for the remainder of the year.

Prior Plan Dental Deductibles. If you were covered for dental benefits under the prior plan, any amount paid for dental benefits during the same calendar year toward your dental deductible under the prior plan will be applied toward your Dental Deductible under this plan, provided that such payments were for charges that would be covered dental expense under this plan.

DENTAL BENEFIT MAXIMUMS

Calendar Year Maximum. Your benefits are subject to the Calendar Year Maximum shown in the SUMMARY OF BENEFITS. The plan will not pay any benefit in excess of that amount for covered dental expense incurred during a calendar year for each covered member. Also, all payments are subject to any waiting periods and limitations specified in this plan description.

Prior Plan Maximum Benefits. If this plan replaces a prior plan, the amount of any benefits paid to you under the prior plan will reduce any maximum amounts for which you are eligible under this plan which apply to the same benefit.

DENTAL CONDITIONS OF SERVICE

The following conditions of service must be met for expense incurred to be considered as covered dental expense.

1. You must incur this expense while you are covered for dental benefits under this plan. Expense is incurred on the date you receive the service for which the charge is made.

2. The service must be provided by a licensed dentist, physician, or dental hygienist and must be for preventive care or for treatment of dental disease, defect or injury.

3. The expense must be incurred for a dental service that is included under DENTAL CARE THAT IS COVERED. Additional limits on covered dental expense are included under specific benefits in the SUMMARY OF BENEFITS.

4. The expense must not be for a dental service listed under DENTAL CARE THAT IS NOT COVERED. If the service is partially excluded, then only that portion which is not excluded will be considered covered dental expense.

5. The expense must not exceed any of the maximum benefits or limitations of this plan.

PRE-TREATMENT REVIEW

If your dentist anticipates the expense for any course of treatment to exceed **$300**, your dentist should prepare a request for a pre-treatment benefit estimation form and submit this form to the claims administrator before any treatment begins. The claims administrator will review this request and send the response to your dentist.

If the course of treatment is not reviewed before treatment is received, such treatment may be subject to review once the claim has been submitted to the claims administrator for payment and to retrospective denial of benefits.

If you or your dentist disagrees with a pre-treatment review decision, you or your dentist may request reconsideration. Any requests for reconsideration (either by telephone or in writing) must be directed to the address and the telephone number included on your written copy of the response.

DENTAL CARE THAT IS COVERED

Each of the following service is covered subject to DENTAL CONDITIONS OF SERVICE, provided it meets the requirements explained under HOW COVERED DENTAL EXPENSE IS DETERMINED, and is not for, or in connection with, an exclusion or limitation listed under DENTAL CARE THAT IS NOT COVERED.

Diagnostic and Preventive Services

- Examinations
- X-rays
- Teeth cleaning
- fluoride application

Restorative Services

- Fillings

Prosthodontic Services (Fixed and Removable)

- Preparation and installation of bridges
- Crowns attached to a bridge
- Crowns not attached to a bridge
- Preparation and installation of partial or complete dentures (including repairs)
- Cast restorations, porcelain inlays

Endodontic Services

- Root canal therapy
- Treatment to prevent or correct conditions that affect the tooth pulp, root and related tissue

Periodontic Services

- Scaling and other procedures to prevent or treat diseases or defects to your gums

Implant Services

- Surgical Placement

- Abutment (crown, supported retainer)

- Implant Supported Retainer
- Scaling and Debridement of Single Implant
- Removal of Implant

Oral Surgery

- Extractions of teeth and minor oral surgery. (General anesthesia will be covered with the oral surgery if it is determined to be necessary.)

Orthodontics

DENTAL CARE THAT IS NOT COVERED

No payment will be made under YOUR DENTAL BENEFITS for expense incurred for, or in connection with, any of the items below. (The titles given to these exclusions and limitations are for ease of reference only; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.)

Services Provided Before or After the Term of This Coverage. Services received before your effective date of coverage. Services received after your coverage ends, except as specifically stated under EXTENSION OF BENEFITS.

Experimental or Investigative Procedures. Any procedures which are considered experimental or investigative or which are not widely accepted as proven and effective procedures within the organized dental community.

Acceptable Services. Any service which is determined not to be an acceptable service as defined. (See DEFINITIONS.)

Workers' Compensation. Any work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise under any workers' compensation, employer's liability law or occupational disease law, even if you did not claim those benefits.

Government Programs. Services provided by, or payment made by, any local, state, county or federal government agency including Medicare and any foreign government agency.

No Charge Services. Services received for which no charge is made to you or for which no charge would be made to you in the absence of insurance coverage.

Results of War. Disease contracted or injuries sustained as a result of war, declared or undeclared, or from exposure to nuclear energy, whether or not the result of war.

Provider Related To Beneficiary. Professional services received from a person who lives in your home or who is related to you by blood or marriage.

Excess Expense. Any amounts in excess of covered dental expense or the Dental Benefit Maximums.

Professionally Acceptable Treatment. If it is determined that more than one treatment plan would be considered an acceptable service for a dental condition, any amount exceeding the cost of the least expensive professionally acceptable treatment plan is not covered.

Transfer of Care. If you transfer from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, the plan shall be liable only for the amount for which the plan would have been liable if one dentist had rendered the services.

Hospital Charges. Hospital costs and any additional charges by the dentist for hospital treatment.

Services NOT Included as a Covered Procedure. Services not included under DENTAL CARE THAT IS COVERED unless they are similar in nature to an included procedure; in such event, the benefit payable will be based on the most nearly comparable services included.

Treatment By An Unlicensed Dentist. Charges for treatment by other than a licensed dentist or physician, except charges for dental prophylaxis performed by a licensed dental hygienist under the supervision and direction of a dentist.

Treatment of the Joint of the Jaw. Diagnosis or treatment by any method of any condition related to the jaw joint (temporomandibular joint) or associated musculature, nerves and other tissues.

Vertical Dimension and Attrition. Procedures requiring appliances or restorations (other than those for replacement of structure lost due to dental

decay) that are necessary to alter, restore or maintain occlusion. These include but are not limited to:

- Changing the vertical dimension
- Replacing or stabilizing tooth structure lost by attrition, abrasion, or erosion
- Realignment of teeth
- Gnathological recording
- Occlusal equilibration
- Periodontal splinting

Prosthetic Replacements. Replacement of fixed or removable prosthesis for which benefits were paid by the plan, if replacement occurs within five years of the original placement, unless the prosthesis is a stayplate used during the healing period for recently extracted anterior teeth.

Crown Replacements. Replacement of crowns and cast restorations including porcelain crowns and inlays for which benefits were paid by the plan, if replacement occurs within five years of the original placement.

Denture Repairs, Adjustments or Relines. Repairs, adjustments or relines of full or partial dentures or other prostheses are not covered for a period of six months from the initial placement if they were not paid for under this plan.

Lost or Stolen Dentures or Appliances. Replacement of existing full or partial dentures or prosthetic appliances which have been lost or stolen.

Malignancies and Neoplasms. Services for treatment of malignancies and neoplasms.

X-rays. More than one set of full-mouth X-rays or its equivalent in a three-year period.

Cosmetic Dentistry. Any services performed for cosmetic purposes, unless they are for correction of functional disorders or as a result of an accidental injury occurring while you were covered for dental benefits under this plan.

Congenital or Developmental Malformation. Services to correct a congenital or developmental malformation including but not limited to cleft

palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (discoloration of the teeth), and anodontia (congenitally missing teeth).

Oral Exams. Oral exams are limited to two per calendar year.

Prophylaxis or Periodontal Prophylaxis. Prophylaxis or periodontal prophylaxis treatments exceeding two treatments in a calendar year. Periodontal prophylaxis must be preceded by an active periodontal treatment, such as scaling and root planing or osseous (gum) surgery.

Sealants. Sealants are limited to children under 16 years of age for permanent molars, unrestored. Treatment is limited to once every 36 months per tooth.

Prescription Drugs and Medications. Any prescribed drugs, pre-medication or analgesia.

Oral Hygiene. Oral hygiene instruction.

REIMBURSEMENT FOR ACTS OF THIRD PARTIES

No payment will be made under this plan for expenses incurred for or in connection with any illness, injury, or condition for which a third party may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation. However, the benefits of this plan will be provided subject to the following:

1. We will automatically have a lien, to the extent of benefits provided, upon any recovery, whether by settlement, judgment or otherwise, that you receive from the third party, the third party's insurer, or the third party's guarantor. The lien will be in the amount of benefits paid under this plan for the treatment of the illness, disease, injury or condition for which the third party is liable.

2. You must advise the claims administrator in writing, within 60 days of filing a claim against the third party and take necessary action, furnish such information and assistance, and execute such papers as the plan may require to facilitate enforcement of our rights. You must not take action which may prejudice our rights or interest under the plan. Failure to give the claims administrator such notice or to cooperate with the claims administrator, or actions that prejudice our rights or interests will be a material breach of this plan and will result in your being personally responsible for reimbursing us.

3. The plan administrator will be entitled to collect its lien even if the amount you or anyone recovered for you (or your estate, parent or legal guardian) from or for account of such third party as compensation for the injury, illness or condition is less than the actual loss you suffered.

COORDINATION OF BENEFITS

If you are covered by more than one group dental plan, your benefits under This Plan will be coordinated with the benefits of those Other Plans, as shown below. These coordination provisions apply separately to each beneficiary, per calendar year, and are largely determined by California law.

DEFINITIONS

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by at least one Other Plan. For the purposes of determining payment, the total value of Allowable Expense as provided under This Plan and all Other Plans will not exceed the greater of: (1) the amount which the plan would determine to be eligible expense, if you were covered under This Plan only; or (2) the amount any Other Plan would determine to be eligible expenses in the absence of other coverage.

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage.

2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;

3. Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.

The term "Other Plan" refers separately to each agreement, policy, contract, or other arrangement for services and benefits, and only to that portion of such agreement, policy, contract, or arrangement which reserves the right to take the services or benefits or other plans into consideration in determining benefits.

Principal Plan is the plan which will have its benefits determined first.

This Plan is that portion of this plan which provides benefits subject to this provision.

EFFECT ON BENEFITS

1. If This Plan is the Principal Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense.

2. If This Plan is not the Principal Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense.

3. The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered under This Plan only.

ORDER OF BENEFITS DETERMINATION

The following rules determine the order in which benefits are payable:

1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision.

2. A plan which covers you as an employee pays before a plan which covers you as a dependent.

3. For a dependent child covered under plans of two parents, the plan of the parent whose birthday falls earlier in the calendar year pays before the plan of the parent whose birthday falls later in the calendar year. But if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

   Exception to Rule 3: For a dependent child of parents who are divorced or separated, the following rules will be used in place of Rule 3:

   a. If the parent with custody of that child for whom a claims has been made has remarried, then the plan of the parent with custody that covers that child as a dependent pays first.

   b. If the parent with custody of that child for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:

i. The plan which covers that child as a dependent of the parent with custody.

ii. The plan which covers that child as a dependent of the stepparent (married to the parent with custody).

iii. The plan which covers that child as a dependent of the parent without custody.

iv. The plan which covers that child as a dependent of the stepparent (married to the parent without custody).

c. Regardless of a and be above, if there is a court decree which establishes a parent's financial responsibility for that child's health care coverage, a plan which covers that child as a dependent of that parent pays first.

4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But, if either plan does not have a provision regarding laid-off or retired employees, provision 6 applies.

5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan do not agree under these circumstances with the order of benefit determination provisions of This Plan, this rule will not apply.

6. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, Allowable Expense is split equally between the two plans.

OUR RIGHTS UNDER THIS PROVISION

Responsibility For Timely Notice. We are not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this provision.

Reasonable Cash Value. If any Other Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of services

provided will be considered Allowable Expense. The reasonable cash value of such service will be considered a benefit paid, and our liability reduced accordingly.

Facility of Payment. If payments which should have been made under This Plan have been made under any Other Plan, we have the right to pay that Other Plan any amount we determine to be warranted to satisfy the intent of this provision. Any such amount will be considered a benefit paid under This Plan, and such payment will fully satisfy our liability under this provision.

Right of Recovery. If payments made under This Plan exceed the maximum payment necessary to satisfy the intent of this provision, we have the right to recover that excess amount from any persons or organizations to or for whom those payments were made, or from any insurance company or service plan.

HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

ELIGIBILITY DATE

1. **For Employees:** You become eligible for coverage on the first day of the bi-weekly pay period following 30 days of continuous employment.

2. **For Dependents**: You become eligible for coverage on the later of: (a) the date the employee becomes eligible for coverage; or, (b) the date you meet the dependent definition.

ENROLLMENT

Please refer to your Employer's Health Benefits Eligibility Policy.

EFFECTIVE DATE

Please refer to your Employer's Health Benefits Eligibility Policy.

OPEN ENROLLMENT PERIOD

Please refer to your Employer's Health Benefits Eligibility Policy.

HOW COVERAGE ENDS

Your coverage ends without notice as provided below:

1. If the plan terminates, your coverage ends at the same time. This plan may be canceled or changed without notice to you.

2. If the plan no longer provides coverage for the class of beneficiaries to which you belong, your coverage ends on the effective date of that change. If this plan is amended to delete coverage for dependents, a dependent's coverage ends on the effective date of that change.

3. Coverage for dependents ends when the employee's coverage ends.

4. Coverage ends at the end of the period for which the required contribution has been paid on your behalf and when the required contribution for the next period is not paid.

5. If you voluntarily cancel coverage at any time, coverage ends on the date determined and reported by your employer.

6. If you no longer meet the requirements set for in the "Eligible Status" provision of HOW COVERAGE BEGINS, your coverage ends on the date determined and reported by your employer.

   Exceptions to Item 6:

   a. **Leave of Absence.** Please refer to your Employer's Health Benefits Eligibility Policy.

   b. **Handicapped Children**. Please refer to your Employer's Health Benefits Eligibility Policy.

CONTINUATION OF COVERAGE

Most employers who employ 20 or more people on a typical business day are subject to The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If the employer who provides coverage under the plans is subject to the federal law which governs this provision (Title X of P.L. 99-272), you may be entitled to a period of continuation of coverage. Check with your employer for details.

GENERAL PROVISIONS

Providing of Care. We are not responsible for providing any type of dental care, nor are we responsible for the quality of such care received.

Independent Contractors. Our relationship with providers is that of an independent contractor. Dentists and other dental health professionals are not our agents nor are we or any of our employees, an employee or agent of any dental group or dental care provider of any type.

Non-Regulation of Providers. The benefits provided under this plan do not regulate the amounts charged by providers of dental care, except to the extent that rates for covered services are regulated with PPO Participating Dentists.

Terms of Coverage

1. In order for you to be entitled to benefits under the plan, both the plan and your coverage under the plan must be in effect on the date the expense giving rise to a claim for benefits is incurred.

2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service for which the charge is made.

3. The plan is subject to amendment, modification or termination according to the provisions of the plan without your consent or concurrence.

Protection of Coverage. We do not have the right to cancel your coverage under this plan while: (1) this plan is in effect; (2) you are eligible; and (3) your required contributions are paid according to the terms of the plan.

Free Choice of Provider. You may choose any dental care professional or facility which provides care covered under this plan, and is properly licensed according to appropriate state and local laws. However, your choice may affect the benefits payable according to this plan.

Acceptable Services. The benefits of this plan are provided only for services which we determine to be acceptable services. The services must be ordered by the attending dentist for the direct care and treatment of a covered condition. They must be standard dental practice where received for the condition being treated and must be legal in the United States.

Expense in Excess of Benefits. The plan is not liable for any expense you incur in excess of the benefits of this plan.

Benefits Not Transferable. Only the enrolled member is entitled to receive benefits under this plan. The right to benefits cannot be transferred.

Notice of Claim. You or the provider of service must send properly and fully completed claim forms to the claims administrator within 90 days of the date you receive the service or supply for which a claim is made. Services received and charges for the services must be itemized, and clearly and accurately described. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. We are not liable for the benefits of the plan if you do not file claims within the required time period. Claim forms must be used; canceled checks or receipts are not acceptable.

Timely Payment of Claims. Any benefits due under this plan shall be due once the claims administrator has received proper, written proof of loss, together with such reasonably necessary additional information the plan may require to determine its obligation.

Payment to Providers. The benefits of this plan will be paid directly to participating dentists. Also, non-participating dentists will be paid directly when you assign benefits in writing. These payments will fulfill the plan's obligation to you for those covered services.

Right of Recovery. When the amount the plan paid exceeds the plan liability under this plan, the plan has the right to recover the excess amount. This amount may be recovered from you, the person to whom payment was made or any other plan.

Worker's Compensation Insurance. The plan does not affect any requirement for coverage by worker's compensation insurance. It also does not replace that insurance.

Entire Contract. This plan description, including any riders and endorsements to it, is a summary of your benefits. All benefits are subject in every way to the entire administrative services agreement which includes this plan description. The terms of the plan may be changed only by a written endorsement signed by one of our authorized officers. No agent or employee has any authority to change any of the terms, or waive the provisions of, the plan.

Liability For Statements. No statements made by you, unless they appear on a written form signed by you or are fraudulent, will be used to deny a

claim under the plan. Statements made by you will not be deemed warranties. With regard to each statement, no statement will be used by us in defense to a claim unless it appears in a written form signed by you and then only if a copy has been furnished to you. After two years following the filing of such claim, if the coverage under which such claim is filed has been in force during that time, no such statement will be used to deny such a claim, unless the statement is fraudulent..

Plan Administrator – COBRA. In no event will the claims administrator be the plan administrator for the purposes of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Liability of Employee to Pay Providers. In accordance with California law, you will not be required to pay any participating dentist any amounts the plan owes to that provider (not including co-insurance or deductibles), even in the unlikely event that the plan fails to pay that provider. You may be liable, however, to pay Non-Participating dentists any amounts not paid to them by the plan.

Physical Examination. At our expense, we have the right and opportunity to examine any member claiming benefits when and as often as reasonably necessary while a claim is pending.

Legal Actions. No attempt to recover on the plan through legal or equity action may be made until at least 60 days after the written proof of loss has been furnished as required by this plan. No such action may be started later than three years from the time written proof of loss is required to be furnished.

DEFINITIONS

The meanings of key terms used in this plan description are shown below.

Acceptable services are services and supplies provided in connection with those services which the claims administrator determines to be:

1. Acceptable and necessary for the symptoms, diagnosis, or treatment of your dental condition.

2. Provided for the prevention, diagnosis, or direct care and treatment of the dental condition.

3. Within community standards of good dental practice.

Accidental injury is physical harm or disability which is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound.

Child meets the plan's eligibility requirements for children as outlined under HOW COVERAGE BEGINS AND ENDS.

Claims administrator refers to LIBERTY Dental Plan. LIBERTY Dental Plan shall perform all administrative services in connection with the processing of claims and determination of medical necessity under the plan.

Covered dental expense (covered expense) is the expense you incur for a covered service or supply, but not more than the maximum amounts described in items 1 and 2 below. Expense is incurred on the date you receive the service or supply. Covered dental expense does not include:

1. For all PPO Participating Dentists, any charge in excess of the dental negotiated rate; or

2. For Non-Participating Dentists, any charge by in excess of the regional customary charge.

Regional Customary charge is a charge that the claims administrator determines to fall within the common range of fees billed by a majority of dentists for a procedure in a given geographic region.

Dental negotiated rate is the amount PPO Participating Dentists agree to accept as payment in full for covered services. It is usually lower than their normal charge. Dental negotiated rates are determined by PPO Participating Provider Agreements.

Dentist is a person who is licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practice of dentistry.

Dependent (dependent) meets the plan's eligibility requirements for dependents as outlined under HOW COVERAGE BEGINS AND ENDS.

Effective date is the date your coverage begins under this plan.

Employee is the primary insured; that is, the person who is allowed to enroll under this plan for himself or herself and his or her eligible dependents.

Investigative procedures or medications are those that have progressed to limited use on humans, but which are not widely accepted as proven and effective within the organized medical community.

Member is the employee or dependent.

Non-Participating Dentist is a dentist who does NOT have a PPO Participating Provider Agreement with the claims administrator at the time services are rendered.

PPO Participating dentist is a dentist who has a PPO Participating Provider Agreement in effect with the claims administrator at the time services are rendered. Participating dentists agree to accept the dental negotiated rate as payment for covered services. A directory of participating dentists is available upon request.

Plan is the set of benefits described in this plan description. These benefits are subject to the terms and conditions of the plan. If changes are made to the plan, a rider or revised plan description will be issued to each employee affected by the change.

Plan administrator refers to your employer, the entity which is responsible for the administration of the plan.

Plan description is this written description of the benefits provided under the plan.

Prior plan is a plan sponsored by us which was replaced by this plan within 60 days. You are considered covered under the prior plan if you: (1) were covered under the prior plan on the date that plan terminated; (2) properly enrolled for coverage within 31 days of this plan's Effective Date; and (3) had coverage terminate solely due to the prior plan's termination.

Spouse meets the plan's eligibility requirements for spouses as outlined under HOW COVERAGE BEGINS AND ENDS.

Year or **calendar year** is a 12 month period starting January 1 at 12:01 a.m. Pacific Standard Time.

You (your) refers to the employee and dependents that are enrolled in benefits under this plan.

COMPLAINT NOTICE

All complains and disputes relating to coverage under this plan must be resolved in accordance with the plan's grievance procedures. Grievances may be made by telephone (888-273-3179) or in writing (LIBERTY Dental Plan, P.O. Box 26110, Santa Ana, CA 92799-6110). If you wish, the LIBERTY Dental Plan will provide a Complaint Form which you may use to explain the matter.

All grievances received under the plan will be acknowledged in writing, together with a description of how the plan proposes to resolve the grievance. Grievances that cannot be resolved by this procedure shall be submitted to arbitration.