SUMMARY PLAN DESCRIPTION

Provided by:
LIBERTY Dental Plan of California, Inc.
P.O. Box 26110
Santa Ana, CA 92799-6110
(888) 703-6999
www.Libertydentalplan.com

Plan Sponsor: Grimmway Enterprises, Inc.

THE SUMMARY PLAN DESCRIPTION CONSTITUTES ONLY A SUMMARY OF THE PROGRAM, AS REQUIRED BY THE CALIFORNIA HEALTH & SAFETY CODE. THIS IS TO ADVISE YOU THAT THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE SUMMARY PLAN DESCRIPTION WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. PLEASE READ THIS SUMMARY PLAN DESCRIPTION CAREFULLY AND COMPLETELY.

A STATEMENT DESCRIBING LIBERTY DENTAL PLAN'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

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

ELIGIBILITY
Please consult with your Plan Sponsor to determine eligibility in this Plan.

ENROLLMENT
For information about enrolling yourself or an eligible family member, please contact your Plan Sponsor. You must enroll yourself in order to enroll any eligible family member.

EFFECTIVE DATE OF COVERAGE
Please contact your Plan Sponsor for determination of the effective date of your coverage.

CHANGE IN COVERAGE
Please contact your Plan Sponsor to make any changes in coverage.

LOSS OF ELIGIBLE STATUS
If you lose eligibility, your coverage and that of any enrolled family member stops at the end of the last month in which premiums are received for you. If your family member loses eligibility, you must contact your Plan Sponsor. Coverage will stop at the end of the month in which he or she no longer meets all of the eligibility requirements. Your Plan Sponsor will advise you if you are eligible to continue coverage under COBRA.

DISENROLLMENT DUE TO FRAUD
Coverage for you or your family members may be terminated for fraud or deception in the use of the services of the Plan, or for knowingly permitting such fraud or deception by another. Such termination shall be effective upon the mailing of written notice to the Subscriber.

CLAIMS PROCESSING
Claims under the Plan are processed by LIBERTY Dental Plan of California, Inc. at the following address and telephone number.

LIBERTY Dental Plan of California, Inc.
P.O. Box 26110
Santa Ana, CA 92799-6110
(888) 703-6999

PLAN YEAR
The plan year is February 1 through January 31.

CONTINUATION OF THE PLAN

The Plan Sponsor intends to continue the Plan of benefits described in this booklet but reserves the right to terminate or amend it at any time. Any amendment or termination shall be carried out by the Plan Sponsor or his or her delegates. The Plan Sponsor will determine the terms of the Plan, such as benefits and what portion of the premiums you and the Plan Sponsor will pay.

FINANCIAL ARRANGEMENTS

The benefits under the Plan are administered by LIBERTY Dental Plan of California, Inc. under a Group Dental Contract.

YOUR RIGHTS UNDER THE PLAN

As a participant, you are entitled to certain rights and protections. All Plan participants shall be entitled to:

1. Examine, without charge, at the Plan Sponsor's office, all Plan documents, including the Insurance contract, at a time and location mutually convenient to the participant and the Plan Sponsor.
2. Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan Sponsor.

DEFINITIONS

Certain words that you will see in this booklet have specific meanings. These definitions should make your dental program easier to understand.

Attending Dentist's Statement (ADS): a form used by your dentist to request payment from LIBERTY Dental Plan for dental treatment or predetermination for proposed dental treatment.

Benefits: those dental services available under the contract and which are described in this booklet.

Contract or Group Dental Contract: the written agreement between LIBERTY Dental Plan and the Plan Sponsor to provider dental benefits. The contract, together with this booklet, forms the terms and conditions of the benefits you are provided.

Covered Services: those dental services to which LIBERTY Dental Plan will apply benefit payments, according to the contract.

Deductible: the amount you must pay for dental care each year before LIBERTY Dental Plan's benefits begin.

PPO Dentist: a dentist who has signed an agreement with LIBERTY Dental Plan to provide services under the terms and conditions established for the Plan.

Dependent: a primary enrollee's dependent who is eligible to be enrolled for benefits in accordance with the conditions of eligibility determined by your Plan Sponsor.

Effective Date: the date this program starts.

Enrollee: A primary enrollee or dependent enrolled to receive benefits.

Maximum: the greatest dollar amount LIBERTY Dental Plan will pay for covered services in any calendar year.

Patient Co-Insurance: the portion of the dentist's fee which is the Enrollee's responsibility.

Primary Enrollee: any employee who is eligible to enroll for benefits in accordance with the conditions of eligibility determined by your Plan Sponsor.

Single Procedure: a dental procedure to which a separate procedure number has been assigned by the American Dental Association in the current version of Common Dental Terminology (CDT).

HOW TO USE YOUR PROGRAM

LIBERTY Dental Plan does not guarantee the availability of any particular dentist.

You are free to choose any dentist for treatment, but it is to your advantage to choose a LIBERTY Dental Plan PPO dentist. This is because his or her fees are approved in advance by LIBERTY Dental Plan. LIBERTY Dental Plan PPO providers have agreed to a pre-negotiated amount per covered procedure. The only amount chargeable to the member by an in-network provider is the actual member percentage (based on the Plan) of the pre-negotiated amount, deducible amount, amount over calendar year maximum, and non-covered services.

Out-of-network providers have no agreement, so the amount chargeable to the member can be any amount over the percentage payable by the Plan. Plan payment is based on the regional usual and customary fee. PPO providers are only available in California, so any claim from a provider outside of California will be paid on the out-of-network payment schedule.

PPO providers can be found by visiting www.libertydentalplan.com on the internet. You can also call LIBERTY Dental Plan at (888) 703-6999 to receive provider information.

COMPLAINT PROCEDURE AND CLAIMS APPEAL

If you have any questions about the services you receive from a LIBERTY Dental Plan provider, we recommend you first discuss the matter with your dentist. If you continue to have concerns, call our Quality Review Department at (888) 703-6999.

We will provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for denial. If you have a question or complaint regarding eligibility, the denial of dental services or claims, the policies, or the procedures and operations of LIBERTY Dental Plan, you may contact us as the telephone number shown on page 1. 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 number, the primary enrollee's name and social security 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 us at the address shown on page 1.

We will review your complaint and will resolve the matter within 30 days of receipt or inform you of the pending status of the complaint if more information or time is needed to resolve the matter. We will respond within three days of receipt of complaints involving severe pain and imminent and serious threat to a patient's health.

COORDINATION OF BENEFITS (DUAL COVERAGE)

If a group insurance policy or any other health benefits programs entitles a person to receive or be reimbursed for the cost of dental services, which are also benefits under this program, and if this program is "primary" under the rules described below, LIBERTY Dental Plan will provide benefits as if the other program did not exist. If the other program is "primary" under these rules, then LIBERTY Dental Plan will provide benefits under this program only to the extent that the other program does not fully provide the dental services. The amount payable will not be more than 100% of the actual cost charged for treatment or service. There will be no coordination of benefits with any DHMO Plan.

If the other program mainly covers services or expenses other than dental care, this program is "primary". Otherwise, LIBERTY Dental Plan will use the following rules to determine which program is "primary":

1. The program which covers the person as other than a dependent is primary over the program which covers the person as a dependent.
2. The program which covers a child as a dependent of a parent whose birthday occurs earlier in a calendar year is primary over the program which covers a child as a dependent of a parent whose birthday occurs later in a calendar year (except for a dependent child whose parents are separated or divorced as described below).
3. In the case of a dependent child whose parents are legally separated or divorced:

a. If the parent with custody has not remarried, the program which covers the child as a dependent of the parent with custody is primary over the program which covers the child as a dependent of the parent without custody.
b. If the parent with custody has remarried, the program which covers the child as a dependent of the parent with custody is primary over the program which covers the child as a dependent of the step-parent, and the program which covers the child as a dependent of the step-parent is primary over the policy or program which covers the child as a dependent of the parent without custody.
c. If there is a court decree that establishes financial responsibility for dental services which are benefits under this program, then notwithstanding (a) and (b), the program which covers the child as a dependent of the parent with such financial responsibility is primary over any other program which covers the child.

If the primary program cannot be determined by the rules described, the program which has covered the person the longer shall be primary.

An enrollee will provide LIBERTY Dental Plan with any information about the person that is needed to administer these rules, and LIBERTY Dental Plan may release any information to or obtain any information from any insurance company or other organization in order to coordinate the benefits of an enrollee. LIBERTY Dental Plan in its sole discretion will determine whether any reimbursement is warranted to an insurance company or other organization under this provision, and it is agreed that any such reimbursement paid by LIBERTY Dental Plan will be benefits under this contract. LIBERTY Dental Plan has the right to recover the value of

any benefits provided by LIBERTY Dental Plan which exceed its obligations under the terms of this provision from a dentist, enrollee, insurance company or other organization, as LIBERTY Dental Plan chooses.

CANCELLATION AND RENEWAL

This dental care program may be cancelled by LIBERTY Dental Plan only on an anniversary date, or at any time if the Plan Sponsor fails to make applicable payments as required by the contract, or upon Plan Sponsor's failure to furnish LIBERTY Dental Plan a list of all individuals enrolled as specified in the contract, or refusal to permit the inspection of Plan Sponsor's records as specified in the contract. Upon cancellation of the program, individual members and their dependents of the group have no right to renewal or reinstatement.

BENEFITS PROVIDED BY THE PROGRAM

Your program covers the following services when they are provided by a licensed dentist and when necessary and customary as determined by the standards of generally accepted dental practice. See also **Limitations and Exclusions.**

Your out-of-pocket expenses may differ depending upon whether you select a LIBERTY Dental Plan PPO dentist or an out-of-network dentist. When receiving treatment from a non-PPO dentist, you will have potentially greater out-of-pocket expenses.

I. DIAGNOSTIC AND PREVENTIVE BENEFITS

***In-Network*: 100% of the PPO dentist fees**
***Out-of-Network*: 80% of the regional usual and customary fees**
Deductible is waived for these services.

Oral examinations, office visits, x-rays (complete series, panoramic, bitewing, occlusal, periapical, extraoral), prophylaxis (routine cleaning), fluoride treatments, sealants, harmful habit appliance, space maintainers.

II. BASIC BENEFITS

***In-Network*: 90% of the PPO dentist fees**
***Out-of-Network*: 80% of the regional usual and customary fees**
Deductible applies to these services.

Fillings, stainless steel crowns, prefabricated resin crowns, endodontic services, periodontal services, oral surgery, other surgical procedures, anesthesia, other services.

III. MAJOR BENEFITS

***In-Network*: 60% of the PPO dentist fees**
***Out-of-Network*: 50% of the regional usual and customary fees**
Deductible applies to these services.

Periodontal surgical procedures, bone replacement grafts, inlays, onlays, crowns, removable full and partial dentures, fixed prosthodontic services.

IV. ORTHODONTIC BENEFITS

***In-Network*: 50% of the PPO dentist fees**
***Out-of-Network*: 50% of the regional usual and customary fees**
Deductible does not apply to these services.

Formal, full-banded retention and treatment, including x-rays and other diagnostic procedures. Removable or fixed appliances for tooth or bony structure guidance or retention.

EXCLUSIONS:

1. Treatment or service that is not for necessary dental care;
2. The services of any person who is not a dentist or dental hygienist;
3. Any part of a charge for treatment or services that exceeds the regional usual and customary fee (out-of-network providers);
4. The services of any person who is in the Member's or Dependent's immediate family;
5. Implants or any service associated with implants;
6. Treatment or service that does not meet professionally recognized standards of quality;
7. Veneers, personalization of dentures or crowns and any other treatment or service that is primarily cosmetic;
8. Drugs, medicines, or therapeutic drug injections;
9. Instructions for plaque control, oral hygiene, or diet;
10. Bite registration or occlusal analysis;
11. Treatment or service to alter or maintain vertical dimension or restore or maintain occlusion;

12. Treatment or service for the purpose of duplicating a prosthetic device or replacing any such device that is lost or stolen;
13. Treatment or service for the purpose of duplicating an appliance or replacing any such appliance that is lost or stolen;
14. Orthodontic treatment or service if the appliance or bands were placed prior to being insured under this Group Policy, unless the member or dependent is currently in a treatment plan which was covered under prior group orthodontic coverage, and there has been no lapse in coverage;
15. Treatment or service for provisional or permanent splinting;
16. Treatment or service for which the member or dependent has no financial liability or that would be provided at no charge or at a different charge in the absence of insurance;
17. Treatment or service that is temporary;
18. Treatment or service that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law);
19. Treatment or service that results from:
    a. an injury arising out of or in the course of any employment for wage or profit if the member or dependent is eligible to be covered under a Workers' Compensation Act or other similar law; except this limitation will not apply to: partners, proprietors, or corporate officers of the Policyholder who are not covered by a Workers' Compensation Act or other similar law
    b. a sickness covered by a Workers' Compensation Act or other similar law;
20. Treatment or service that results from war or act of war;
21. Treatment or service that results from commission of or attempted commission of a felony or voluntary participation in an illegal occupation;
22. Treatment or service provided outside the United States, unless the member or dependent are outside the United States for one of the following reasons:
    a. travel, provided the travel is for a reason other than securing dental care diagnosis or treatment, and travel is for a period of six months or less; or
    b. a business assignment, provided the member or dependent are temporarily outside the United States for a period of six months or less; or
    c. full-time student status, provided the student is either:
        - enrolled and attending an accredited school in a foreign country; or

- is participating in an academic program in a foreign country, for which the institution of higher learning at which the student is enrolled in the U.S. grants academic credit; or
- Mormon missionary work of a dependent child, and such missionary work is for a period of two year or less;

23. Treatment or service replacing tooth structure lost from abrasion, attrition, erosion, or abfraction;
24. Crowns for the primary purpose of splinting, altering, or maintaining vertical dimension or restoring occlusion are not covered;
25. Crowning of implant replacing a tooth missing prior to the effective date is not covered;
26. Covered charges for complete or partial denture do not include any additional charges for over-dentures or for precision or semi-precision attachments;
27. Treatment or service which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years;
28. Treatment or service that is paid for by a Medicare Supplement Insurance Plan;
29. Treatment or service for temporomandibular joint disorders.

LIMITATIONS:

1. Two oral examinations in any 12 consecutive month period (oral examination/evaluation, periodic examination/evaluation, emergency examination/evaluation, office visit);
2. One complete series (full-mouth x-rays including bitewings) or one panoramic x-ray in any 60 consecutive month period. Only one of the listed full mouth surveys will be covered;
3. One set of bitewing x-rays in any 12 month period;
4. Occulsal/periapical x-rays – only two films will be covered in any 12 consecutive month period;
5. One extraoral x-ray will be covered in any six consecutive month period (sialography, cephalometric film, posterior-anterior or lateral skull and facial bone survey, other extraoral);
6. Diagnostic x-rays performed in conjunction with root canal therapy or orthodontic treatment will not be considered for Diagnostic benefits;
7. Two dental prophylaxes (routine cleaning or periodontal cleaning/maintenance procedure) in any 12 consecutive month period. Both routine cleaning and periodontal cleaning

(maintenance procedure) will apply towards the two per 12 consecutive month period frequency limit;

8. Topical fluoride treatment for dependent children only under the age of 14 limited to one application in any 12 consecutive month period;
9. Sealants are covered for first and second permanent molars only for dependent children under the age of 16. Limited to once per tooth in any 36 consecutive month period;
10. Harmful habit appliance limited to one time per person under age 16;
11. Space maintainers are limited to dependent children under the age of 16. Repairs to space maintainers are not covered. Limited to one bilateral space maintainer per arch or one unilateral space maintainer per quadrant;
12. Multiple filling restorations on one surface will be considered as a single surface restoration. Multiple restorations on different surfaces of the same tooth will be considered connected. Replacement of existing fillings are covered only if at least 24 consecutive months have passed since placement of prior filling, unless required by new decay in an additional tooth surface. Mesial-lingual, distal-lingual, mesial-bucccal, and distal-buccal restorations on anterior teeth will be considered single surface restorations;
13. Benefits for composite restorations on molar teeth will be based on the benefits for the corresponding amalgam restorations;
14. Stainless steel and prefabricated resin crowns are covered for dependent children under the age of 19 only and limited to one in any 24 consecutive month period;
15. Vital pulpotomy covered for deciduous (primary) teeth only;
16. Root canal therapy includes treatment plan, diagnostic x-rays, clinical procedures, and follow-up care;
17. Retreatment of previous root canal therapy, apicoectomy, and retrograde filling limited to once per tooth per lifetime;
18. Periodontal scaling and root planing limited to once each quadrant in any 24 consecutive month period ;
19. Periodontal prophylaxis (includes probing, charting, exam, polishing, scaling, root planing, and similar maintenance procedures). Covered only if at least three months have elapsed after completion of active therapeutic scaling and root planing or active surgical periodontal treatment. Limited to two dental prophylaxis (routine cleaning or periodontal cleaning/maintenance procedure) in any 12 consecutive month period frequency limit;
20. There will be no separate benefit payable for bone grafting of an extraction site;

21. General anesthesia and IV sedation is covered only when required for complex oral surgical procedures covered under this plan and only when performed in a dental office. Benefits for anesthesia is limited to one hour unless complexity of service warrants extended time;
22. Consultation with a specialist limited to once in any 12 consecutive month period. Covered as a separate procedure only if no other service (except x-rays) is provided during the visit;
23. Office visit after regularly scheduled hours covered as a separate procedure only if no other services (except x-rays) is provided during the visit;
24. Palliative treatment covered as a separate procedure only if no other service (except x-rays) is provided during the visit;
25. Periodontal surgical procedures are limited to once per quadrant in any 36 consecutive month period (gingival flap procedure, gingivectomy, osseous surgery, pedicle soft tissue graft, free soft tissue graft, subepithelial connective tissue graft, distal or proximal wedge procedure, crown lengthening);
26. Bone replacement graft limited to once per site per lifetime;
27. Recementing inlay, onlay, crown covered if done more than 12 months are initial insertion, limited to one time in any 24 consecutive month period;
28. Repairs to complete or partial denture, bridge, or crown; relining and rebasing of complete or partial dentures; tissue conditioning covered if done more than 12 months after initial insertion, limited to one time in any 24 consecutive month period;
29. Relining or rebasing complete or partial dentures covered only if relining or rebasing is done more than 12 months after initial insertion of the denture and then not more than one time in any 24 consecutive month period;
30. Tissue conditioning covered only if at least 12 months have elapsed since the insertion of a complete or partial denture and not more than once in any 24 consecutive month period;
31. Denture adjustment covered only if at least 12 months have elapsed since the insertion, limited to once in any 12 consecutive month period;
32. Inlay or onlay restorations covered only if the tooth cannot be restored by a filling and (for replacements) at least 60 consecutive months have elapsed since the last placement. For persons under 16 years of age, the benefit for inlay is limited to amalgam or resin filling. For persons under 16 years of age, the benefit for onlay is limited to resin or stainless steel crowns;
33. Crowns are covered only if the tooth cannot be restored by a filling and (for replacements) at least 60 consecutive months have

elapsed since the last placement. Crowns for the replacement of inlay or onlay or bridge abutment are covered only if at least 60 consecutive months have elapsed since the last placement of the restoration. For persons under 16 years of age, the benefit for crowns on vital teeth are limited to resin or stainless steel crowns. Crowning of implant replacing a pontic will not be covered unless at least 60 consecutive months has elapsed since placement of the pontic;

34. Cast post and core covered only for teeth that have had root canal therapy, limited to once per tooth per 60 consecutive months;
35. Core buildup covered only when required for retention and preservation of the tooth, limited to once per tooth per 60 consecutive month period;
36. Fixed bridges limited to persons over age 16. Benefits for fixed bridges are payable only for the replacement of those teeth which were extracted while insured under this Group Policy. Fixed bridge must be more than 60 consecutive months old and not serviceable for replacement to be covered;
37. Complete and partial dentures are covered only for the replacement of those teeth which were extracted while insured under this Group Policy. Appliance must be more than 60 consecutive months old and not serviceable for replacement to be covered;
38. If LIBERTY Dental Plan determines that more than one procedure could be performed to correct a dental condition, the covered benefit will be the least expensive of the procedures that would provide professionally acceptable results;
39. Covered charges will include only those charges for treatment or services that begins while the member or dependent is insured under this Group Policy.

AMOUNT OF BENEFITS PAYABLE

After you have satisfied the deductible requirements stated below, the program provides payment of the indicated percentage of the remaining covered fees up to the maximum of **$1,500** (combined In-Network and Out-of-Network) for each enrollee in each calendar year.

The separate Orthodontic Lifetime Maximum is **$1,500** (combined In-Network and Out-of-Network).

DEDUCTIBLE

Calendar year deductibles per enrolled member you must meet:

***In-Network*: $25 (waived for Diagnostic & Preventive Services)**
***Out-of-Network*: $50 (waived for Diagnostic & Preventive Services)**

The maximum combined deductible amount for all persons in the same family (a member and his or her dependents) each calendar year will be:

***In-Network*: $75**
***Out-of-Network*: $150**

When the family maximum deductible is satisfied, benefits will be payable as if the individual deductibles for each person in the family had been satisfied for the calendar year.

Covered Orthodontic Services are not subject to a deductible.

PRE-ESTIMATE OF DENTAL TREATMENT PLAN

It is advised to have all treatment plans estimated to be over $300 reviewed by LIBERTY Dental Plan prior to having services performed. The filing of the Dental Treatment Plan is intended to help avoid any misunderstanding between the dentist, the insured, and LIBERTY Dental Plan as to how much will be paid for dental work. A Dental Treatment Plan pre-estimate is not a guarantee, but simply informs you and your dentist, in advance, what the Plan will pay for the covered dental services submitted. The pre-estimate is subject to change based member eligibility, deductibles met, maximums used, treatment changes, provider participation, and any plan changes on the actual date of service.

ADDRESS FOR CLAIMS SUBMISSION

LIBERTY Dental Plan of California, Inc.
Attention: Claims
P.O. Box 26110
Santa Ana, CA 92799-6110