



# LIBERTY Dental Plan of California, Inc. Children's Dental HMO

- ✓ Members must select, and be assigned to, a LIBERTY Dental Plan contracted dental office to utilize covered benefits. Your dental office will initiate a treatment plan or will initiate the specialty referral process with LIBERTY Dental Plan if the services are dentally necessary and outside the scope of general dentistry.
- ✓ Member Co-payments are payable to the dental office at the time services are rendered.
- ✓ This Schedule does not guarantee benefits. All services are subject to eligibility and dental necessity at the time of service.
- ✓ Dental procedures not listed are available at the dental office's usual and customary fee.

**Patient has an annual Out-of-Pocket Maximum of \$350 and a Family Out-of-Pocket Maximum of \$700. The out-of-pocket maximum is the amount a covered Individual will pay in copays for all allowable expenses, including orthodontic copayments, in any contract year. There may be other costs incurred for optional, non-covered and upgraded material services that do not apply toward Out-of-Pocket maximums. A single child will have an out-of-pocket maximum of \$350. A family with two (2) or more children will have an aggregate out-of-pocket maximum of \$700 for children age 0 to the age of 19.**

CDT Code	Description	Pediatric Copay
<b>Diagnostic Services</b>		
D0120	Periodic oral evaluation	\$0.00
D0145	Oral evaluation under age 3	\$0.00
D0150	Comprehensive oral evaluation	\$0.00
D0210	Intraoral, complete series of radiographic images	\$0.00
D0220	Intraoral, periapical, first radiographic image	\$0.00
D0230	Intraoral, periapical, each add '1 radiographic image	\$0.00
D0240	Intraoral, occlusal radiographic image	\$0.00
D0270	Bitewing, single radiographic image	\$0.00
D0272	Bitewings, 2 radiographic images	\$0.00
D0273	Bitewings, 3 radiographic images	\$0.00
D0274	Bitewings, 4 radiographic images	\$0.00
D0277	Vertical bitewings, 7 to 8 radiographic images	\$0.00
D0330	Panoramic radiographic image	\$0.00
D0460	Pulp vitality tests	\$0.00
<b>Preventive services</b>		
D1110	Prophylaxis, adult	\$0.00
D1120	Prophylaxis, child	\$0.00
D1206	Topical application of fluoride varnish	\$0.00
D1208	Topical application of fluoride, excluding varnish	\$0.00
D1310	Nutritional counseling for control of dental disease	\$0.00
D1320	Tobacco counseling for the control and prevention	\$0.00
D1330	Oral hygiene instruction	\$0.00
D1351	Sealant, per tooth	\$0.00
D1510	Space maintainer, fixed, unilateral	\$0.00
D1515	Space maintainer, fixed, bilateral	\$0.00
D1520	Space maintainer, removable, unilateral	\$0.00
D1525	Space maintainer, removable, bilateral	\$0.00
<b>Restorative services</b>		
D2140	Amalgam, 1 surface, primary or permanent	\$25.00
D2150	Amalgam, 2 surfaces, primary or permanent	\$39.00
D2160	Amalgam, 3 surfaces, primary or permanent	\$51.00
D2161	Amalgam, 4 or more surfaces, primary or permanent	\$65.00
D2330	Resin-based composite, 1 surface, anterior	\$48.00
D2331	Resin-based composite, 2 surfaces, anterior	\$61.00
D2332	Resin-based composite, 3 surfaces, anterior	\$75.00
D2335	Resin-based composite, 4+ surfaces/incisal angle	\$89.00
D2391	Resin-based composite, 1 surface, posterior	\$56.00



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<b>Restorative services (continued)</b>		
D2392	Resin-based composite, 2 surfaces, posterior	\$74.00
D2393	Resin-based composite, 3 surfaces, posterior	\$91.00
D2394	Resin-based composite, 4+ surfaces/incisal angle, posterior	\$112.00
D2542	Onlay, metallic, 2 surfaces	\$307.00
D2543	Onlay, metallic, 3 surfaces	\$321.00
D2544	Onlay, metallic, 4 or more surfaces	\$334.00
<b>*GUIDELINES for Single Crowns:</b>		
<p><b>The total maximum amount chargeable to the member for elective upgraded procedures</b> (explained below) is \$250.00 per tooth. Providers are required to explain covered benefits as well as any elective differences in materials and fees prior to providing an elective upgraded procedure.</p> <p><b>1. Brand name restorations:</b> (e.g. Sunrise, Captek, Vitadure-N, Hi-Ceram, Optec, HSP, In-Ceram, Empress, Cerec, AllCeram, Procera, Lava, etc.) may be considered elective upgraded procedures if their related CDT procedure codes are not listed as covered benefits.</p> <p><b>2. Benefits for anterior and bicuspid teeth:</b> Resin, porcelain and any resin to base metal or porcelain to base metal crowns are covered benefits for anterior and bicuspid teeth. Adding a porcelain margin may be considered an elective upgraded procedure.</p> <p><b>3. Benefits for molar teeth:</b> Cast base metal restorations are covered benefits for molar teeth. Resin-based composite and porcelain to metal crowns may be considered elective upgraded procedures. Adding a porcelain margin may be considered an elective upgraded procedure.</p> <p><b>4. Base metal is the benefit:</b> If elected, a) noble, b) high noble metal, or c) titanium may be considered an elective upgraded procedure.</p>		
D2710	Crown, resin-based composite (indirect)*	\$131.00
D2712	Crown, ¾ resin-based composite (indirect)*	\$131.00
D2720	Crown, resin with high noble metal*	\$275.00
D2721	Crown, resin with predominantly base metal*	\$200.00
D2722	Crown, resin with noble metal*	\$250.00
D2740	Crown, porcelain/ceramic substrate*	\$350.00
D2750	Crown, porcelain fused to high noble metal*	\$350.00
D2751	Crown, porcelain fused to predominantly base metal*	\$300.00
D2752	Crown, porcelain fused to noble metal*	\$350.00
D2780	Crown, ¾ cast high noble metal*	\$325.00
D2781	Crown, ¾ cast predominantly base metal	\$300.00
D2782	Crown, ¾ cast noble metal*	\$325.00
D2783	Crown, ¾ porcelain/ceramic substrate*	\$350.00
D2790	Crown, full cast high noble metal*	\$325.00
D2791	Crown, full cast predominantly base metal	\$275.00
D2792	Crown, full cast noble metal*	\$325.00
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	\$28.00
D2920	Re-cement or re-bond crown	\$29.00
D2930	Prefabricated stainless steel crown, primary tooth	\$78.00
D2931	Prefabricated stainless steel crown, permanent tooth	\$114.00
D2932	Prefabricated resin crown	\$122.00
D2933	Prefabricated stainless steel crown w/ resin window	\$140.00
D2934	Prefabricated esthetic coated stainless steel crown, primary tooth	\$72.00
D2940	Protective restoration (temporary)	\$38.00
D2950	Core build-up, including any pins when required	\$97.00
D2951	Pin retention, per tooth, in addition to restoration	\$22.00
D2952	Post & core in addition to crown, indirect fabric.	\$153.00
D2953	Each additional indirectly fabricated post, same tooth	\$77.00
D2954	Prefabricated post & core in addition to crown	\$122.00
D2957	Each additional prefabricated post, same tooth	\$61.00
D2980	Crown repair, restorative material failure	\$0.00
<b>Endodontic services</b>		
D3110	Pulp cap, direct (excluding final restoration)	\$31.00
D3220	Therapeutic pulpotomy (excluding final restoration)	\$63.00
D3221	Pulpal debridement, primary and permanent teeth	\$69.00



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<b>Endodontic services (continued)</b>		
D3222	Partial pulpotomy for apexogenesis, permanent tooth	\$69.00
D3230	Pulpal therapy, anterior, primary tooth	\$53.00
D3240	Pulpal therapy, posterior, primary tooth	\$65.00
D3310	Anterior (excluding final restoration)	\$206.00
D3320	Bicuspid (excluding final restoration)	\$252.00
D3330	Molar (excluding final restoration)	\$300.00
D3346	Retreatment of previous root canal, anterior	\$274.00
D3347	Retreatment of previous root canal, bicuspid	\$323.00
D3348	Retreatment of previous root canal, molar	\$350.00
D3351	Apexification/recalcification, initial visit	\$119.00
D3352	Apexification/recalcification, interim med.	\$53.00
D3353	Apexification/recalcification, final visit	\$164.00
D3410	Apicoectomy, anterior	\$235.00
D3421	Apicoectomy, bicuspid	\$262.00
D3425	Apicoectomy, molar	\$297.00
D3426	Apicoectomy, each add 'l root	\$100.00
D3430	Retrograde filling, per root	\$74.00
D3450	Root Amputation, per root	\$153.00
<b>Periodontal services</b>		
D4210	Gingivectomy/gingivoplasty, 4+ teeth per quadrant	\$150.00
D4211	Gingivectomy/gingivoplasty, 1-3 teeth per quadrant	\$98.00
D4260	Osseous surgery, 4+ teeth per quadrant	\$350.00
D4261	Osseous surgery, 1-3 teeth per quadrant	\$250.00
<b>GUIDELINE:</b>		
No more than two (2) quadrants of periodontal scaling and root planing per appointment/ per day are allowable.		
D4341	Periodontal scaling & root planing, 4+ teeth per quadrant	\$70.00
D4342	Periodontal scaling & root planing, 1-3 teeth per quadrant	\$40.00
<b>Removable prosthodontic services</b>		
D5110	Complete denture, maxillary	\$350.00
D5120	Complete denture, mandibular	\$350.00
D5211	Maxillary partial denture, resin base	\$350.00
D5212	Mandibular partial denture, resin base	\$350.00
D5213	Maxillary partial denture, cast metal/resin base	\$350.00
D5214	Mandibular partial denture, cast metal/resin base	\$350.00
D5281	Removable unilateral partial denture, 1 pc. cast	\$175.00
D5410	Adjust complete denture, maxillary	\$24.00
D5411	Adjust complete denture, mandibular	\$24.00
D5421	Adjust partial denture, maxillary	\$24.00
D5422	Adjust partial denture, mandibular	\$24.00
D5510	Repair broken complete denture base	\$48.00
D5520	Replace missing/broken teeth, complete denture	\$40.00
D5610	Repair resin denture base	\$52.00
D5620	Repair cast framework	\$56.00
D5630	Repair or replace broken clasp	\$68.00
D5640	Replace broken teeth, per tooth	\$44.00
D5650	Add tooth to existing partial denture	\$60.00
D5660	Add clasp to existing partial denture	\$72.00
D5670	Replace all teeth and acrylic, cast metal framework, maxillary	\$177.00
D5671	Replace all teeth and acrylic, cast metal framework, mandibular	\$177.00
D5710	Rebase complete maxillary denture	\$179.00
D5711	Rebase complete mandibular denture	\$171.00



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CDT Code	Description	Pediatric Copay
<b>Removable prosthodontic services (continued)</b>		
D5720	Rebase maxillary partial denture	\$169.00
D5721	Rebase mandibular partial denture	\$169.00
D5730	Reline complete maxillary denture, chairside	\$101.00
D5731	Reline complete mandibular denture, chairside	\$101.00
D5740	Reline maxillary partial denture, chairside	\$92.00
D5741	Reline mandibular partial denture, chairside	\$92.00
D5750	Reline complete maxillary denture, laboratory	\$135.00
D5751	Reline complete mandibular denture, laboratory	\$135.00
D5760	Reline maxillary partial denture, laboratory	\$133.00
D5761	Reline mandibular partial denture, laboratory	\$133.00
D5820	Interim partial denture, maxillary	\$165.00
D5821	Interim partial denture, mandibular	\$175.00
D5850	Tissue conditioning, maxillary	\$42.00
D5851	Tissue conditioning, mandibular	\$42.00
D5999	Unspecified maxillofacial prosthesis, by report	\$150.00
<b>Fixed prosthodontic services</b>		
<b>*GUIDELINES for Pontics, Onlays, Crowns:</b>		
<p><b>The total maximum amount chargeable to the member for elective upgraded procedures</b> (explained below) is \$250.00 per tooth. Providers are required to explain covered benefits as well as any elective differences in materials and fees prior to providing an elective upgraded procedure.</p> <p><b>1. Brand name restorations:</b> (e.g. Sunrise, Captek, Vitadure-N, Hi-Ceram, Optec, HSP, In-Ceram, Empress, Cerec, AllCeram, Procera, Lava, etc.) may be considered elective upgraded procedures if their related CDT procedure codes are not listed as covered benefits.</p> <p><b>2. Benefits for anterior and bicuspid teeth:</b> Resin, porcelain and any resin to base metal or porcelain to base metal crowns are covered benefits for anterior and bicuspid teeth. Adding a porcelain margin may be considered an elective upgraded procedure.</p> <p><b>3. Benefits for molar teeth:</b> Cast base metal restorations are covered benefits for molar teeth. Resin-based composite and porcelain to metal crowns may be considered elective upgraded procedures. Adding a porcelain margin may be considered an elective upgraded procedure.</p> <p><b>4. Base metal is the benefit:</b> If elected, a) noble, b) high noble metal, or c) titanium may be considered an elective upgraded procedure.</p>		
D6205	Pontic, indirect resin based composite*	\$132.00
D6210	Pontic, cast high noble metal*	\$325.00
D6211	Pontic, cast predominantly base metal	\$275.00
D6212	Pontic, cast noble metal*	\$325.00
D6240	Pontic, porcelain fused to high noble metal*	\$350.00
D6241	Pontic, porcelain fused to predominantly base metal*	\$300.00
D6242	Pontic, porcelain fused to noble metal*	\$350.00
D6245	Pontic, porcelain/ceramic*	\$350.00
D6250	Pontic, resin with high noble metal*	\$275.00
D6251	Pontic, resin with predominantly base metal*	\$200.00
D6252	Pontic, resin with noble metal*	\$250.00
D6610	Onlay, cast high noble metal, two surfaces*	\$245.00
D6611	Onlay, cast high noble metal, three or more surfaces*	\$268.00
D6612	Onlay, cast predominantly base metal, two surfaces	\$244.00
D6613	Onlay, cast base metal, three or more surfaces	\$255.00
D6614	Onlay, cast noble metal, two surfaces*	\$239.00
D6615	Onlay, cast noble metal, three or more surfaces*	\$248.00
D6710	Crown, indirect resin based composite*	\$132.00
D6720	Crown, resin with high noble metal*	\$275.00
D6721	Crown, resin with predominantly base metal	\$200.00
D6722	Crown, resin with noble metal*	\$250.00
D6740	Crown, porcelain/ceramic*	\$350.00
D6750	Crown, porcelain fused to high noble metal*	\$350.00
D6751	Crown, porcelain fused to predominantly base metal*	\$300.00
D6752	Crown, porcelain fused to noble metal*	\$350.00



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CDT Code	Description	Pediatric Copay
<b>Fixed prosthodontic services (continued)</b>		
D6780	Crown, ¾ cast high noble metal*	\$325.00
D6781	Crown, ¾ cast predominantly base metal	\$300.00
D6782	Crown, ¾ cast noble metal*	\$325.00
D6783	Crown, ¾ porcelain/ceramic*	\$350.00
D6790	Crown, full cast high noble metal*	\$325.00
D6791	Crown, full cast predominantly base metal	\$275.00
D6792	Crown, full cast noble metal*	\$325.00
D6930	Re-cement or re-bond fixed partial denture	\$46.00
D6980	Fixed partial denture repair, restorative material failure	\$0.00
<b>Oral and maxillofacial services</b>		
<b>GUIDELINE:</b>		
The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists		
D7111	Extraction, coronal remnants, deciduous tooth	\$49.00
D7140	Extraction, erupted tooth or exposed root	\$65.00
D7210	Surgical removal of erupted tooth	\$107.00
D7220	Removal of impacted tooth, soft tissue	\$134.00
D7230	Removal of impacted tooth, partially bony	\$178.00
D7240	Removal of impacted tooth, completely bony	\$160.00
D7241	Removal of impacted tooth, completely bony, with unusual surgical complications	\$263.00
D7250	Surgical removal residual tooth roots, cutting procedure	\$112.00
D7285	Incisional Biopsy of oral tissue, hard (bone, tooth)	\$99.00
D7286	Incisional Biopsy of oral tissue, soft	\$157.00
D7310	Alveoloplasty with extractions, 4+ teeth, quadrant	\$193.00
D7311	Alveoloplasty with extractions, 1-3 teeth, quadrant	\$169.00
D7320	Alveoloplasty, w/o extractions, 4+ teeth, quadrant	\$314.00
D7321	Alveoloplasty, w/o extractions, 1-3 teeth, quadrant	\$266.00
D7410	Excision of benign lesion, up to 1.25	\$106.00
D7411	Excision of benign lesion, over 1.25	\$150.00
D7412	Excision of benign lesion, complicated	\$200.00
D7450	Removal, benign odontogenic cyst/tumor, up to 1.25	\$350.00
D7451	Removal, benign odontogenic cyst/tumor, over 1.25	\$350.00
D7460	Removal, benign nonodontogenic cyst/tumor, to 1.25	\$125.00
D7461	Removal, benign nonodontogenic cyst/tumor, 1.25+	\$203.00
D7472	Removal of torus palatinus	\$350.00
D7473	Removal of torus mandibularis	\$350.00
D7510	Incision & drainage of abscess, intraoral soft tissue	\$208.00
D7511	Incision/drainage, abscess, intraoral soft, complicated	\$80.00
D7520	Incision & drainage, abscess, extraoral soft tissue	\$100.00
D7521	Incision/drainage, abscess, extraoral soft, complicate	\$278.00
D7960	Frenulectomy (frenectomy or frenotomy), separate procedure	\$266.00
D7999	Unspecified oral surgery procedure, by report	\$0.00
<b>Adjunctive general services</b>		
D9110	Palliative (emergency) treatment, minor procedure	\$66.00
D9210	Local anesthesia not in conjunction with operative or surgical procedures	\$18.00
D9211	Regional block anesthesia	\$20.00
D9212	Trigeminal division block anesthesia	\$31.00
D9215	Local anesthesia with operative/surgical procedure	\$15.00
<b>GUIDELINE:</b>		
Deep Sedation and IV Conscious Sedation are covered benefits only in conjunction with covered oral surgery procedures when dispensed in a dental office by a practitioner acting within the scope of his/her licensure. Patient apprehension and/or nervousness are not of themselves sufficient justification.		
D9220	Deep sedation/general anesthesia, 1 <sup>st</sup> 30 minutes	\$181.00



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CDT Code	Description	Pediatric Copay
<b>Adjunctive general services (continued)</b>		
D9221	Deep sedation/general anesthesia, each add 'l 15 minutes	\$81.00
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	\$30.00
D9241	Intravenous conscious sedation/analgesia, 1 <sup>st</sup> 30 minutes	\$140.00
D9242	IV conscious sedation/analgesia, each add 'l 15 minutes	\$68.00
D9248	Non-intravenous conscious sedation	\$68.00
D9310	Consultation, other than requesting dentist	\$59.00
D9999	Unspecified adjunctive procedure, by report	\$0.00

**Pediatric Benefits – Children to the age of 19**

Payment for services that are Optional, that are upgraded treatment (such as precious or semi-precious metals and material upgrades) or that are not covered under the Policy will not count toward the Out-of-Pocket Maximum, and payment for such services still applies after the annual Out-of-Pocket Maximum is met.



# Children's Dental HMO

## ORTHODONTIC COVERAGE & SERVICES

For Pediatric Dental EHB, orthodontic treatment is a benefit of this Dental Plan ONLY when the patient's orthodontic needs meet medically necessary requirements as determined by a verified score of 26 or higher (or other qualify conditions) on Handicapping Labio-Lingual Deviation (HLD) Index analysis. All treatment must be prior authorized by the Plan prior to banding.

CDT Code	Description	Pediatric Copay
<b>Orthodontic Diagnostic Records</b>		
<b>Beginning Records</b>		
D0210	Intraoral - complete series (including bitewings)	\$ 200.00
D0322	Tomographic survey	
D0330	Panoramic image	
D0340	Cephalometric x-ray and tracings for orthodontic purposes	
D0350	2D oral/facial photographic images	
D0470	Diagnostic casts for orthodontic purposes	
<b>Final Records</b>		
D0210	Intraoral - complete series (including bitewings)	\$ 150.00
D0470	Diagnostic casts for orthodontic purposes	
<b>Comprehensive Orthodontic Treatment (24 months of Usual and Customary Orthodontic Treatment) \$350 maximum copayment per 24 months of comprehensive orthodontic treatment.</b>		
D8070	Comprehensive orthodontic treatment of the transitional dentition	\$ 350.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition	\$ 350.00
D8090	Comprehensive orthodontic treatment of the adult dentition	\$ 350.00
<b>Other Orthodontic Services</b>		
D8660	Pre-orthodontic treatment exam to monitor growth and development	no charge
D8670	Periodic orthodontic visit	no charge
D8680	Orthodontic retention (removal of appliance, construction and placement of retainer(s))	\$ 175.00
	Broken appointment (less than 24 hour notice)	\$ 15.00

**Pediatric Benefits – Children to the age of 19**

## Limitations:

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1. Bitewing x-rays in conjunction with periodic examinations are limited to one series of four films in any 6 consecutive month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.
2. Full mouth x-rays in conjunction with periodic examinations are limited to once every 24 consecutive months.
3. Panoramic image x-rays are limited to once every 24 consecutive months.
4. Prophylaxis services (cleanings) are limited to two in a 12-month period.
5. Dental sealant treatments are limited to permanent first and second molars only.
6. For the treatment of caries, if the tooth can be restored with amalgam, composite resin, acrylic, synthetic or plastic restorations. Any other restoration such as a crown or jacket is considered optional.
7. Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary.
8. Retreatment of root canals is a covered benefit only if clinical or radiographic signs are present, and /or the patient is experiencing symptoms. Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in canal, in the absence of pathology, is not a covered benefit.
9. Periodontal scaling and root planing, and subgingival curettage are limited to four (4) quadrant treatments in any 12 consecutive months.
10. Crown limitations are as follows:
  - A. Replacement of each unit is limited to once every 36 consecutive months, except when the crown is no longer functional as determined by the Dental Plan.
  - B. Only acrylic crowns and stainless steel crowns are a benefit for children under 12 years of age. If other types of crowns are chosen as an optional benefit for children under 12 years of age, the covered dental benefit level will be an acrylic or stainless steel crown.
  - C. Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.
11. Removable Prosthodontics limitations are as follows:
  - A. Partial dentures will not be replaced within 36 consecutive months, unless: 1) It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, or 2) The denture is unsatisfactory and cannot be made satisfactory.
  - B. The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges.
  - C. A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional.
  - D. Full upper and/or lower denture are not to be replaced within 36 consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by relines or repair.
  - E. The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the patient will be responsible for all additional charges.
  - F. Office or laboratory relines or rebases are limited to one (1) per arch in any 12 consecutive months.
  - G. Tissue conditioning is limited to two per denture.
  - H. Implants are considered an Optional Benefit.
  - I. Stayplates (interim partial dentures) are a benefit only when used as anterior space maintainers for children.
12. Fixed Partial Dentures (bridges) limitations are as follows:
  - A. Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.
  - B. A fixed partial denture is covered when it is necessary to replace a missing permanent anterior tooth in a person 16 years of age or older and the patient's oral health and general dental condition permits. For children under the age of 16, it is considered optional dental treatment. If performed on a Member under the age of 16, the applicant must pay the difference in cost between the fixed bridge and a space maintainer.
  - C. Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.
  - D. Fixed bridges are optional when provided in connection with a partial denture on the same arch.
  - E. Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.
  - F. The Program allows up to five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction, which is optional treatment.

## **Exclusions:**

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1. Services which, in the opinion of the attending dentist, are not necessary to the member's dental health.
2. Procedures, appliances, or restoration to correct congenital or developmental malformations are not covered benefits unless specifically listed in the Benefits section above.
3. Cosmetic dental care.
4. General anesthesia or intravenous/conscious sedation unless specifically listed as a benefit or is given by a dentist for covered oral surgery.
5. Experimental procedures or investigational services, including any treatment, therapy, procedure or drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional standards or for which the safety and efficiency have not been determined for use in the treatment for which the item in service in question is recommended or prescribed.
6. Services that were provided without cost to the Member by State government or an agency thereof, or any municipality, county or other subdivisions.
7. Hospital charges of any kind.
8. Major surgery for fractures and dislocations.
9. Loss or theft of dentures or bridgework.
10. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Member became eligible for such services.
11. Any service that is not specifically listed as a covered benefit.
12. Malignancies.
13. Dispensing of drugs not normally supplied in a dental office.
14. Additional treatment costs incurred because a dental procedure is unable to be preformed in the dentists office due to the general health and physical limitations of the patient.
15. The surgical removal of implants.
16. Services of a pedodontist/pediatric dentist, except when the Member is unable to be treated by his or her panel provider, or treatment by a pedodontist/pediatric dentist is Medically Necessary, or his or her plan provider is a pedodontist/pediatric dentist.
17. Dental Services that are received in an Emergency Care setting for conditions that are not emergencies if the subscriber reasonable should have known that an Emergency Care situation did not exist.



**CALIFORNIA  
SMALL GROUP PLAN  
COMBINED EVIDENCE OF COVERAGE (EOC)  
AND DISCLOSURE FORM**

**This EOC contains information for Enrollees covered by small group COVERED CALIFORNIA “SHOP Exchange” plans including Children’s Dental HMO, Family Dental HMO plans and commercial plans including DHMO and DHMO/EPO plans.**

Your employer group arranges for your dental benefits coverage to be provided by LIBERTY Dental Plan of California.

## **ANNOUNCEMENTS**

**Availability of Language Assistance:** Interpretation and translation services may be available for Members with limited English proficiency, including translation of documents into certain threshold languages. To ask for language services call 1-888-844-3344.

### **Spanish (Español)**

**IMPORTANTE:** ¿Puede leer esta noticia? Si no, alguien le puede ayudar a leerla. Además, es posible que reciba esta noticia escrita en su propio idioma. Para obtener ayuda gratuita, llame ahora mismo al 1-888-844-3344.

Hereinafter in this document, LIBERTY Dental Plan of California, Inc. may be referred to as “LIBERTY” or “the Plan.”

**This COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM constitutes only a summary of the dental plan. The dental plan contract must be consulted to determine the exact terms and conditions of coverage.**

A specimen of the dental plan contract will be furnished upon request.

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

**Section I** of this document contains a Benefit Matrix for general reference and comparison of Your Benefits under this plan followed by an Overview of Your Dental Benefit Plan.

**Section II** of this document contains definitions of terms used throughout this document.

# I. GENERAL INFORMATION – OVERVIEW OF YOUR DENTAL BENEFIT PLAN

## BENEFITS MATRIX

**THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM AND THE PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.**

(A) Deductibles	None
(B) Lifetime Maximums	An Enrollee has a lifetime maximum copayment of \$350 for 24 months of covered comprehensive orthodontic treatment. Applies to benefits for Children to the age of 19 Only.
(C) Out of Pocket Maximums	An Enrollee has an annual Out of Pocket Maximum of \$350 and a Family Out of Pocket Maximum of \$700, all copayments paid by the enrollee for covered services, including orthodontic copayments, apply towards the Annual Out of Pocket Maximum. There may be other costs incurred for optional, non-covered and upgraded material services that do not apply toward Out-of-Pocket maximums. Applies to benefits for Children to the age of 19 Only.
(D) Professional services	<p>An Enrollee may be required to pay a Copayment amount for each procedure as shown in the Description of Benefits and Copayments, subject to the Limitations and Exclusions.</p> <p>Copayments range by category of service. Examples are as follows:</p> <ul style="list-style-type: none"> <li>• Diagnostic Services ..... No Cost</li> <li>• Preventive Services ..... No Cost</li> <li>• Restorative Services.....No Cost - \$350.00</li> <li>• Periodontic Services .....\$40.00 - \$350.00</li> <li>• Prosthodontic Services .....No Cost - \$350.00</li> <li>• Oral and Maxillofacial Surgery .....No Cost - \$350.00</li> <li>• Orthodontic Services .....No Cost - \$350.00</li> </ul> <p><b>Note:</b> Some services may not be covered. Certain services may be covered only if provided by specified Dentists, or may be subject to additional charges. Limitations apply to the frequency with which some services may be obtained. For example: bitewing x-rays in conjunction with periodic examinations are limited to one series of four films in any 6 consecutive month period; Full upper and/or lower denture are not to be replaced within 36 consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair.</p>
(E) Outpatient Services	Not Covered
(F) Hospitalization Services	Not Covered
(G) Emergency Dental Coverage	The Enrollee may receive a maximum Benefit of up to \$75 per emergency for out-of - area Emergency Services.
(H) Ambulance Services	Not Covered
(I) Prescription Drug Services	Not Covered
(J) Durable Medical Equipment	Not Covered
(K) Mental Health Services	Not Covered
(L) Chemical Dependency Services	Not Covered
(M) Home Health Services	Not Covered

(N) Other	Not Covered
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Each individual procedure within each category listed above that is covered under the Program has a specific Copayment, which is shown in the Schedule of Benefits and in the Combined Evidence of Coverage.

## OVERVIEW OF YOUR DENTAL BENEFIT PLAN

### A. How to Use Your LIBERTY Dental Plan

This booklet is your group's Evidence of Coverage. It explains what LIBERTY covers and does not cover. Your comprehensive Schedule of Benefits, which lists copays and other fees, is provided with this document at the inception of the contract, and is available separately upon request or when required, attached as Appendix 1. Your LIBERTY Dental Plan is a group dental plan. Group plans are provided through a group, such as an employer. Your group or employer is purchasing this dental benefit for You. To be eligible for this coverage, You must be employed or affiliated with the group or employer purchasing dental Benefits from LIBERTY.

### B. How to Contact LIBERTY

Our Member Services department is here to help You. Call us if You have a question or a problem:

**LIBERTY Dental Plan of California, Inc.**  
**P.O. Box 26110**  
**Santa Ana, CA 92799-6110**  
**Member Services (Toll-Free): (888) 844-3344**  
**Website: [www.LIBERTYDentalPlan.com](http://www.LIBERTYDentalPlan.com)**

### C. LIBERTY's Service Area

LIBERTY has a Service Area which is the entire state of California. This is the area in which LIBERTY provides dental coverage. You must live or work in the Service Area [region]. You must receive all dental service services within the Service Area, unless You need emergency or Urgent Care. If You move out of the Service Area You must tell LIBERTY.

### D. LIBERTY's Network

Our network is all the Primary Care Providers and Specialists that LIBERTY has contracted with to provide services to our Members. You must get your dental services from your Primary Care Provider and other Providers who are in the network. Call 888-703-6999 to ask for a LIBERTY Provider Directory or use the website.

If You go to Providers outside the network, You will have to pay all the cost, unless You received pre-approval from LIBERTY or You had an emergency or You needed Urgent Care away from home. If You are new to LIBERTY or LIBERTY ends your Provider's contract, You can continue to see your current dentist in some cases. This is called *continuity of care* (see page 9).

### E. Your Primary Care Provider (see page 7)

When You join LIBERTY, in most cases You need to choose a Primary Care Provider to whom You will be assigned, unless otherwise stated below. The first page of your Schedule of Benefits indicates if you must choose, and become assigned to a Primary Care Provider. Your Primary Care Provider is usually a General Dentist who provides your basic care and coordinates the care You need from other dental specialty Providers.

**For Covered California:** Members residing in Covered California Regions 1, 2, 5, 8, 9, 10, 11, 12 and 13 do not require choosing a primary care dentist.

**For DHMO/EPO Options:** Some LIBERTY plans do not require You to choose and be assigned to a Primary Care Provider. On those plans, You may access services from any contracted Primary Care Provider in the network. Refer to the first page your Schedule of Benefits to determine if your plan requires You to choose and be assigned to a Primary Care Provider.

### F. Language and Communication Assistance (see page 19)

If English is not your first language, LIBERTY provides interpretation services and translation of certain written materials in your preferred language. To ask for language services call 888-844-3344. If You have a preferred language, please notify us of your personal language needs by calling 888-844-3344.

### G. How to Get Dental Care When You Need It

Call your Primary Care Provider first for all your care, unless it is an emergency.

- You usually need a referral and pre-approval to get care from a Provider other than your Primary Care Provider. See the next section.
- The care must be medically necessary for your health. Your dentist and LIBERTY follow guidelines and policies to decide if the care is medically necessary. If You disagree with LIBERTY about whether a service You want is medically necessary, You can file a Grievance or, in some cases, You may request an Independent Medical Review (see page 18).
- The care must be a service that LIBERTY covers. Covered dental services are also called Benefits. To see what services LIBERTY covers, see the Schedule of Benefits. Your comprehensive Schedule of Benefits is provided with this document at the inception of the contract, and is also available separately upon request from Member Services or via the LIBERTY website. When required, the Schedule of Benefits may be attached as Appendix 1.

#### **H. Referrals and Pre-approvals** (see page 9)

You need a referral from your Primary Care Provider and pre-approval from LIBERTY for specialty services or to receive a second opinion or to see a dentist who is not in LIBERTY’s network. Pre-approval is also called *prior Authorization*.

- Make sure your Primary Care Provider gives You a referral and gets pre-approval if it is required.
- If You do not have a referral and pre-approval when it is required, You will have to pay all of the cost of the service.

You do **not** need a referral and pre-approval to see your primary care provider, get Emergency Care or Urgent Care.

#### **I. Emergency Care** (see page 8)

Emergency Care is covered anywhere in the world. It is an emergency if You reasonably believe that not getting immediate care could be dangerous to your life or to a part of your body. Emergency Care may include care for a bad injury, severe pain, or a sudden serious dental illness. You should seek emergency care from your Primary Care Provider whenever possible. If you are unable to access your Primary Care Provider or are out of the service area and it is an emergency, call 9-1-1 or go to the nearest hospital or emergency room. Go to your Primary Care Provider for follow-up care. Do not go back to the emergency room for follow-up care. Coverage for Urgent Care and Emergency Care is explained fully on page 8.

#### **J. Urgent Care** (see page 8)

Urgent care is care that You need soon to prevent a serious health problem. Urgent care is covered anywhere in the world. Coverage for Urgent Care and Emergency Care is explained fully on page 8.

#### **K. Care When You Are Out of the LIBERTY Service Area** (see page 8)

Only emergency and Urgent Care is covered.

#### **L. Costs** (see the “ Fees and Charges – What You Pay” section on page 10)

- The premium is what You and/or your employer group pays to LIBERTY to keep coverage.
- A co-pay (Co-payment) is the amount that You must pay for a particular covered procedure.
- **For Covered California:** The yearly Out-of-Pocket maximum is the most money You have to pay for your Covered Services in a year. An Enrollee has an annual Out of Pocket Maximum of \$350 and a Family Out of Pocket Maximum of \$700, all copayments paid by the enrollee for covered services, including orthodontic copayments, apply towards the Annual Out of Pocket Maximum. There may be other costs incurred for optional, non-covered and upgraded material services that do not apply toward Out-of-Pocket maximums. Applies to benefits for Children to the age of 19 Only. To verify your Out-of-Pocket maximum You can visit LIBERTY’s website at [www.LIBERTYdentalplan.com](http://www.LIBERTYdentalplan.com) or call LIBERTY’s Member Services 888-844-3344 (toll-free). After You have reached the yearly Out-of-Pocket maximum, LIBERTY will pay the rest of the cost of dental services for that year, as long as the service You receive is a covered benefit performed by your assigned contracted dental Provider or authorized dental Provider.

#### **M. If You Have a Complaint About Your LIBERTY Dental Plan** (see page 16)

LIBERTY provides a Grievance resolution process. You can file a complaint (also called an *appeal* or a *Grievance*) with LIBERTY for any dissatisfaction You have with LIBERTY, your Benefits, a claim determination, a benefit or coverage determination, your Provider or any aspect of your dental Benefit Plan. If You disagree with LIBERTY’s decision about your complaint, You can get help from the State of California’s HMO Help Center. In some cases, the HMO Help Center can help You apply for an Independent Medical Review (IMR) or file a complaint. IMR is a review of your case by doctors who are not part of your health plan.

## **II. DEFINITIONS OF USEFUL TERMS CONTAINED IN THIS DOCUMENT**

The following terms are used in this EOC document:

**Authorization:** The notification of approval by LIBERTY that You may proceed with treatment requested

**Benefits:** Services covered by your LIBERTY dental plan

**Benefit Plan:** The LIBERTY dental product that You purchased to provide coverage for dental services

**Benefit Year:** The year of coverage of your LIBERTY dental plan

**Cal-COBRA:** State law requiring an individual in a small group of 2-19 members to purchase continuing coverage at the termination of employment or at the termination of employer group-sponsored health coverage

**Capitation:** Pre-paid payments made by LIBERTY to a Contracted Primary Care Provider to provide services to assigned Members

**Charges:** The fees requested for proposed services or services rendered

**COBRA:** Federal law requiring an individual to purchase continuing coverage at the termination of employment or at the termination of employer group-sponsored health coverage

**Contracting Dentist:** A dentist who has signed a contract to provide services to LIBERTY Members in accordance with LIBERTY's rules and regulations

**Covered Services:** Services listed in this document as a benefit of this dental plan

**Co-payment:** Any amount charged to a Member at the time of service for Covered Services. Fixed Co-payment amounts are listed in the Schedule of Benefits

**Dental Records:** Refers to diagnostic aid, intraoral and extra-oral radiographs, written treatment record including but not limited to progress notes, dental and periodontal chartings, treatment plans, consultation reports, or other written material relating to an individual's medical and dental history, diagnosis, condition, treatment, or evaluation

**Dependent:** Any eligible Member of a Subscriber's family who is enrolled in LIBERTY Dental Plan

**Dental Necessity or Dentally Necessary:** A Covered Service that meets Plan guidelines for appropriateness and reasonableness by virtue of a clinical review of submitted information. Covered Services may be reviewed for Dental Necessity prior to or after rendering. Payment for services occurs for Covered Services that are deemed Dentally Necessary by the Plan

**Dental Office:** A dental facility and its dentists that are under contract to provide services to LIBERTY Members in accordance with LIBERTY's rules and regulations

**Disputed Dental Service:** Any service that is the subject of a dispute filed by either Member or Provider

**Domestic Partner:** A person that is in a committed life-sharing relationship with the Member.

**Enrollee:** see Member

**Emergency Care / Emergency Dental Service:** Emergency Dental Service and care include (and are covered by LIBERTY Dental Plan) dental screening, examination, evaluation by dentist or dental Specialist to determine if an emergency dental condition exists, and to provide care that would be acknowledged as within professionally recognized standards of care and in order to alleviate any emergency symptoms in a Dental Office. Medical emergencies are not covered by LIBERTY Dental Plan if the services are rendered in a hospital setting which are covered by a Medical Plan, or if LIBERTY Dental Plan determines the services were not dental in nature.

**EPDB: Essential Pediatric Dental Benefit:** Refers to benefits required by the Affordable Care Act to provide essential pediatric dental Benefits to children.

**Exclusion:** A statement describing one or more services or situations where coverage is not provided for dental services by the Plan

**General Dentist:** A licensed dentist who provides general dental services and who does not identify as a Specialist

**Grievance:** Any expression of dissatisfaction; also known as a complaint. See Grievance Section of EOC for pertinent rules, regulations and processes

**Independent Medical Review (IMR):** A California program where certain denied services may be subject to an external review. IMR is only available for medical services or services that are available due to enrollment in a related full-service medical plan

**In-Network Benefits:** Benefits available to You when You receive services from a Contracted Provider

**Member:** Subscriber or eligible Dependent(s) who are actually enrolled in the Plan. Also known as Enrollee

**Non-Participating Provider:** A dentist that has no contract to provide services for LIBERTY

**Open Enrollment Period:** A period of time where enrollment in a dental plan may be started or changed

**Out-of Area Coverage:** Benefits provided when You are out of the Plan's Service Area, or away from Your Primary Care Provider

**Out-of area Urgent Care:** Urgent services that are needed while You are located out of the Service Area or away from your Primary Care Provider

**For Covered California: Out-of-Pocket Maximum:** Refers to the maximum amount You will spend for Covered Services each year. An Enrollee has an annual Out of Pocket Maximum of \$350 and a Family Out of Pocket Maximum of \$700, all copayments paid by the enrollee for covered services, including orthodontic copayments, apply towards the Annual Out of Pocket Maximum. There may be other costs incurred for optional, non-covered and upgraded material services that do not apply toward Out-of-Pocket maximums. Applies to benefits for Children to the age of 19 Only. After meeting this amount of expense, all additional Covered Services during the year are covered by Your Plan.

**Plan:** LIBERTY Dental Plan of California, Inc.

**Pre-Authorization:** A document submitted in your behalf requesting an advance determination and approval to render desired treatment services for You

**Premium:** The fee received by LIBERTY, paid by You or your employer to LIBERTY for this Benefit Plan

**Primary Care Provider:** A General Dentist affiliated with LIBERTY to provide general dental services to covered members of the Plan. The Primary Care Provider is responsible to provide or arrange for needed dental services. Primary Care Provider may include one or more General Dentists or Specialists in the same facility

**Professional Services:** Dental services or procedures provided by a licensed dentist or approved auxiliaries

**Provider:** A contracted dentist providing services under this Plan

**Specialist:** A Dentist that has received advanced training in one of the dental specialties approved by the American Dental Association as a dental specialty, and practices as a Specialist. Examples are Endodontists, Oral and Maxillofacial Surgeon, Periodontists and Pediatric Dentist

**Subscriber:** Member, Enrollee or "You" are equivalent in this document

**Surcharge:** An amount charged in addition to a listed Co-payment for a requested service or feature

**Terminated Provider:** A dentist that formerly delivered services under contract that is no longer associated with the Plan

**Service Area:** The counties in California where LIBERTY provides coverage

**Urgent Care:** See Emergency Care

**Usual Charges:** A Dentist's usual charge for a service

**You:** pertains to Members who are the beneficiary of this dental Benefit Plan

### **III. ACCESS TO SERVICES – SEEING A DENTIST**

LIBERTY Dental Plan contracts with Primary Care Providers and Specialists to provide services covered by your Plan. Contact us toll-free at (888) 844-3344 or via our website, [www.LIBERTYdentalplan.com](http://www.LIBERTYdentalplan.com), to find a dentist in your area. All services and Benefits

described in this publication are covered only if provided by a contracted Primary Care Provider or Specialist. The only time You may receive care outside the network is for Emergency Dental Services as described herein under “Emergency Dental Care” or “Urgent Care”.

## **A. FACILITIES**

**LIBERTY** makes available primary care (General Dentist) and specialty care dental facilities throughout the state of California within a reasonable distance from your home or workplace. Contact **LIBERTY** toll-free at **888-844-3344** or via website at [www.LIBERTYdentalplan.com](http://www.LIBERTYdentalplan.com) to find a dentist in your area.

Our goal is to provide You with appropriate dental Benefits, delivered by highly qualified dental professionals in a comfortable setting. All of **LIBERTY** Dental Plan’s contracted dentists have undergone strict credentialing procedures, background checks and office evaluations. In addition, each participating dentist must adhere to strict contractual guidelines. All dentists are pre-screened and reviewed on a regular basis. We conduct a quality assessment program which includes ongoing contract management to assure compliance with continuing education, accessibility for Members, appropriate diagnosis and treatment planning. Your Primary Care Provider will provide for all of your dental care needs including referring You to a Specialist, should it be necessary. Most Enrollees should have a residence or workplace within thirty (30) minutes or fifteen (15) miles of a Primary Care Dental Office.

## **B. DENTAL HEALTH EDUCATION**

For further information on using your dental Benefits, please see the website at [www.LIBERTYdentalplan.com](http://www.LIBERTYdentalplan.com). The website contains other helpful information on dental and oral health information to assist You in assessing your risk of future dental disease, home care measures You can take to keeping your teeth and mouth healthy. Further, the condition of your teeth, gums and mouth can have profound effect on your total overall health. Information on how your oral health can affect your overall health conditions such as cardiovascular conditions, diabetes, obesity, pregnancy and pre- and peri-natal health as well as other health conditions can be found on the website.

## **C. CHOICE OF PROVIDERS**

### **PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHAT PROVIDER DENTAL SERVICES MAY BE OBTAINED**

1. **General Dentistry/Primary Care Dentistry:** Except as noted below when You join **LIBERTY** Dental Plan, You must choose a Primary Care Provider to whom You will be assigned. The first page of your Schedule of Benefits indicates if you must choose, and become assigned to a Primary Care Provider. Your assigned Primary Care Provider is responsible for coordinating any specialty care dental services You might need. You must obtain general dental services from your assigned Primary Care Provider. Your assigned primary care facility will share information with any Specialist to coordinate your overall care.

If You do not select a Primary Care Provider, one will be chosen for You by **LIBERTY** upon your enrollment and You will be notified of this assignment.

**For Covered California:** Members residing in Covered California Regions 1, 2, 5, 8, 9, 10, 11, 12 and 13 do not require choosing a primary care dentist.

**For DHMO/EPO Options:** To determine if your plan requires Provider office assignment, please refer to the first page of your Schedule of Benefits. If your plan does not require Provider office assignment, in order to access care under one of these plans, contact any **LIBERTY** Dental Plan Provider who is contracted to provide services under your selected plan for an appointment. The Primary Care Provider will then contact **LIBERTY** Dental Plan to verify your eligibility. You may obtain information on contracted Providers by phone or website. Refer to your Schedule of Benefits to determine if your plan requires You to choose and be assigned to a Primary Care Provider, or if You may access services from any contracted Primary Care Provider in the network.

**For Covered California:** In regions requiring assignment, all Members in the Essential Pediatric Benefit Plan must be assigned to and receive treatment from the same Primary Care Provider.

2. **Changing Primary Care Providers:** You may contact **LIBERTY** at any time to change your Primary Care Provider. Contact our Member Services Department toll-free at (888) 844-3344 (during regular business hours) or submit a change request in writing to: **LIBERTY** Dental Plan, P.O. Box 26110, Santa Ana, CA, 92799-6110. Your requested change to a Primary Care Provider will be in effect on the first (1<sup>st</sup>) day of the following month if the change is received by **LIBERTY** Dental Plan prior to the twentieth (20<sup>th</sup>) of the current month. Your request to change dentists will not be processed if You have an outstanding balance with your current dentist.

3. **Care from a Dental Specialist:** You may only obtain care from a dental Specialist only after your referral to a Specialist has been submitted by your assigned Primary Care Provider to LIBERTY for approval. You may only receive services from a dental Specialist that have been pre-approved for You. Your Specialist will submit a Pre-Authorization for services to LIBERTY for pre-approval.

#### **D. URGENT CARE**

Urgent care is care You need within 24 to 72 hours, and are services needed to prevent the serious deterioration of your dental health resulting from an unforeseen illness or injury for which treatment cannot be delayed. The Plan provides coverage for urgent dental services only if the services are required to alleviate severe pain or bleeding or if an Enrollee reasonably believes that the condition, if not diagnosed or treated, may lead to disability, dysfunction or death. Contact your assigned Primary Care Provider for your urgent needs during business hours or after hours. If You are out of the area, You may contact LIBERTY for referral to another contracted dentist that can treat your urgent condition. For after-hours Urgent Care outside the Service Area, You may proceed to find a dentist who can assist You. LIBERTY will reimburse You for covered dental expenses up to a maximum of seventy-five dollars (\$75), less applicable Co-payments per calendar year. You should notify LIBERTY as soon as possible after receipt of Urgent Care services, preferably within 48 hours. If it is determined that your treatment was not due to a dental emergency, the services of any non-contracted dentist will not be covered.

#### **E. EMERGENCY DENTAL CARE**

All affiliated LIBERTY Dental Plan Primary Care Providers provide availability of emergency dental care twenty-four (24) hours per day, seven (7) days per week. The Plan provides coverage for Emergency Dental Services only if the services are required to alleviate severe pain or bleeding or if an Enrollee reasonably believes that the condition, if not diagnosed or treated, may lead to disability, dysfunction or death. If You encounter a dental emergency condition or situation in which there is an imminent and serious threat to your health including but not limited to, the potential loss of life, limb, or other major body function, You may also wish to consider contacting the “911” emergency response system. The use of such system should be done so responsibly.

In the event You require Emergency Dental Care, contact your Primary Care Provider to schedule an immediate appointment. For urgent or unexpected dental conditions that occur after-hours or on weekends, contact your Primary Care Provider for instructions on how to proceed.

If your Primary Care Provider is not available, or if You are out of the area and cannot contact LIBERTY to redirect You to another contracted Dental Office, contact any licensed dentist to receive Emergency Care. LIBERTY will reimburse You for covered dental expenses up to a maximum of seventy-five dollars (\$75), less applicable Co-payments per calendar year. You should notify LIBERTY as soon as possible after receipt of emergency services, preferably within 48 hours. If it is determined that your treatment was not due to a dental emergency, the services of any non-contracted dentist will not be covered.

**Emergency Dental Service** (*covered by your LIBERTY Dental Plan*) is defined in the California Health & Safety Code, to include a dental screening, examination, evaluation by dentist or dental Specialist to determine if an emergency dental condition exists, and to provide care that would be acknowledged as within professionally recognized standards of dental care and in order to alleviate any emergency symptoms in a Dental Office. Medical and/or psychiatric emergencies are not covered by LIBERTY Dental Plan and are generally covered by a Medical Plan. LIBERTY does not cover services that LIBERTY determines the services were not dental in nature.

**Reimbursement for Emergency Dental Care:** If the requirements in the section titled “Emergency Dental Care” are satisfied, LIBERTY will cover up to \$75 of such services less applicable Co-payments per calendar year. If You pay a bill for covered Emergency Dental Care, submit a copy of the paid bill to LIBERTY Dental Plan, Claims Department, P.O. Box 26110, Santa Ana, CA, 92799-6110. Please include a copy of the claim from the Provider’s office or a legible statement of services/invoice. Please forward to LIBERTY Dental Plan with the following information:

- Your membership information.
- Individual’s name that received the emergency services.
- Name and address of the dentist providing the emergency service.
- A statement explaining the circumstances surrounding the emergency visit.

If additional information is needed, You will be notified in writing. If any part of your claim is denied You will receive a written Explanation of Benefits (EOB) within 30 days of LIBERTY Dental Plan’s receipt of the claim that includes:

- The reason for the denial.
- Reference to the pertinent Evidence of Coverage provisions on which the denial is based.
- Notice of your right to request reconsideration of the denial, and an explanation of the Grievance procedures. You may also refer to the EOC section, GRIEVANCE PROCEDURES below.

## **F. SECOND OPINION**

At no cost to You, You may request a second dental opinion when appropriate, by directly contacting Member Services either by calling the toll-free number (888) 844-3344 or by writing to: LIBERTY Dental Plan, P.O. Box 26110, Santa Ana, CA, 92799-6110. Your Primary Care Provider may also request a second dental opinion on your behalf by submitting a Standard Specialty or Orthodontic Referral form with appropriate x-rays. All requests for a second dental opinion are approved by LIBERTY Dental Plan within 72 hours of receipt of such request. Upon approval, LIBERTY Dental Plan will make the appropriate second dental opinion arrangements and advise the attending dentist of your concerns. You will then be advised of the arrangement so an appointment can be scheduled. Upon request, You may obtain a copy of LIBERTY Dental Plan's policy description for a second dental opinion.

## **G. REFERRAL TO A SPECIALIST**

In the event that You need to be seen by a Specialist, LIBERTY Dental Plan requires prior benefit Authorization. Your Primary Care Provider is responsible for obtaining Authorization for You to receive specialty care.

The Pre-Authorization submission will be responded to within five (5) business days of receipt, unless urgent.

If your specialty referral Pre-Authorization is denied or You are dissatisfied with the Pre-Authorization, You have the right to file a Grievance. See EOC section, "GRIEVANCE PROCEDURES" below.

If your Primary Care Provider has difficulty locating a Specialist in your area, contact LIBERTY Member Services for assistance in locating a Specialist.

## **H. AUTHORIZATION, MODIFICATION OR DENIAL OF SERVICES**

No prior benefit Authorization is required in order to receive general dental services from your Primary Care Provider. The Primary Care Provider has the authority to make most coverage determinations. The coverage determinations are achieved through comprehensive oral evaluations which are covered by your plan. Your Primary Care Provider is responsible for communicating the results of the comprehensive oral evaluation and advising of available Benefits and associated cost.

Referral to a Specialist is the responsibility of your assigned contracted Primary Care Provider (see Referral to a Specialist above).

Specialty services proposed by any Specialist to whom You are referred must be pre-authorized prior to rendering care, except for emergency services (Emergency Dental Care and Urgent Care services described above).

You or your Providers may call Member Services toll-free at 1-888-844-3344 for information on Pre-Authorization of services policies, procedures or the status of a particular referral or Pre-Authorization.

Specialty referral and Pre-Authorization of specialty services proposed by the Specialist is processed within 5 days of receipt of all information necessary to make the determination. When LIBERTY is unable to make the determination within the 5-day requirement, LIBERTY will notify your Provider and You of the information needed to complete the review and the anticipated date when the determination will be made.

Any denial, delay or modification of services will contain a clear and concise description of the utilization review criteria, guideline, clinical reason or contractual section of the coverage documentation used to make such a determination. Such determinations will include the name and telephone number of the health care professional responsible for the determination and information on how You can

Determinations to deny, delay or modify treatment requested on your behalf will contain information on how You may file a Grievance based on this determination.

**Urgent requests:** If You or your Primary Care Provider encounter an urgent condition in which there is an imminent and serious threat to your health including but not limited to, the potential loss of life, limb, or other major body function, or the normal timeframe for the decision making process as described above would be detrimental to your life or health, the response to the request for referral should not exceed seventy-two (72) hours from the time of receipt of such information, based on the nature of the urgent or emergent condition.

The decision to approve, modify or deny will be communicated to the Primary Care Provider within twenty-four (24) hours of the decision. In cases where the review is retrospective (services already provided), the decision shall be communicated to the Enrollee within thirty (30) days of the receipt of the information.

## **I. CONTINUITY OF CARE**

**Current Members:** Current Members may have the right to the benefit of completion of care with their terminated Provider for certain specified acute or serious chronic dental conditions. Please call the Plan at 1-888-844-3344 to see if You may be eligible for this benefit. You may request a copy of the Plan's Continuity of Care Policy. You must make a specific request to continue under the care of your

terminated Provider. We are not required to continue your care with that Provider if You are not eligible under our policy or if we cannot reach agreement with your terminated Provider on the terms regarding your care in accordance with California law.

**New Members:** A New Member may have the right to the qualified benefit of completion of care with their non-participating Provider for certain specified acute or serious chronic dental conditions. Please call the Plan at 1-888-844-3344 to see if You may be eligible for this benefit. You may request a copy of the Plan's Continuity of Care Policy. You must make a specific request to continue under the care of your current Provider. We are not required to continue your care with that Provider if You are not eligible under our policy or if we cannot reach agreement with your Provider on the terms regarding your care in accordance with California law. This policy does not apply to new Members of an individual Subscriber contract.

#### **J. LANGUAGE ASSISTANCE**

Interpretation and translation services may be available for Members with limited English proficiency, including translation of documents into certain threshold languages. To ask for language services call 888-844-3344.

### **IV. FEES AND CHARGES – WHAT YOU PAY**

#### **A. PREMIUMS AND PREPAYMENT FEES**

In most cases, your employer will make payments of your premium directly to LIBERTY. In some cases, You will make payments to your employer (see COBRA and Cal-COBRA) or will arrange for a payroll deduction to pay the premium. Your employer will provide to LIBERTY the collected premium.

Your Premium and payment terms, including mailing address for payments, are provided directly to your employer or group administrator. If disclosure of this information is required, it is listed in Appendix 2.

Covered California – Premium payments are paid directly to Covered California by your employer or group.

Premiums must be paid for the period in which services are received.

#### **B. CHANGES TO BENEFITS AND PREMIUMS**

LIBERTY Dental Plan may change the covered Benefits, Co-payments, and premium rates annually. LIBERTY Dental Plan will not decrease the covered Benefits or increase the premium rates during the term of the agreement without giving notice to You at least sixty (60) days before the proposed change.

At renewal, LIBERTY may change the premium and your employer will provide 60 days' notice of any premium change that may affect You.

**For Covered California:** For Covered California Members, renewal and benefit changes may be subject to additional Covered California terms and conditions, which are provided by Covered California.

#### **C. OTHER CHARGES**

You are responsible only for premiums and listed Co-payments for Covered Services. You may be responsible for other Charges for non-covered or optional services as described in this Evidence of Coverage document. You should discuss any Charges for non-covered or optional services directly with your Provider. In order to be certain which services on your treatment plan are covered Benefits of your plan and which services, if any, are non-covered or optional services (for which You may be responsible for paying out-of-pocket), You may wish to obtain a written disclosure of all services proposed or received, whether covered or not.

If You receive services that require Pre-Authorization without the necessary Authorization (other than emergent or Urgent Care services as medically necessary), You will be responsible for full payment of the Provider's usual fee to the Provider for any such services.

You may be responsible for additional fees for returned or dishonored checks, cancelled credit card payments, broken or missed appointment Charges or other administrative Charges such as finance Charges to any third party payment organizations as agreed upon mutually by You and your Provider as per business arrangements and disclosures made by LIBERTY or the treating Provider.

#### **D. LIABILITY FOR PAYMENT**

In most cases, your employer will make payments of your premium directly to LIBERTY. In some cases, You will make payments to your employer (see COBRA and Cal-COBRA) or will arrange for a payroll deduction to pay the premium. You are responsible for listed Co-payments for any services subject to the limitations and Exclusions of your plan.

You are responsible for the treating dentist's usual fee in the following situations:

- For non-Covered Services
- If You have services from a non-contracted dentist or facility
- If a Pre-Authorization was required and You did not have the treatment pre-authorized
- Services received out of area that are later deemed to not qualify as emergency or Urgent Care services, such as (but not limited to) routine treatment beyond the stabilization of the emergency situation

Emergency services may be available out-of-network or without Pre-Authorization in some situations (see Emergency Dental Care section above).

**IMPORTANT:** Prior to providing You with non-Covered Services, your Contracted Dentist should provide You a treatment plan that includes each anticipated service and the estimated cost. If You would like more information about dental coverage options, You may contact our Member Services Department at 888-844-3344.

In no event are You ever responsible for any sums owed to a contracted Provider by LIBERTY. In the event that LIBERTY fails to pay a Non-contracting Provider, You may be liable to the Non-contracting Provider for the cost of services You received.

#### **E. PROVIDER REIMBURSEMENT**

LIBERTY pays for Covered Services to contracted dentists via a variety of arrangements including Capitation, fee-for-service and supplemental surpayments in addition to Capitation. Reimbursement varies by geographic area, General Dentist, specialty dentist and procedure code. For more information on reimbursement, You may address a request in writing to LIBERTY at the address shown above.

## **V. ELIGIBILITY AND ENROLLMENT**

### **A. WHO IS ENTITLED TO BENEFITS**

Your LIBERTY Dental Plan is provided by your employer or group and coordinated through LIBERTY. If LIBERTY receives your completed enrollment form payment by the 20<sup>th</sup> day of the month, You are eligible to receive care on the first day of the following month. You may call your selected dentist at any time after the effective date of your coverage. Be sure to identify yourself as a Member of LIBERTY Dental Plan when You call the dentist for an appointment. We also suggest that You keep this Evidence of Coverage or the Schedule of Benefits and applicable Limitations and Exclusions with You when You go to your appointment. Your comprehensive Schedule of Benefits, which lists copays and other fees, is provided with this document at the inception of the contract, and is available separately upon request [or when required, attached as Appendix I]. You can then reference Benefits and applicable Co-payments which are the out-of-pocket costs associated with your plan, as well as any non-covered treatment.

### **B. WHO IS ELIGIBLE TO ENROLL**

**For Essential Pediatric Dental Benefit plans:** You must live in the plan Service Area. Enrollment is available for:

- Unmarried Dependent children (including adopted) up to the nineteenth (19) birthday
- New Dependent children placed for adoption and stepchildren up to the nineteenth (19) birthday, and newborns.

**For all plans other than EPDB plans:** As an Employee or Group Member, You and your eligible Dependents are eligible to enroll in LIBERTY Dental Plan. You must live in the plan Service Area. Prospective Group Subscribers must also meet their employer's eligibility requirements. You may enroll:

- Your spouse.
- Your Domestic Partner. A Domestic Partner is any person whose domestic partnership is currently registered with a governmental body pursuant to state or local law. This includes both same-sex and opposite-sex couples.
- Unmarried Dependent children (including adopted) who are under the age of twenty-six (26) and other Dependent children if your group provides Benefits for those Dependents.
- Disabled children Dependent upon You for support and are not able to support themselves due to physical or mental handicap. You must provide proof of disability or handicap at the time You enroll
- New Dependents such as new spouse, children placed with You for adoption, and newborns

## **VI. COVERED SERVICES**

You are covered for the dental services and procedures listed below when necessary for your dental health in accordance with professionally recognized standards of practice, subject to the limitations and Exclusions described for each category and for all services. Please see the Schedule of Benefits for a detailed listing of specific covered dental procedures and the co-payments applicable to each, and a list of the Exclusions and limitations that are applicable to all dental services covered under your LIBERTY Dental Plan. Schedules of Benefits are provided with this document at the inception of the contract and are available separately upon request from

LIBERTY Dental Plan by contacting Member Services at (Toll-Free): (888) 844-3344, or from the LIBERTY Dental Website at [www.LIBERTYDentalPlan.com](http://www.LIBERTYDentalPlan.com). When required, the Schedule of Benefits may also be included in Appendix 1 of this document.

#### **A. Diagnostic Dental Services**

Diagnostic dental services are those that are used to diagnose your dental condition and evaluate necessary dental treatment when deemed necessary for your dental health in accordance with professionally recognized standards of practice.

You are covered for the Diagnostic dental services listed in Your comprehensive Schedule of Benefits provided with this document at the inception of the contract, and available separately upon request, together with related limitations and Exclusions.

#### **B. Preventive Dental Services**

Preventive dental services are those that are used to maintain good dental condition or to prevent deterioration of dental condition when deemed necessary for your dental health in accordance with professionally recognized standards of practice.

You are covered for the Preventive dental services listed in Your comprehensive Schedule of Benefits provided with this document at the inception of the contract, and available separately upon request, together with related limitations and Exclusions.

#### **C. Restorative Dental Services**

Restorative dental services are those that are used to repair and restore the natural teeth to healthy condition when deemed necessary for your dental health in accordance with professionally recognized standards of practice.

You are covered for the Restorative dental services listed in Your comprehensive Schedule of Benefits provided with this document at the inception of the contract, and available separately upon request, together with related limitations and Exclusions.

#### **D. Endodontic Services**

Endodontic dental services are procedures that involve treatment of the pulp, root canal and roots, when deemed necessary for your dental health in accordance with professionally recognized standards of practice.

You are covered for the following types of Endodontic dental services listed in Your comprehensive Schedule of Benefits provided with this document at the inception of the contract, and available separately upon request, together with related limitations and Exclusions.

#### **E. Periodontic Services**

Periodontic dental services are those procedures that involve the treatment of the gum and bone supporting the teeth and the management of gingivitis (gum inflammation) and periodontitis (gum disease), when deemed necessary for your dental health in accordance with professionally recognized standards of practice.

You are covered for the Periodontic dental services listed in Your comprehensive Schedule of Benefits provided with this document at the inception of the contract, and available separately upon request, together with related limitations and Exclusions.

#### **F. Prosthodontic Services**

Removable prosthodontics is the replacement of lost teeth by a removable prosthesis and the maintenance of those appliances. Fixed prosthodontics is the replacement of lost teeth by a fixed prosthesis.

You are covered for the Prosthodontic dental services listed in Your comprehensive Schedule of Benefits provided with this document at the inception of the contract, and available separately upon request, together with related limitations and Exclusions.

#### **G. Oral Surgery Services**

Oral surgery services are procedures that involve the extraction of teeth and other surgical procedures as listed in the Schedule of Benefits.

You are covered for the Oral Surgery dental services listed in Your comprehensive Schedule of Benefits provided with this document at the inception of the contract, and available separately upon request, together with related limitations and Exclusions.

#### **H. Adjunctive Dental Services**

Adjunctive Dental Services are ancillary services such as anesthesia during dental services, bleaching, mouthguards, etc. You are covered for the Adjunctive dental services listed in Your comprehensive Schedule of Benefits provided with this document at the inception of the contract, and available separately upon request, together with related limitations and Exclusions.

## **I. Orthodontic Services**

Orthodontic services are procedures that involve straightening teeth and treating discrepancies in the bite relationship of the teeth and jaws. Orthodontic services are not a required covered category of dental service. See Your comprehensive Schedule of Benefits provided with this document at the inception of the contract, and available separately upon request, for a list of any covered orthodontic services provided in your Benefit Plan, and any pertinent relevant limitations and Exclusions.

## **J. Urgent and Emergency Services**

See information provided above in this Evidence of Coverage document for a description of coverage for Emergency Dental Services, including out of area urgent services, and how to access them.

## **K. Services Provided by a Specialist**

See information provided above in this Evidence of Coverage document for a description of coverage for services available performed by a Specialist, including a list of the types of dental Specialists covered and how to access Specialist services.

# **VII. LIMITATIONS, EXCLUSIONS, EXCEPTIONS, REDUCTIONS**

See Your comprehensive Schedule of Benefits provided with this document at the inception of the contract, and available separately upon request, for limitations to covered procedures and Exclusions to your plan Benefits as part of the Schedule of Benefits.

## **A. GENERAL EXCLUSIONS**

LIBERTY will not cover:

- Care You get from a doctor who is not in the LIBERTY network, unless You have pre-approval from LIBERTY, or You need Urgent Care or Emergency Care and are outside the LIBERTY Service Area.
- Care that is not medically necessary
- Procedures that are not listed or included in the Schedule of Benefits.
- Exams that You need only to get work, go to school, play a sport, or get a license or professional certification.
- Services that are ordered for You by a court, unless they are medically necessary and covered by LIBERTY.
- The cost of copying your medical records. (This cost is usually a small fee per page)
- Expenses for travel, such as taxis and bus fare, to see a doctor or get health care.
- Other Exclusions are listed in Your comprehensive Schedule of Benefits provided with this document at the inception of the contract, and available separately upon request.

## **B. MISSED APPOINTMENTS**

LIBERTY strongly recommends that if You need to cancel or reschedule an appointment with your Provider that You notify the dental office as far in advance as possible. This will allow the LIBERTY and the Provider to accommodate another person in need of attention. Providers may charge a fee for missed or broken appointments with less than the recommended notice.

# **VIII. TERMINATION, RESCISSION AND CANCELLATION OF COVERAGE**

## **A. TERMINATION OF BENEFITS**

### **1. Termination Due to Loss of Eligibility**

Your LIBERTY Plan may be terminated by your Employer or Group that subscribes to LIBERTY for dental coverage. If this happens, You will receive notice through your employer or group administrator at least 30 days before the change takes effect. Coverage for your Dependents will also end.

Your LIBERTY Plan coverage may also end if your job ends or You no longer work enough hours to be on your employer's plan. In this case coverage for your Dependents also ends.

Your LIBERTY Plan coverage may also end if You no longer live or work in the LIBERTY Service Area or if your Employer or Group stops offering any dental plan.

**For EPDB plans:** This is an EPDB plan, and therefore You will be terminated upon reaching the limiting age for coverage stated in this EOC document

## **2. Termination Due to Non-Payment of Premium**

If your employer or group does not pay the premium, LIBERTY will send a notice to your employer or group saying that the premium is overdue.

If premiums are not paid according to the agreement, termination will be effective on midnight 30 days after the last day of the month for which premiums were last received, subject to compliance with notice requirements accepted by LIBERTY Dental Plan. This is equivalent to a minimum of a 30-day grace period. Termination by LIBERTY will comply with Health and Safety Code, Section 1365(a) as amended and any associated guidance or regulation in force at that time.

## **3. Completion of Treatment In Progress After Termination**

If You terminate from the Plan while the contract between You and LIBERTY Dental Plan is in effect, your Primary Care Provider or Specialist must complete any procedure in progress that was started before your termination, abiding by the terms and conditions of the Plan.

If You terminate coverage from the Plan after the start of orthodontic treatment, You will be responsible for any Charges on any remaining orthodontic treatment.

## **4. Termination Due to Fraud**

Existing in-force coverage may be terminated by LIBERTY if LIBERTY can demonstrate that a Subscriber has performed an act of practice constituting fraud or made an intentional misrepresentation of material fact. Fraudulent practices or acts include, but are not limited to, permitting any other person to use their Member ID card to obtain services under this dental plan, or otherwise engages in fraud or deception in the provision of incomplete or incorrect "material" information to LIBERTY or to the Provider that would affect enrollment information, for use of the services or facilities of the plan or knowingly permits such fraud or deception by another. In such cases, Subscriber will receive a letter via certified mail at least 30 days prior to the effective date of the termination explaining the reason for the intended termination, and the notice of appeal rights. A Subscriber who alleges that an enrollment has been or will be improperly canceled, rescinded, or not renewed may request a review by the Director of the DMHC. Upon notice of completion of the appeal process, termination will be effective immediately upon such notice from LIBERTY Dental Plan.

## **5. Termination Due to Health Status**

LIBERTY does not terminate based on any health status. If You believe that your coverage has been terminated, improperly canceled, rescinded or not renewed based on your health status or requirements for health care services, You may request a review to be performed by the Director of the Department of Managed Health Care. If the Director determines that a proper complaint exists under the provisions of this section, the Director shall notify the plan. Within 15 days after receipt of such notice, the plan shall either request a hearing or reinstate the Enrollee or Subscriber. A reinstatement shall be retroactive to time of cancellation or failure to renew and the plan shall be liable for the expenses incurred by the Subscriber or Enrollee for covered health care services from the date of cancellation or non-renewal to and including the date of reinstatement. You can contact the Department of Managed Health Care at (1-888-HMO-2219) or on a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's Internet web site is <http://www.hmohelp.ca.gov>.

## **B. EFFECTIVE DATE OF TERMINATION**

Coverage may be terminated, cancelled or non-renewed following 30 days since the date of notification of termination, except for fraud and intentional misrepresentation of material fact, which is effective immediately upon notification.

## **C. DISENROLLMENT**

You may disenroll from the plan by contacting LIBERTY by phone or in writing. Disenrollment is effective as of the end of the last day of the period for which premium was paid.

## **D. RESCISSION**

Rescission means that LIBERTY may cancel your coverage as if no coverage ever existed. Rescission may be elected by LIBERTY only in the event of fraud or intentional misrepresentation of material fact such as, but not limited to, if You intentionally submitted incomplete or incorrect material information in your enrollment application. You have the right to appeal any decision to rescind your membership. Appeal procedures will be provided to You in the notice of rescission. A Subscriber who alleges that an enrollment has been or will be improperly canceled, rescinded, or not renewed may request a review by the Director of the DMHC. Upon notice of completion of the appeal process, termination will be effective immediately upon such notice from LIBERTY Dental Plan. Except as provided by law, LIBERTY may not rescind Your coverage after 24 months from the issuance of the coverage contract.

# **IX. RENEWAL AND REINSTATEMENT OF COVERAGE**

Your coverage will be automatically renewed at the same terms and conditions unless LIBERTY notifies You in writing at least 30 days before the end of your coverage term describing any changes in the premium, coverage or other terms or conditions of your coverage.

## **X. INDIVIDUAL CONTINUATION OF DENTAL COVERAGE (COBRA, CAL-COBRA, CONVERSION COVERAGE AND HIPAA)**

### **A. COBRA**

For more information on COBRA, call the Federal Employee Benefits Security Administration (EBSA), toll-free, at 1-866-444-3272.

- COBRA is a U.S. law that applies to employers who have 20 or more employees in their group health plan.
- COBRA may allow You and your Dependents to keep LIBERTY coverage for up to 18 or 36 months, depending on the qualifying event and other circumstances. If You are no longer eligible for COBRA after 18 months, You may be able to keep your Benefits through Cal-COBRA. See below.
- Each qualified person may independently elect/enroll in COBRA coverage. A parent or legal guardian may elect COBRA for a minor child.
- With COBRA, You have the same Benefits as current Members with LIBERTY coverage.
- You have to pay all of the monthly premium.

#### **Important deadlines for electing/enrolling in COBRA with LIBERTY Dental Plan:**

It is important to meet the following deadlines. If You do not, You lose your right to COBRA coverage.

1. **Notification of qualifying event:** Employers must notify LIBERTY within 30 days after the following qualifying events:
  - The employee's job ends
  - The employee's hours of employment are reduced
  - The employee becomes eligible to receive Medicare Benefits
  - The employee diesYou or your Dependent must notify LIBERTY in writing within 60 days after any of the following qualifying events:
  - The employee divorces or legally separates
  - A child or other Dependent no longer qualifies as a Dependent under plan rules
2. **Election notice:** Generally, You must be sent an election notice not later than 14 days after your Employer receives notice that a qualifying event has occurred.
3. **Election period:** You have 60 days to notify your employer in writing that You want to elect/enroll in COBRA coverage. The 60 days starts on the later of the following two dates:
  - The date You receive the election notice.
  - The date your coverage ended.
4. **Premium payment:** You must pay the premiums for your COBRA coverage as per instructions provided by your Employer. LIBERTY must receive your first premium within 45 days after You enroll in COBRA. This first premium covers the time from the date your coverage ended because of the qualifying event up to the day You signed up for COBRA. You must then pay a monthly premium as instructed by your Employer and/or LIBERTY as long as You stay on COBRA.

#### **If your COBRA is ending, You may be able to elect/enroll in Cal-COBRA:**

When your 18 months of COBRA ends, You may be able to keep LIBERTY coverage for up to 18 more months under Cal-COBRA. If You were on COBRA for 36 months, You cannot get Cal-COBRA for any additional period of time.

Your employer should send You an enrollment form. You must fill out the enrollment form, and return it to your employer as instructed, and pay your premium no more than 30 days after You receive the enrollment form.

#### **You will lose COBRA if:**

- You do not pay your premiums on time.
- You move outside the LIBERTY Service Area.
- Your former employer no longer offers any health plan.
- You become eligible for Medicare.
- You sign up for another health plan.

- You commit fraud, which means that You intentionally deceive LIBERTY or You misrepresent yourself or allow someone else to do so in order to get health care services.

## **B. Cal-COBRA**

Cal-COBRA is a California law that applies to Employers who have between 2 and 19 employees in their group health plan.

- Cal-COBRA may allow You, your Dependents, and former Dependents to keep LIBERTY coverage for up to 36 months.
- You have the same Benefits as current Members with LIBERTY coverage.
- You have to pay all of the monthly premium.

### **Important deadlines for electing/enrolling in Cal-COBRA with LIBERTY:**

It is important to meet the following deadlines. If You do not, You lose your right to Cal-COBRA coverage.

1. **Notification of qualifying event:** Employers must notify LIBERTY within 30 days after the following qualifying events:
  - The employee's job ends
  - The employee's hours of employment are reduced

You or your Dependent must notify your employer and LIBERTY in writing within 60 days after any of the following qualifying events:

- The employee dies
  - The employee divorces or legally separates
  - A child or other Dependent no longer qualifies as a Dependent under plan rules
  - The employee becomes eligible to receive Medicare Benefits
2. **Election notice:** Generally, You must be sent an election notice not later than 14 days after your employer receives notice that a qualifying event has occurred.
  3. **Election period:** You have 60 days to notify your employer and/or LIBERTY in writing that You want to elect/enroll in Cal-COBRA continuation coverage. The 60 days starts on the later of the following two dates:
    - The date You receive the election notice.
    - The date your coverage ended.
  4. **Premium payment:** You must pay the premiums for your Cal-COBRA coverage as instructed by your employer. LIBERTY must receive your first premium from your employer within 45 days after You enroll in Cal-COBRA. This first premium covers the time from the date your coverage ended because of the qualifying event up to the day You signed up for Cal-COBRA. You must then pay a monthly premium as instructed by your employer as long as You stay on Cal-COBRA.

### **If your former employer stops offering LIBERTY when You are on Cal-COBRA:**

- You can elect/enroll in Cal-COBRA with the new health plan offered by your employer.
- You must enroll and pay your first premium as instructed by your employer with the new health plan no more than 30 days after You receive notice that LIBERTY is no longer being offered. If You do not meet this deadline, your Cal-COBRA Benefits end.

### **You will lose Cal-COBRA if:**

- You do not pay your premiums on time.
- You move outside the LIBERTY Service Area.
- Your former employer no longer offers any health plan.
- You sign up for or become eligible for Medicare.
- You sign up for another health plan. (However, if your new plan has a waiting period for pre-existing conditions and You have not used up all of your Cal-COBRA, You can keep your Cal-COBRA until the waiting period is over.)
- You commit fraud, which means that You intentionally deceive LIBERTY or You misrepresent yourself or allow someone else to do so in order to get health care services.

## **XI. GRIEVANCE PROCEDURES**

If You are dissatisfied with your selected Primary Care Provider, personnel, facilities, specialty referral, Pre-Authorization, claim, or the dental care You receive, You have the right to complain to the dental plan. A Complaint is the same as a Grievance. Grievance Forms

may be requested by contacting LIBERTY Dental Plan's Member Services Department at (888) 844-3344. Grievance Forms are also available on our website, [www.libertydentalplan.com](http://www.libertydentalplan.com), or by calling LIBERTY Member Services or by asking your Provider. Grievance Forms are not necessary. LIBERTY will investigate a Grievance submitted in any format. Your complaint or Grievances may be:

- Sent in writing to: LIBERTY Dental Plan, P.O. Box 26110, Santa Ana, CA, 92799-6110, or
- Sent by facsimile to: LIBERTY Dental Plan's Member Services Department facsimile at (949) 223-0011, or
- Submitted verbally to: LIBERTY Dental Plan Member Services Representative at LIBERTY's toll-free number: (888) 844-3344, or
- Submitted using our website online Grievance filing process by visiting [www.libertydentalplan.com](http://www.libertydentalplan.com).

You may use a "patient advocate" to help You file a Grievance. For Grievances involving minors or incapacitated or incompetent individuals, the parent, guardian, conservator, relative or other designee of the Member, as appropriate may submit the Grievance to LIBERTY, or to the DMHC for urgent matters (see "Urgent Grievances" below)

If You have limited English proficiency, visual or other communication impairment, LIBERTY will assist You in filing a Grievance. Assistance may include translation of Grievance procedures, forms and LIBERTY's responses, and may also include access to interpreters, telephone relay systems to aid disabled individuals to communicate.

You will not be discriminated against in any way by LIBERTY or your Provider for filing a Grievance.

You may file a Grievance for at least 180 calendar days following any incident or action that is the subject of your dissatisfaction.

LIBERTY Dental Plan's representatives will review the problem with You and take appropriate steps for a quick resolution. You will receive acknowledgement of your Grievance within five (5) calendar days of receipt. Grievances will be resolved within 30 days.

**Grievances Exempt from Written Acknowledgement and Response:** In some cases Grievances that are received by telephone, facsimile, e-mail or through a website that are not coverage disputes, or are not involving Dental Necessity and are resolved by the next business day do not require a written acknowledgement or response. In these cases You will be contacted by the same method by which You submitted the Grievance or otherwise discussed with You at the time You reported your complaint.

The following information is required by the State of California pertaining to your dental plan.

#### **A. STATE OF CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE (DMHC) COMPLAINT PROCEDURE**

The DMHC has established a toll-free number for You as a Member to utilize should You have a complaint against a health care service plan, or requests for review of cancellations, rescissions and non-renewals under Health and Safety Code section 1365(b) and related guidance and rules. This number is **888-HMO-2219**. As a Member You may file a complaint against LIBERTY Dental Plan; however, You may only do so after contacting your plan directly to utilize its complaint resolution process.

A Member may immediately file a complaint with the California DMHC in the event of a dental emergency situation. In addition a Member may also file a complaint in the event that the plan does not satisfactorily resolve the complaint (Grievance) within thirty (30) days of filing with your health care service plan.

**California Required Statement:** The California Department of Managed Health Care is responsible for regulating health care service plans. If You have a grievance against your Health Plan, You should first telephone your Health Plan at **1-888-844-3344** and use your Health Plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to You. If You need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your Health Plan, or a grievance that remained unresolved for more than 30 days, You may call the Department for assistance. You may also be eligible for Independent Medical Review (IMR). If You are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a Health Plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (**1-888-HMO-2219**) and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The Department's Internet web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.

**Grievance Resolutions and Responses:** For Grievances related to requested services that were denied, delayed or modified based in whole or in part on a finding that the proposed health care service is not a covered benefit, the response will indicate the exact document, page and provision applicable to the Grievance response.

For Grievances related to requested health care services that were denied, delayed or modified in whole or in part based on a determination that the service is not medically (dentally) necessary, the response will indicate the criteria, clinical guideline or policy used in reaching the determination.

**Urgent Grievances:** For cases involving an imminent and serious threat to your health including, but not limited to, severe pain, potential loss of life, limb, or major bodily function, LIBERTY will expedite the processing of your Grievance upon notification of this urgent condition. LIBERTY will resolve to the urgent condition within 3 calendar days of receipt of the Grievance, or sooner, based on the condition. In the case of urgent Grievances, You are not required to await the determination by LIBERTY before accessing the DMHC as noted above.

If You are not satisfied with the resolution initially provided, You may contact the DMHC as noted above. You may also submit additional materials for additional consideration to LIBERTY Dental Plan's Quality Management Department. Your requests must be in writing with a detailed summary and should be directed to:

LIBERTY Dental Plan, Inc.  
Quality Management Department  
P.O. Box 26110  
Santa Ana, CA 92799-6110

Any additional information will be processed as a new Grievance.

## **B. MEDIATION**

You may also request voluntary mediation with LIBERTY before exercising your right to submit a Grievance to the DMHC. The use of mediation does not preclude your right to submit a Grievance to the DMHC upon completion of mediation. In order to initiate mediation, You or your agent must voluntarily agree to the mediation process. Expenses for mediation will be borne equally by You and LIBERTY.

## **C. INDEPENDENT MEDICAL REVIEW (IMR)**

In cases which result in the denial of the Pre-Authorization request for Covered Services by a LIBERTY Dental Plan Provider, and are considered the practice of medicine or are provided pursuant to a contract between LIBERTY and a health plan (that covers hospital, medical or surgical Benefits) may be eligible for the DMHC Independent Medical Review (IMR) program. Subscribers may request a form for the independent medical review of their case by contacting LIBERTY Dental Plan at 888-844-3344 or writing to: LIBERTY Dental Plan, P.O. Box 26110, Santa Ana, CA, 92799-6110. You may also request the forms from the Department of Managed Health Care. The Department of Managed Health Care may be reached at 1-888-HMO-2219 or by visiting their website at: <http://www.hmohelp.ca.gov>. Independent Medical Review is only available for certain medical services.

## **D. ARBITRATION**

If You or one of your eligible Dependents is not satisfied with the results of LIBERTY Dental Plan's complaint resolution process, and all the complaint resolution procedures have been exhausted, the matter can be submitted to arbitration for resolution. If You, or one of your eligible Dependents, believe that some conduct arising from or relating to your participation as a LIBERTY Dental Plan Member, including contract or medical liability, the matter shall be settled by arbitration. The arbitration will be conducted according to the American Arbitration Association rules and regulations in force at the time of the occurrence of the Grievance (dispute or controversy) and subject to Section 1295 of the California code of Civil Procedure.

# **XII. MISCELLANEOUS PROVISIONS**

## **A. COORDINATION OF BENEFITS**

As a covered Member, You will always receive your LIBERTY Benefits. LIBERTY does not consider your Individual Plan secondary to any other coverage You might have. You are entitled to receive Benefits as listed in this EOC document despite any other coverage You might have in addition. However, any Covered California coverage that you have that is embedded into a full service health plan will act as the primary payor when you have a supplemental pediatric dental benefit through a family benefit plan.

## **B. THIRD PARTY LIABILITY**

If services otherwise covered by virtue of this Individual Plan are deemed to be necessary due to a work-related injury or which are the liability of another third party, You agree to cooperate in LIBERTY's processes to be reimbursed for these services.

## **C. OPPORTUNITY TO PARTICIPATE IN LIBERTY'S PUBLIC POLICY COMMITTEE**

If You wish to participate in LIBERTY's Public Policy Committee, which reviews plan performance and assists in establishing LIBERTY's public policies, please contact Member Services Department at (888) 844-3344, or contact Quality Management Department at [qm@libertydentalplan.com](mailto:qm@libertydentalplan.com)

## **D. REPORTING POSSIBLE FRAUD**

LIBERTY has established a specific fraud hotline number: (888) 704-9833. The Fraud Hotline provides the opportunity to report reasonable and good faith fraud suspicions or concerns in an anonymous/confidential manner. This hotline is monitored by a designated Member of the LIBERTY Corporate Compliance Committee. All information reported on the anonymous hotline is then forwarded to LIBERTY Dental Plan's Quality Management team for full investigation.

The Chairman of the Committee and the Chief Compliance Officer, in conjunction with Legal Counsel, determine whether LIBERTY shall take any additional action, which may include, without limitation:

- The provision of information, for purposes of education, to the participating Provider describing the incident involving suspected fraudulent activity;
- Seek restitution from the participating Provider for any amounts paid by LIBERTY in connection with the incident involving suspected fraudulent activity;
- Termination of the Provider agreement in effect between LIBERTY and the participating Provider; and/or
- Referral of the matter to an appropriate governmental agency, including, without limitation, the State Board of Dental Examiners and Centers for Medicare and Medicaid Services.

## **E. NON DISCRIMINATION**

LIBERTY and contracted Providers provide care in a non-discriminatory environment. Discrimination due to race, color, national origin, ancestry, religion, sex, marital status, sexual orientation or age, disease status, blindness or physical/mental impairment is not tolerated.

## **F. FILING CLAIMS**

As stated throughout this document, You are not required to file claims directly with LIBERTY. Your general dental services are arranged with the participating Primary Care Provider who submits claims or encounters on your behalf. Your specialty care services are reported to LIBERTY via the Specialist. If You receive services out-of-network due to an emergency after-hours or out-of-area situation, consult the section above for submitting your expenses to LIBERTY to receive reimbursement (see Reimbursement for Emergency Dental Services section above).

## **G. ORGAN DONATION**

LIBERTY is required by DMHC to inform You that organ donation options are available to You. Organ donation has many Benefits to society, and You may wish to consider this option in the event of any health situation that may lead to the option to do so. You may find more information about organ donation at <http://donatelife.net>

## **H. LANGUAGE ASSISTANCE**

Interpretation and translation services may be available for Members with limited English proficiency, including translation of documents into certain threshold languages. See statements below:

**IMPORTANT:** Can You read this document? If not, we can have somebody help You read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-844-3344.

### **Spanish (Español)**

**IMPORTANTE:** ¿Puede leer esta noticia? Si no, alguien le puede ayudar a leerla. Además, es posible que reciba esta noticia escrita en su propio idioma. Para obtener ayuda gratuita, llame ahora mismo al 1-888-844-3344.

## **I. LIBERTY DENTAL PLAN MEMBER SERVICES DEPARTMENT**

LIBERTY Dental Plan Member Services provides toll-free customer service support Monday through Friday 8:00 a.m. to 5:00 p.m. on normal business days to assist members with simple inquiries and resolution of dissatisfactions. The hearing and speech impaired may

use the California Relay Service's toll-free telephone numbers 1-800-735-2929 (TTY) or 1-888-877-5378 (TTY) to contact the department. Our toll-free number is (888) 844-3344.

## **J. MEMBER RIGHTS**

As a Member, You have the right to:

- Be treated with respect, dignity and recognition of your need for privacy and confidentiality
- Express Grievances and be informed of the Grievance process
- Have access and availability to care
- Access your Dental Records
- Participate in decision-making regarding your course of treatment
- Be provided information regarding a Provider
- Be provided information regarding the organization's services, Benefits and specialty referral process.

LIBERTY Dental Plan Policies and Procedures for preserving the confidentiality of medical records are available and will be furnished to You upon request.

## **K. MEMBER RESPONSIBILITIES**

As a Member, You have the responsibility to:

- Identify yourself to your selected Dental Office as a LIBERTY Dental Plan Member
- Treat the Primary Care Provider, office staff and LIBERTY Dental Plan staff with respect and courtesy
- Keep scheduled appointments or contact the Dental Office twenty-four (24) hours in advance to cancel an appointment
- Cooperate with the Primary Care Provider in following a prescribed course of treatment
- Make Co-payments at the time of service
- Notify LIBERTY Dental Plan of changes in family status
- Be aware of and follow the organization's guidelines in seeking dental care

**LIBERTY Dental Plan of California, Inc.**

P.O. Box 26110

Santa Ana, CA 92799-6110

(888) 844-3344



**Appendix 1:**

**SCHEDULE OF BENEFITS  
COVERED SERVICES**

**Your plan-specific Schedule of Benefits is provided in a separate document.**

**Appendix 2:**

**PREMIUM, PRE-PAYMENT FEES  
AND CHARGES**

**Your Group's Premium and various other Fees and Charges are provided to the Group  
sponsor**