GROUP EVIDENCE OF COVERAGE AND DISCLOSURE FORM

LIBERTY Dental Plan of California, Inc.

This Evidence of Coverage and Disclosure Form provides the following information:

* The advantages of your LIBERTY Dental Plan and how to use your benefits
* An evidence of coverage
* How to enroll in the plan
* Answers to your frequently asked questions

Information required by the state of California in regards to your dental plan.

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. 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.

This brochure will provide you with the information you should know about your Dental Plan. It explains clearly how it works and the many advantages LIBERTY Dental Plan provides you.

LIBERTY Dental Plan BENEFITS ARE EASY TO USE

Dental Benefits should be simple to use for you and your family. Our plans offer comprehensive dental coverage without claim forms, prohibitive deductibles, or restrictive annual maximums.

The difference with LIBERTY Dental Plan: good provider selection, clear communication, and, most importantly, requiring the dentists to perform to the standards of the participating contract they signed with the plan.

That is the difference in LIBERTY Dental Plan. We have open communication and provide excellent support to our panel of participating dentists.

Our goal is to provide you with the comprehensive dental benefits you purchased. We pledge to support your choice of LIBERTY Dental Plan by giving you confidence through the excellent customer service you deserve. After all, isn't that what it is all about?

At LIBERTY Dental Plan, you get quality dental benefits at a very reasonable price.

THE LIBERTY Dental Plan ADVANTAGES

* **No Claim Forms**
* **No Deductibles or Maximums**
* **Low Out-of-Pocket Costs**
* **Selection of Pre-screened Dentists & Specialists**
* **Multi-Lingual Provider Network**
* **Change Dentist Selection Any Time**
* **Orthodontic Coverage**
* **Most Pre-existing Conditions Covered**
* **Network Dentists Provide 24-hour Access to Emergency Care**
* **Toll-Free Member Assistance Lines**
  The hearing and speech impaired may use the California Relay Service toll-free telephone numbers (800) 735-2929 (TTY) or (888) 877-5378 (TTY) to contact the department.

This booklet includes your Evidence of Coverage and Disclosure From. Please keep this together with your records and your Schedule of Benefits, which includes the member co-payments, exclusions and limitations of the benefits and additional provisions of your dental plan.

This is a summary of how your LIBERTY Dental Plan dental plan works. This Evidence of Coverage and Disclosure Form will assist you in properly understanding your dental plan.

This Evidence of Coverage and Disclosure Form constitutes only a summary of the dental plan. The Agreement between LIBERTY Dental Plan of California, Inc. and the Employer must be consulted to determine the exact terms and conditions of coverage.

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) 703-6999 or by writing to: LIBERTY Dental Plan, P.O. Box 26110, Santa Ana, CA 92799-6110. Your primary care dentist 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 five (5) days 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.

YOUR DENTAL PLAN

LIBERTY Dental Plan has been providing and administering dental benefits in California for over twenty-five (25) years. LIBERTY Dental Plan is in the on-going process of enhancing our statewide panel of participating dentists and specialists to accommodate the needs of our Subscribers.

Our goal is to provide Californians with appropriate dental benefits, delivered by highly qualified dental professionals in a comfortable setting. All of LIBERTY Dental Plan's contracted private practice dentists have undergone strict credentialing procedures, background checks and office evaluations. In addition, each LIBERTY Dental Plan participating dentist must adhere to strict contractual guidelines. All dentists are pre-screened and reviewed on a regular basis. Our Provider Relations Department conducts a quality assessment program which includes ongoing contract management to assure compliance with continuing education, accessibility for members, appropriate diagnosis and treatment planning. In addition, we conduct random surveys of member groups to evaluate their view of the dental plan overall. This includes both Primary Care Dentists (General Dentists) and Specialists. Your Primary Care Dentist will provide for all of your dental care needs, including referring you to a specialist should it be necessary.

When you join LIBERTY Dental Plan, you must choose a Primary Care Dentist. If you desire to make a change, you may do so at any time. (Please note: Your request to change dentists will not be processed if you have an outstanding balance with your current dentist.) Simply contact our Member Services Department toll-free at (888) 703-6999 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 Dentist will be in effect on the first (1st) day of the following month if the change is received by LIBERTY Dental Plan prior to the twentieth (20th) of the current month.

NOTE: Those enrolling in plans CA80, CA90, Prestige II or Prestige III are not required to select a Primary Care Dentist at the point of enrollment. To access care under one of these plans, simply contact a LIBERTY Dental Plan provider who is contracted to provide services under your selected plan for an appointment. The Primary Care Dentist will then contact LIBERTY Dental Plan to verify your eligibility.

All services and benefits described in this publication are covered only if provided by a contracted LIBERTY Dental Plan participating Primary Care Dentist or Specialist. The only time you may receive care outside the network is for emergency dental services as described herein under "Emergency Dental Care".

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

WHO IS ELIGIBLE TO ENROLL

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
* Unmarried dependent children (including adopted) who are under the age of nineteen (19) and other dependent children if your group provides benefits for those dependents
* Unmarried children under the age of twenty four (24), if they are a full-time student at an accredited college or university
* 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

WHAT IF I HAVE A QUESTION ABOUT MY DENTAL PLAN

LIBERTY Dental Plan provides toll-free telephone access to covered members. Just call our Member Services Department if you have a question or inquiry. Our Member Service representatives will be glad to provide you information or resolve your inquiry. **Call (888) 703-6999, between the hours of 8:00 a.m. to 5:00 p.m. (PST) Monday through Friday.**

HOW DO I RECEIVE CARE

You must choose a Primary Care Dentist when you enroll in the plan. (See note under "Your Dental Plan" regarding selecting a Primary Care Dentist for plans CA80, CA90, Prestige II and Prestige III.) This dentist will be responsible for providing the dental care needs for you and your family, including referring you to a specialist should it be necessary (remember you can change dentists at anytime by calling LIBERTY Dental Plan or by submitting a request for provider change in writing). A directory of participating dentists will be sent to you upon request.

You may select any LIBERTY Dental Plan contracted provider accepting your plan. However, you may want to consider a choice convenient to your residence or work. You and your entire family must use the same dentist.

As a member, you should be able to make an appointment to be seen for dental hygiene and routine care within three weeks of the date of your request. This is based upon available schedule times.

HOW TO MAKE AN APPOINTMENT

After completing your enrollment form, you are eligible to receive care on the first of the month following LIBERTY Dental Plan's receipt of your enrollment application and notification of your eligibility by your employer or group administrator.

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 material handy and take this information and the Schedule of Benefits and applicable Limitations and Exclusions with you when you go to your appointment. You can then reference benefits and applicable co-payments which are the out-of-pocket costs associated with your plan.

HOW DO I FILE A CLAIM FORM

There are no claim forms to worry about with your plan. LIBERTY Dental Plan prepays participating Primary Care Dentists in advance for covered services (less applicable co-payments of your plan).

IS PRIOR BENEFIT AUTHORIZATION NECESSARY

No prior benefit authorization is required in order to receive dental services from your Primary Care Dentist. The Primary Care Dentist 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 Dentist is responsible for communicating the results of the comprehensive oral evaluation and advising of available benefits and associated cost.

If your Primary Care Dentist encounters a situation that requires the services of a specialist, LIBERTY Dental Plan requires a preauthorization submission, which will be responded to within five (5) business days of receipt, unless urgent.

If you or your Primary Care Dentist 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. The decision to approve, modify or deny will be communicated to the Primary Care Dentist within twenty-four (24) hours of the decision. In cases where the review is retrospective, the decision shall be communicated to the enrollee within thirty (30) days of the receipt of the information.

In the event that you need to be seen by a specialist, LIBERTY Dental Plan does require prior benefit authorization. Your Primary Care Dentist is responsible for obtaining authorization for you to receive specialty care.

In the instance that there are no contracted specialty providers listed in the Provider Directory for your county, benefits will be provided to you as if the specialty providers were contracted with the plan.

If your specialty referral preauthorization is denied or you are dissatisfied with the preauthorization, please refer to Page 9, GRIEVANCE PROCEDURES.

INDEPENDENT MEDICAL REVIEW

In cases which result in the denial of the preauthorization requests by a LIBERTY Dental Plan Provider, Subscribers may request a form for the independent medical review of their case by contacting LIBERTY Dental Plan at (888) 703-6999 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 (888) HMO-2219 or by visiting their website at: **http://www.hmohelp.ca.gov.**

EMERGENCY DENTAL CARE

All affiliated LIBERTY Dental Plan Primary Care Dental offices provide availability of emergency dental care services twenty-four (24) hours per day, seven (7) days per week.

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

If after you contact your Primary Care Dentist and are advised that your Primary Care Dentist is not available, simply contact any licensed dentist to receive care. Liberty Dental will reimburse you for dental expenses up to a maximum of seventy-five dollars ($75), less applicable co-payments.

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.

Emergency Dental Service and care include *(and are covered by LIBERTY Dental Plan*), as defined in the California Health & Safety Code, 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 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 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.

Emergency services and care (*and are not covered by LIBERTY Dental Plan*) also means an additional screening and examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility. **LIBERTY Dental Plan does not provide coverage for such emergency services and care**.

Reimbursement for Emergency Dental Care: If the requirements in the section titled "Emergency Dental Care" are satisfied, LIBERTY Dental Plan will cover up to $75 of such services 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. Please refer to Page 9, GRIEVANCE PROCEDURES.

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 dental conditions. Please call the Plan at (888) 703-6999 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 dental conditions. Please call the Plan at (888) 703-6999 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.

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 (800) 735-2929 (TTY) or (888) 877-5378 (TTY) to contact the department. Our toll-free number is (888) 703-6999.

GRIEVANCE PROCEDURES

If you are dissatisfied with your selected Primary Care Dentist, personnel, facilities, specialty referral, preauthorization, claim, or the dental care you receive, grievances may be:

Sent in writing to LIBERTY Dental Plan,
P.O. Box 26110, Santa Ana, CA 92799-6110,

Or

LIBERTY Dental Plan's Member Services Department facsimile at (949) 223-0011,

Or

Contact a LIBERTY Dental Plan Member Services Representative at (888) 703-6999,

Or

Use our online grievance filing process by visiting www.libertydentalplan.com.

Grievance Forms may be requested by contacting LIBERTY Dental Plan's Member Services Department at (888) 703-6999. Grievance Forms are also available on our website, www.libertydentalplan.com.

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.

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 (888) 703-6999 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, (888) HMO-2219 and a TDD line, (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.

If you are not satisfied with the resolution initially provided, you may request a review by LIBERTY Dental Plan's Quality Management Committee or Public Policy Committee. Your requests must be in writing with a detailed summary and should be directed to:

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

All levels of appeal will be completed within 30 days of receipt.

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).

PREPAYMENT FEES (PREMIUMS); CHANGES TO BENEFITS AND PREMIUMS

LIBERTY Dental Plan provides coverage for you under an agreement with your employer or plan administrator, and your employer or plan administrator will pay all premiums to us. Your employer or plan administrator will let you know the part you must pay. LIBERTY Dental Plan may change the covered benefits, co-payments, and premium rates from time to time. LIBERTY Dental Plan will not decrease the covered benefits or increase the premium rates during the term of that agreement without giving notice to your employer or plan administrator at least sixty (60) days before the proposed change.

TERMINATION OF COVERAGE

All rights to coverage stop on the date your employer or group coverage is terminated. Your employer, plan administrator or LIBERTY Dental Plan has the right to cancel the contract and terminate coverage if either party violates the terms and conditions of the contract, or upon the contract expiration date. If prepayment fees are not paid according to the agreement, termination will be effective on midnight of the last day of the month for which prepayment fees were last received, subject to compliance with notice requirements and accepted by LIBERTY Dental Plan.

If you terminate from the Plan while the contract between LIBERTY Dental Plan and your employer or plan administrator is in effect, your Primary Care or Specialty Dentist 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.

If a subscriber permits 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 use of the services or facilities of the plan or knowingly permits such fraud or deception by another, termination will be effective immediately upon notice from LIBERTY Dental Plan.

If an enrollee or subscriber's coverage is allegedly terminated based on their health status or requirements for health care services, a review may be requested 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 (888) HMO-2219 or on a TDD line at (877) 688-9891 for the hearing and speech impaired. The Department's Internet web site is http://www.hmohelp.ca.gov.

CONTINUATION OF COVERAGE

Please check with your employer or plan administrator for eligibility and details.

Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefits provisions in 1986. The law amends the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage that otherwise would be terminated.

The law generally covers group health plans maintained by employers with 20 or more employees in the prior year. It applies to plans in the private sector and those sponsored by state and local governments. The law does not, however, apply to plans sponsored by the Federal government and certain church-related organizations.

Qualifying events for employees are:
- Voluntary or involuntary termination of employment for reasons other than "gross misconduct"
- Reduction in the number of hours of employment

Qualifying events for spouses are:
- Termination of the covered employee's employment for any reason other than "gross misconduct"
- Reduction in the hours worked by the covered employee
- Covered employee's becoming entitled to Medicare
- Divorce or legal separation of the covered employee
- Death of the covered employee

Qualifying events for dependent children are the same as for the spouse with one addition:

- Loss of "dependent child" status under the plan rules

Periods of coverage:

Qualifying Event	Beneficiary	Coverage
• Termination • Reduced hours	Employee Spouse Dependent Child	18 months
• Employee entitled to Medicare • Divorce or legal separation • Death of covered employee	Spouse Dependent Child	36 months
• Loss of "dependent child" status		36 months

Special rules for disabled individuals may extend the maximum periods of coverage. If a qualified beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled at the time of a termination of employment or reduction in hours of employment and the qualified beneficiary properly notifies the plan administrator of the disability determination, the 18-month period is expanded to 29 months.

Qualified beneficiaries have the right to elect to continue coverage that is identical to the coverage provided under the plan. Employers and plan administrators have an obligation to determine the specific rights of beneficiaries with respect to election, notification and type of coverage options. Qualified beneficiaries must be offered benefits identical to those received immediately before qualifying for continuation coverage.

Beneficiaries may be required to pay the entire premium for coverage. It cannot exceed 102 percent of the cost to the plan for similarly situated individuals who have not incurred a qualifying event. Premiums reflect the total cost of group health coverage, including both the portion paid by employees and any portion paid by the employer before the qualifying event, plus two percent for administrative costs.

For disabled beneficiaries receiving and additional 11 months of coverage after the initial 18 months, the premium for those additional months may be increased to 150 percent of the plan's total cost of coverage.

Recent legislation in California provides for continuation of coverage for Federal COBRA beneficiaries enrolled in California health plans. This Cal-COBRA coverage is governed by California law. The idea behind Cal-COBRA's extension of Federal COBRA coverage is to provide California

enrollees who exhaust their COBRA coverage additional coverage under California law, as well as to provide uniformity in its duration.

Other Cal-COBRA is coverage available under California law and applies to employers who have 2 to 19 employees (small group employers). Recent California legislation expands the duration of coverage for these enrollees in Cal-COBRA. The idea of Cal-COBRA is to provide the same general advantages to small groups in California as federal COBRA provides to larger groups.

You may enroll in Cal-COBRA if you are either one of the following and meet certain criteria:

1. An employee of an employer with more than 20 employees (or a dependent of such an employee) and you are continuing coverage after exhausting federal COBRA coverage.

If you are covered under federal COBRA, you exhaust federal COBRA and you had less than 36 months of COBRA coverage, you may have the opportunity to continue coverage for up to a total of 36 months through a combination of COBRA and Cal-COBRA.

This Cal-COBRA extension of Federal COBRA takes effect September 1, 2003, and applies to individuals who begin receiving COBRA coverage on or after January 1, 2003.

When you extend your Federal COBRA coverage under Cal-COBRA, you have the opportunity to receive the same benefits in the same health plan as under COBRA. *However, if you have non-medical coverage under COBRA (dental or vision care) from a specialized health plan, you can not continue this under Cal-COBRA*.

2. An employee of a small employer (2 – 19 employees) (or a dependent of such an employee) and have a "qualifying event".

Qualifying events for Cal-COBRA if you are an employee of an employer with 2 – 19 employees (or the spouse or dependent of such an employee):

- Loss of coverage because employment of the covered employee ends (unless employment ends because of gross misconduct of the employee), or loss of coverage because the hours of the covered employee's employment are reduced
- Loss of coverage because of divorce or legal separation from the covered employee

- Loss of coverage because one is no longer a dependent of the employee under the group plan
- Loss of coverage because the covered employee has become eligible for Medicare
- Loss of coverage because of the death of the covered employee

You are not eligible for Cal-COBRA if you are one of the following:

- Eligible for Medicare
- Covered by another group health plan, when your group plan is with an employer of 2 – 19 employees, unless:
    a. that other group health plan has a pre-existing condition exclusion or limitation that applies to you;
    b. that other group health plan is a group conversion plan (basically the offer of an individual plan) that you choose not to accept.
- Terminated from employment because of gross misconduct
- Someone who fails to timely choose Cal-COBRA in writing when it is available
- Someone who fails to timely pay the required premium for Cal-COBRA
- Someone whose allowed eligibility period has been used up

Anyone covered under Cal-COBRA has the same benefits as active covered employees. *If the group plan offers special coverage, such as dental or vision coverage, that must be provided to the Cal-COBRA enrollee as well, unless you are continuing from federal COBRA as indicated above*.

Duration of coverage if Cal-COBRA coverage began before January 1, 2003:

- If a former employee gets Cal-COBRA coverage because employment ended or because working hours were reduced, Cal-COBRA for the former employee, spouse, and dependents may continue for up to 18 months.
- If the former employee's spouse or dependent gets Cal-COBRA coverage because of any of the following reasons, their coverage may continue for up to 36 months:
    a. death of the former employee
    b. divorce or legal separation from the former employee
    c. the former employee becomes eligible for Medicare
    d. the dependent is no longer considered a dependent under the group plan
- Certain people found eligible for Social Security Disability may be eligible for up to 29 months.

Duration of coverage if Cal-COBRA coverage beginning on or after January 1, 2003:

- If a former employee gets Cal-COBRA coverage because employment ended or because working hours were reduced, Cal-COBRA for the former employee, spouse, and dependents may continue for up to 36 months.
- If the former employee's spouse or dependent gets Cal-COBRA coverage because of any of the following reasons, their coverage may continue for up to 36 months:
    a. death of the former employee
    b. divorce or legal separation from the former employee
    c. the former employee becomes eligible for Medicare
    d. the dependent is no longer considered a dependent under the group plan
- Certain people found eligible for Social Security Disability may be eligible for up to 36 months.

Cal-COBRA ends when:

- The time period stated in the law passes (no more than 36 months)
- Premiums are not paid when due
- The covered person moves outside the health plan's service area
- The employer no longer offers any health coverage to its employees
- The covered person becomes entitled to Medicare
- The covered person enrolls in another group policy

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.

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 Dentist, 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 Dentist 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.
Limitations

1. Prophylaxes are covered once every six consecutive months.
2. Full Mouth X-rays are limited to once every 36 consecutive months.
3. Fluoride Treatments are covered once every 6 consecutive months, up to the 18th birthday.
4. Sealants are covered only on the first and second permanent molars and up to the 14th birthday.
5. Crowns, Jackets, Inlays and Onlays are benefits on the same tooth only once every five years, and consistent with professionally recognized standards of dental practice.
6. Replacement of existing Full and Partial Dentures are covered once per arch every 5 years, except when they cannot be made functional through reline or repairs.
7. Denture Relines are covered twice per year, and only when consistent with professionally recognized standards of dental practice.
8. Any routine dental services performed by a Primary Care Dentist or Specialist in an inpatient/outpatient hospital setting, under certain circumstances, will be considered for coverage.

LIBERTY Dental Plan of California, Inc.
Exclusions

1. Any procedure not specifically listed as a Covered Benefit.
2. Replacement of lost or stolen prosthetics or appliances including crowns, bridges, partial dentures, full dentures, and orthodontic appliances.
3. Any treatment requested, or appliances made, which are either not necessary for maintaining or improving dental health, or are for cosmetic purposes unless otherwise covered as a benefit.
4. Procedures considered experimental, treatment involving implants or pharmacological regimens (see "Independent Medical Review" on Page 7).
5. Oral surgery requiring the setting of bone fractures or bone dislocations.
6. Hospitalization.
7. Out-patient services.
8. Ambulance services.
9. Durable Medical Equipment.
10. Mental Health services.
11. Chemical Dependency services.
12. Home Health services.
13. General anesthesia, analgesia, intravenous/intramuscular sedation or the services of an anesthesiologist.
14. Treatment started before the member was eligible, or after the member was no longer eligible.
15. Procedures, appliances, or restorations to correct congenital, developmental or medically induced dental disorder, including but not limited to: myofunctional (e.g. speech therapy), myoskeletal, or temporomandibular joint dysfunctions (e.g. adjustments/corrections to the facial bones) unless otherwise covered as an orthodontic benefit.
16. Procedures which are determined not to be dentally necessary consistent with professionally recognized standards of dental practice.
17. Treatment of malignancies, cysts, or neoplasms.
18. Orthodontic treatment started prior to member's effective date of coverage.
19. Appliances needed to increase vertical dimension or restore occlusion.
20. Any services performed outside of your assigned dental office, unless expressly authorized by LIBERTY Dental Plan, or unless as outlined and covered in "Emergency Dental Care" section.

1. Lost, stolen or broken appliances.
2. Extractions for orthodontic purposes (will not be applied if extraction is consistent with professionally recognized standards of dental practice or arises in the context of an emergency dental condition).
3. Temporomandibular joint syndrome (TMJ) surgical orthodontics.
4. Myofunctional therapy.
5. Treatment of cleft palate.
6. Treatment of micrognathia.
7. Treatment of macroglossia.

DEFINITIONS

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.

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.

Group (or Organization): Employer group or other entity which has contracted with LIBERTY Dental Plan to arrange for the provision of the benefits of this Plan.

Member: Subscriber or eligible dependent(s) who are actually enrolled in the Plan.

Non-Participating Provider: A dentist that has no contract to provide services for the Plan

Primary Care Dentist: A dentist affiliated with the Plan to provide services to covered members of the Plan. The Primary Care Dentist is responsible to provide or arrange for needed dental services.

Provider: A dentist providing services under contract with the Plan.

Plan: LIBERTY Dental Plan of California, Inc.

Specialist: Refers to Endodontists, Oral Surgeons, Orthodontists, Pediatric Dentists or Periodontists.

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

ANSWERS TO COMMON QUESTIONS

Are my cleanings covered?
Yes. LIBERTY Dental Plan covers routine cleanings (prophylaxis) at your selected dental office once every 6 months. Some members may require more than a "routine" cleaning due to more involved dental needs. When more frequent cleanings or extensive treatment, such as root planing or scaling are required, your dentist may charge you in accordance with your dental plan.

What if I have a pre-existing condition?
Most pre-existing conditions are covered. However, a procedure started prior to your coverage effective date will not be covered by the Plan.

Are there waiting periods to be met?
No. Once your enrollment become effective, simply make an appointment with your selected network dentist.

Does the Plan include dental specialists?
Yes. LIBERTY Dental Plan has a contracted network of Dental Specialists. If specialty is deemed necessary by your Primary Care Dentist, you will be referred to a specialist after coordinating your needs with your Primary Care Dentist.

What if I have other dental coverage?
Your LIBERTY Dental Plan network Primary Care Dentist will apply your reimbursement from any additional coverage you have to your co-payment if

allowable by your other dental plan carrier. This may reduce your out-of-pocket costs.

How will I know what my co-payment will be?
Refer to your Schedule of Benefits which lists all of the services covered under your plan. The co-payment schedule is listed by ADA code. If you have any questions, ask your dentist before you receive services and/or call the LIBERTY Dental Plan Member Services Department.

Who do I call if I have a question?
If you have a question about enrollment, talk to your Benefits Manager. Should you have questions once you become a member, contact our Member Services Department.

LIBERTY Dental Plan of California, Inc.

P.O. Box 26110

Santa Ana, CA 92799-6110

(888) 703-6999

NEW MEMBER CONTINUATION OF CARE INFORMATION AND PRIVACY STATEMENT

Dear New LIBERTY Dental Plan Member:

If you have been receiving care from a dental care provider, you may have a right to keep your dental care provider for a designated time period. Please contact LIBERTY Dental Plan's Member Services Department at (888) 703-6999, and if you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers. You can contact the Department of Managed Health Care by telephone at its toll-free number (888) HMO-2219, or at a TDD number for the hearing impaired at (877) 688-9891, or online at www.hmohelp.ca.gov. You may also obtain a copy of LIBERTY Dental Plan's policy on continuation of care from our Member Services Department. This policy does not apply to a newly covered enrollee covered under an individual subscriber agreement.

You must make a specific request to continue under the care of your current provider. LIBERTY Dental Plan is not required to continue your care with that provider if you are not eligible under our policy or if we cannot reach an agreement with your provider on the terms regarding your care in accordance with California law.

Privacy Statement

We protect the privacy of our members' health information as required by law, accreditation standards and our internal policies and procedures. This Notice explains our legal duties and your rights as well as our privacy practices.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We collect, use and disclose information provided by and about you for health care/dental payment and operations, or when we are otherwise permitted or required by law to do so.

For Payment: We may use and disclose information about you in managing your account or benefits, and paying claims for medical/dental care you receive through your plan. For example, we maintain information about your premium and deductible payments. We may also provide information to a doctor/dentist's office to confirm your eligibility for benefits or we may ask a doctor/dentist for details about your treatment so that we may review and pay the claims for your dental care.

For Health/Dental Care Operations: We may use and disclose medical/dental information about you for our operations. For example, we may use information about you to review the quality of care and services you receive, or to evaluate a treatment plan that is being proposed for you.

We may contact you to provide information about treatment alternatives or other health-related benefits and services. For example, when you or your dependents reach a certain age, we may notify you about additional programs or products for which you may become eligible, such as individual coverage.

We may, in the case of some group health plans, share limited health information with your employer or other organizations that help pay for your membership in the plan, in order to enroll you, or to permit the plan sponsor to perform plan administrative functions. Plan sponsors receiving this information are required, by law, to have safeguards in place to protect it from inappropriate uses.

As Permitted or Required by Law: Information about you may be used or disclosed to regulatory agencies, such as during audits, licensure or other proceedings; for administrative or judicial proceedings; to public health authorities; or to law enforcement officials, such as to comply with a court order or subpoena.

Authorization: Other uses and disclosures of protected health information will be made only with your written permission, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing. We will then stop using your information. However, if we have already used your information based on your authorization, you cannot take back your agreement for those past situations.

Your Rights

Under new regulations that will be effective in April 2003, you will have additional rights over your health/dental information. Under the new rules, you will have the right to:

- Request restrictions on certain uses and disclosures of your protected health/dental information. However, we are not required to agree to a requested restriction.
- Receive confidential communications of protected health/dental information, using reasonable alternative means or at an alternative address, if communications to your home address could endanger you.
- Inspect and copy protected health/dental information. To obtain a copy of such information, please send us a written request. You also have the right to amend the information if you believe it is incomplete or inaccurate. If we did not create the information, we will refer you to the source, such as your doctor/dentist.
- Receive an accounting of our disclosures of your medical information, except when those disclosures are made for treatment, payment or health care/dental operations, or the law otherwise restricts the accounting. We are not required to give you a list of disclosures made before April 14, 2003.
- If you have agreed to receive this notice electronically, you are still entitled to a paper copy upon request.

Complaints

If you believe your privacy rights have been violated, you have the right to file a complaint with us, and/or with the Federal Government. You will not be penalized for filing a complaint.

Copies and Changes

You have the right to receive an additional copy of this notice at any time.

We reserve the right to change the terms of this notice. A revised notice will be effective for information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever privacy notice is currently in effect. We will communicate any changes to our notice through subscriber newsletters, direct mail or our website, www.libertydentalplan.com.

Contact Information

If you want to exercise your rights under this notice, or if you wish to communicate with us about privacy issues, or to file a complaint with us, please contact our Member Services Department at (888) 703-6999.