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

This EOC contains information for Enrollees covered by small group COVERED CALIFORNIA "Small Business Exchange" plans including "LIBERTY Dental Plan Family Dental HMO" plans and commercial.

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 at no cost to You. To ask for language services call 1-888-844-3344. Make sure to notify your provider (Dentist) of Your personal language needs upon your initial dental visit.

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 sin ningún costo a usted. 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 LIBERTY'S 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

THIS BENEFITS 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.

LIBERTY Dental Plan Family Dental HMO			
Copay Plan			
Member Cost Share amounts describe the Enrollee's out-of-pocket costs.			
	Benefit Type	**Pediatric Dental EHB**	**Adult Dental**
	Age	**Up to Age 19**	**Age 19 and Older**
	Actuarial Value	84.80%	Not Calculated
	Network Type	**In-Network**	**In-Network**
	Individual Deductible	None	None
	Family Deductible (Two or more children)	Not applicable	Not Applicable
	Individual Out of Pocket Maximum	$350	Not Applicable
	Family Out-of-Pocket Maximum (Two or More Children)	$700	Not Applicable
	Office Copay	$0	$0
	Waiting Period	None	None
	Annual Benefit Limit (the maximum amount the dental plan will pay in the benefit year)	None	None
Procedure Category	**Service Type**	**Member Cost Share**	**Member Cost Share**
Diagnostic & Preventive	Oral Exam	No Charge	No Charge if Covered
	Preventive - Cleaning	No Charge	No Charge if Covered
	Preventive - X-ray	No Charge	No Charge if Covered
	Sealants per Tooth	No Charge	No Charge if Covered
	Topical Fluoride Application	No Charge	No Charge if Covered
	Space Maintainers - Fixed	No Charge	No Charge if Covered
Basic Services	Restorative Procedures	$25-$70	$25-$70
	Periodontal Maintenance	$30	$30
Major Services	Periodontics (other than maintenance)	$10-$350	$10-$220
	Endodontics	$20-$365	$20-$365
	Crowns and Casts	$20-$310	$20-$310
	Prosthodontics	$35-$350	$35-$400
	Oral Surgery	$40-$350	$35-$280
Orthodontia	Medically Necessary Orthodontia	$350	Not Covered

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 Appendix I of the Combined Evidence of Coverage.

OVERVIEW OF YOUR DENTAL BENEFIT PLAN

A. HOW TO USE YOUR LIBERTY DENTAL PLAN

This booklet is Your Evidence of Coverage (EOC). It explains what LIBERTY covers and does not cover. Also read Your Schedule of Benefits, which lists co-pays and other fees. 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

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 includes General Dentists and Specialists with which LIBERTY has contracted to provide Covered Services to Members under the Benefit Plan. To use Your Benefits, Covered Services must be performed by Your Primary Care Dentist and other Participating Providers. Call 888-844-3344 to ask for a LIBERTY Provider Directory or use the website.

If You are unable to access a Contracting Dentist in a reasonable time period or location, for medically necessary care, You may contact Member Services for assistance in finding another Provider, or to make special arrangements to access care from a Non-Participating Provider. In such cases, You are financially responsible only for the listed copayments for covered services. You would also be financially responsible for the provider's usual fee for any non-covered, elective services, or for services not deemed to be medically necessary upon review by LIBERTY.

If You go a Non-Participating Provider, You will have to pay all the cost, unless You received pre-approval from LIBERTY or You require Emergency/Urgent Care or Out-of-Area Urgent Care. 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 10).*

E. YOUR PRIMARY CARE DENTIST (see Access to Services on page 7)

When You join LIBERTY, in most cases You need to choose a Primary Care Dentist 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 Dentist. Your Primary Care Dentist 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 products that do not require office assignment:** Some LIBERTY plans do not require You to choose and be assigned to a Primary Care Dentist. On those plans, You may access services from any contracted Primary Care Dentist 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 Dentist.

F. LANGUAGE AND COMMUNICATION ASSISTANCE (see page *21*)

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 completing an online survey at https://www.libertydentalplan.com/Members/Member-Language-Survey.aspx or calling 888-844-3344. Make sure to notify your provider (Dentist) of Your personal language needs upon your initial dental visit.

G. HOW TO GET DENTAL CARE WHEN YOU NEED IT

Call Your Primary Care Dentist 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 Dentist. See the next section titled Referrals and Pre-Authorizations.

- The care must be Medically Necessary for Your health. Your dentist and LIBERTY follow guidelines and policies to decide if the care is Medically Necesary. 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 19).
- The care must be a service that LIBERTY covers. Covered 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. TIMELY ACCESS TO CARE

You are entitled to schedule an appointment with Your Primary Care Dentist within a reasonable time that is appropriate to Your condition:

- Urgent appointments should be scheduled within 72 hours. Discuss Your individual needs with Your Primary Care Dentist to determine how soon You can be seen (See *page* 8)
- Non-Urgent Appointments should be offered within 36 business days.
- Preventive dental care appointments should be offered within 40 business days.

If for any reason You are unable to schedule an appointment within these timeframes, please call the Member Services Department at 1-888-844-3344 for assistance.

LIBERTY provides language assistance services at all points of contact, including at Your dental appointment. If your Primary Care Dentist or Specialist, or their office staff, cannot communicate with You in Your language, LIBERTY can arrange for interpretation services at Your appointment at no cost to You. LIBERTY makes these services available to You even if You are accompanied at Your appointment by a family member or friend that can assist with interpretation. Please contact LIBERTY's Member Services Department at 1-888-844-3344 to arrange these services as far in advance of Your appointment time as possible.

I. REFERRALS AND PRE-AUTHORIZATIONS (SEE PAGE 9)

You need a referral from Your Primary Care Dentist and pre-approval from LIBERTY for services to be provided by a Specialist or to receive a second opinion or to see a dentist who is not in LIBERTY's network. Pre-approval is also called Pre-Authorization.

- Make sure Your Primary Care Dentist 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 Dentist, or to get Emergency Care or Urgent Care.

J. EMERGENCY CARE (SEE PAGE *8*)

Emergency Care is a Covered Service, regardless of whether the care was rendered within the Service Area. A condition may be considered an emergency if, without treatment, Your health may be in serious jeopardy, You may experience serious impairment to bodily functions or serious dysfunction of any bodily organ or part. Emergency Care may include care for a bad injury, severe pain, or a sudden serious mental illness. Emergency Care may include care for a bad injury, severe pain, or a sudden serious dental illness. If You receive Emergency Care, go to your Primary Care Dentist for follow-up care. Do not return to the emergency room for follow-up care.

K. URGENT CARE (see page *8*)

Urgent Care is care that You need soon to prevent a serious health problem. Urgent Care is a Covered Service, regardless of whether care is rendered within the Service Area.

L. CARE WHEN YOU ARE OUT OF THE LIBERTY SERVICE AREA (see page *8*)

Only Emergency and Urgent Care is covered outside of the LIBERTY Service Area.

M. 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-payment is the amount that You must pay to the Provider for a particular covered procedure.
- **For Covered California**: The yearly Out-of-Pocket Maximum is the maximum amount of money that a covered Pediatric Enrollee can pay in co-pays for all allowable expenses, including orthodontic copayments, in any Plan Year. A single Pediatric Enrollee will have an out-of-pocket maximum of $350. A family with two (2) or more Pediatric Enrollees will have a combined Out-of-Pocket Maximum of $700. Once the amount paid by all Pediatric Enrollee(s) equals the Out-of-Pocket Maximum shown on the Schedule of Benefits, no further payment will be required by any of the Pediatric Enrollee(s) for the remainder of the Calendar Year for covered services. Adult benefits are not subject to Out-of-Pocket Maximums..
    - There may be other costs incurred for optional, non-covered and upgraded material services that do not apply toward Out-of-Pocket maximums.
    - Out-of-Pocket Maximums applys 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 or call LIBERTY's Member Services 888-844-3344 (toll-free). After.

N. IF YOU HAVE A COMPLAINT ABOUT YOUR LIBERTY DENTAL PLAN (see page 17)
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:

Appeal: A request made to LIBERTY by a member, a provider acting on behalf of a member, or other authorized designee to review an action by the Plan to delay, modify or deny services.

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

Benefits: Services covered by Your LIBERTY Dental Plan.

Benefit Plan or Dental 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 Contracting General Dentist 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.

Contracting General Dentist: A General 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.

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.

Emergency Care / Emergency Dental Service: Emergency Dental Service and care include (and are covered by LIBERTY Dental Plan) dental screening, examination, evaluation by a Dentist or dental Specialist to determine if an emergency dental condition exists. A condition may be considered an emergency if, without treatment, Your health may be in serious jeopardy, You may experience serious impairment to bodily functions or serious dysfunction of any bodily organ or part. 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.

Enrollee: see "Member".

EPDB or Essential Pediatric Dental Benefit: Refers to plans mandated 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.

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

Medical Necessity or Medically **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 Medical Necessity prior to or after rendering. Payment for services occurs for Covered Services that are deemed Medically Necessary by the Plan.

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 Dentist.

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 Dentist.

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.

Participating Dental Group, Dental Office, or Provider: A dental facility and its dentists that are under contract to provide services to LIBERTY Members in accordance with LIBERTY's rules and regulations.

Plan: LIBERTY Dental Plan of California, Inc.

Pre-Authorization: A document submitted on Your behalf requesting an advance determination and approval to render desired treatment services for you.

Premium: The fee paid to LIBERTY for this Benefit Plan.

Primary Care Dentist: Normally, a General Dentist affiliated with LIBERTY to provide services to covered Members of the Plan. The Primary Care Dentist is responsible for providing or arranging for needed dental services.

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

Provider: A contracted dentist providing services under contract with the 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: Care that You need soon to prevent a serious health problem.

Usual Charges: A dentist's usual charge for a service

You: pertains to Members who are the beneficiary of this Dental Plan.

III. ACCESS TO SERVICES – SEEING A DENTIST

LIBERTY Dental Plan contracts with General Dentists and Specialists to provide services covered by Your Plan. Your Primary Care Dentist will provide for all of Your dental care needs, including referring You to a Specialist, should it be necessary. All services and Benefits described in this publication are covered only if provided by a contracted 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" or "Urgent Care."

LIBERTY makes available Primary Care Dentists (General Dentists) and Specialists throughout the state of California within a reasonable distance from Your home or workplace. Most Enrollees should have a residence or workplace within thirty (30) minutes or fifteen (15) miles of a Primary Care Dental office. Contact LIBERTY toll-free at **888-844-3344** or via website at **www.LIBERTYdentalplan.com** to find a dentist in Your area.

A. FACILITIES

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 private practice dentists must meet LIBERTY's credentialing criteria, prior to joining our network. 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.

B. DENTAL HEALTH EDUCATION

For further information on using Your dental Benefits, please see the website at 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 under Exception, when You join LIBERTY Dental Plan, You must choose a Primary Care Dentist to which You will be assigned. Your assigned Primary Care Dentist is responsible for coordinating any specialty care dental services You might need. You must obtain general dental services from Your assigned Primary Care Dentist. Your assigned Primary Care Dentist will share information with any Specialist to coordinate Your overall care.

Unless otherwise noted in the Exception below, if You do not select a Primary Care Dentist, 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 products that do not require office assignment: 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 Dentist 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 Dentist, or if You may access services from any contracted Primary Care Dentist 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 Dentist.

2. Changing Primary Care Dentists: You may contact LIBERTY at any time to change Your Primary Care Dentist. 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 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. 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 Dentist to LIBERTY for approval. You may only receive services from a dental Specialist that has been Pre-Authorized for You by LIBERTY. Your Specialist will submit a Pre-Authorization for services to LIBERTY for Pre-Authorization.

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. Services received by a Non-Participating Provider are not covered. The only time You may receive care outside the network is for Emergency Dental Services as described herein under "Emergency Dental Care".

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 Primary Care Dentist 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 We determine that Your treatment was not due to a dental emergency, the services rendered by a Non-Participating Provider will not be covered.

E. EMERGENCY DENTAL CARE

All affiliated Primary Care Providers provide availability of Emergency Dental Services twenty-four (24) hours per day, seven (7) days per week. The Dental Plan provides coverage for Emergency Dental Services if, without treatment, Your health may be in serious jeopardy, You may experience serious impairment to bodily functions or serious dysfunction of any bodily organ or part. Emergency Care may include care for a bad injury, severe pain, or a sudden serious dental illness. You may also wish to consider contacting the "911" emergency response system.

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 Your Primary Care Dentist 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. You should notify LIBERTY as soon as possible after receipt of Emergency Dental Services, preferably within 48 hours. If it is determined that Your treatment was not due to a dental emergency, the services of any Non-Participating Provider 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 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/clinic setting and emergency department in a hospital. Emergency medical services may be an allowable benefit, in accordance with the schedule of benefits. LIBERTY shall provide benefits for such emergency dental services and shall ensure the availability of a provider in the event that an on-call network provider is unavailable in a dental setting or hospital.LIBERTY does not cover services that LIBERTY determines 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 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 Dental Services.
- Name and address of the dentist providing the Emergency Dental 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, 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 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 processed by LIBERTY Dental Plan within five (5) business days of receipt of the request, or 72 hours of receipt 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. 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 Pre-Authorization. Your Primary Care Dentist 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 GRIEVANCE PROCEDURES below.

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

Any Specialty services deemed necessary and pre-approved by LIBERTY as medical necessary services are for the treatment prescribed by the Specialist that proposed the treatment. Treatment plans are not transferrable to another Specialist unless the subsequent Specialist agrees with the treatment proposed by the prior Specialist.

If You are unable to access in-network Specialty services in a reasonable time period or location (as determined by published access requirement), You may contact Member Services for assistance in finding another in-network Specialist, or to make arrangements to access care from an out-of-network Specialist. All Specialty care must be pre-approved for coverage determination, medical necessity and/or appropriateness to the presenting conditions. In such cases, You would be financially responsible only for the listed copayment for covered services. You would also be financially responsible for the provider's usual fee for any non-covered, elective services, or for services not deemed to be medically necessary upon review by LIBERTY.

H. AUTHORIZATION, MODIFICATION OR DENIAL OF SERVICES

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.

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

Specialty services proposed by any Specialist to whom You are referred must be Pre-Authorized before rendering care, except for Emergency Dental 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 be provided in writing and 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 file an Appeal.

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 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, based on the nature of the urgent or emergent condition.

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 (services already provided), the decision shall be communicated to You in writing 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 at no cost to You. To ask for language assistance services call 888-844-3344. Make sure to notify your provider (Dentist) of Your personal language needs upon your initial dental visit.

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.

Covered California: Premium payments are paid directly to Covered California by Your employer or group.

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.

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 from time to time. 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. To avoid any financial misunderstandings, 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 appointments. Charges are as agreed upon mutually by You and Your Provider as per business arrangements and disclosures made by 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 Provider;
- 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 Dentist by LIBERTY. In the event that LIBERTY fails to pay a Non-Participating Provider, You may be liable to the Non-Participating 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 LIBERTY Dental Plan, P.O. Box 26110, Santa Ana, CA, 92799-6110.

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. You are eligible to receive care upon Your effective date provided by Your employer or group. 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. 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 or work in the plan Service Area. An enrolled Dependent child who reaches age 26 during a benefit year may remain enrolled as a dependent until the end of that benefit year. The dependent coverage shall end on the last day of the benefit year during which the Dependent child becomes ineligible, unless both of the following are true:

- The dependent is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition; AND
- The dependent is chiefly dependent upon the subscriber for support and maintenance.

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 or work 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.
- Your Dependent children (including adopted) who are under the age of twenty-six (26). *Please note:* An enrolled Dependent child who reaches age 26 shall have their coverage end on the last day of the birthday month during which the Dependent child becomes ineligible, unless both of the following are true:
    - The dependent is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition; AND
    - The dependent is chiefly dependent upon the subscriber for support and maintenance;

  If You wish to continue coverage for Your dependent who qualifies, You will be asked to submit supporting documentation.
- 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 Schedule of Benefits (Appendix 1) for a detailed listing of specific Covered Services and the Co-payments applicable to each, and a list of the Limitations and Exclusions that are applicable to all dental services covered under Your LIBERTY Dental Plan.

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 Appendix 1, 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 Appendix 1, 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.

You are covered for the Restorative dental services listed in Appendix 1, 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 Endodontic dental services listed in Appendix 1, 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 Appendix 1, 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 Appendix 1, 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 Appendix 1, 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 Appendix 1, 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. See Appendix 1 for a list of any covered orthodontic services provided in Your Benefit Plan, and any pertinent 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 services from a Specialist.

VII. LIMITATIONS, EXCLUSIONS, EXCEPTIONS, REDUCTIONS

See Appendix 1 for limitations to covered procedures and exclusions to your plan 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 Emergency or Urgent 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.
- IMPORTANT: If You opt to receive dental services that are not covered services under this plan, a Contracting Dentist may charge You his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If You would like more information about dental coverage options, call Member Services at (888) 844-3344 or speak with Your Benefits Administrator. To fully understand Your coverage, carefully review this Evidence of Coverage.

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.

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 Dentist 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 and 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 is 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 15 days following the date of notification of termination, except in the event of fraud or deception as stated above, in which case termination is effective immediately upon notification.

C. DISENROLLMENT

You may disenroll at any time from the plan with reasonable notice of at least fourteen (14) days by contacting Covered California or LIBERTY Dental Plan by phone or in writing. Disenrollment is effective on the date specified or fourteen (14) days after termination is requested, if reasonable notice is not provided.

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 if You intentionally submitted incomplete or incorrect material information in Your enrollment application that would have affected our decision to accept You as a covered Member. 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 on 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.

II. 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.

i. **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 dies

   You 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

ii. **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.

iii. **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.

iv. **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.

X. GRIEVANCE PROCEDURES

If You are dissatisfied with Your selected Primary Care Dentist, 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, or by asking Your primary care dentist. 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 Quality Management Department facsimile at (949) 270-0109, or
- Submitted verbally to: LIBERTY Dental Plan's Member Services Department at LIBERTY's toll-free number: (888) 844-3344, or
- Submitted using our website online Grievance filing process by visiting 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 Primary Care Dentist 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 that You can 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 (DMHC) 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 DMHC 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 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 review and determine if Your case meets the expedite criteria for processing of this urgent condition. In the event Your case meets the expedited criteria, LIBERTY will resolve to the urgent condition within three (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 reconsideration 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
Attn: Grievance and Appeals
P.O. Box 26110
Santa Ana, CA 92799-6110

Any additional information will be processed as a new Grievance.

Your Right to File an Appeal:

If You are not satisfied with LIBERTY's determination, You have up to 180 days from the date listed on the notice of determination to file an appeal. An appeal allows You to submit additional information that is relevant to Your claim and ask that LIBERTY review it.

You may include documents, records, or other written information with Your appeal. You may also request, free of charge, copies of all documents, records and other information from LIBERTY that are relevant to Your claim. LIBERTY will review the information that You submit and will reconsider Your claim. As part of Your appeal, You may request from LIBERTY the name of any medical expert or other individual that LIBERTY sought advice from while reconsidering Your claim.

You may send Your written grievance to:

LIBERTY Dental Plan
Attn: Grievances and Appeals
Quality Management Department
P.O. Box 26110, Santa Ana, CA 92799-6110
Fax: 949-270-0109

Or You may contact LIBERTY's Member Services Department by telephone at (877) 877-1893, or by fax at (888) 334-6034, in order to initiate the appeal process.

If Your situation meets the definition of urgent under the law, LIBERTY's review of Your appeal will be conducted as expeditiously as possible. Generally, an urgent situation is one in which Your health may be in serious jeopardy or, in the opinion of Your physician, You may experience pain that cannot be adequately controlled while You wait for a decision on the external review of Your claim. If You believe Your situation is urgent, You may request an expedited external review by contacting LIBERTY's Member Services Department by telephone at (877) 877-1893.

You may submit Your grievance for arbitration, which will allow a neutral arbiter to review Your situation and determine whether LIBERTY is responsible for any further services or payments. You may contact LIBERTY's Member Services Department by telephone at (877) 877-1893 in order to initiate the arbitration process. You also have the right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act in response to an unsuccessful 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.

XI. MISCELLANEOUS PROVISIONS

A. COORDINATION OF BENEFITS

As a covered Member, You will always receive Your LIBERTY Benefits. However, if You have coverage under a plan or policy from any Qualified Health Plan that provides the Pediatric Dental Essential Health Benefit, Your coverage under this Plan is a secondary dental benefit. In such case, this Plan shall pay the lesser of either the amount that it would have paid in the absence of any other dental benefit coverage, or the total out-of-pocket cost that is payable under Your primary dental benefit plan for benefits covered under this Plan. If You do not have coverage under a plan or policy from a Qualified Health Plan that provides the Pediatric Dental Essential Health Benefit, Your coverage under this Plan is considered to be Your primary dental coverage and You are entitled to receive Benefits as listed in this EOC document despite any other coverage You might have in addition to this coverage.

B. THIRD PARTY LIABILITY

If services otherwise covered by virtue of this 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.

D. NON DISCRIMINATION

Discrimination is against the law. LIBERTY complies with all applicable Federal civil rights laws and does not discriminate, exclude people or treat them differently based on race, color, national origin, age, disability, or sex. LIBERTY provides free aids and services to people with disabilities, and free language services to people whose primary language is not English, such as:

- Qualified interpreters, including sign language interpreters
- Written information in other languages and formats, including large print, audio, accessible electronic formats, etc.

If You need these services, please contact us at (888) 844-3344. If You believe LIBERTY has failed to provide these services or has discriminated based on race, color, national origin, age, disability, or sex, You can file a grievance with LIBERTY's Civil Rights Coordinator:

- **Phone: (888) 704-9833**
- **TTY: (800) 735-2929**
- **Fax: (888) 273-2718**
- **Email: compliance@libertydentalplan.com**
- **Online: https://www.libertydentalplan.com/About-LIBERTY-Dental/Compliance/Contact-Compliance.aspx**

If You need help filing a grievance, LIBERTY's Civil Rights Coordinator is available to help You. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TDD) / Online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

E. 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 Dentist who submits claims or encounters on Your behalf. Services provided by a Specialist 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).

F. 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/

G. LANGUAGE ASSISTANCE

Interpretation and translation services may be available for Members with limited English proficiency, including translation of documents into certain threshold languages at no cost to You. Please see Appendix 3 for more information on how to obtain language assistance services.

H. 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.

I. 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 a complaint and be informed of the Grievance process;
- Have access and availability to care;
- Have access to language assistance services;
- 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.

J. MEMBER RESPONSIBILITIES

As a Member, You have the responsibility to:

- Pay the Premium for Your coverage on time;
- 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 your Primary Care Dentist of Your personal language needs;
- Notify LIBERTY Dental Plan of changes in family status; and
- Be aware of and follow the organization's guidelines in seeking dental care.

K. FISCAL SEPARATION OF DECISION MAKING

It is LIBERTY's policy that all clinical review decisions made by staff and or contractors are based solely on appropriateness of care and services and the existence of coverage. LIBERTY does not reward or incentivize reviewers for issuing denials for coverage or care, nor provide incentives that would encourage decisions that result in underutilization.

LIBERTY's Utilization Management staff annually signs an attestation that review decisions were made based solely on appropriateness of care and services and existence of coverage.

XII. COMPLIANCE PLAN

A. COMPLIANCE PLAN OBJECTIVE:

LIBERTY Dental Plan is dedicated to ensuring that it complies with all applicable Federal and state laws, rules, regulations and procedures, including Health Insurance Marketplace requirements, in a timely and effective manner. All LIBERTY Dental Plan Board Members, officers, employees, contractors, providers and members are expected to meet these various legal requirements. For these reasons, LIBERTY Dental Plan has developed and instituted a Corporate Compliance Plan. The Plan is designed to ensure LIBERTY Dental Plan fulfills all statutory and contractual obligations in a fair, accurate and consistent manner.

The compliance plan not only addresses health care fraud, waste and abuse, but the requirements and obligations set forth by the Centers for Medicare and Medicaid (CMS), employment, whistleblower and insurance laws.

B. DEFINITIONS:

Fraud – includes, but is not limited to, "knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit." Fraud also includes fraud or misrepresentation by a subscriber or enrollee with respect to coverage of individuals and fraud or deception in the use of the services or facilities of LIBERTY or knowingly permitting such fraud or deception by another.

Waste – means the thoughtless or careless expenditure, consumption, mismanagement, use, or squandering of resources. Waste also includes incurring unnecessary costs because of inefficient or ineffective practices, systems, or controls. Waste does not normally lead to an allegation of "fraud", but it could.

Abuse – means the excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive use so to abuse one's position or authority. "Abuse" does not necessarily lead to an allegation of "fraud", but it could.

C. POLICY:

It is the policy of LIBERTY to review and investigate all allegations of fraud, waste, and abuse, whether internal or external, to take corrective action for any supported allegation and to report confirmed misconduct to the appropriate parties both internal and external.

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.

- LIBERTY'S Corporate Compliance Hotline: (888) 704-9833
- LIBERTY'S Compliance Unit email: compliance@libertydentalplan.com
- LIBERTY'S Special Investigations Unit Hotline: (888) 704-9833
- LIBERTY'S Special Investigations Unit email: SIU@libertydentalplan.com

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.

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

Appendix 3:
NOTICE OF LANGUAGE ASSISTANCE SERVICES

Discrimination is against the law. LIBERTY Dental Plan ("LIBERTY") follows State and Federal civil rights laws. LIBERTY does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

LIBERTY provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - ✓ Qualified sign language interpreters
  - ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - ✓ Qualified interpreters
  - ✓ Information written in other languages

If you need these services, please contact us between 8 a.m. to 5 p.m (PST) by calling (888) 844-3344. Or, if you cannot hear or speak well, please call (800) 735-2929

HOW TO FILE A GRIEVANCE

If you believe that LIBERTY has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with LIBERTY's Civil Rights Coordinator. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact LIBERTY's Civil Rights Coordinator, Monday through Friday, 8 a.m to 5 p.m (PST) by calling 888-704-9833. Or if you cannot hear or speak well, please call (800) 735-2929.
- In writing: Fill out a complaint form or write a letter and send it to:
  P.O. Box 26110
  Santa Ana, CA 92799
- In person: Visit your doctor's office or LIBERTY Dental Plan and say you want to file a grievance.
- Electronically: Visit LIBERTY Dental Plan website at https://www.libertydentalplan.com.

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- By phone: Call **916-440-7370**. If you cannot speak or hear well, please call **711 (Telecommunications Relay Service)**.
- In writing: Fill out a complaint form or send a letter to:

  Michele Villados
  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Complaint forms are available at http://www.dhcs.ca.gov/Pages/Language_Access.aspx.
- Electronically: Send an email to CivilRights@dhcs.ca.gov.

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.
- In writing: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

LIBERTY's HIPAA Privacy Notice provides you with information about your rights and our legal duties and privacy practices with respect to Protected Health Information (PHI), including how we use and disclose your PHI. You can always request a written copy of our most current privacy notice from LIBERTY's Privacy Officer by calling 888.704.9833, or online at: www.libertydentalplan.com/HIPAA-Privacy-Notice.

LIBERTY DENTAL PLAN

Notice of Language Assistance

IMPORTANT: You can get an interpreter at no cost to talk to your doctor or health plan. To get an interpreter or to request written information (in your language or in a different format, such as Braille or larger font), first call your health plan's phone number at 1-888-844-3344. Someone who speaks (your language) can help you. If you need more help, call the HMO Help Center at 1-888-466-2219.

IMPORTANTE: Puede obtener la ayuda de un intérprete sin costo alguno para hablar con su médico o con su plan de salud. Para obtener la ayuda de un intérprete o pedir información escrita (en su idioma o en algún formato diferente, como Braille o tipo de letra más grande), primero llame al número de teléfono de su plan de salud al 1-888-844-3344. Alguien que habla español puede ayudarle. Si necesita ayuda adicional, llame al Centro de ayuda de HMO al 1-888-466-2219. (Spanish)

重要提示： 您與您的醫生或保健計劃工作人員交談時，可獲得免費口譯服務。如需口譯員服務或索取（用給您的語言或布萊葉盲文或大字體等不同格式提供的）書面資料，請先打電話給您的保健計劃，電話號碼 1-888-844-3344。會講（您的語言）的人士將為您提供協助。 如需更多協助，請打電話給 HMO 協助中心，電話號碼 1-888-466-2219。 (Cantonese or Mandarin)

هام: يمكنك الحصول على خدمات مترجم فوري مجاناً للتحدث مع طبيبك أو خطتك الصحية. للحصول على مترجم فوري أو لطلب معلومات مكتوبة (بلغتك أو بصيغة أخرى، مثل طريقة برايل أو بخط كبير)، اتصل أولاً برقم هاتف الخطة الصحية على 1-888-844-3344. سيساعدك شخص ما يتحدث (نفس لغتك). إذا كنت تريد المزيد من المساعدة، اتصل بمركز مساعدة HMO على الرقم 1-888-466-2219. (Arabic)

ԿԱՐԵՎՈՐ ՏԵՂԵԿՈՒԹՅՈՒՆ. Դուք կարող եք խոսել Ձեր բժշկի կամ առողջապահական ծրագրի հետ՝ օգտվելով թարգմանչի ծառայություններից առանց որևէ վճարի: Թարգմանիչ ունենալու կամ գրավոր տեղեկություն խնդրելու համար (հայերենով կամ մեկ այլ ձևաչափով, օրինակ՝ Բրայլը կամ մեծ տառաչափը), նախ զանգահարեք առողջապահական ծրագրի հեռախոսահամարով՝ 1-888-844-3344: Ցանկացած մեկը, ով խոսում է հայերեն, կարող է օգնել Ձեզ: Եթե Ձեզ լրացուցիչ օգնություն է անհրաժեշտ, ապա զանգահարեք Առողջապահական օժանդակության կազմակերպության (HMO) Օգնության կենտրոն՝ 1-888-466-2219 հեռախոսահամարով: (Armenian)

សារៈសំខាន់: អ្នកអាចទទួលអ្នកបកប្រែផ្ទាល់មាត់ដោយឥតគិតថ្លៃ ដើម្បីនិយាយទៅកាន់វេជ្ជបណ្ឌិត ឬគំរោងសុខភាពរបស់អ្នក។ ដើម្បីទទួលអ្នកបកប្រែផ្ទាល់មាត់ ឬស្នើសុំព័ត៌មានជាលាយលក្ខណ៍អក្សរ (ជាភាសាខ្មែរ ឬជាទំរង់ផ្សេងទៀត ដូចជាអក្សរប្រ៊ែល ឬអក្សរពុម្ពធំៗ) សូមទូរស័ព្ទទៅគំរោងសុខភាពរបស់អ្នក តាមលេខ 1-888-844-3344 ជាមុនសិន។ អ្នកនិយាយភាសាខ្មែរ អាចជួយអ្នកបាន។ បើសិនអ្នកត្រូវការជំនួយបន្ថែម សូមទូរស័ព្ទទៅមជ្ឈមណ្ឌលជំនួយអង្គការថែរក្សាសុខភាព HMO តាមលេខ 1-888-466-2219។ (Khmer)

مهم: برای گفتگو با پزشک معالج یا طرح بیمه می توانید بطور رایگان مترجم حضوری داشته باشید. برای درخواست مترجم حضوری یا برای دریافت اطلاعات بصورت کتبی (به زبان خود، یا با فرمت های دیگر مانند بریل یا چاپ درشت) ابتدا با شماره تلفن طرح خود یعنی 1-888-844-3344 تماس حاصل نمایید. فردی که (زبان شما را) صحبت می کند، می تواند شما را یاری دهد. اگر به کمک بیشتر نیاز دارید با مرکز کمک رسانی اچ ام او (HMO) به شماره 1-888-466-2219 تماس حاصل نمایید. (Farsi)

TSEEM CEEB: Muaj tus neeg txhais lus pub dawb rau koj kom koj tham tau nrog koj tus kws kho mob los yog nrog lub chaw pab them nqi kho mob rau koj. Yog xav tau ib tug neeg txhais lus los yog xav tau cov ntaub ntawv (sau ua koj yam lus los sis ua lwm yam ntawv, zoo li ua lus Braille los sis ua ntawv loj loj), xub hu rau koj lub chaw pab them nqi kho mob tus xov tooj ntawm 1-888-844-3344. Yuav muaj ib tug neeg hais lus Hmoob pab tau koj. Yog koj xav tau kev pab ntxiv, hu rau HMO Qhov Chaw Txais Tos Pab Neeg ntawm 1-888-466-2219. (Hmong)

중요: 의사나 건강 플랜과 대화하실 때 무료 통역 서비스를 받으실 수 있습니다. 통역을 구하시거나 문자 정보(한국어 번역본 또는 점자나 큰 글자 같이 다른 형식으로 된 정보)를 요청하시려면, 가입하신 건강 플랜에 1-888-844-3344 로 먼저 전화하십시오. 한국어를 하는 사람이 도와드릴 수 있습니다. 도움이 더 필요하시면 HMO 도움 센터에 1-888-466-2219 로 연락하십시오. (Korean)

ВАЖНО: Вы можете бесплатно воспользоваться услугами переводчика во время обращения к врачу или в страховой план. Чтобы запросить услуги переводчика или письменную информацию (на русском языке или в другом формате, например, шрифтом Брайля или крупным шрифтом), позвоните в свой страховой план по телефону 1-888-844-3344. Вам окажет помощь русскоговорящий сотрудник. Если вам нужна помощь в других вопросах, позвоните в справочный центр Организации медицинского обеспечения (HMO) по телефону 1-888-466-2219. (Russian)

MAHALAGA: Maaari kang kumuha ng isang tagasalin nang walang bayad upang makipag-usap sa iyong doktor o planong pangkalusugan. Upang makakuha ng isang tagasalin o upang humiling ng nakasulat na impormasyon (sa iyong wika o sa ibang anyo, tulad ng Braille o malalaking letra), tawagan muna ang numero ng telepono ng iyong planong pangkalusugan sa 1-888-844-3344. Ang isang tao na nakapagsasalita ng Tagalog ay maaaring tumulong sa iyo. Kung kailangan mo ng karagdagang tulong, tawagan ang Sentro ng Pagtulong ng HMO sa 1-888-466-2219. (Tagalog)

LIBERTY DENTAL PLAN

LƯU Ý QUAN TRỌNG: Quý vị có thể được cấp dịch vụ thông dịch miễn phí khi đi khám tại văn phòng bác sĩ hoặc khi cần liên lạc với chương trình bảo hiểm sức khỏe của quý vị. Để được cấp dịch vụ thông dịch hoặc yêu cầu văn bản thông tin bằng tiếng Việt hoặc bằng một hình thức khác như chữ nổi hoặc bản in bằng chữ khổ lớn, trước tiên hãy gọi số điện thoại của chương trình bảo hiểm sức khỏe của quý vị tại 1-888-844-3344. Sẽ có người nói tiếng Việt giúp đỡ quý vị. Nếu quý vị cần được giúp đỡ thêm, vui lòng gọi Trung tâm Hỗ trợ HMO theo số 1-888-466-2219. (Vietnamese)

ENPÒTAN: Ou kapab jwenn yon moun pou entèprete pou ou gratis pou w ka pale avèk doktè ou oswa plan sante ou. Pou jwenn yon entèprèt oswa mande enfòmasyon ekri (nan lang kreyòl ayisyen oswa yon diferan fòma tankou ekriti Bray oswa pi gwo lèt), rele nimewo telefòn plan sante ou a ki se 1-888-844-3344. Yon moun ki pale kreyòl ayisyen kapab ede ou. Si ou bezwen plis asistans, rele HMO Help Center nan nimewo 1-888-466-2219. (Haitian Creole)

IMPORTANTE: Você pode usar um intérprete gratuitamente para falar com seu médico ou comunicar-se com seu plano de saúde. Para pedir um intérprete ou solicitar informações por escrito (no seu idioma ou em outro formato, como em Braille ou em letras grandes), primeiramente, ligue para o telefone de seu plano de saúde no número 1-888-844-3344. Uma pessoa que fala português irá atendê-lo. Se precisar de mais ajuda, ligue para o HMO Help Center no telefone 1-888-466-2219. (Portuguese)

ਮਹੱਤਵਪੂਰਨ: ਤੁਸੀਂ ਆਪਣੇ ਡਾਕਟਰ ਜਾਂ ਸਿਹਤ ਯੋਜਨਾ ਲਈ ਗੱਲ ਕਰਨ ਵਾਸਤੇ ਮੁਫਤ ਅਨੁਵਾਦਕ ਪਾ ਸਕਦੇ ਹੋ| ਅਨੁਵਾਦਕ ਪਾਉਣ ਲਈ ਜਾਂ ਲਿਖਤੀ ਜਾਣਕਾਰੀ (ਆਪਣੀ ਭਾਸ਼ਾ ਜਾਂ ਵੱਖਰੇ ਫਾਰਮੈਟ ਵਿੱਚ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਜਾਂ ਵੱਡੇ ਅੱਖਰ) ਦੀ ਬੇਨਤੀ ਕਰਨ ਲਈ, ਪਹਿਲਾਂ 1-888-844-3344 'ਤੇ ਆਪਣੀ ਸਿਹਤ ਯੋਜਨਾ ਦੇ ਫੋਨ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ| ਜੋ ਵੀ (ਤੁਹਾਡੀ ਭਾਸ਼ਾ) ਬੋਲੇਦਾ ਹੈ, ਉਹ ਤੁਹਾਡੀ ਸਹਾਇਤਾ ਕਰ ਸਕਦਾ ਹੈ| ਜੇਕਰ ਤੁਹਾਨੂੰ ਹੋਰ ਸਹਾਇਤਾ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ 1-888-466-2219 'ਤੇ HMO Help Center (ਐਚ.ਐਮ.ਓ. ਸਹਾਇਤਾ ਸੈਂਟਰ) ਨੂੰ ਕਾਲ ਕਰੋ| (Punjabi)

重要 通訳を通して医師や医療保険会社とお話しいただけます。料金はかかりません。日本語でサポートを受けたり、日本語で書かれた情報を入手するには、あなたの医療保険会社（1-888-844-3344）までお電話ください。日本語が話せるスタッフがお手伝いします。さらなるサポートが必要な場合は、HMO Help Center（1-888-466-2219）までお電話ください。(Japanese)