
## Individual/Family Plus Plan

# Evidence of Coverage & Disclosure Form

## LIBERTY DENTAL PLAN OF FLORIDA, INC.

**P.O. Box 15149**
**Tampa, FL 33684-5149**
**(877) 877-1893**
**Monday-Friday 8am-5pm**

**www.libertydentalplan.com**

THIS COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM CONSTITUTES A SUMMARY OF THE DENTAL PREPAID PLAN. THIS DOCUMENT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE.

# WELCOME TO
# LIBERTY DENTAL PLAN

This Evidence of Coverage ("EOC") provides you with important information about your prepaid Individual/Family Dental Plan.

Your dental care is received through LIBERTY's network of dentists. Our goal is to provide you with the highest quality of dental care and help you maintain good oral health. As a member of this dental plan, we encourage you to take an active part in ensuring the success of your dental health by seeing your dentist on a regular basis. When you choose a network dentist from our list of participating providers you will receive any necessary covered preventive or corrective dental care services at that location. LIBERTY and our participating dental providers are here to arrange and coordinate dental care services for you.

We want you to understand your dental program and its benefits: the services you can receive, the services that are not covered, and any limitations on covered services. We can also assist you with information about how to get services, such as how to obtain transportation to and from your dental office if you are unable to get to your appointments.

This Evidence of Coverage provides the following information:

* The advantages of your dental plan and how to use your benefits
* Eligibility requirements
* Enrollment procedures
* Reasons for Termination of Coverage

* Grievance Procedures
* Answers to your frequently asked questions

Please also refer to your Schedule of Benefits. The Schedule of Benefits list the benefits available to you as well as Copayments, Exclusions and Limitations of coverage.

This Evidence of Coverage and Schedule of Benefits will provide you with the information you should know about your dental plan. It explains clearly how it works and the many advantages LIBERTY provides you.

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

Amir Neshat, D.D.S.
President & CEO

**LIBERTY Dental Plan of Florida, Inc. provides benefits as a Prepaid Limited Health Service Organization as described in Chapter 636 of the Florida Statutes.**

## Table of Contents

## DEFINITIONS

**Adverse Benefit Determination** means a coverage determination by the Plan that an admission, availability of care, or other health care service has been reviewed and based on the information provided, does not meet the organization's requires for medical necessity, appropriateness, health care setting, level of care of effectiveness, and coverage for the requests services and is therefore denied, reduced or terminated (in whole or in part).

An Adverse Benefit Determination includes the failure to cover services because they are determined to be Experimental, Investigational, cosmetic, not dentally necessary, or inappropriate. The denial of payment for services or charges pursuant to the Plan's dental contracts with Plan Providers, where the Member is not liable for such services or charges, are not Adverse Benefit Determinations.

**Authorized Representative** means an individual authorized by the Member or state law either verbally or in writing, to act on the Member's behalf in requesting a dental care service, obtaining claim payment, or participating during the Grievance process. A Provider may act on behalf of a Member without the Member's express consent when it involves an Urgent Grievance.

**Benefits** or **Coverage** means those dental care services available under this dental plan in which a Member is enrolled.

**Clinical Peer** means a dental care professional in the same or similar specialty as typically manages the dental condition, procedure, or treatment under review, who was neither involved in the initial Adverse Benefit Determination nor a subordinate of such individual. A Clinical Peer may include a Plan dental director not involved in the initial Adverse Benefit Determination with the appropriate expertise.

**Complaint** means any oral expression or dissatisfaction including dissatisfaction with the administration, claims practices or provision of services, which relates to the quality of care provided by a Provider and is submitted to the Plan or to a State agency. A Complaint is part of the informal steps of a Grievance procedure and is not part of the formal steps of a Grievance procedure, unless it is a Grievance as defined herein.

**Concurrent Review:** means utilization review conducted during a Member's course of treatment.

**Contract Year** means a period of twelve (12) consecutive months from your Coverage effective date, *i.e.,* January 1st through December 31st.

**Copayment** means a specific dollar amount that the Member must pay upon receipt of Dental Care Services**.** Fixed copayment amounts are listed in the Schedule of Benefits.

**Dental Care Services** means those services, procedures and operations covered under this Contract.

**Dental Facilities** means those dental centers and dental providers selected by the Plan to provide dental care services for its Members.

**Dental Records** means diagnostic aid, intraoral and extra-oral radiographs, written treatment records 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** means family members eligible for coverage as described under the Eligibility Rules section of this EOC.

**Emergency Dental Services** means those services in a dental office only, which are required immediately due to an injury or unforeseen condition, and which provide for the relief of pain or prevent worsening of any dental condition that would be caused by delay.

**Evidence of Coverage** ("EOC") means this certificate, which is issued to the Subscriber, setting forth the Plan administration as well as the benefits Members are entitled.

**Exclusion** is any provision of the EOC or Schedule of Benefits, whereby coverage for a specified hazard or condition is entirely eliminated.

**Expedited Appeal** means a Grievance of an Adverse Benefit Determination in which the standard processing timeframe would seriously jeopardize the life or health or the member or would jeopardize the subscriber's ability to regain maximum function.

**Experimental** means any evaluation, treatment, or therapy which involves the application, administration or use of procedures, techniques, equipment, supplies, products, or remedies that are considered experimental by the Plan based on reports, articles or written assessments published by the American Dental Association or in other authoritative medical and scientific literature published in the United States.

**Federal Exchange** means a governmental agency or non-profit entity that makes Qualified Health Plans available to Qualified Individuals. Unless otherwise identified, this term refers to State Exchanges, regional Exchanges, subsidiary Exchanges and a Federally-qualified Exchange.

**Grievance** means an oral or written Complaint submitted by or on behalf of a Member to the Plan or a State agency regarding the:

a. Availability, coverage for the delivery, or quality of dental care services, including a Complaint regarding an Adverse Benefit Determination made pursuant to utilization review;
b. Claims payment, handling, or reimbursement for dental care services; or
c. Matters pertaining to the Contractual relationship between a Member and the Plan.

A Grievance includes both Pre-Service Appeals and Post-Service Appeals as defined herein.

**Limitation** is any provision other than an Exclusion that restricts coverage under the EOC or Schedule of Benefits.

**Member** means any eligible person who is enrolled under this dental plan and is entitled to the benefits available under the EOC in return for the payment required to be made to the Plan.

**Non-Covered Services** means and refers to those dental care services not described in the Schedule of Benefits for which the Plan has no financial responsibility.

**Non-Plan Provider** A dentist that has no contract to provide services for the Plan.

**Plan Provider or Dentist** refers to a provider of dental services licensed by the State of Florida to render services to any Member in accordance with the provisions of the EOC in which a Member is enrolled. The names, locations, hours of service and other information regarding Plan Providers may be obtained by contacting the Plan or our website, www.libertydentalplan.com.

**Post-Service Appeal** means a Grievance for which an Adverse Benefit Determination was rendered for a service that was already provided.

**Pre-Service Appeal** means any Grievance for which an Adverse Benefit Determination was rendered for a service was not provided.

**Premium** is the amount payable each month by the Subscriber to obtain Benefits under this EOC.

**Primary Care Dentist** is A dentist affiliated with the Plan to provide services to covered Members of the Plan. The Primary Care Dentist is responsible for providing or arranging needed dental services.

**Relevant** means a document, record, or other information that:

a. Was relied upon in making a benefit determination;
b. Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
c. Demonstrates compliance with the federal requirements for safeguards designed to ensure and to verify that benefit claim determinations were made in accordance with governing plan documents and that, where appropriate, the plan provisions were applied consistently with respect to similarly situated Members; or
d. Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Member's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

**Retrospective Review** means a review, for coverage purposes, of dental necessity conducted after services were provided to the Member.

**Schedule of Benefits** is the document that lists the benefits, copayments, limitations, and exclusions for the plan.

**Service Area** means the geographic area in Florida in which the Plan has contracted with a network of dental providers to provide the services detailed in this EOC. The Service Area may be revised from time to time as specified in the Provider Directory.

**Specialist** refers to Endodontists, Oral Surgeons, Orthodontists, Pediatric Dentists or Periodontists.

**Subrogation** is the right for the Plan to pursue a third party that caused an insurance loss to the Subscriber or Member. Through subrogation, the Plan would recover the amount of the claim paid to the Subscriber or Member for the loss.

**Subscriber** is the Member who applied for coverage and is responsible for submitting premium to the Plan.

**The Plan** means LIBERTY Dental Plan of Florida, Inc.

## BENEFITS THAT ARE EASY TO USE

Dental benefits should be simple to use for you and your family. Our goal is to provide you with the comprehensive dental benefits you purchased. Our plans offer comprehensive dental coverage without claim forms, prohibitive deductibles, or restrictive annual maximums.

**Advantages to LIBERTY members include:**

- No claim forms
- No deductibles
- Low out-of-pocket costs
- Selection of pre-screened dentists and specialists
- Multi-lingual provider network
- Change dentist selection at any time
- Most pre-existing conditions covered

- 24-hour access to emergency care provided by Network Dentists
- Toll-free member assistance lines

LIBERTY provides toll-free telephone access to covered Members. Just call our Member Services Department if you have a question or inquiry. Our Member Service representatives will be glad to provide you information or resolve your inquiry. **Call (877) 877-1893, between the hours of 8:00 a.m. to 5:00 p.m. (EST) Monday through Friday.** The hearing and speech impaired may use the Florida Relay Service toll-free telephone number (800) 955-8771 (TTY).

**SECOND OPINION**

You may request a second dental opinion, at no cost to you, by directly contacting Member Services either by calling the toll-free number (877) 877-1893 or by writing to: P.O. Box 15149 Tampa, FL 33684-5149. 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.

LIBERTY processes all requests for a standard second dental opinion within 5 days of receipt of such request, or within 72 hours of receipt for cases involving 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 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's policy description for a second dental opinion.

**YOUR DENTAL PLAN**

Your Primary Care Dentist will provide for all of your dental care needs, including referring you to a specialist should it be necessary.

When you join LIBERTY, you must choose a Primary Care Dentist. If a Primary Care Dentist is not selected at time of enrollment, LIBERTY will assign one to you. If you desire to make a change, you may do so at any time. LIBERTY reserves the right to modify its network of Plan Providers at any time with or without notice. Since Plan Providers may enroll or unenroll in LIBERTY's network at their own option, LIBERTY makes no warranty that a particular Plan Provider will participate or remain in the network. (Please note: your request to change dentists will not be processed if you have an outstanding balance with your current dentist.)

To select a new dentist, simply contact our Member Services Department toll-free at 877) 877-1893 or submit a change request in writing to: LIBERTY Dental Plan, P.O. Box 15149 Tampa, FL 33684-5149. You may also review a listing of dentists near you by visiting www.libertydentalplan.com and selecting "Find a Dentist". Make sure you choose "LIBERTY FL Family Plus Dental" as your plan. Your requested change to a Primary Care Dentist will be in effect on the 1st day of the following month if the change is received by LIBERTY prior to the 20th of the current month. You and your enrolled Dependents must use the same dentist.

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

Be sure to identify yourself as a Member of LIBERTY Dental Plan when you call the dentist for an appointment. We also suggest that you keep this material handy and take this information with you when you go to your appointment. You can then reference benefits and applicable copayments which are the out-of-pocket costs associated with your plan.

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

**ELIGIBILITY RULES**

To be eligible to enroll in a LIBERTY Individual/Family plan you must:

1. Have applied for coverage through Healthcare.gov, and be considered a qualified enrollee by the Federal Exchange or directly with LIBERTY, and
2. Reside or work within the Plan's Service Area.

Your Eligible Dependents includes the following individuals only if they reside or work within the Plan's Service Area:

1. Spouse (unless legally separated or divorced).
2. Registered Domestic Partner;
3. Dependent Child, including adopted, (or in the case of a newborn child, the Dependent Child of the Member's covered Dependents), up to the child's 26th birthday. Pursuant to Chapter 63, Florida Statutes, adopted children are considered Dependents from the moment of permanent placement in your residence, or from the moment of birth if a written agreement to adopt such child has been entered into by you prior to the birth of the child
4. A Dependent Child who can be certified to the Plan as incapable of self-sustaining employment by reason of mental retardation or physical handicap and is chiefly dependent upon You for support and maintenance. Proof of such incapacity must be furnished to the Plan by within 30 days of the request for such proof by the Plan. Recertification of such incapacity may be required by the Plan, but not more frequently than once annually.

Full-time student dependents who attend school outside the Plan's Service Area must travel back to the Plan's Service Area to receive covered dental services from Plan Providers. The only exception is for Emergency Dental Care.

Coverage will not be considered active until the applicable premium is received by LIBERTY prior to the effective date of coverage.

If you enroll directly with LIBERTY, and we receive your completed dental application along with the initial binder payment by the payment deadline, you may receive care on the day you are considered eligible by LIBERTY. You may add Dependents to Your coverage later only when a life event qualifies your family for a special enrollment period. You may renew your coverage or add any eligible Members upon renewal.

**OPEN ENROLLMENT**

If You enrolled through the Federal Exchange, your plan has an annual open enrollment period. During the annual open enrollment period, you may renew your coverage, select a new plan, or add any eligible family Members. The Federal Exchange determines when the annual open enrollment period takes place and may provide notice to you up to 60 days before January 1st of the next Calendar Year.

Dependents eligible at the time of your initial enrollment but not previously enrolled may be added to your coverage only during an open enrollment period.

You may add Dependents to Your coverage later only when a life event qualifies your family for a special enrollment period.

**SPECIAL ENROLLMENT PERIODS**

Special enrollment periods are available to qualified individuals that become eligible as a result of the following triggering events:

1. A qualified individual or dependent loses minimum essential coverage;
2. A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, placement in foster care;
3. An individual, who was not previously a citizen, national, or lawfully present gains such status;
4. A qualified individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error,

misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;

5. An enrollee adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
6. An individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP. The Exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
7. A qualified individual or enrollee gains access to new QHPs as a result of a permanent move;
8. An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month; and
9. A qualified individual or enrollee demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide.
10. A qualified individual or enrollee may enroll with the Federal Exchange within 60 days from the date coverage is lost under Medicaid or CHIP, or for exceptional circumstances as determined appropriate by the Federal Exchange.

To successfully enroll dependents due to a special enrollment period, premium must be received no later than 30 calendar days from the date LIBERTY receives the required enrollment form(s).

## ANNUAL AND LIFETIME LIMITS

The Pediatric dental EHB portion of this plan is offered without annual and lifetime limits.

## COST-SHARING

Under 45 CFR 155.1065, coverage for the Pediatric dental EHB portion of this plan is offered with an annual cost-sharing limit of $375 for a single child and $750 for plans with two or more child enrollees.

## EFFECTIVE DATE AND TERMINATION DATE

Coverage is based on a Calendar Year. Membership will become effective on the date indicated on the Plan Information Page. The coverage effective and termination time for any dates used is 12:01 A.M.

The effective date will be based on when the enrollment process is completed for the following Special Enrollment Events:

- On the 1st Day of the following month
- For enrollments received by the 15th day of the month
- For newborns or newly acquired children due to adoption, or placement for adoption or foster care
- For marriage or loss of minimum essential coverage; or
- On the 1st Day of the 2nd following month for enrollments received by the 16th day of the month.

The following Special Enrollment Events may take effect on the date of the event or the regular effective date as determined by the Exchange:

- For newborns or newly acquired children due to adoption, or placement for adoption or foster care;
- Unintentional enrollment or non-enrollment;

- Enrollment or non-enrollment as the result of an error or misrepresentation or inaction of the Exchange or QHP, in which the enrolled person violated a material provision of the contract;
- Due to other exceptional circumstances as determined by the Exchange or where non-enrollment was a result of misconduct on the part of a non-Exchange entity providing enrollment assistance or activity.

**TERMINATION OF A MEMBER'S COVERAGE**

Coverage for a Member will end on the last day of the paid through month if coverage is terminated for any of the following reasons.

Except for non-payment of Premium, the Plan will give 45 day's advance written notice of coverage termination:

1. Non-payment of Premium;
2. The Member ceases to be eligible for coverage;
3. The Member commits any action of fraud or material misrepresentation in applying for or seeking any benefits under this Contract;
4. For cause due to disruptive, unruly, abusive, unlawful, fraudulent, or uncooperative behavior towards a health care provider or administrative staff that seriously impairs the Plan's ability to provide services to the Member and/or to other Members;
5. Misuse of the documents provided as evidence of benefits available pursuant to this Contract including the Member Identification Card;
6. The Member furnishes incorrect or incomplete information for the purpose of fraudulently obtaining services;
7. The Member leaves the Plan's Service Area with the intention to relocate or establish a new residence; or

8. A covered child dependent reaches the limiting age as specified in the Eligibility Section of this Contract, or if a court order, including a qualified medical child support order covering a dependent is no longer in effect.
9. Before we term a Member for cause, we will document the Member's problem and make a reasonable effort to resolve the problem, including the use or attempted use of the Plan's Grievance Procedure. We will also to the extent possible, determine that the Member's behavior is not related to the use of services or mental illness.

**TERMINATION OF COVERAGE BY A MEMBER'S REQUEST**

The Member and/or any of his or her covered dependents may terminate coverage with the Plan at any time with appropriate notice of at least 14 days to the Federal Exchange. Coverage will terminate on the date specified or 14 days after termination is requested, whichever is later. Should any Member and/or any of his or her covered dependents in the Plan terminate coverage because of eligibility for Medicaid, CHIP or a Basic Health Plan or termination is due to the Member moving from one Qualified Health Plan to another during an Annual or Special Enrollment Period, the termination effective date will be the day before the effective date of the new coverage.

**TERMINATION OF COVERAGE BY THE FEDERAL EXCHANGE**

The Federal Exchange may terminate the Member's coverage with the Plan in the following circumstances. Should the Member's coverage be terminated, LIBERTY will provide the Member with a notice of termination consistent with the effective date established with the Federal Exchange. Coverage may be terminated if:

1. The Member is no longer eligible for coverage;
2. Member becomes covered in other minimum essential coverage;
3. Non-payment of premium provided that the applicable grace period has expired;

4. The Member's coverage is rescinded due to an act, practice or omission that constitutes fraud, or an intentional misrepresentation of material fact; in which case, LIBERTY will provide 30-day advance notice;
5. LIBERTY terminates or is decertified by the Federal Exchange;
6. The Member changes from one Qualified Health Plan to another during annual open enrollment or special enrollment;
7. Or by any other reason as determined by the Federal Exchange.

**PREMIUM TAX CREDIT RECIPIENTS**

Members receiving an advanced premium tax credit and lose coverage due to non-payment of premiums will be extended a three-month grace period. LIBERTY will cover all allowable claims for the first month of the three-month grace period and may pend subsequent claims in the second and third months of the grace period. During the grace period, LIBERTY will continue to collect subsidy payments on the delinquent member's behalf and return such payments of the premium tax credit for the second and third months of the grace period if the member exhausts the grace period without paying premium.

If your premium is not received by the end of the third month of the grace period, your coverage ends.

**TERMINATION DUE TO NON-PAYMENT OF PREMIUM**

If Premiums are not paid before the Grace Period ends, your coverage will end as of midnight of the last day of the month for which Premiums were last received, subject to compliance with any applicable notice and grace period requirements.

**EXTENSION OF BENEFITS**

In the event Coverage is terminated for any reason, a Member is entitled to continue services for a specific treatment or procedure that was undertaken prior to termination. This extension of benefits will cease on the earliest of completion of treatment or 90 days from the date coverage terminates.

During the period required for completion of such procedures, each Member shall continue to pay Copayments directly to the Plan dentist, as required under the Schedule of Benefits and all exclusions and limitations will continue to apply during the extension.

## CLAIM PROCEDURES

There are three types of claims: (1) Pre-Service Claims; (2) Post-Service Claims; and (3) Claims Involving Urgent Care. It is important that Members become familiar with the types of claims that can be submitted to LIBERTY and the time frames and other requirements that apply.

### *A. Urgent Care Claims*

**Initial Claim -** An Urgent Care Claim will be considered filed based on the date received by LIBERTY. We shall notify the Member of Our benefit determination (whether adverse or not) as soon as possible, taking into account the dental exigencies, but not later than 72 hours after We receive, either orally or in writing, the Urgent Care Claim, unless the Member fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the dental plan. If such information is not provided, LIBERTY shall notify the Member as soon as possible, but not later than 24 hours after We receive the Claim, of the specific information necessary to complete the Claim. The Member shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. LIBERTY shall notify the Member of Our benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

1. LIBERTY's receipt of the specified information; or
2. The end of the period afforded the Member to provide the specified additional information.

If the Member fails to supply the requested information within the 48-hour period, the Claim shall be denied. LIBERTY may notify the Member of its benefit determination orally or in writing. If the notification is provided orally, a written or electronic notification shall be provided to the Member no later than 3 days after the oral notification. A Member may appeal an Urgent Care Claim as set forth in the Appeals Section.

### *B. Pre-Service Claims*

**Initial Claim** – A Pre-Service Claim will be considered filed based on the date received by LIBERTY. We shall notify the Member of Our benefit determination (whether adverse or not) within a reasonable period of time appropriate to the dental circumstances, but not later than 15 days after LIBERTY receives the Pre-Service Claim. LIBERTY may extend this period one time for up to 15 days, provided that LIBERTY determines that such an extension is necessary due to matters beyond control and notifies the Member, before the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary because the Member failed to submit the information necessary to decide the Claim, the notice of extension shall specifically describe the required information, and the Member shall be afforded at least 45 days from receipt of the notice within which to provide the specified information

In the case of a failure by a Member to follow the Plan's procedures for filing a Pre-Service Claim, the Member shall be notified of the failure and the proper procedures to be followed in filing a Claim for benefits not later than 5 days following such failure. The Plan's period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the Member until the date on which the Member responds to the request for additional information. If the Member fails to supply the requested information within the 45-day period, the Claim shall be denied. A Member may appeal a Pre-Service Claim as set forth in the Appeals Section.

### *C. Post-Service Claims*

**Initial Claim** – A Post-Service Claim shall be deemed to be filed on the date received by Plan. LIBERTY shall notify the Member of LIBERTY's Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after the Plan receives the Post-Service Claim.

The Plan may extend this period one time for up to 15 days, provided that LIBERTY determines that such an extension is necessary due to matters beyond LIBERTY's control and notifies the Member, before the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If such an extension is necessary because the Member failed to submit the information necessary to decide the Post-Service Claim, the notice of extension shall specifically describe the required information, and the Member shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. The Plan's period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the Member until the date on which the Member responds to the request for additional information. If the Member fails to supply the requested information within the 45-day period, the Claim shall be denied. A Member may appeal a Post-Service Claim as set forth in the Appeals Section.

### *D. Initial Claim Determination Notice*

LIBERTY shall provide a Member with written or electronic notification of any Adverse Benefit Determination. The notification shall set forth, in a manner calculated to be understood by the Member, the following:

1. The specific reason(s) for the Adverse Benefit Determination.
2. Reference to the specific dental plan provisions on which the determination is based.
3. A description of any additional material or information necessary for the Member to perfect the claim and an explanation of why such material or information is necessary.
4. A description of LIBERTY's review procedures and the time limits applicable to such procedures.
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy shall be provided free of charge to the Member upon request.
6. If the Adverse Benefit Determination is based on whether the treatment or service is Experimental and/or Investigational or not Medically Necessary, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the dental plan

to the Member's dental circumstances, or a statement that such explanation shall be provided free of charge upon request.

7. In the case of an Adverse Benefit Determination involving an Urgent Care Claim, a description of the expedited review process applicable to such Claim.

### *E. Concurrent Care Claims*

Any reduction or termination by the Plan of Concurrent Care (other than by plan amendment or termination) before the end of an approved period of time or number of treatments shall constitute an Adverse Benefit Determination. LIBERTY shall notify the Member of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Member to appeal and obtain a determination on review of the Adverse Benefit Determination before the benefit is reduced or terminated.

Any request by a Member to extend the course of treatment beyond the period of time or number of treatments that relates to an Urgent Care Claim shall be decided as soon as possible, taking into account the dental exigencies, and LIBERTY shall notify the Member of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the Claim, provided that any such Claim is made to the Plan at least 24 hours before the expiration of the prescribed period of time or number of treatments. Notification and appeal of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether involving an Urgent Care Claim or not, shall be made in accordance with this Grievance Procedure.

## FILING A CLAIM FORM

There are no claim forms to worry about with your plan. LIBERTY prepays Primary Care Dentists in advance for covered services (less applicable copayments of your plan).

In the case of a specialty referral, Members are referred to one of our plan specialists. Once a specialty referral is processed, we will send a copy of the approved referral to the Member, the referring Primary Care Dentist who originally submitted the referral, and the Specialist.

The referral will include the services approved, the Member Copayment and the amount we will pay the Specialist (according to their contracted fees). Once the services have been performed by the Specialist, the Specialist will send LIBERTY a claim form and we will pay the Specialist directly for the approved services.

**PRIOR BENEFIT AUTHORIZATION**

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

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

If you or your Primary Care Dentist encounter an urgent condition in which there is an imminent and serious threat to your health, including but not limited to the potential loss of life, limb, or other major body function, or the normal timeframe for the decision-making process as described above would be detrimental to your life or health, the response to the request for referral should not exceed 72 hours from the time of receipt of such information. The decision to approve, modify or deny will be communicated to the Primary Care Dentist within 24 hours of the decision.

In cases where the review is retrospective, the decision shall be communicated to the enrollee within 30 days of the receipt of the information.

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

If your specialty referral preauthorization is denied or you are dissatisfied with the preauthorization, please refer to the Grievance Procedure.

**EMERGENCY DENTAL CARE**

All affiliated LIBERTY Primary Care Dental offices provide availability of emergency dental care services 24 hours per day, 7 days per week.

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

If your Primary Care Dentist is not available, simply contact any licensed dentist to receive care. LIBERTY will reimburse you for dental expenses up to a maximum of $75, less applicable copayments.

The Plan provides coverage for emergency dental services only if the services are required to alleviate severe pain or bleeding or if an enrollee reasonably believes that the condition, if not diagnosed or treated, may lead to disability, dysfunction or death (e.g. emergency extraction when no other palliative treatment would suffice and severe gum tissue infection).

**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 with the following information:

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

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

- The reason for the denial.
- Reference to the pertinent Evidence of Coverage provisions on which the denial is based.
- Notice of your right to request reconsideration of the denial, and an explanation of the grievance procedures. Please refer to the Grievance Procedure.

**MEMBER SERVICES DEPARTMENT**

LIBERTY's Member Services Department 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 toll-free telephone numbers (800) 955-8771 (TTY). Our toll-free number is (877) 877-1893.

**LANGUAGE ASSISTANCE SERVICES**

If English is not your first language, LIBERTY provides interpretation services in your preferred language. To ask for language services call (877) 877-1893. If you have a preferred language, please notify us of your personal language needs by calling (877) 877-1893.

## COMPLAINTS, GRIEVANCES AND APPEALS PROCEDURE

### Introduction

The LIBERTY complaints, grievances and appeals procedures are available to you in the event that you are dissatisfied with some aspect of the Plan administration, you wish to appeal an Adverse Benefit Determination or there is another concern that you wish to bring to LIBERTY's attention.

Concerns about dental services are best handled at the service site level before being brought to LIBERTY. If a Member contacts LIBERTY regarding an issue related to the dental service site and has not attempted to work with the site staff, the Member may be directed to that site to try to solve the problem there, if the issue is not a Claim for Benefits.

LIBERTY processes complaints and grievances in the same manner. LIBERTY processes appeals separately and in accordance with all applicable state and federal regulatory requirements.

Members can submit written narratives, records, and other information in support of their grievance and/or appeal at any time. Additionally, upon request, LIBERTY will provide our Members with copies of any records used as part of the grievance and appeals process, free of charge.

LIBERTY will provide you a written acknowledgement letter within 5 business days of receipt of your Grievance and/or Appeal, advising that your concerns were received.

## COMPLAINT PROCESS

An expression of dissatisfaction from You, or Your authorized Representative, about the Plan or a Plan provider that is submitted over the telephone to a LIBERTY Member Services Department is considered a complaint. Complaints may include, but are not limited to, dissatisfaction with the quality of service you received from dental office staff, LIBERTY staff or a LIBERTY vendor.

The Member Services Representative will attempt to resolve Your complaint over the telephone within 24 hours but no later than the end of the next business day. In the event that the Member Services Representative is unable to resolve the concerns to Your satisfaction, and You wishes to pursue the matter further, the Member must file a Grievance.

**GRIEVANCE PROCESS**

Any expression of dissatisfaction that could not be resolved as a Complaint, or a Complaint that was not resolved in a manner that is satisfactory to You or when You choose not to file a Complaint and wish to pursue the matter further. You must file a Grievance.

Grievances must be submitted in writing, with the exception of expedited cases, and may include, but are not limited to, dissatisfaction with payment, reimbursement, availability, delivery, or quality of care. Grievances must be submitted to LIBERTY within 365 calendar days (1 year) from the date of the event that cause your dissatisfaction.

LIBERTY will investigate Your Grievance and provide you with an written resolution letter within 60 calendar days of the receipt of the request by LIBERTY.

**Appeal Process**

**EXPEDITED APPEALS**

You can ask (either orally or in writing) for an Expedited Appeal of an initial adverse benefit determination for a Pre-Service Claim that You or Your Dentist believes that Your health could be seriously harmed by waiting for a routine appeal decision.

Expedited Appeals are not available for appeals regarding Post-Service Claims. Appeals must be submitted to LIBERTY within 365 calendar days (1 year) from the initial adverse benefit determination.

If insufficient information is received, LIBERTY shall notify You as soon as possible, but no later than 24 hours after receipt of the claim of the specific information necessary to complete the claim.

If a request for an Expedited Appeal is submitted without support of Your Dentist, LIBERTY will decide whether Your health requires an Expedited Appeal. If an Expedited Appeal is not granted, LIBERTY will provide a decision within standard appeal process.

**STANDARD APPEALS**

When You receive an adverse benefit determination or Grievance response from LIBERTY and you do not agree with our decision, you must file a Standard Appeal.

The Standard Appeal must be submitted in writing, with the exception of expedited cases, to LIBERTY within 365 calendar days (1 year) of the initial adverse benefit determination. Standard Appeals not filed within the time frame above will be denied due to timely filing, with the exception of good cause for the delay in the submission.

The Standard Appeal must include at least the following information:

- Your name (or name of Member's Authorized Representative), address, and telephone number;
- Your LIBERTY membership ID number;
- A copy of the initial adverse benefit determination, claim number associated with the initial adverse benefit determination or previous Grievance tracking number
- A brief statement of the reason(s) for the appeal, and why the You feels that LIBERTY's previous decision was wrong.

Additionally, You may submit any supporting medical/dental records, Dentist's letters or other information that explains why LIBERTY should approve the services. You can request the assistance of a Member Services Representative at any time during this process. In the event the Grievance and/or Appeals was filed by Your authorized representative, the Plan will require a signed and completed Authorized Representative form.

LIBERTY will investigate Your Appeal and provide you with an written resolution letter within the following timeframes:

- **Expedited appeals** will be responded to within 72 hours from time of receipt or within 48 hours after the receipt of requested additional information.
- **Pre-Service appeals** will be responded to within 15 calendar days
- **Post-Service appeal** will be responded to within 60 calendar days

**SUBMISSION PROCESS**

You may submit a grievance or appeal in writing to the following within the timeframes mentioned above:

**Address:** LIBERTY Dental Plan, Grievance and Appeals, P.O. Box 26110, Santa Ana, CA 92799-6440

**Phone:** (877) 877-1893/TTY: (800) 955-8771

**Fax:** (833) 250-1814

**Online:** www.libertydentalplan.com

**RESOLUTION PROCESS**

LIBERTY will investigate Your Grievance and/or Appeal and provide you with a written resolution letter within the timeframes mentioned above.

LIBERTY will ensure that your written Grievance and Appeals resolution letter(s) include the following information, as applicable:

- The outcome and specific reason for the Plan's decision
- Any Corrective Actions taken to resolve the matter
- The name and title of the individual involved in making the decision.
    - LIBERTY ensures that all clinical appeals are reviewed by a licensed dentist who was not a part of the initial adverse benefit determination.

- Appeals that result in an adverse benefit determination, that uphold or partially upholds the Plan's initial decision will also include the following:
    - A clear and easily understood explanation of the Plan's decision
    - A reference to the specific plan provision use to make the decision
    - A reference to the internal rules, guidelines, protocol, or criteria used to make the adverse benefit determination.
    - A reference to the explanation of clinical judgement for Adverse benefit determinations based on medical necessity or experimental treatment.
    - A description of the external appeal process

If you are not satisfied with LIBERTY's final decision, you may contact the Florida Department of Financial Services (FDFS) in writing within 365 days (1 year) of receipt of the final decision letter. You also have the right to contact FDFS at any time to inform them of an unresolved grievance.

**The Florida Department of Financial Services**

**Office of Insurance Regulation, Division of Consumer Services**

200 East Gaines Street

Tallahassee, Florida 32399

Telephone 1-877-693-5236

**ARBITRATION**

If you or one of your eligible dependents is not satisfied with the results of LIBERTY's grievance resolution process, and you have exhausted all LIBERTY grievance resolution procedures available to you under this EOC, you may request that the matter be submitted to arbitration for resolution by providing written notice of your arbitration request to LIBERTY.

The arbitration will be conducted according to the American Arbitration Association rules and regulations in force at the time the matter is submitted to arbitration. All costs and expenses of arbitration shall be borne by you and LIBERTY equally. You shall bear all costs and expenses, including counsel, experts, and witnesses, involved in preparing and presenting Your case.

In the event a Member's grievance goes through arbitration, pursuant to Chapter 682, Florida Statutes, an additional time limitation will be granted, not to exceed 270 days from the date the LIBERTY is first notified of the grievance. No Member shall be denied services or benefits under the Agreement solely on the grounds that he or she filed a complaint.

**SUBROGRATION AND THIRD-PARTY RECOVERY**

If LIBERTY makes any payment on your behalf for Covered Services, we are permitted to be fully subrogated (a legal principle that allows the plan to be reimbursed for certain payments we have made on your behalf, in certain circumstances) to any and all rights you have against any person, entity or insurer that may be responsible for payment of medical expenses and/or benefits related to your dental injury, illness or condition.

Members and providers must agree to cooperate with LIBERTY and any LIBERTY designated representatives and to take any actions or steps necessary to secure our interests, including but not limited to:

1. Fully responding to requests for information about any accidents or injuries;
2. Fully responding to LIBERTY requests for information and providing any relevant information that we have requested; and
3. Fully participating in all phases of any legal action LIBERTY may need to protect our rights, including but not limited to participating in discovery, attending depositions, and appearing and testifying at trial.

In addition, you agree not to do anything to affect LIBERTY rights, including but not limited to assigning any rights or causes of action that you may have against any person or entity relating to your injury, illness, or condition without our prior authorized written consent.

Your failure to cooperate shall be deemed a violation or breach of your obligations, and LIBERTY may seek any available legal action against you to protect our rights.

LIBERTY is also entitled to be fully reimbursed for any and all benefit payments we make to you or on your behalf that are the responsibility of any person, organization, or insurer. Our right of reimbursement is separate and apart from our subrogation right and is limited only by the amount of actual benefits paid under the Plan.

**MEMBER RESPONSIBILITIES**

As a Member, you have the responsibility to:

* Identify yourself to your selected dental office as a LIBERTY Dental Plan Member
* Treat the Primary Care Dentist or Specialist, office staff and LIBERTY staff with respect and courtesy
* Follow all dental office rules about care and conduct
* Keep scheduled appointments or contact the dental office 24 hours in advance to cancel an appointment
* Provide your Plan Provider or Plan Specialist, to the best of your knowledge, correct information about your physical and dental health
* Inform your Plan Provider or Plan Specialist of any sudden changed to your physical or dental health
* Cooperate with the Primary Care Dentist or Specialist in following a prescribed course of treatment
* Stay and continue with any treatment plan that you understood and agreed to with your Plan Provider or Plan Specialist

* Make copayments at the time of service
* Notify LIBERTY of changes in family status
* Be aware of and follow the organization's guidelines in seeking dental care
* Your own actions if you refused treatment or do not follow your Plan Provider's or Plan Specialist's treatment plan, instructions
* Understanding your dental benefits, including what is and is not covered

## GENERAL PROVISIONS

### RELATIONSHIP OF PARTIES

The relationship between LIBERTY and Plan Providers is an independent contractor relationship. Plan Providers and LIBERTY have not created any agency, partnership, joint venture, or other form of joint enterprise, employment, or fiduciary relationship. Plan Providers are not agents or employees of LIBERTY, nor is LIBERTY or any employee of LIBERTY an employee or agent of a Plan Provider. LIBERTY does not have any right, power, or authority to act or create an obligation, express or implied, on behalf of Plan Provider in any manner whatsoever. Moreover, Plan Providers do not have any right, power, or authority to act or create an obligation, express or implied, on behalf of LIBERTY in any manner whatsoever. Therefore, LIBERTY is not bound by statements or promises made by Plan Providers or their employees.

Plan Providers assume responsibility for their own actions and the actions of their employees. LIBERTY is not liable for any claims, actions, judgments, damages, lawsuits, costs, expenses, or demands arising of, or in any manner related to, incident or event on any Plan Provider's premises or Plan Provider's act or omission, including, but not limited to, standard of care, harassment, injury, fraud, conversion, or other tort.

**ENTIRE AGREEMENT**

This EOC, along with the Enrollment Forms/Application and Plan Information Page, constitute the entire agreement between the Member and LIBERTY and as of its Effective Date, replace all other agreements between the parties.

**CONTESTABILITY**

Any and all statements made to LIBERTY by any Subscriber or Dependent will, in the absence of fraud, be considered representations and not warranties. Also, no statement, unless it is contained in a written application for coverage, shall be used in defense to a claim under this agreement.

**MODIFICATION OF THE FORM OR CONTENT OF THE EOC**

LIBERTY makes Coverage available to Members who are eligible under the applicable dental plan. LIBERTY may change applicable Premium rates without the Subscriber's consent upon at least thirty (30) days' written notice to the Subscriber. LIBERTY may otherwise amend, modify, or terminate this EOC without the Subscriber's consent upon at least sixty (60) days' written notice to the Subscriber. No Plan Provider or other third party is authorized to amend or modify this EOC or waive any of its provisions.

By electing dental coverage with LIBERTY or otherwise accepting benefits under this plan, you (or, if applicable, your legal representative) agree to all terms and provisions contained in this EOC.

**IDENTIFICATION CARD**

Cards issued by LIBERTY to Members are for identification only. Possession of the LIBERTY identification card does not grant you or your Dependents the right to receive services or other benefits under this Plan.

To be entitled to such services or benefits, the holder of the card must be a current Member whose applicable premiums have been paid. Any person not entitled to receive services or other benefits will be liable for the actual cost of such services or benefits.

**NOTICE**

Any notice to the Plan may be given by United States mail, first class, postage paid, addressed as follows:

LIBERTY Dental Plan of Florida, Inc.

P.O. Box 15149

Tampa, FL 33684-5149

Notice to a Member by LIBERTY will be sent to the Member's last known address.

**OVERPAYMENTS TO PROVIDERS**

LIBERTY has the right to collect overpayments, or otherwise seek reimbursement for incorrect payments, made for healthcare services. Plan Providers and other providers have the responsibility to return to LIBERTY, or reimburse LIBERTY for, any overpayments or incorrect payments made by LIBERTY. LIBERTY has the right to offset any overpayment/incorrect payment against any future payments to such providers. In some cases, LIBERTY may have the right to seek reimbursement of overpayments from you.

**GOVERNING LAW**

Except as preempted by federal law, this EOC is governed in accordance with Florida law, and any provision that is required to be in this EOC by applicable law shall bind Members and LIBERTY whether or not explicitly set forth in this EOC.

**GRACE PERIOD**

The Parties acknowledge and agree that if LIBERTY does not receive Premium payment in full by the end of the month in coverage, this EOC and all coverage afforded under it may be terminated by LIBERTY in accordance with the Termination provisions in this EOC.

**ANSWERS TO COMMON QUESTIONS**

**Are my cleanings covered?** Yes. LIBERTY covers routine cleanings (prophylaxis) at your selected dental office once every 6 months. Some Members may require more than a routine cleaning due to their individual dental needs. If you require a cleaning more frequently than every 6 months, or if you require more extensive treatment (such as root planing or scaling) your Primary Care Dentist may charge you in accordance with your dental plan.

**What if I have a pre-existing condition?** Most pre-existing conditions are covered. However, a procedure started within 3 months prior to your coverage effective date will not be covered by the Plan. A pre-existing condition will not be excluded longer than 2 years from the coverage effective date.

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

**Does the Plan include dental specialists?** Yes. LIBERTY has a contracted network of Dental Specialists. If specialty care is deemed necessary by your Primary Care Dentist, you will be referred to a specialist after coordinating your needs with your Primary Care Dentist. Care from a Prosthodontist is not covered under this plan.

**What if I have other dental coverage?** Your LIBERTY network Primary Care Dentist will apply your reimbursement from any additional coverage you have to your copayment if allowable by your other dental plan carrier. This may reduce your out-of-pocket costs.

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

**Who do I call if I have a question?** Should you have questions once you become a Member, contact our Member Services Department.

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

**P.O. Box 15149**

**Tampa, FL 33684-5149**

**(877) 877-1893**

**REPORTING FRAUD, WASTE, & ABUSE:**

LIBERTY is dedicated to ensuring that it complies with all applicable Federal and state laws, rules, regulations, and procedures, including Federal Exchange requirements. LIBERTY has accordingly developed and instituted a compliance plan (the "Compliance Plan"). The Plan is designed to ensure LIBERTY complies with its regulatory and contractual obligations.

The Compliance Plan not only addresses health care fraud, waste, and abuse ("FWA"), but the requirements and obligations set forth by the Centers for Medicare and Medicaid (CMS) and other applicable laws.

**FWA 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.

**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 as appropriate, and to report confirmed misconduct to the appropriate parties both internal and external.

**Initial Identification:** LIBERTY has established several options, which allow for confidential reporting of violations to LIBERTY'S Special Investigations Unit and LIBERTY'S Compliance Department. LIBERTY has established the following internal mechanisms:

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

In support of the federal Whistleblower Protection Act, Fraud, Waste, or Abuse can be reported confidentially directly to the U.S. Department of Health & Human Services, Office of Inspector General (HHS-OIG) Whistle Blower phone number by dialing 1-800-HHS-TIPS (1-800-377-4950) or TTY 1-800-377-4950.

To Report Fraud, Waste, and Abuse in Federal programs, you may also contact the Government Accountability Office:

Website: http://www.gao.gov/fraudnet/fraudnet.htm
E-mail: fraudnet@gao.gov
Automated answering system: (800) 424-5454 & (202) 512-7470

# NEW MEMBER CONTINUATION OF CARE INFORMATION

# AND PRIVACY STATEMENT

Dear New LIBERTY Dental Plan Member:

If you have been receiving care from a dental care provider, you may have a right to keep your dental care provider for a designated time period. Please contact LIBERTY's Member Services Department at (877) 877-1893.

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

**Privacy Statement**

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

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

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

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

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

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

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

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

Authorization: Other uses and disclosures of protected health information will be made only with your written permission, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing. We will then stop using your information. However, if

we have already used your information based on your authorization, you cannot take back your agreement for those past situations.

## COPIES AND CHANGES

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

## CONTACT INFORMATION

If you want to exercise your rights under this notice, or if you wish to communicate with us about privacy issues, or to file a complaint with us, please contact our Member Services Department at (877) 877-1893.