LIBERTY Dental Plan of Nevada, Inc.

Evidence of Coverage
Nevada Health Link Individual Plans

(Including Essential Pediatric Benefit (EPB) Plans)

This Evidence of Coverage (EOC) provides the following information:

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

A glossary of terms used in this EOC is provided at the end of this document.

For any questions, please contact LIBERTY Dental Plan Member Services Department
(888) 401-1128

LIBERTY Dental Plan of Nevada, Inc. ("LIBERTY" or "the Plan") provides toll-free customer service support Monday through Friday from 5:00 a.m. through 5:00 p.m. to assist members.

Members (also known as "Subscribers") may also log onto our internet site, **www.libertydentalplan.com** to view plan information, view claim status, print ID cards, search for Plan Providers, and send an e-mail notice to our Member Services Department.

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

The Department of Business and Industry
State of Nevada
Division of Insurance
Telephone Numbers for
Consumers of Healthcare

The State of Nevada Division of Insurance ("Division") has established a telephone service to receive inquiries and complaints from consumers of healthcare in Nevada concerning healthcare plans.

The hours of operation of the Division are:
Monday through Friday from 8:00 a.m. until 5:00 p.m., Pacific Standard Time (PST)

The Division local telephone numbers are:
Carson City (775) 687-0700
Las Vegas (702) 486-4009

The Division also provides a toll-free number for consumers residing outside of the above areas:
(888) 872-3234

All questions about any possible Limitation on Pre-existing Conditions should be directed to LIBERTY's Member Services Department:
Address: LIBERTY Dental Plan of Nevada, Inc.
6385 S. Rainbow Suite 200
Las Vegas, NV 98118

Phone: (888) 401-1128 (Monday - Friday from 5:00 a.m. until 5:00 p.m., Pacific Standard Time)

Phone: 855-7-NVLINK (855-768-5465)
Fax: 775-687-9932
email: contact@exchange.nv.gov

EVIDENCE OF COVERAGE

SECTION 1. ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

Subscribers and Dependents who meet the following criteria are eligible for coverage under this EOC.

1.1 WHO IS ELIGIBLE

Subscriber: To be eligible to enroll as a Subscriber, you must:

- Be a United States citizen or national or must be lawfully present in the United States;
- Not be incarcerated (in prison; does not apply if you are awaiting disposition of charges); and
- Live in the plan Service Area.
- [Any and all children up to 19 years of age may be enrolled as subscribers as part of the Essential Pediatric Benefit (EPB) plans. Up to 19 years means up to the 19th birthday.]

Dependent: To be eligible to enroll as a Dependent, a person must be one of the following:

- A Subscriber's legal spouse or a legal spouse for whom a court has ordered coverage.
- A Subscriber's Domestic Partner meeting all of the criteria set forth by the State of Nevada. "Domestic Partner" means a person of at least 18 years of age that has registered for a domestic partnership with the Subscriber under the laws of the State of Nevada with the Nevada Secretary of State.
- Any unmarried dependent child (including an adopted child) who is up to the limiting age of 26 years [19 years as part of the Essential Pediatric Benefit (EPB) plan.]
- Any unmarried child, under the age of 26, who is a full-time student in an accredited educational institution which is eligible for payment of benefits under the Veterans Administration program, and who is financially dependent on the Subscriber. Proof of full-time student status must be given to LIBERTY each semester.
- Any unmarried child, under the age of 26, who is on a religious mission and who is financially dependent on the Subscriber. The religious organization must give LIBERTY a letter, which states the Dependent, is on a religious mission. Proof of the continuation of the religious mission status must be given to LIBERTY at least twice a year.

- Any unmarried child who is incapable of self-sustaining employment due to mental or physical handicap, chiefly dependent upon the Subscriber for economic support and maintenance, who was a Dependent enrolled under this EOC before reaching the limiting age. Proof of incapacity and dependency must be given to LIBERTY by the Subscriber within thirty-one (31) days of the child reaching the limiting age.

LIBERTY requires proof of disability or handicap upon enrollment and may require proof of continuing incapacity and dependency, but not more often than once a year after the first two (2) years beyond when the child reaches the limiting age. LIBERTY's determination of eligibility is final.

Evidence of any court order needed to prove eligibility must be given to LIBERTY.

1.2 WHO IS NOT ELIGIBLE

Eligible Dependents do not include:

- A foster child.
- A child placed in the Subscriber's home other than for the purpose of adoption.
- A grandchild other than:
    - A grandchild that has been adopted by the grandparents and/or has been placed in the home of the grandparents for the purposes of adoption; or
    - For the first thirty-one (31) days after birth only, a grandchild that is also the child of a Dependent as defined in Section 1.1 of this EOC.
- Any other person not defined in Section 1.1.

1.3 CHANGES IN ELIGIBILITY STATUS

It is the Subscriber's responsibility to give LIBERTY written notice within thirty-one (31) days of changes, which affect his Dependents' eligibility. Changes include:

- Reaching the limiting age;
- Death;
- Divorce;
- Marriage;

- Termination of a Domestic Partnership that qualifies for coverage under LIBERTY's Affidavit of Domestic Partnership; or
- Transfer of residence or work outside LIBERTY's Service Area.

If Subscriber fails to give notice, which would have resulted in termination of coverage, LIBERTY shall have the right to terminate coverage retroactively.

1.4 ENROLLMENT

Enrollment is the process through which a Subscriber completes the LIBERTY enrollment documents for himself and for any eligible Dependent, LIBERTY's acceptance for membership of Subscriber and any eligible Dependent and timely payment of the applicable Plan premiums.

LIBERTY can deny membership to or revoke membership of any person who:

- Violates or has violated any provision of a LIBERTY EOC;
- Misrepresents or fails to disclose a material fact which would affect coverage under this Plan;
- Fails to follow LIBERTY rules; or
- Fails to make a premium payment.

1.5 ENROLLMENT THROUGH THE NEVADA HEALTH LINK

A qualified individual may enroll in this Plan through Nevada Health Link. Nevada Health Link follows enrollment rules specified by the Federal Government and the State of Nevada. These enrollment rules may or may not apply if you enroll in this plan directly with LIBERTY. If you enroll in this Plan through Nevada Health Link, you may be eligible for tax credits to help pay for your cost of coverage. The following sections discuss certain rules and benefits of enrollment through Nevada Health Link. Nevada Health Link and full details may be accessed at: http://www.nevadahealthlink.com/.

Eligibility for Advanced Payment of the Premium Tax Credit

A key feature of the Affordable Care Act is the introduction of Advance Payments of the Premium Tax Credit (APTC). These are payments made monthly on your behalf by the Federal government directly to your insurance carrier thereby decreasing your monthly premium payment. It should be noted that you will need to reconcile these credits when you file your taxes with the IRS at the end of the year.

You are generally eligible for the APTC if you:

- Enroll in this Plan through Nevada Health Link;
- Expect to have a household income below 400% of the Federal Poverty Level (FPL) during the plan year;
- Are not eligible for Medicare Part A, Medicaid or other minimum essential coverage; and
- Attest that, for the plan year:
    - You will file an income tax return;
    - You will file a joint tax return (only applies if you are married);
    - No other taxpayer will be able to claim you as a tax dependent; and
    - You will claim a personal exemption deduction on your tax return for the members of your family, including you and your spouse.

Amount of the Advanced Payment of the Premium Tax Credit (APTC)

When you enroll in this Plan through Nevada Health Link, Nevada Health Link will automatically calculate the amount of APTC you should receive. Additionally, the IRS will release guidance to calculate the amount of the APTC when you reconcile your taxes at the end of the year.

1.6 EFFECTIVE DATE OF COVERAGE

Before coverage can become effective, LIBERTY must receive and accept the applicable premium payments and an Enrollment Form for the person applying to be a Member.

If the Enrollment process is completed by the 20th of the month, Plan coverage will begin on the first day of the following calendar month.

A Subscriber's newborn natural child is covered for the first thirty-one (31) days from birth. Coverage continues after thirty-one (31) days only if the Subscriber enrolls the child as a Dependent and the applicable premium is paid within thirty-one (31) days of the date of birth.

An adopted child is covered for the first thirty-one (31) days from birth only if the adoption has been legally completed before the child's birth. A child placed for adoption at any other age is covered for the first thirty-one (31) days after the placement for adoption. Coverage continues after thirty-one (31) days only if the Subscriber enrolls the child as a Dependent and the applicable premium is paid within thirty-one (31) days following the placement of the child in the Subscriber's home. In the event adoption proceedings are terminated, coverage of a child placed for adoption ends on the date the adoption proceedings are terminated.

If a court has ordered Subscriber to cover his or her legal spouse or unmarried minor child, that person will be covered for the first thirty-one (31) days following the date of the court order. Coverage continues after thirty-one (31) days if the Subscriber enrolls the Dependent and the Dependent's applicable premium is paid. A copy of the court order must be given to LIBERTY.

Subscriber must give LIBERTY a copy of the certified birth certificate, decree of adoption, or certificate of placement for adoption for coverage to continue after thirty-one (31) days for newborn and adopted children.

Subscriber must give LIBERTY a copy of the certified marriage certificate, proof of state-registered domestic partnership, proof of student status or any other required documents before coverage can be effective for other Eligible Dependents.

Effective Dates for Eligibility Determinations if Subscriber Enrolls through Nevada Health Link

Nevada Health Link will use the following guidelines to establish your effective dates of coverage:

- The initial open enrollment period begins October 1, 2013 and extends through March 31, 2014. During that period, generally, if you select a Plan and remit payment to Nevada Health Link:
    - On or before December 15, 2013, your coverage effective date will be January 1, 2014;
    - Between the first and the fifteenth day of any subsequent month between January 1, 2014 and March 15, 2014, your coverage effective date will be the first day of the following month;
    - Between the sixteenth and last day of the month of any month between December 15, 2013 and March 31, 2014, your coverage effective date will be the first day of the second following month.
- The annual open enrollment period for plan years beginning on or after January 1, 2015 begins October 15 and extends through December 7 of the preceding calendar year. During that period, generally, if you select a plan and remit payment to Nevada Health Link on or before December 7 your coverage effective date will be the following January 1.

Certain special enrollment situations may result in a mid-plan-year eligibility redetermination that varies from the above open enrollment periods. See Nevada Health Link's website for more details.

1.7 PAYMENT OF PREMIUMS

[Subscribers purchasing this Individual Plan through Nevada Health Link will make payments directly to Nevada Health Link as instructed through www.nevadahealthlink.com. In such cases, any premiums paid to LIBERTY in error will be forwarded by LIBERTY to the Nevada Health Link.]

A Subscriber shall pay all applicable premiums directly to LIBERTY when due. Premiums must be received by LIBERTY by the 1st of the month for each month the Subscriber is insured by LIBERTY. If a Subscriber has questions about the amount, method and frequency of premium payments, the Subscriber should contact LIBERTY.

Premium payments are to be made payable to LIBERTY Dental Plan of Nevada, Inc. and mailed to:

6385 S. Rainbow Blvd, Suite 200
Las Vegas, NV 89118

1.8 RENEWAL

This EOC and Plan coverage is renewable, subject to all the terms and conditions of this EOC. LIBERTY may change the Plan benefits and applicable premiums with at least 60 days written notice to the Subscriber. Plans purchased through Nevada Health Link are subject to the renewal terms of Nevada Health Link as stated in their enrollment materials or posted on their website.

SECTION 2. TERMINATION

2.1 TERMINATION BY LIBERTY

LIBERTY may terminate coverage under this Plan at the times shown for any one or more of the following reasons:

- Failure to maintain eligibility requirements as set forth in Section 1.
- Payment is due on the first day of each month that you are insured by LIBERTY. LIBERTY will provide notice of delinquent payments. The member will be terminated on the 1st day following the grace period, if payment has not been received by LIBERTY.
    - There is a 90 day grace period for payment to be received by LIBERTY for an individual eligible to receive APTC.
    - There is a 30 day grace period for payment to be received by LIBERTY for individuals not eligible to receive APTC. LIBERTY
- On the first day of the month that a contribution was due and not received by LIBERTY.
- With thirty (30) days written notice if the Member allows his or any other Member's LIBERTY ID card to be used by any other person or uses another person's card. The Member will be liable to LIBERTY for all costs incurred as a result of the misuse of the LIBERTY Member card.
- If information given to LIBERTY by the Member in his Enrollment Form is untrue, inaccurate, or incomplete, LIBERTY has the right to declare the coverage under the Plan null and void as of the original Effective Date of coverage if the discovery is made within two (2) years of the document being received by LIBERTY.
- When a Subscriber moves his primary residence outside the Service Area or when a Dependent moves his primary residence outside LIBERTY's Service Area. Subscriber must notify LIBERTY within thirty-one (31) days of the change. LIBERTY will request proof of the change of residence.
- If a Subscriber permits any other person to use their member ID card to obtain services under this dental plan, or otherwise engages in fraud or deception in the 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, termination will be effective immediately upon notice from LIBERTY Dental Plan.

- You may be terminated for abusive or disruptive behavior that impairs LIBERTY activities in engaging contracted Providers and/or furnish or arrange for services to other Members.

- You may be terminated for threatening the life or otherwise threatening the safety of dental office staff, Providers or other Member or Provider's patients.

- You may be terminated from the plan for failure to reimburse LIBERTY for payments made in error on your behalf after a stated billing period is provided. LIBERTY may then send you a notice of termination.

2.2 TERMINATION BY THE SUBSCRIBER

Subscriber has the right to terminate his coverage under the Plan. Such termination is effective on the last day of the month when the notice is received by LIBERTY.

2.3 REINSTATEMENT

Any coverage which has been terminated in any manner may be reinstated by LIBERTY at its sole discretion. Coverage purchased through Nevada Health Link may have additional terms and conditions involving reinstatement as stated in their enrollment materials or website.

2.4 EFFECT OF TERMINATION

No benefits will be paid under this Plan by LIBERTY for services provided after termination of a Member's coverage under this Plan. You will be responsible for payment of all services and supplies incurred after the effective date of the termination of this EOC.

In some cases, an individual procedure that was started during coverage, for which premium payment was received by LIBERTY and for which payment has been made by LIBERTY or the Subscriber, may be completed after the date of termination, by the provider who started the procedure. This is not available if you were terminated due to fraud or not following the rules of the LIBERTY dental plan.

2.5 TERMINATION FOR SUBSCRIBERS ENROLLED THROUGH NEVADA HEALTH LINK

During the course of the benefit plan year, either the Subscriber or Nevada Health Link may need to terminate a Subscriber's coverage in a Plan. The following events may also trigger a termination:

- **Voluntary Termination** – Subscriber provides notice to Nevada Health Link that Subscriber would like to terminate coverage;

- **Loss of Eligibility** – Subscriber is no longer eligible for coverage through Nevada Health Link;

- **Non-payment** – Subscriber fails to pay premiums by the appropriate deadlines and the following grace periods have been exhausted:

    - For an individual eligible to receive APTC, the 3-month grace period provided by Nevada Health Link has been exhausted; and

    - For individuals not eligible to receive APTC, the 30 day grace period has been exhausted;

- **Rescission** – Subscriber's coverage is rescinded by LIBERTY;

- **Withdrawal of Product or Decertification** – The Plan is withdrawn by LIBERTY and terminates or is decertified by Nevada Health Link; or

- Subscriber changes from one Plan to another during an annual open enrollment period or special enrollment period.

For the purposes of this section, reasonable or appropriate notice is defined as fourteen days from the requested effective date of termination.

In the case of voluntary termination by Subscriber, the last day of coverage is:

- The termination date specified by Subscriber, if Subscriber provides reasonable notice.

- Fourteen days after the termination is requested by Subscriber, if Subscriber does not provide reasonable notice.

- On a date determined by LIBERTY, if LIBERTY is able to complete the termination in fewer than fourteen days and Subscriber requests an earlier termination effective date.

- If the enrollee is newly eligible for Medicaid, Medicare, or CHIP, the last day of coverage is the day before such coverage begins.

In the case of termination for non-payment coverage ends:

- For individuals who are eligible for the APTC, on the last day of the month for which premium payment was received in full during the non-payment grace period, but no earlier than the last day of the first month of that grace period.

- For individuals who are not eligible for the APTC, on the last day of the month for which premium payment was received in full.

In the case of termination due to Subscriber changing from one Plan to another during an annual open enrollment period or special enrollment period, the last day of coverage in the Plan is the day before the effective date of coverage in his or her new plan.

EVIDENCE OF COVERAGE

SECTION 3. USING THIS PLAN

3.1 PRIMARY CARE GENERAL DENTISTRY

LIBERTY offers you a choice of where you receive your dental care. You must receive care from one of our contracted primary care Plan Providers. When you receive your care from any dentist that is a contracted Plan Provider, your costs will be limited by the costs identified in the Schedule of Benefits. You will also not need to submit any claim forms when you receive your care from a Plan Provider. To receive in-network benefits for care provided by a Specialist your primary care Plan Provider must initiate the referral process with LIBERTY. LIBERTY will then refer you to a Specialist who is a participating Specialty Provider for approved Specialty services.

You and your dependents can choose a contracted primary care Plan Provider from a network of private practice dental offices. A list of Plan Providers is available through the Plan.

3.2 REFERRAL TO A SPECIALIST

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

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

If your specialty referral preauthorization is denied or you are dissatisfied with the preauthorization, you have the right to file a grievance. See EOC section, 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.

3.3 LIABILITY FOR PAYMENT

You are responsible for payment of premiums and listed co-payments for any covered services subject to the limitations and exclusions of your plan.

You may be responsible for other charges for non-covered or optional services as described in this Evidence of Coverage document. For non-covered services you will be responsible for the dentist's usual fee. You should discuss any charges for non-covered or optional services directly with your Provider.

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. To

avoid any financial misunderstandings, you may wish to obtain a written disclosure of all services proposed or received, whether covered or not.

Unless pre-approved by LIBERTY, if you have services from a non-contracted dentist or facility, you are responsible for that dentist's usual fee. If a pre-authorization was required and you did not have the treatment pre-authorized, you are responsible for the provider's usual fee. Emergency services may be available out-of-network or without pre-authorization in some situations (see Emergency Dental Care section below).

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

In no event are you ever responsible for any sums owed to a contracted Provider by LIBERTY.

EVIDENCE OF COVERAGE

SECTION 4. COVERED SERVICES

This section tells you what services are covered under this Plan. Only services and supplies, which meet LIBERTY's definition of Dentally Necessary and are identified as covered benefits on the Benefits Schedule will be considered to be Covered Services. The Benefit Schedule shows applicable Copayments and benefit limitations for Covered Services.

4.1 BENEFITS AVAILABLE

Subject to the Exclusions listed herein, dental services related to a Member's dental health as identified In the Benefits Schedule and that are Dentally Necessary are available to Members. In-network benefits must be obtained from Plan Providers. The Benefit Schedule identifies the member copayments that are to be paid to Plan Providers at the time of service.

4.2 CLAIM PAYMENTS

Plan Providers are paid an amount agreed upon between the Plan and the Plan Provider plus any copayment from the Member required by the Benefit Schedule.

No payments shall be made under this EOC with respect to any claim, including additions or corrections to a claim which has already been submitted, that is not received by LIBERTY within twelve (12) months after the date Covered Services were provided.

Denials of claims can be submitted to the Plan's Grievance procedures described in this EOC.

4.3 EMERGENCY SERVICES

In the event of an emergency outside of LIBERTY's service, the Member should contact LIBERTY at (888) 401-1128. LIBERTY will direct you to an available Plan Provider if possible. Should no Plan Provider be available in a fifty (50) mile radius you can seek treatment from an out-of-network provider. In such an event, the Plan will reimburse you for the cost of qualified emergency services received from an out-of-network provider up to a maximum of seventy-five dollars ($75), less any applicable member co-payments based on the In-Network Benefits.

LIBERTY 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.

Qualified emergency dental service and care include a dental screening, examination, evaluation by a dentist or dental specialist to determine if an emergency dental condition exists, and to provide care that would be acknowledged as within professionally recognized standards of care in order to alleviate any emergency symptoms in a dental office. You should return to your primary care Plan Provider for any necessary continuing care following the emergency services received.

4.4 SECOND OPINIONS

At no cost to you, you may request a second dental opinion when appropriate, by directly contacting Member Services either by calling the toll-free number (888) 401-1128 or by writing to: LIBERTY Dental Plan of Nevada, 6385 S. Rainbow Blvd. suite 200, Las Vegas, NV, 89118. Your primary care dentist may also request a second dental opinion on your behalf by submitting a Standard Specialty or Orthodontic Referral form with appropriate x-rays. All requests for a second dental opinion are approved by LIBERTY Dental Plan within 72 hours of receipt of such request. Upon approval, LIBERTY Dental Plan will make the appropriate second dental opinion arrangements and advise the attending dentist of your concerns. You will then be advised of the arrangement so an appointment can be scheduled. Upon request, you may obtain a copy of LIBERTY Dental Plan's policy description for a second dental opinion.

SECTION 5. EXCLUSIONS AND LIMITATIONS

5.1 EXCLUSIONS

In addition to items identified as NOT COVERED In the Benefits Schedule, this section tells you what services or supplies are excluded from coverage under this Plan.

- Any procedure not specifically listed as a Covered Benefit.
- Replacement of lost or stolen prosthetics or appliances including partial dentures, full dentures, and orthodontic appliances.
- General anesthesia, analgesia, intravenous/intramuscular sedation or the services of an anesthesiologist other than those situations described in the Schedule of Benefits.
- Treatment started prior to coverage or after termination of coverage.
- Services for cosmetic purposes or for conditions that are a result of hereditary developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.
- Procedures which are determined not to be dentally necessary consistent with professionally recognized standards of dental practice.
- Procedures performed on natural teeth solely to increase vertical dimension or restore occlusion.
- Any service performed outside of a contracted LIBERTY dental office, unless expressly authorized by LIBERTY, or unless as outlined and covered in the "Emergency Dental Care" section of the Evidence of Coverage.
- The removal of asymptomatic, un-erupted third molars (or other teeth) that appear to have an unimpeded pathway to eruption and no active pathology.
- Procedures or appliances that are provided by a dentist who specializes in prosthodontic services.
- Services for restoring tooth structure lost from wear (abrasion, erosion, attrition or abfraction), for rebuilding occlusion or maintaining chewing surfaces or teeth that are out of alignment or for stabilizing teeth. Examples of such treatment are equilibration and periodontal splinting.
- Any routine dental services performed by a dentist or dental specialist in an inpatient/outpatient hospital setting.
- Consultations for non-covered services.

- Procedures, appliances or restorations to treat congenital or developmental situations (including supernumerary teeth) or medically induced dental disorders, including but not limited to; myofunctional treatment (e.g. speech therapy) or myoskeletal dysfunctions, unless otherwise covered as an orthodontic benefit.

5.2 LIMITATIONS

In addition to the limitations of coverage identified in the Benefits Schedule, this section tells you when LIBERTY's duty to provide or arrange for services is limited.

- Oral Examinations are limited to two (2) units per plan year
- Complete series of x-rays (full mouth x-rays) is limited to one (1) per 11 month period.
- Panoramic Image is limited to one (1) per three (3) plan years.
- Occlusal radiographic image is limited to two (2) units per 12 month period.
- Bitewing radiographic images are limited to one (1) series per 6 month period.
- Prophylaxis procedures are covered two (2) per plan year.
- Fluoride treatments are covered two (2) per plan year.
- Sealants are covered only on the first and second permanent molars, limited to one (1) per tooth per lifetime
- Fillings are limited to one (1) per tooth per surface every 12 consecutive months. If replacement restoration is less than 12 months performed by same dental office or provider it is not chargeable to the plan or member.
- Fabricated Crowns, Inlays, Onlays, Veneers, and Bridges are limited to one (1) per permanent tooth in a five (5) year period. Member must meet medical necessity as determined by a dentist.
- Prefabricated Stainless Steel Crowns, primary teeth is limited to one (1) per tooth per 36 month period, permanent teeth is limited to one (1) per tooth in a lifetime.
- Periodontal Surgical Services are limited to one (1) surgical procedure per site or quadrant per 60 month period.

- Periodontal Scaling & Root Planing is limited to one (1) per site or quadrant per 12 month period
- Full Mouth Debridement is limited to one (1) per 24 consecutive months
- Full Dentures and/or Partial Dentures are limited one (1) appliance per arch per 60 month period. Members must meet medical necessity as determined by a dentist
- Denture and/or Partial Relines are limited to one (1) per arch per 6 month period
- Complete and/or Partial Interim Dentures are limited to one (1) per arch per 5 year period. Member must meet medical necessity as determined by a dentist.
- Deep Sedation/General Anesthesia is a plan benefit only in conjunction with covered oral surgery procedures and covered pedodontic procedures.
- Procedures that appear to have a poor prognosis as determined by a licensed LIBERTY dental consultant are not covered.

SECTION 6. GENERAL PROVISIONS

6.1 RELATIONSHIP OF PARTIES

The relationship between LIBERTY and Plan Providers is an independent contractor 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 is not liable for any claim or demand on account of damages as a result of, or in any manner connected with, any injury suffered by a Member while receiving care from any Plan Provider or in any Plan Provider's facility. LIBERTY is not bound by statements or promises made by its Plan Providers.

6.2 ENTIRE AGREEMENT

This EOC along with the Enrollment Forms/Application constitute the entire agreement between the Member and LIBERTY and as of Its Effective Date, replaces all other agreements between the parties.

6.3 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.

6.4 AUTHORITY TO CHANGE THE FORM OR CONTENT OF EOC

No agent or employee of LIBERTY is authorized to change the agreement or waive any of its provisions. Such changes can be made only through an amendment authorized and signed by an officer of LIBERTY.

6.5 IDENTIFICATION CARD

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

To be entitled to such services or benefits, the holder of the card must in fact be a Member and all applicable premiums must actually 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.

6.6 NOTICE

Any notice under this plan may be given by United States mail, first class, postage paid, addressed as follows:
LIBERTY Dental Plan of Nevada, Inc.
6385 S. Rainbow Blvd. Suite 200
Las Vegas, NV 89118

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

6.7 ASSIGNMENT

This EOC, the coverage and any benefits under this Plan are not assignable by any Member without the written consent of LIBERTY.

6.8 MODIFICATIONS

This EOC is subject to amendment or modification by LIBERTY with at least sixty (60) days written notice to the Subscriber prior to the effective date of the amendment or modification.

By electing dental coverage with LIBERTY or accepting benefits under this Plan, all Members legally capable of contracting and the legal representatives of all Members incapable of contracting, agree to all terms and provisions.

6.9 CLERICAL ERROR

Clerical error in keeping any record pertaining to the coverage will not invalidate coverage in force or continue coverage terminated.

6.10 POLICIES AND PROCEDURES

LIBERTY may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this EOC with which Members shall comply. These policies and procedures are maintained by LIBERTY at its offices. Such policies and procedures may have bearing on whether dental service and/or supply are covered.

6.11 OVERPAYMENTS

LIBERTY has the right to collect payments for healthcare services made in error. Dentists, Specialists and other providers have the responsibility to return any overpayments or incorrect payments to LIBERTY. LIBERTY has the right to offset any overpayment against any future payments. In some cases LIBERTY may have the right to seek reimbursement of overpayments from you as the covered Member.

6.12 RELEASE OF RECORDS

Each Member authorizes their providers to permit the examination and copying of the Member’s medical records, as requested by LIBERTY.

6.13 GENDER REFERENCES

Whenever a masculine pronoun is used in this EOC, it also includes the feminine pronoun.

6.14 AVAILABILITY OF PROVIDERS

LIBERTY does not guarantee the continued availability of any Plan Provider.

6.15 GOVERNING LAW

Except as pre-empted by federal law, this EOC is governed in accordance with Nevada law and any provision that is required to be in this EOC by state or federal law shall bind Members and LIBERTY whether or not set forth in this Agreement.

6.16 NO WAIVER

LIBERTY's failure to enforce any provision of this EOC will not constitute waiver of that or any other provision, or impair LIBERTY's right thereafter to require a Member's strict performance of any provision.

EVIDENCE OF COVERAGE

SECTION 7. APPEALS AND GRIEVANCES

The LIBERTY Appeals Procedures are available to you in the event you are dissatisfied with some aspect of the Plan administration, you wish to appeal an Adverse Benefit Determination or there is another concern you wish to bring to LIBERTY's attention. This procedure does not apply to any problem of misunderstanding or misinformation that can be promptly resolved by the Plan supplying the Member with the appropriate information.

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 considers complaints, grievances and appeals as the same.

Please see the Glossary terms for a description of the terms used in this section.

The following Appeals Procedures will be followed if the dental service site matter cannot be resolved at the site or if the concern involves the Adverse Benefit Determination of a Claim for Benefits.

- **Informal Review:** An Adverse Benefit Determination or other complaint/concern which is directed to the LIBERTY Member Services Department via phone or in person. If an Informal Review is resolved to the satisfaction of the Member, the matter ends. The Informal Review is voluntary.

- **1st Level Formal Appeal:** An appeal of an Adverse Benefit Determination filed either orally or in writing which LIBERTY's Quality Management Department investigates. If a 1st Level Formal Appeal is resolved to the satisfaction of the Member, the appeal is closed. The 1st Level Formal Appeal is mandatory if the Member is not satisfied with the initial determination and the Member wishes to appeal such determination.

- **Additional Formal Appeals:** If a 1st Level Formal Appeal is not resolved to the Member's satisfaction, a Member may then file subsequent appeals. Subsequent appeals must be submitted in writing and are reviewed by the Grievance Review Committee. Subsequent appeals are voluntary for all Adverse Benefit Determinations.

- **Grievance Review Committee:** A committee of three (3) or more individuals which may include a Dental Consultant or Dental Director when necessary to evaluate clinical issues.

- **Member Services Representative:** An employee of LIBERTY that is assigned to assist the Member or the Member's authorized representative in filing a grievance with LIBERTY or appealing an Adverse Benefit Determination.

- **Grievance Analyst:** An employee of LIBERTY whose primary duty is to research and process the Member's complaint, grievance or appeal.

7.1 INFORMAL REVIEW

A Member who has received an Adverse Benefit Determination of a Claim for Benefits may request an Informal Review. All Informal Reviews must be made to LIBERTY's Member Services Department within sixty (60) days of the Adverse Benefit Determination. Informal Reviews not filed in a timely manner will be deemed waived. The Informal Review is a voluntary level of appeal.

Upon the initiation of an Informal Review, a Member must provide Member Services with at least the following information:

- The Member's name (or name of Member and Member's Authorized Representative), address, and telephone number;

- The Member's LIBERTY membership number; and

- A brief statement of the nature of the matter, the reason(s) for the appeal, and why the Member feels that the Adverse Benefit Determination was wrong.

The Member Services Representative will inform the Member that upon review and investigation of the relevant information, LIBERTY will make a determination of the Informal Review. The determination will be made as soon as reasonably possible but will not exceed thirty (30) days unless more time is required for fact-finding. If the determination of the Informal Review is not acceptable to the Member and the Member wishes to pursue the matter further, the Member may file a 1st Level Formal Appeal.

7.2 FIRST LEVEL FORMAL APPEAL

When an Informal Review is not resolved in a manner that is satisfactory to the Member or when the Member chooses not to file an Informal Review and the Member wishes to pursue the matter further, the Member must file a 1st Level Formal Appeal. The 1st Level Formal Appeal may be submitted either verbally or in writing to LIBERTY's Quality Management Department within one hundred eighty (180) days of an Adverse Benefit Determination. 1st Level Formal Appeals not filed in a timely manner will be deemed waived with respect to the Adverse Benefit Determination to which they relate.

The 1st Level Formal Appeal shall contain at least the following information:

- The Member's name (or name of Member and Member's Authorized Representative), address, and telephone number;
- The Member's LIBERTY membership number; and
- A brief statement of the nature of the matter, the reason(s) for the appeal, and why the Member feels that the Adverse Benefit Determination was wrong.

Additionally, the Member may submit any supporting medical/dental records, Dentist's letters or other information that explains why LIBERTY should approve the Claim for Benefits. The Member can request the assistance of a Member Services Representative at any time during this process.

The 1st Level Formal Appeals should be sent or faxed to the following:

Address: LIBERTY Dental Plan of Nevada, Inc.
Attn: Quality Management Dept.
6385 S. Rainbow Blvd. Suite 200
Las Vegas, NV 89118
Fax: (888) 401-1129

LIBERTY will investigate the appeal. When the investigation is complete, the Member will be informed in writing of the resolution within thirty (30) days of receipt of the request for the 1st Level Formal Appeal. This period may be extended one (1) time by LIBERTY for up to fifteen (15) days, provided that the extension is necessary due to matters beyond the control of LIBERTY and LIBERTY notifies the Member prior to the expiration of the initial thirty (30) day period of the circumstances requiring the extension and the date by which LIBERTY expects to render a decision. If the extension is necessary due to a failure of the Member 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 forty-five (45) days from receipt of the notice to provide the information.

1st Level Formal Appeals will be decided by a Grievance Review Committee.
If the 1st Level Formal Appeal results in an Adverse Benefit Determination, the Member will be informed in writing of the following:

- The specific reason or reasons for upholding the Adverse Benefit Determination;
- Reference to the specific Plan provisions on which the determination is based;
- A statement that the Member is entitled to receive, upon request reasonable access to, and copies of, all documents, records, and other information relevant

to the Member's Claim for Benefits used by LIBERTY in the processing of the grievance or appeal;

- A statement describing any voluntary appeal procedures offered by LIBERTY and the Member's right to receive additional information describing such procedures;

- A statement that any internal rule, guideline, protocol or other similar criteria that was relied on in making the determination is available free of charge upon the Member's request; and

- If the Adverse Benefit Determination is based on Medical Necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment or a statement that such explanation will be provided free of charge.

Limited extensions may be required if additional information is required in order for LIBERTY to reach a resolution.

If the resolution to the 1st Level Formal Appeal is not acceptable to the Member and the Member wishes to pursue the matter further, the Member is entitled to file a subsequent Formal Appeal. The Member will be informed of this right at the time the Member is informed of the resolution of his 1st Level Formal Appeal.

7.3 EXPEDITED APPEAL

The Member can ask (either orally or in writing) for an Expedited Appeal of an Adverse Benefit Determination for a Pre-Service Claim that the Member or his Dentist believe that the health of the Member could be seriously harmed by waiting for a routine appeal decision. Expedited Appeals are not available for appeals regarding denied claims for benefit payment (Post-Service Claim). Expedited Appeals must be decided no later than seventy-two (72) hours after receipt of the appeal, provided all necessary information has been submitted to LIBERTY. If the initial notification was oral, LIBERTY shall provide a written or electronic explanation to the Member within three (3) days of the oral notification.

If insufficient information is received, LIBERTY shall notify the Member as soon as possible, but no later than twenty-four (24) hours after receipt of the claim of the specific information necessary to complete the claim. The Member will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. LIBERTY shall notify the Member of the benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of:

- LIBERTY's receipt of the specified information, or

- The end of the period afforded the Member to provide the specified information.

If the Member's Dentist requests an Expedited Appeal, or supports a Member's request for an Expedited Appeal, and indicates that waiting for a routine appeal could seriously harm the health of the Member or subject the Member to unmanageable severe pain that cannot be adequately managed without care or treatment that is the subject of the Claim for Benefits, LIBERTY will automatically grant an Expedited Appeal.

If a request for an Expedited Appeal is submitted without support of the Member's Dentist, LIBERTY shall decide whether the Member's health requires an Expedited Appeal. If an Expedited Appeal is not granted, LIBERTY will provide a decision within thirty (30) days, subject to the routine appeals process for Pre-Service Claims.

7.4 SUBSEQUENT APPEALS

When a 1st Level Formal Appeal is not resolved in a manner that is satisfactory to the Member, the Member may initiate a subsequent Formal Appeal. This appeal must be submitted in writing within thirty (30) days after the Member has been informed of the resolution of the 1st Level Formal Appeal.

Exhaustion of the 1st Level Formal Appeal procedure is a precondition to filing a subsequent Formal Appeal. Subsequent Formal Appeals not filed in a timely manner will be deemed waived with respect to the Adverse Benefit Determination to which it relates. A subsequent Appeal is voluntary for all Pre-Service and Post-Service Claims for Benefits.

The Member shall be entitled to the same reasonable access to copies of documents used in the processing of the previous grievance or appeal as referenced above under the 1st Level Formal Appeal.

The Member can request the assistance of a Member Services Representative at any time during this process.

Upon request a Member is entitled to attend and provide a formal presentation of their Appeal. If such a hearing is requested LIBERTY shall make every reasonable effort to schedule one at a time mutually convenient to the parties involved. Hearings may be in person or telephonic as deemed appropriate by the LIBERTY Dental Director. LIBERTY will provide reasonable accommodation to the Member in scheduling the Hearing. Repeated refusal on the part of the Member to cooperate in the scheduling of the formal presentation shall relieve LIBERTY of the responsibility of hearing a formal presentation, but not of reviewing the Appeal. If a formal presentation is held, the Member will be permitted to provide documents to the Grievance Review Committee and to have assistance in presenting the matter to the Grievance Review Committee, including representation by counsel. However, LIBERTY must be notified at least five (5) business days before the date of the scheduled formal presentation of the Member's

intent to be represented by counsel and/or to have others present during the formal presentation. Additionally, the Member must provide LIBERTY with copies of all documents the Member may use at the formal presentation (5) business days before the date of the scheduled formal presentation.

Upon LIBERTY's receipt of the written request, the request will be forwarded to the Grievance Review Committee along with all available documentation relating to the appeal.

The Grievance Review Committee shall:

- consider the Appeal;
- schedule and conduct a formal presentation if applicable;
- obtain additional information from the Member and/or staff as it deems appropriate; and
- make a decision and communicate its decision to the Member within thirty (30) days following LIBERTY's receipt of the request for a Subsequent Formal Appeal.

If the resolution of the Appeal results in an Adverse Benefit Determination, the Member will be informed in writing of the following:

- The specific reason or reasons for upholding the Adverse Benefit Determination;
- Reference to the specific Plan provisions on which the benefit determination is based; and
- A statement describing additional voluntary levels of appeal available, if any.

Limited extensions may be required if additional information is required or a formal presentation is requested and the Member agrees to the extension of time.

SECTION 8: MISCELLANEOUS PROVISIONS

8.1 COORDINATION OF BENEFITS

As a covered Member, you will always receive your LIBERTY benefits. LIBERTY does not consider your Individual Plan secondary to any other coverage you might have. You are entitled to receive benefits as listed in this EOC document despite any other coverage you might have in addition.

8.2 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 the liabilities of another third party are, you agree to cooperate in LIBERTY's processes to be reimbursed for these services.

8.3 ACCESS TO PATIENT RECORDS

You have the right to receive upon request, reasonable access to, and copies of, all documents, records and other information relevant to any claim for benefits used by LIBERTY in the processing of a claim, grievance or appeal. Routine requests for records from your dentist may carry a nominal charge for duplication of these materials as per NV state law. In addition, dentists may have a reasonable time to comply with requests for record duplication as per NV state law.

8.4 NON DISCRIMINATION

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

8.5 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 general dentist who submits claims or encounters on your behalf. Your specialty care services are reported to LIBERTY via the specialist. If you receive services out-of-network due to an emergency after-hours or out-of-area situation, consult the section above for submitting your expenses to LIBERTY to receive reimbursement (see Section 4.4 Emergency Services above).

SECTION 9. GLOSSARY

"**Adverse Benefit Determination**" means a decision by the Plan to deny, in whole or in part, a Member's Claim for Benefits. Receipt of an Adverse Benefit Determination entitles the Member or his Authorized Representative to appeal the decision, utilizing LIBERTY's Appeals Procedures.

The External Review provision in this EOC only applies if the Adverse Benefit Determination was made based on the Plan's determination that the denied service or supply was not necessary or that the denied service or supply was determined to be experimental or investigational. External Reviews are not available when the Adverse Benefit Determination was based on an exclusion of the dental benefit plan or when a service is not a covered service of the plan.

An Adverse Benefit Determination is final if the Member has exhausted all complaint and Appeal Procedures set forth herein for the review of such Adverse Benefit Determination.

"**Aesthetic Dentistry**" means any dental procedure performed for cosmetic purposes and/or where there is not restorative value.

"**Authorized Representative**" means a person designated by the Member to act on his behalf in pursuing a Claim for Benefits to file an appeal of an Adverse Benefit Determination, or in obtaining an External Review of a final Adverse Benefit Determination.

"**Benefit Schedule**" means the brief summary of benefits, limitations and Copayments given to the Subscriber by LIBERTY. It is Attachment A to this EOC.

"**Calendar Year**" means January 1 through December 31 of the same year.

"**Claim for Benefits**" means a request for a Plan benefit or benefits made by a Member or his Dentist in accordance with the Plan's processing or Appeals Procedures, including any Pre-Service Claims (requests for Prior Authorization) and Post-Service Claims (requests for benefit payment).

"**Copayment**" means the amount the Member pays directly to a Plan Provider when a Covered Service is received.

"**Covered Services**" means the dental services, related supplies and accommodations for which the plan pays benefits under this Plan.

"**Dental Director**" means a Nevada licensed dentist who is contracted with or employed by LIBERTY to provide professional advice concerning dental care to Members under the applicable EOC.

"**Dentist**" means an individual who is licensed as a Doctor of Dental Surgery (D.D.S.) or a Doctor of Dental Medicine (D.M.D.) in accordance with applicable state laws and regulations and who is practicing within the scope of such license.

"**Dependent**" means an Eligible Family Member or Qualified Domestic Partner of the Subscriber's family who:

- meets the eligibility requirements of the Plan as set forth in Section 1 of this EOC, including services pursuant to a plan purchased through Nevada Health Link;
- is enrolled under this Plan; and
- for whom premiums have been received and accepted by LIBERTY.

"**Domestic Partner**" means a person of at least 18 years of age has registered for a domestic partnership with Subscriber under the laws of the State of Nevada with the Nevada Secretary of State.

"**Effective Date**" means the initial date on which Members are covered for services under the LIBERTY Plan provided any applicable premiums have been received and accepted by LIBERTY.

"**Elective Dentistry**" means any dental procedure that is unnecessary to the dental health of the patient as determined by LIBERTY's Dental Director.

"**Eligible Family Member**" means a member of a Subscriber's family that is or becomes eligible to enroll for coverage under this Plan.

"**Emergency Services**" means Covered Services provided after the sudden onset of a dental condition with symptoms including pain, bleeding or swelling severe enough to cause a prudent person to believe that lack of immediate medical attention could result in serious:

- jeopardy to his health;
- jeopardy to the health of an unborn child;
- impairment of a bodily function; or
- dysfunction of any bodily organ or part.

"**Enrollment Date**" means the first day of coverage under this Plan or, if there is a Waiting Period, the first day of the Waiting Period.

"**Evidence of Coverage**" or "**EOC**" means this document, including any attachments or endorsements, the Member identification card, health statements and all applications received by LIBERTY.

"**Dentally Necessary**" or "**Necessary**" means a service or supply needed to improve a specific condition or to preserve the Member's dental health and which, as determined by LIBERTY is:

- consistent with the diagnosis and treatment of the Member;
- consistent with generally acceptable clinical practices of the community;
- the most appropriate level of service which can be safely provided to the Member; and
- not solely for the convenience of the Member or the Provider(s).

In determining whether a service or supply is Necessary, LIBERTY may give consideration to any or all of the following:

- the likelihood of a certain service or supply producing a significant positive outcome;
- reports in professional dental literature;
- evidence-based reports and guidelines published by nationally recognized professional organizations that include supporting scientific data;
- professional standards of safety and effectiveness that are generally recognized in the United States for diagnosis, care or treatment;
- the opinions of independent expert Dentists (including dental specialists) when such opinions are based on broad professional consensus; or
- other relevant Information obtained by LIBERTY.

Services will not automatically be considered Dentally Necessary simply because they were prescribed by a Dentist.

"**Member**" means a person who meets the eligibility requirements of Section 1, who has enrolled under this Plan and for whom premiums have been received by LIBERTY. (Also known as "Subscriber")

"**Non-Plan Provider**" or "**Out-of-network Provider**" means a Provider who does not have an independent contractor agreement with LIBERTY.

"**Plan**" means LIBERTY Dental Plan of Nevada, Inc.

"**Plan Provider**" means a Provider who has an independent contractor agreement with LIBERTY to provide certain Covered Services to Members. A Plan Provider's agreement with LIBERTY may terminate, and a Member will be required to select another Plan Provider.

"**Post-Service Claim**" means any Claim for Benefits under a Plan regarding payment of benefits for services already completed or rendered that is not considered a Pre-Service Claim.

"**Prescription Drug**" means a Federal Legend drug or medicine that can only be obtained by a prescription order or that is restricted to prescription dispensing by state law. It also includes insulin and glucagon.

"**Pre-Service Claim**" means any Claim or authorization or determination of Benefits under a LIBERTY dental plan, in advance of obtaining the requested services.

"**Prior Authorization**" or "**Prior Authorized**" means a system that requires a Provider to get approval from LIBERTY before providing non-emergency health care services to a Member for those services to be considered Covered Services. Prior authorization is not an agreement to pay for a service.

"**Qualified Domestic Partner**" means a Domestic Partner that is *in* a Qualified Domestic Partnership with Subscriber.

"**Qualified Domestic Partnership**" means a relationship between Subscriber and a Domestic Partner in which:

- A valid domestic partnership is registered in the State of Nevada when two persons who satisfy the requirements of subsection 2:
    - File with the Office of the Secretary of State, on a form prescribed by the Secretary of State, a signed and notarized statement declaring that both persons:
        - Have chosen to share one another's lives in an intimate and committed relationship of mutual caring; and
        - Desire of their own free will to enter into a domestic partnership; and
    - Pay to the Office of the Secretary of State a reasonable filing fee established by the Secretary of State, which filing fee must not exceed the total of an amount set by the Secretary of State to estimate:
        - The cost incurred by the Secretary of State to issue the Certificate described in subsection 3; and
        - Any other associated administrative costs incurred by the Secretary of State.

- To be eligible to register pursuant to subsection 1, two persons desiring to enter into a domestic partnership must furnish proof satisfactory to the Office of the Secretary of State that:
    - Both persons have a common residence;
    - Except as otherwise provided in NRS 122A.500, neither person is married or a member of another domestic partnership;
    - The two persons are not related by blood in a way that would prevent them from being married to each other in this State;
    - Both persons are at least 18 years of age; and
    - Both persons are competent to consent to the domestic partnership.
- The Office of the Secretary of State shall issue a Certificate of Registered Domestic Partnership to persons who satisfy the applicable requirements of this section.
- As used in this section:
    - "Common residence" means a residence shared by both domestic partners on at least a part-time basis, irrespective of whether:
        - Ownership of the residence or the right to occupy the residence is in the name of only one of the domestic partners; and
        - One or both of the domestic partners owns or occupies an additional residence.
    - "Residence" means any house, room, apartment, tenement or other building, vehicle, vehicle trailer, semitrailer, house trailer or boat designed or intended for occupancy as a residence.

"**Referral**" means a recommendation for a Member to receive a service or care from another Provider or facility.

"**Retrospective**" or "**Retrospectively**" means a review of an event after it has taken place.

"**Rider**" means a provision of the dental plan coverage added to the agreement or the EOC to expand benefits or coverage.

"**Service Area**" means the geographical area where LIBERTY is licensed to operate. Subscribers must live (or work) in the Service Area to be covered under this Plan. Dependent children that are covered under this Plan, due to a court order, do not have to reside within the Service Area.

"**Specialist**" means a Plan Provider who has an independent contractor agreement with LIBERTY to assume responsibility for the delivery of specialty dental services to Members. These specialty dental services include any services not related to the ongoing primary or regular dental care of a patient. Specialty dental services include specific fields of dentistry such as endodontics, periodontics, oral surgery, or orthodontics.

"**Subscriber**" means an individual who meets the eligibility requirements, who has enrolled under the Plan, and for whom premiums have been received; also known as "Member".