Group Evidence of Coverage

Evidence of Coverage & Disclosure Form

Plan LIBERTY

FL Pediatric Low with Adult Option

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 ONLY A SUMMARY OF THE DENTAL PLAN. THE DENTAL PLAN CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE.

LIBERTY Dental Plan is in compliance with the Federal Patient Protection and Affordable Coverage Act of 2010 (PPACA). If any provision of PPACA conflicts with any of the provisions of this Certificate of Coverage, the Certificate will be interpreted to be compliant with PPACA

WELCOME TO LIBERTY DENTAL

Your group has joined LIBERTY Dental Plan. This document provides you with essential information about your Group Contract.

Your dental care is received through LIBERTY Dental'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 are also here to assist you with information about non-dental services, such as how to obtain transportation to and from your dental office if you are unable to get to your appointments.

This is your Evidence of Coverage, Disclosure Form, and Member Services Guide. This form is a summary of the dental services available to you as an Enrollee of LIBERTY Dental Plan. It is only a summary of your Group plan.

This Evidence of Coverage provides the following information:

- * The advantages of your LIBERTY 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 Copayment Schedule of Benefits and any applicable Benefit Riders which are attached to the Evidence of Coverage. The Schedule and applicable Riders detail the benefits available to you as well as Exclusions and Limitations of coverage.

This Evidence of Coverage and Copayment 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 Dental Plan 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.

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LIBERTY Dental Plan BENEFITS ARE EASY TO USE

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

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

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

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

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

THE LIBERTY Dental Plan ADVANTAGES

* No Claim Forms
* No Deductibles
* Low Out-of-Pocket Costs
* Selection of Pre-screened Dentists & Specialists
* Multi-Lingual Provider Network
* Change Dentist Selection Any Time
* Orthodontic Coverage
* Most Pre-existing Conditions Covered

* Network Dentists Provide 24-hour Access to Emergency Care
* Toll-Free Member Assistance Lines

The hearing and speech impaired may use the Florida Relay Service toll-free telephone number (800) 955-8771 (TTY).

SECOND OPINION

At no cost to you, you may request a second dental opinion, when appropriate, by directly contacting Member Services either by calling the toll-free number (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. All requests for a second dental opinion are approved by LIBERTY Dental Plan within five (5) days of receipt of such request. Upon approval, LIBERTY Dental Plan will make the appropriate second dental opinion arrangements and advise the attending dentist of your concerns. You will then be advised of the arrangement so an appointment can be scheduled. Upon request, you may obtain a copy of LIBERTY Dental Plan's policy description for a second dental opinion.

YOUR DENTAL PLAN

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

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

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

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

ELIGIBILITY RULES

To be eligible to become a Subscriber a person must:

1. Be an active full-time employee with a workweek of at least twenty-five (25) hours, or Member of the Plan Sponsor as defined by the Plan Sponsor.
2. Have applied for Membership on enrollment forms supplied by the Plan and submitted the applicable Premium, and
3. Reside or work within the Plan's Service Area.

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

1. The lawful spouse of the Subscriber.
2. Registered Domestic Partner;
3. The Dependent Child of a Subscriber, (or in the case of a newborn child, the Dependent Child of the Subscriber's covered Dependents), up to the child's nineteenth (19th) birthday, or up to the child's twenty-sixth (26th) birthday.
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 the Subscriber for support and maintenance. Proof of such incapacity

must be furnished to the Plan by the Subscriber within thirty (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.

Dependents eligible at the time of the Subscriber's initial enrollment but not previously enrolled may be added to the Subscriber's coverage only during an open enrollment period. Subscribers wanting to add Dependents to his or her coverage due to a change in status created by the following circumstances must do so within thirty (30) days of the date the Dependent becomes eligible:

1. Legal Spouse newly acquired as a result of marriage;
2. Registered Domestic Partner;
3. Other Dependents newly acquired as a result of marriage or registered domestic partnership;
4. Children who are legally adopted by the Subscriber pursuant to Chapter 63, Florida Statutes, are considered Dependents from the moment of permanent placement in the residence of the Subscriber, or from the moment of birth if a written agreement to adopt such child has been entered into by the Subscriber prior to the birth of the child; or placed in foster care; or
5. Newborn children of the Subscriber or the Subscriber's covered Dependents are covered from the moment of birth.
6. Enrollee loses minimum essential coverage.
7. Enrollees who lose coverage under a Medicaid or CHIP plan, may apply for enrollment within sixty (60) days from the date such coverage is lost.

Eligible Dependents must be enrolled by timely completing and submitting an enrollment form to the Plan Sponsor along with the applicable Premium.

ENROLLMENT APPLICATION AND DATE OF ELIGIBILTY

Newly eligible Subscribers must complete The Plan approved enrollment application available from Plan Sponsor within thirty (30) days of the date of his/her eligibility to assure timely coverage. Eligible Subscribers who choose not to elect coverage for themselves or any eligible Dependents must complete and sign a Waiver of Coverage within thirty (30) days of initial eligibility. A new Subscriber and any newly eligible Dependents who do not complete an enrollment application (or waive coverage) within thirty (30) days of initial eligibility, and requests coverage at a later date, will have to wait until the next annual open enrollment period to apply for coverage.

All persons including the Subscriber and eligible Dependents who have applied for Membership and for whom the appropriate Premium has been paid prior to the 20th day of the month shall be eligible for Benefits commencing on the 1st day of the following month. Should the required enrollment form(s) and Premium be received after the 20th day, eligibility will commence on the 1st of the second following month. The effective date of coverage will be provided on the Subscriber's ID card, which will list all enrolled Dependents.

OPEN ENROLLMENT

An annual open enrollment period of at least thirty (30) days each Contract Year that this Group Contract is in

effect, will be designated on a date agreed upon by the Plan and the Plan Sponsor. During the annual open enrollment period, eligible Subscribers who have waived coverage voluntarily terminated coverage or did not elect coverage in a timely manner for him or herself and any eligible family Members, may elect coverage during the annual open 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. 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;
4. 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;

5. A qualified individual or enrollee gains access to new QHPs as a result of a permanent move;
6. 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
7. 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.
8. A qualified individual or enrollee may enroll with the Marketplace within sixty (60) days from the date coverage is lost under Medicaid or CHIP, or for exceptional circumstances as determined appropriate by the Marketplace.

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 $350 for a single child and $700 for plans with two or more child enrollees.

EFFECTIVE DATE AND TERMINATION DATE

This Group Contract is effective on the date indicated on the Plan Information Page. The coverage effective time and termination time for any dates used is 12:01 A.M.

TERMINATION OF A MEMBER'S COVERAGE

Coverage for the Subscriber and each of his or her covered Dependents will cease if the Subscriber's affiliation with the Plan Sponsor is terminated for any reason as set forth in this Group Contract. A Member shall <u>not</u> have his/her coverage terminated under this Group Contract because of the amount, variety or cost of services required by such Member.

Coverage for a Member will cease on the last day of the month for which Premium is paid if coverage is terminated for any of the following reasons. Except for non-payment of Premium, the Plan will give forty-five (45) days advance written notice of coverage termination:

1. Non-payment of Premium;
2. The Subscriber or Member ceases to be eligible for coverage for any reason as set forth in this Group Contract;
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 Group 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 Group Contract, or if a court order, including a qualified medical child support order covering a dependent is no longer in effect.

Prior to terminating a Member for cause, the Plan 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, ascertain 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 Subscriber and/or any of his or her covered dependents may terminate coverage with the Plan at any time with appropriate notice of at least fourteen (14) days to the Health Insurance Marketplace. Coverage will terminate on the date specified or fourteen (14) days after termination is requested, whichever is later. Should any Subscriber 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 Subscriber 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 Health Insurance Marketplace

Should the Member's coverage with the Plan be terminated for any reason, as requested by the Health Insurance Marketplace, LIBERTY will provide the Health Insurance Marketplace and the Member with a notice of termination of coverage, consistent with the effective date established by the Exchange pursuant to 155.430(d). Coverage may be terminated if:

1. The Member is no longer eligible for coverage;
2. The Member obtains other minimum essential coverage;
3. Non-payment of premium provided that the applicable grace period required by 156.270 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 to each participant per 147.128 if coverage is rescinded;
5. LIBERTY Dental Plan terminates or is decertified by the Health Insurance Marketplace;

6. The Member changes from one Qualified Health Plan to another during annual open enrollment or special enrollment.

EXTENSION OF BENEFITS

In the event this Group Contract 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 ninety (90) days from the date the Group Contract terminates.

It is the responsibility of the Plan Sponsor to notify each Subscriber of termination of the Group Contract. 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 Benefit Schedule and all exclusions and limitations will continue to apply during the extension.

COORDINATION OF BENEFITS

As a covered Member, you will always receive your LIBERTY benefits. LIBERTY does not consider your Dental 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.

CONVERSION

A Member, who has been continuously covered for at least three months under this Group Contract, has the right to apply for a conversion plan if coverage terminates due to:

1. Termination of employment;
2. Loss of coverage due to the termination of this Group Contract, if it is not replaced by a similar plan within thirty-one (31) days of termination.

A Subscriber's dependents who are covered as dependents under this Group Contract may also convert, but only as dependents of the Subscriber, not on their own.

However, a Subscriber's dependents who have been covered for three (3) consecutive months before coverage ends may, on their own, convert to a conversion plan under one of these following conditions:

1. If the Subscriber's conversion coverage terminates, Covered Dependents may convert as dependents under a new conversion plan.
2. If the Subscriber dies, the covered spouse may convert.
3. If the Subscriber and the covered spouse die simultaneously or upon the death of the last surviving parent, the covered children may convert if they are of contracting age.
4. If the covered spouse is no longer a qualified family Member, the spouse may convert.
5. If a covered dependent child is no longer an eligible Dependent as defined in this Group Contract, such dependent may convert.

A Member who is eligible for conversion may obtain conversion coverage without having to submit evidence of

health qualification. However, the Member must apply in writing and pay the first annual premium for the conversion plan within thirty-one (31) days after his or her coverage under this Group Contract terminates. The application form to be used, and information about conversion benefits may be obtained by contacting the Plan.

If the Subscriber qualifies for federal COBRA continuation benefits, conversion may take place at the end of the federal continuation period, if written application is made and the first annual Premium payment is made within sixty-three (63) days of the date coverage under the continuation period ends. Please consult with your Plan Sponsor regarding any applicable COBRA rights.

Unless otherwise prohibited by law, conversion is not available if:

1. The Member has not been continuously covered for at least three months under this Group Contract prior to termination of coverage;

2. Coverage under this Group Contract ends due to failure to pay any required Premium;

3. This Group Contract is replaced by similar group coverage within thirty-one (31) days of the termination date of this Group Contract;

4. The Member has left the Plan’s Service Area with the intent to relocate or establish a new residence;

5. The Member is terminated for any reason set forth in the Termination of a Member’s Coverage provision, except for a dependent child reaching the limiting age.

WHAT IF I HAVE A QUESTION ABOUT MY DENTAL PLAN

LIBERTY Dental Plan provides toll-free telephone access to covered Members. Just call our Member Services Department if you have a question or inquiry. Our Member Service representatives will be glad to provide you information or resolve your inquiry. **Call (877) 877-1893, between the hours of 8:00 a.m. to 5:00 p.m. (EST) Monday through Friday.**

HOW DO I RECEIVE CARE

You must choose a Primary Care Dentist when you enroll in the plan. This dentist will be responsible for providing the dental care needs for you and your family; including referring you to a specialist should it be necessary (you can change dentists at any time by calling LIBERTY Dental Plan or by submitting a request for provider change in writing). A directory of Plan dentists will be sent to you upon request or you can visit www.libertydentalplan.com.

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

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

HOW TO MAKE AN APPOINTMENT

After completing your enrollment form, you are eligible to receive care on the first of the month following LIBERTY Dental Plan's receipt of your enrollment application,

premium and notification of your eligibility by your Plan Sponsor.

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.

HOW DO I FILE A CLAIM FORM

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

In the case of a specialty referral, we will refer a Member to one of our Plan specialists. In the instance that there are no Plan specialty providers within a reasonable distance from your home address, we will refer you to a non-Plan specialist and benefits will be provided to you as if the specialty provider was contracted with the Plan. Once a specialty referral is processed, the Member, the referring Primary Care Dentist who originally submitted the referral and the Specialist, receive a copy of the approved referral which includes 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 the Plan a claim form and we will pay the Specialist directly for the approved services.

IS PRIOR BENEFIT AUTHORIZATION NECESSARY

No prior benefit authorization is required in order to receive dental services from your Primary Care Dentist.

The Primary Care Dentist has the authority to make most coverage determinations. The coverage determinations are achieved through comprehensive oral evaluations which are covered by your plan. Your Primary Care Dentist is responsible for communicating the results of the comprehensive oral evaluation and advising of available benefits and associated cost.

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

If you or your Primary Care Dentist encounter an urgent condition in which there is an imminent and serious threat to your health, including but not limited to the potential loss of life, limb, or other major body function, or the normal timeframe for the decision making process as described above would be detrimental to your life or health, the response to the request for referral should not exceed seventy-two (72) hours from the time of receipt of such information. The decision to approve, modify or deny will be communicated to the Primary Care Dentist within twenty-four (24) hours of the decision. In cases where the review is retrospective, the decision shall be communicated to the enrollee within thirty (30) days of the receipt of the information.

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

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

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

EMERGENCY DENTAL CARE

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

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

If after you contact your Primary Care Dentist and are advised that your Primary Care Dentist is not available, simply contact any licensed dentist to receive care. LIBERTY Dental will reimburse you for dental expenses up to a maximum of seventy-five dollars ($75), less applicable 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 Dental Plan will cover up to $75 of such services per calendar year. If you pay a bill for covered Emergency Dental Care, submit a copy of the paid bill to:

LIBERTY Dental Plan, Claims Department, P.O. Box 26110, Santa Ana, CA 92799-6110. Please include a copy of the claim from the provider's office or a legible statement of services/invoice. Please forward to LIBERTY Dental Plan with the following information:

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

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

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

MEMBER SERVICES DEPARTMENT

LIBERTY Dental Plan Member Services provides toll-free customer service support Monday through Friday 8:00 a.m. to 5:00 p.m. on normal business days to assist Members

with simple inquiries and resolution of dissatisfactions. The hearing and speech impaired may use the toll-free telephone numbers (800) 955-8771 (TTY). Our toll-free number is (877) 877-1893.

GRIEVANCE PROCEDURE

Introduction

LIBERTY Dental Plan of Florida, Inc., (hereinafter referred to as the Plan) has a grievance and appeal procedure, which complies with applicable state and federal law ("The Grievance Procedure"). We will try to resolve any problems you may encounter over the telephone, but sometimes, additional steps are necessary. In these cases, we have a Grievance Procedure available that provides channels for you, or a provider acting on your behalf, to voice your concerns and have them reviewed and addressed at several levels within the organization.

Grievance and Appeal Program Definitions

The following terms, as used in the Grievance section, are defined as follows:

Adverse Benefit Determination: means a denial of a request for service or a failure to provide or make payment (in whole or in part) for a benefit. An Adverse Benefit Determination also includes any reduction or termination of a benefit, or any other coverage determination that availability of care or other dental care service does not meet the Plan's requirements for dental necessity, appropriateness, dental care setting, or level of care or effectiveness. As Adverse Benefit Determination based in whole or in part on dental judgment, 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 (in whole or in part) 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.

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.

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 Grievances and Post-Service Grievances as defined herein. A Grievance does not include a written Complaint submitted by or on behalf of a Member eligible for a grievance and appeals procedure provided by the Plan pursuant to Contract with the Federal Government under Title XVIII of the Social Security Act or other government programs.

Grievance and Appeals Committee (Committee): means a panel comprised of a majority of Clinical Peers, established to review second level Grievances related to Adverse Benefit Determinations. In cases in which there was a denial of coverage, persons previously involved with the Adverse Benefit Determination will not be a Member of the Committee but may appear before the Committee to present information or answer questions. The Committee has the authority to bind the Plan to its decisions. Committee Members, Clinical Peer or otherwise, shall not be subordinate to those person(s) who made the initial Adverse Benefit Determination, or those person(s) who made the first level Grievance review decision. The Committee shall conduct regular meetings on at least a biweekly or monthly basis (unless there is no business to be transacted at such meeting).

Post-Service Grievance: means a Grievance for which an Adverse Benefit Determination was rendered for a service that was already provided, and the Grievance was received within one (1) year after the date of occurrence of the action that initiated the Grievance, which in the case of a Grievance involving an Adverse Benefit Determination would be one (1) year from the date of the Member's

receipt of the initial notice of such Adverse Benefit Determination.

Pre-Service Grievance: means any Grievance for which a requested service requires Prior Authorization, an Adverse Benefit Determination was rendered and the requested service was not provided and the Grievance was received within one (1) year after the date of occurrence of the action that initiated the Grievance, which in the case of a Grievance involving an Adverse Benefit Determination would be one (1) year from the date of the Member's receipt of the initial notice of such Adverse Benefit Determination.

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.

Urgent Grievance: means a Grievance for which a requested service requires Prior Authorization, or an extension of concurrent care is being requested; an Adverse Benefit Determination was rendered; the requested service has not been provided; and the application of non-urgent care Grievance time frames could seriously jeopardize: (a) the life or health of the Member; or (b) the Member's ability to regain maximum function. An Urgent Grievance is also a Grievance where application of the non-Urgent timeframes would, in the opinion of a Dentist with knowledge of the Member's dental condition, subject the Member to severe pain that could not be adequately managed without the care or treatment that is being requested.

CLAIM AND APPEAL 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 Dental Plan of Florida, Inc. and the time frames and other requirements that apply.

A. Urgent Care Claims

Initial Claim - An Urgent Care Claim shall be deemed to be filed on the date received by LIBERTY Dental Plan of Florida, Inc. 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 Dental Plan of Florida, Inc. 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 Dental Plan of Florida, Inc. 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 Dental Plan of Florida, Inc.'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 Dental Plan of Florida, Inc. 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 or a provider acting on behalf of the Member, who is not satisfied with the benefit determination, may appeal an Urgent Care Claim to:

Send in writing to LIBERTY Dental Plan

P.O. Box 15149 Tampa, FL 33684-5149, Or

LIBERTY Dental Plan's Member Services Department facsimile at:

(888) 334-6034, Or

Contact a LIBERTY Dental Plan Member Services Representative at:

(877) 877-1893,

B. Pre-Service Claims

Initial Claim – A Pre-Service Claim shall be deemed to be filed on the date received by LIBERTY Dental Plan of Florida, Inc. 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 Dental Plan of Florida, Inc. may extend this period one time for up to 15 days, provided that LIBERTY Dental Plan of Florida, Inc. 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 five (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 Health Plan. LIBERTY Dental Plan of Florida, Inc. shall notify the Member of LIBERTY Dental Plan of Florida, Inc.'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 Health Plan may extend this period one time for up to 15 days, provided that LIBERTY Dental Plan of Florida, Inc. determines that such an extension is necessary due to matters beyond LIBERTY Dental Plan of Florida, Inc.'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. Appeals

A Member may appeal a Pre-Service Claim or a Post-Service Claim within 180 days of receiving the benefit determination. LIBERTY Dental Plan of Florida, Inc. shall notify the Member of Our benefit determination on review as soon as possible, taking into account the dental exigencies, but not later than 72 hours after the Plan

receives the Member's request. You may submit an appeal to:

Send in writing to LIBERTY Dental Plan

P.O. Box 15149 Tampa, FL 33684-5149, or

LIBERTY Dental Plan's Member Services Department facsimile at:

(888) 334-6034, or

Contact a LIBERTY Dental Plan Member Services Representative at:

(877) 877-1893

If you are not satisfied with LIBERTY Dental Plan of Florida, Inc.'s final decision, you may contact the Florida Department of Financial Services (FDFS) in writing within 365 days 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

GENERAL INFORMATION AND PROCEDURES

A 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 Dental Plan of Florida, Inc. 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 Dental Plan of Florida, Inc. 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.

B. Initial Claim Determination Notice

LIBERTY Dental Plan of Florida, Inc. 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 Dental Plan of Florida, Inc.'s review procedures and the time limits applicable to such procedures, including, when applicable a statement of the Member's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), following an Adverse Benefit Determination on final review.
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.

C. Review Procedures upon Appeal

LIBERTY Dental Plan of Florida, Inc.'s appeal procedures shall include the following substantive procedures and safeguards:

1. Member may submit written comments, documents, records, and other information relating to the claim.
2. Upon request and free of charge, the Member shall have reasonable access to and copies of any relevant Document.
3. The appeal shall take into account all comments, documents, records, and other information the Member submitted relating to the Claim, without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.
4. The appeal shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial Adverse Benefit Determination nor the subordinate of such individual. Such person shall not defer to the initial Adverse Benefit Determination.
5. In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a dental judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental and/or Investigational or not Medically Necessary, the appropriate named

fiduciary shall consult with a dental care professional who has appropriate training and experience in the field of medicine involved in the dental judgment.

6. The appeal shall provide for the identification of dental or vocational experts whose advice was obtained on behalf of the Plan in connection with a Member's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the Adverse Benefit Determination.
7. The appeal shall provide that the dental care professional engaged for purposes of a consultation for an Adverse Benefit Determination, shall be an individual who is neither an individual who was consulted in connection with the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
8. In the case of an Urgent Care Claim, there shall be an expedited review process pursuant to which:
   a. a request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Member; and
   b. all necessary information, including LIBERTY Dental Plan of Florida, Inc.'s benefit determination on review, shall be transmitted between the Plan and the Member by telephone, facsimile, or other available similarly expeditious methods.

D. Appeal Notification

LIBERTY Dental Plan of Florida, Inc. shall provide a Member with written or electronic notification of LIBERTY

Dental Plan of Florida, Inc.'s benefit determination upon review.

In the case of an Adverse Benefit Determination, the notification shall set forth, in a manner calculated to be understood by the Member, all of the following, as appropriate:

1. The specific reason(s) for the Adverse Benefit Determination.
2. Reference to the specific dental plan provision on which the Adverse Benefit Determination is based.
3. A statement that the Member is entitled to receive, upon request, and free of charge, reasonable access to, and copies of any relevant Document.
4. A statement describing any voluntary appeal procedures offered by the Plan and the Member's right to obtain the information about such procedures and a statement of the Member's right to bring an action under ERISA Section 502(a) when applicable.
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.

ARBITRATION

If you or one of your eligible dependents is not satisfied with the results of LIBERTY Dental Plan's grievance resolution process, and all the grievance resolution procedures have been exhausted, you or one of your eligible dependents have the option to submit the matter to arbitration for resolution. If you, or one of your eligible dependents, believe that some conduct arising from or relating to your participation as a LIBERTY Dental Plan Member, including contract or medical liability, the matter may be settled by arbitration. The arbitration will be conducted according to the American Arbitration Association rules and regulations in force at the time of the occurrence of the grievance (dispute or controversy).

A grievance which is arbitrated pursuant to Chapter 682, Florida Statutes, is permitted an additional time limitation not to exceed 270 days from the date the Plan 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.

Subrogation and third party recovery

If LIBERTY Dental Plans 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 Dental Plans and any LIBERTY Dental Plan 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 Dental Plans requests for information and providing any relevant information that we have requested; and

3. Fully participating in all phases of any legal action LIBERTY Dental Plans 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 Dental Plans 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 Dental Plans may seek any available legal action against you to protect our rights.

LIBERTY Dental Plans 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, office staff and LIBERTY Dental Plan staff with respect and courtesy
* Keep scheduled appointments or contact the dental office twenty-four (24) hours in advance to cancel an appointment
* Cooperate with the Primary Care Dentist in following a prescribed course of treatment
* Make copayments at the time of service
* Notify LIBERTY Dental Plan of changes in family status
* Be aware of and follow the organization's guidelines in seeking dental care

DEFINITIONS

Benefits and Coverage means those dental care services available under the Plan Sponsor Group Contract in which a Member is enrolled.

Contract Year means a period of twelve (12) consecutive months as determined from the effective date of this Group Contract.

Copayment is a specific dollar amount that the Member must pay upon receipt of covered dental services**.** Fixed copayment amounts are listed in the Copayment Schedule.

Dental Care Services shall mean and refer to those services, procedures and operations covered under this Group Contract.

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

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

Dependent includes the following individuals only if they reside or work within the Plan's Service Area**:**

1. The lawful spouse of the Subscriber.
2. Registered domestic partner.
3. The Dependent Child of a Subscriber, (or in the case of a newborn child, the Dependent Child of the Subscriber's covered

Dependents), up to the child's twenty-sixth (26th) birthday.

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 the Subscriber for support and maintenance. Proof of such incapacity must be furnished to the Plan by the Subscriber within thirty (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.

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 means the certificate issued to the Subscriber setting forth the Plan Administration as well as the Benefits Members are entitled.

Exclusion is any provision of the Plan Sponsor Group Contract whereby coverage for a specified hazard or condition is entirely eliminated. Limitation is any provision other than an Exclusion that restricts coverage under the Plan Sponsor Group Contract.

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.

Health Insurance Marketplace (Marketplace) 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.

Member means any Subscriber or Dependent, who is enrolled under the Group Contract and is entitled to the Benefits available under the Group Contract 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 Copayment Schedule 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 Group Contract 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.

Plan Sponsor is the organization or company which has entered into an agreement with the Plan under which Benefits are made available to the eligible Subscribers and their Dependents.

Premium is the amount payable each month by the Plan Sponsor to obtain Benefits provider under this Group Contract.

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.

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 Group Contract. The Service Area may be revised from time to time as specified in the Provider Directory.

Small Employer refers to an employer that has its principal place of business in the state of Florida, employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year, and employs at least 1 employee on the first day of the plan year.

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

Subrogation is the right for an insurer to pursue a third party that caused an **insurance** loss to the insured. This is done as a means of recovering the amount of the claim paid to the insured for the loss.

Subscriber shall mean the employee or member of the Group who is eligible to enroll on behalf of himself/herself and his/her Dependents with LIBERTY for Dental Services through the Marketplace.

The Plan means LIBERTY Dental Plan of Florida, Inc.

ANSWERS TO COMMON QUESTIONS

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

What if I have a pre-existing condition? Most pre-existing conditions are covered. However, a procedure started prior to your coverage effective date will not be covered by the Plan. A pre-existing condition will not be excluded for longer than 2 years prior to your 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. However a dependent child receiving orthodontic services must be enrolled in the same plan option for an entire and continuous 24-month waiting period to receive orthodontic coverage.

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

What if I have other dental coverage? Your LIBERTY Dental Plan network Primary Care Dentist will apply your reimbursement from any additional coverage you have to your 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 Copayment Schedule 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 Dental Plan Member Services Department.

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

LIBERTY Dental Plan of Florida, Inc.

P.O. Box 15149

Tampa, FL 33684-5149

(877) 877-1893

NEW MEMBER CONTINUATION OF CARE INFORMATION AND PRIVACY STATEMENT

Dear New LIBERTY Dental Plan Member:

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

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