Group Evidence of Coverage

Evidence of Coverage & Disclosure Form

MO Pediatric High w/Adult Option Plan

LIBERTY DENTAL PLAN OF MISSOURI INC.

P.O. Box 26110
Santa Ana, CA 92799-6110
(888) 902-0407
Monday-Friday 7am-7pm

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

This Evidence of Coverage (EOC) describes the dental care plan made available to Eligible Employees of the Employer (referred to as "Group") and their Eligible Family Members. LIBERTY Dental Plan of Missouri, Inc. (LIBERTY), and the Group have agreed to all of the terms of this EOC. It is part of the contract (Group Enrollment Agreement or "GEA") between LIBERTY and the Group. This EOC may be terminated by LIBERTY or the Group upon appropriate written notice in accordance with the GEA. The Group is responsible for giving Members notice of termination.

We encourage you to contact us with your questions or concerns. You may contact LIBERTY's Member Services Department at:

LIBERTY Dental Plan
P.O. Box 26110
Santa Ana, CA 92799-6110
Monday – Friday from 7:00 a.m. until 7:00 p.m., CST.
1.888.902.0407

Also, you may directly contact the Missouri Department of Insurance, Financial Institutions and Professional Registration ("MDI"). MDI has established a process to receive inquiries and complaints from consumers of healthcare in Missouri concerning healthcare plans.

For More Information Contact MDI's Consumer Hotline: 1- 800-726-7390. Inquiries and complaints may be filed online at:
http://insurance.mo.gov/consumer/complaints/index.htm

Or by mailing or faxing your inquiry or complaint to:
Missouri DIFP, Attn: Consumer Affairs, P.O. Box 690, Jefferson City, MO 65102-0690.
Fax Number: 573-526-4898.

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 Missouri, Inc.

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

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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 Missouri 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 (888) 902-0407 or by writing to: P.O. Box 26110, Santa Ana, CA 92799-6110. Your Plan Provider 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 Missourians 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 Plan Providers (General Dentists) and Specialists. Your Plan Provider will provide for all of your dental care needs, including referring you to a specialist should it be necessary.

After you join LIBERTY Dental Plan, you may choose any Plan Provider within our network. To find a Plan Provider nearest you, simply contact our Member Services Department toll-free at (888) 902-0407. 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 MO Pediatric High w/Adult Option" as your Benefit Plan.

All services and benefits described in this publication are covered only if provided by a contracted LIBERTY Dental Plan Provider 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, up to the child's twenty-sixth (26^{th}) birthday unless such child is eligible for employer-sponsored coverage (other than coverage through the Subscriber).
4. A Dependent Child who can be certified to the Plan as incapable of self-sustaining employment by reason of mental or physical handicap and is chiefly dependent upon the Subscriber for economic support and maintenance. The child must be a Dependent enrolled under this EOC before reaching the limiting age. Proof of continuing incapacity and dependency must be furnished to the Plan by the Subscriber within thirty-one (31) days of the child reaching the limiting age. Or, if the handicap started before the child reached the limiting age, but the Group was enrolled with another health insurance carrier that covered the child as a handicapped Dependent prior to the Group

enrolling with LIBERTY. Proof of coverage under the prior carrier will satisfy this requirement.

LIBERTY 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.

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 unmarried Dependents newly acquired as a result of marriage or registered domestic partnership;
4. Children who are legally adopted by the Subscriber, including stepchildren, minor children whom a court has ordered coverage, children being placed for Adoption with the Subscriber, children the court has appointed the Subscriber or the Subscriber's spouse the legal guardian, 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 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.

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

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 move from one Plan to another 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 not 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. Non-payment of premium provided that the applicable grace period required by 156.270 has expired;
3. 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;

4. LIBERTY Dental Plan terminates or is decertified by the Health Insurance Marketplace;
5. The Member changes from one Qualified Health Plan to another during annual open enrollment or special enrollment.

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

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.

WHAT IF I HAVE A QUESTION ABOUT MY DENTAL PLAN

LIBERTY Dental Plan provides toll-free telephone access to covered Members. Just call our Member Services Department if you have a question or inquiry. Our Member Service representatives will be glad to provide you information or resolve your inquiry. **Call (888) 902-0407 between the hours of 7:00 a.m. to 7:00 p.m. (EST) Monday through Friday.**

HOW DO I RECEIVE CARE

This Plan offers you a choice of Plan Providers from whom you can receive your dental care. You must receive services from a Plan Provider to utilize benefits covered by this Plan. To receive benefits for care provided by a Specialist, you must be referred to a specialist by a Plan Provider and have your care pre-authorized by the Plan. 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 may use different dentists.

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 has contracted with Plan Providers to reimburse them 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 Plan Provider 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 Plan Provider. The Plan Provider has the authority to make most coverage determinations. The coverage determinations are achieved through comprehensive oral evaluations which are covered by your plan. Your Plan Provider is responsible for communicating the results of the comprehensive oral evaluation and advising of available benefits and associated cost.

If your Plan Provider 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 Plan Provider 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 Plan Provider 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 Plan Provider 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 Provider 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 Plan Provider to schedule an immediate appointment. For urgent or unexpected dental conditions that occur after-hours or on weekends, contact your Plan Provider for instructions on how to proceed.

In the event of a dental emergency outside the service area of the Plan or if after you contact your Plan Provider and are advised that your Plan Provider is not available, you should contact LIBERTY at 888.902.0407. The Plan will direct you to an available dentist or Specialist. 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 Emergency Services received from an out-of-network provider as if you had visited a Plan Provider, up to a maximum of seventy-five dollars ($75) less applicable co-payments.

The Plan provides coverage for emergency dental services only if the services are required to alleviate severe pain or bleeding or if an enrollee reasonably believes that the condition, if not diagnosed or treated, may lead to disability, dysfunction or death (e.g. emergency extraction when no other palliative treatment would suffice and severe gum tissue infection). Covered emergency dental services and care include a dental screening, examination, evaluation by dentist or dental specialist to determine if an emergency dental condition exists, and to provide care that would be acknowledged as within professionally recognized standards of care and in order to alleviate any emergency symptoms in a dental office. Medical and/or psychiatric emergencies are not covered by LIBERTY if the services are rendered in a hospital setting which are covered by a Medical Plan, or if LIBERTY determines the services were not dental in nature.

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 date of service. 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 7:00 a.m. to 7:00 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 (888) 902-0407.

APPEALS AND GRIEVANCES

Introduction

LIBERTY Dental Plan of Missouri, Inc., (hereinafter referred to as the Plan) has a grievance and appeal procedure, which complies with applicable state and federal law ("The Appeals 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 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 or her Authorized Representative to appeal the decision, utilizing LIBERTY's Appeals and Grievance Procedures. 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.

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, participating during the Appeals process, or in obtaining an External Review of a final Adverse Benefit Determination. 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.

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

Dental Director: means a Missouri licensed dentist who is contracted with LIBERTY to provide professional advice concerning dental care to Members under the applicable EOC.

Dentally Necessary of Necessary: means a service or supply needed to improve a specific dental 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
- 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 peer-review 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 in the health specialty involved 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.

Elective Dentistry: means any dental procedures that are unnecessary to the dental health of the patient as determined by LIBERTY's Dental Director.

Grievance: means a written complaint submitted by or on behalf of a Member regarding the:

- availability, delivery or quality of Covered Services, including a complaint regarding an Adverse Benefit Determination;
- claims payment, handling or reimbursement for Covered Services; or
- matters pertaining to the contractual relationship between LIBERTY and a Member.

Post-Service Claim: means any Claim for Benefits under a Group Health Plan regarding payment of benefits that is not considered a Pre-Service Claim.

Pre-Service Claim: means any Claim for Benefits under a Group Health Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

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.

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.

Grievance and Appeals Process

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.

If a Member's Plan is governed by ERISA, a Member must exhaust all mandatory levels of mandatory appeal before bringing a claim in court for a Claim of Benefits.

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.

A Member may contact MDI for assistance at any time using the contact information provided on the cover page of this EOC. A Member that receives an Adverse Benefit Determination may file a grievance with MDI without exhausting the Appeals Procedures.

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

The following Appeals Procedures will be followed for all Grievances:

- **Informal Review:** Available for all Grievances, including a complaint regarding an Adverse Benefit Determination, which are directed to the LIBERTY Member Services Department via phone or in person. If the Informal Review resolves the Grievance to the satisfaction of the Member, the matter ends. The Informal Review is **voluntary**.

- **1st Level Formal Appeal:** Available for all Grievances, including a complaint regarding an Adverse Benefit Determination, which LIBERTY's Customer Response and Resolution Department investigates. If a 1st Level Formal Appeal resolves the Grievance 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.

- **2nd Level Formal Appeal:** If a 1st Level Formal Appeal is not resolved to the Member's satisfaction, a Member may then file a 2nd Level Formal Appeal. A 2nd Level Formal Appeal is submitted in writing and reviewed by the Grievance Advisory Panel. The 2nd Level Formal Appeal is **voluntary** for all Adverse Benefit Determinations.

- **Grievance Advisory Panel:** A committee consisting of other Members, representatives of LIBERTY that were not involved in the circumstances giving rise to the Grievance or any subsequent investigation or determination, and, where the Grievance involves an Adverse Benefit Determination, a majority of persons that are appropriate clinical peers in the same or similar specialty as would typically manage the case being reviewed who were not involved in the circumstances giving rise to the Grievance or any subsequent investigation or determination.

- **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.

INFORMAL REVIEW

A Member who has a Grievance, including a complaint regarding an Adverse Benefit Determination of a Claim for Benefits, may request an Informal Review. All Informal Reviews regarding an Adverse Benefit Determination must be made to LIBERTY's Member Services Department within sixty (60) days of the Adverse Benefit Determination. Informal Reviews of Adverse Benefit Determinations 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 Group name; and
- A brief statement of the nature of the matter, the reason(s) for the appeal, and, if applicable, 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.

1ST LEVEL FORMAL APPEAL

When an Informal Review does not resolve the Grievance 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 Grievance requesting a 1st Level Formal Appeal. A Grievance requesting a 1st Level Formal Appeal regarding an Adverse Benefit Determination must be submitted in writing to LIBERTY's Customer Response and Resolution Department within 180 days of the Adverse Benefit Determination. A Grievance requesting a 1st Level Formal Appeal regarding any other type of Grievance must be submitted in writing to LIBERTY's Customer Response and Resolution Department within 180 days of the event giving rise to the Grievance. Grievances requesting 1st Level Formal Appeals not filed in a timely manner will be deemed waived with respect to the Grievance, including the Adverse Benefit Determination, to which they relate.

The Grievance requesting a 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 Group name; and

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

Additionally, the Member may submit any supporting medical 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 Member has the right to have any other person help them with the Grievance requesting a 1st Level Formal Appeal of the Grievance.

The Grievance requesting a 1st Level Formal Appeal should be sent or faxed to the following:

LIBERTY Dental
Attn: Customer Response and Resolution Dept.
LIBERTY Dental Plan
P.O. Box 26110
Santa Ana, CA 92799-6110
Fax: (888) 223-0011

LIBERTY will acknowledge receipt of the Grievance requesting a 1st Level Formal Appeal from a Member within ten (10) working days of its receipt by LIBERTY. LIBERTY will conduct a complete investigation within twenty (20) working days after receipt of the Grievance requesting a 1st Level Formal Appeal, unless the investigation cannot be completed within this time. If the investigation cannot be completed within twenty (20) working days after receipt of the Grievance requesting a 1st Level Formal Appeal, LIBERTY shall notify the Member in writing on or before the twentieth (20th) working day and the investigation shall be completed within thirty (30) working days thereafter.

The notice will set forth with specificity the reasons for which additional time is needed for the investigation. 1st Level Formal Appeals will be decided by a grievance review committee established by LIBERTY.

Within five (5) working days of the completion of the investigation, the Member will be informed in writing of the resolution. 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 and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's Claim for Benefits;
- A statement describing any voluntary appeal procedures offered by LIBERTY and the Member's right to receive additional information describing such procedures;
- For Member's whose coverage is subject to ERISA, a statement of the Member's right to bring a civil action under ERISA Section 502(a) following an Adverse Benefit Determination, if applicable;
- 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.

If the resolution to the Grievance requesting a 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 2nd Level 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.

If the person who submitted the Grievance requesting a 1st level Formal Appeal was not the Member, LIBERTY will notify the person submitting the request of the resolution within fifteen (15) working days after the investigation is completed.

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 for which 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.

2ND LEVEL FORMAL APPEAL

When a 1st Level Formal Appeal is not resolved in a manner that is satisfactory to the Member, the Member may initiate a 2nd Level Formal Appeal. This appeal must be submitted in writing within one hundred eighty (180) 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 filling a 2nd Level Formal Appeal. A 2nd Level Formal Appeal not filed in a timely manner will be deemed waived with respect to the Grievance, including the Adverse Benefit Determination, to which it relates. The 2nd Level Formal 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 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 on a 2nd Level Formal 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. Repeated refusal on the part of the Member to cooperate in the scheduling of the formal presentation shall relieve the Grievance Advisory Panel of the responsibility of hearing a formal presentation, but not of reviewing the 2nd Level Formal Appeal. If a formal presentation is held, the Member will be permitted to provide documents to the Grievance Advisory Panel and to have assistance in presenting the matter to the Grievance Advisory Panel, 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 for a 2nd Level Formal Appeal, the request will be forwarded to the Grievance Advisory Panel along with all available documentation relating to the appeal.

The Grievance Advisory Panel shall:

- acknowledge receipt of the request for a 2nd Level Formal Appeal within ten (10) working days of its receipt by LIBERTY;
- consider the 2nd Level of Appeal;
- schedule and conduct a formal presentation if applicable;
- obtain additional information from the Member and/or staff as it deems appropriate;
- conduct a complete investigation within twenty (20) working days after receipt of the request for a 2nd Level Formal Appeal, unless the investigation cannot be completed within this time. If the investigation cannot be completed within twenty (20) working days after receipt of the request for a 2nd Level Formal Appeal, LIBERTY shall notify the Member in writing on or before the twentieth (20th) working day and the investigation shall be completed within thirty (30) working days thereafter. The notice will set forth with

specificity the reasons for which additional time is needed for the investigation; and

- make a decision and communicate its decision to the Member within five (5) working days of the completion of the investigation. This notice of the Grievance Advisory Panel's decision will also include notice of the Member's right to file an appeal with MDI of the Grievance Advisory Panel's decision and the toll-free telephone number and address of MDI.

If the resolution of the 2nd 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 benefit determination is based;
- A statement describing any additional voluntary levels of appeal; and
- For Member's whose coverage is subject to ERISA, a statement of the Member's right to bring a civil action under ERISA Section 502(a) following an Adverse Benefit Determination, if applicable.

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 Plan Provider, 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 Plan Provider 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, up to the child's twenty-sixth (26^{th}) birthday unless such child is eligible for employer-

sponsored coverage (other than coverage through the Subscriber).

4. A Dependent Child who can be certified to the Plan as incapable of self-sustaining employment by reason of mental or physical handicap and is chiefly dependent upon the Subscriber for economic support and maintenance. The child must be a Dependent enrolled under this EOC before reaching the limiting age. Proof of continuing incapacity and dependency within thirty-one (31) days of the child reaching the limiting age. Or, if the handicap started before the child reached the limiting age, but the Group was enrolled with another health insurance carrier that covered the child as a handicapped Dependent prior to the Group enrolling with LIBERTY. Proof of coverage under the prior carrier will satisfy this requirement. Recertification of such incapacity may be required by the Plan, but not more frequently than once a year after the first two (2) years beyond when the child reaches the limiting age.

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 Missouri 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.

Service Area means the geographic area in Missouri 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 Missouri, 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.

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 Missouri, 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.

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 Plan Provider, you will be referred to a specialist after coordinating your needs with your Plan Provider. Care from a Prosthodontist is not covered under this program.

What if I have other dental coverage? Your LIBERTY Dental Plan network Plan Provider 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 Missouri, Inc.
P.O. Box 26110
Santa Ana, CA 92799-6110
(888) 902-0407

NEW MEMBER CONTINUATION OF CARE INFORMATION AND PRIVACY STATEMENT

Dear New LIBERTY Dental Plan Member:

If you have been receiving care from a dental care provider, you may have a right to keep your dental care provider for a designated time period. Please contact LIBERTY Dental Plan's Member Services Department at (888) 902-0407.

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 Missouri 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 (888) 902-0407.