LIBERTY Dental Plan of Nevada, Inc.

Individual Plan Evidence of Coverage

(Including Essential Pediatric Benefit (EPB) Plans)

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

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

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

This EOC relates to a dental care plan offered through the Individual Health Marketplace, administered by Healthcare.gov, that is designed to assist qualified individuals into qualified health plans, including Essential Pediatric Benefit (EPB) plans. A qualified individual may enroll in this plan through Healthcare.gov. Healthcare.gov follows enrollment rules specified by the US Federal Government and the State of Nevada. These enrollment rules may or may not apply if you enroll in a dental care plan directly with LIBERTY. Healthcare.gov and full details may be accessed at: http://www.healthcare.gov/

This EOC and your attached Benefit Schedule tell you about your benefits, rights and duties as a LIBERTY Member. They also tell you about LIBERTY's duties to you.

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

For any questions, please contact LIBERTY Dental Plan Member Services Department (866) 609-0417. LIBERTY Dental Plan of Nevada, Inc. ("LIBERTY" or the Plan") provides toll-free customer service support Monday through Friday from 6:00 a.m. through 5:00 p.m. to assist members.

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

The Department of Business and Industry
State of Nevada
Division of Insurance

Telephone Numbers for
Consumers of Healthcare

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

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

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

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

Healthcare.gov
Contact Information

Healthcare.gov
http://www.healthcare.gov/
Phone: 1-800-318-2596
TTY: 1-855-889-4325

The hours of Healthcare.gov are:
Monday through Friday from 5:00 a.m. until 5:00 p.m., Pacific Standard Time (PST).

All questions about any possible Limitation on Pre-existing Conditions should be directed to LIBERTY's Member Services Department:

Address: LIBERTY Dental Plan of Nevada, Inc.
6385 S. Rainbow Suite 200
Las Vegas, NV 98118

Phone: (866) 609-0417 (Monday - Friday from 6:00 a.m. until 5:00 p.m., Pacific Standard Time.

EVIDENCE OF COVERAGE

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SECTION 1. ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

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

1.1 WHO IS ELIGIBLE

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

- Be enrolled on a Qualified Health Plan through Healthcare.gov;
- Be a United States citizen or national or must be lawfully present in the United States;
- Not be incarcerated (in prison; does not apply if you are awaiting disposition of charges); and
- Live or work in the plan Service Area.

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

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

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

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

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

1.2 WHO IS NOT ELIGIBLE

Eligible Dependents do not include:

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

1.3 CHANGES IN ELIGIBILITY STATUS

It is the Subscriber's responsibility to give Healthcare.gov notice as soon as possible but in most cases within sixty (60) days of any life and/or income changes, which may affect eligibility status. For instructions on how to report a life change to Healthcare.gov, You may contact the Healthcare.gov call center at 1-800-318-2596 (TTY: 1-855-889-4325) or use the following link for additional information: https://www.healthcare.gov/how-do-i-report-life-changes-to-the-marketplace/

Life changes may include:

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

- Marriage;
- Termination of a Domestic Partnership that qualifies for coverage under LIBERTY's Affidavit of Domestic Partnership;
- Gain or lose a dependent;
- Have a child, adopt a child, or place a child for adoption;
- Get health coverage through a job or a program like Medicare or Medicaid; or
- Transfer of residence or work outside the Service Area.

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

1.4 SPECIAL ELIGIBILITY STANDARDS AND PROCESS FOR AMERICAN INDIANS

If you are a verified American Indian or Alaskan Native, you are permitted to change your plan selection a maximum of once every 30 days. Healthcare.gov will check your tribal status against available federal data sources or a roster of tribe members from an authorized representative of your federally recognized tribe, if provided. If Healthcare.gov cannot verify your status as a tribe member, you may be required to provide other proof of tribal status. Please note that if you change your plan selection, all of your plan accumulators such as deductibles and out of pocket maximums will be reset under the new plan.

1.5 ENROLLMENT

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

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

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

1.6 ENROLLMENT THROUGH Healthcare.gov

Subscriber must enroll in this plan through Healthcare.gov in accordance with enrollment rules specified by the Federal Government and the State of Nevada. Certain provisions of the enrollment rules and procedures of Healthcare.gov are included in this EOC; however, for full details access Healthcare.gov at: http://www.healthcare.gov/. Enrollment applications may be submitted to Healthcare.gov through the web portal, over the phone with the Healthcare.gov Customer Contact Center, or by mailed paper application.

Eligibility for Advanced Payment of the Premium Tax Credit

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

You are generally eligible for the APTC if you:

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

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

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

Data Inconsistency Resolution

For an individual requesting eligibility to enroll in a plan through Healthcare.gov for whom Healthcare.gov receives information on the application that is inconsistent, Healthcare.gov will –

- Make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors;

- Provide the individual with a period of 30 days from the date on which the notice described in this section is sent to the individual to either present satisfactory documentary evidence to support the individual's application, or resolve the inconsistency; and

- If, after the 30-day period described in this section, Healthcare.gov has not received satisfactory documentary evidence, Healthcare.gov will notify the individual of its denial of eligibility.

Healthcare.gov will notify an individual seeking to enroll in a plan offered through the Healthcare.gov of the determination by Healthcare.gov whether the individual is eligible and their right to appeal the determination. For instructions on how to file an appeal through Healthcare.gov use the following link: https://www.healthcare.gov/can-i-appeal-a-marketplace-decision/.

1.7 EFFECTIVE DATE OF COVERAGE

Effective Dates for Eligibility Determinations if Subscriber Enrolls through Healthcare.gov

Healthcare.gov will establish your effective dates of coverage depending on when you enroll:

- ***Annual open enrollment period.*** The annual open enrollment period for plan years beginning on or after January 1, 2018 begins November 1 and extends through December 15 of the preceding calendar year. During that period, generally, if you select a plan, successfully submit your application, and remit payment to LIBERTY Dental Plan on or before December 15 your coverage effective date will be the following January 1.

- ***Special enrollment period.*** Outside of the annual open enrollment periods, you may encounter a life event that makes you newly eligible for another plan, ineligible for your current plan, or entitles you to add or delete from coverage a member of your household. These life events trigger a special enrollment period, in which you are permitted to change your plan selection. You may have up to 60 days from the date of a triggering event to complete a plan selection. "Plan selection" includes selecting a plan and providing the required documentation, if applicable, to Healthcare.gov. Certain special enrollment situations may result in a mid-plan-year eligibility redetermination that varies from the above open enrollment period. Contact Healthcare.gov for full details, a list of the events which trigger a special enrollment period and the related effective dates of coverage.

1.8 RIGHT TO DENY MEMBERSHIP

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

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

1.9 PAYMENT OF PREMIUMS

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

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

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

1.10 REFUNDS

There are no pro-rated refunds given for terminating coverage in the middle of the month, and all coverage begins at the beginning of the month according to the policies and guidelines outlined in this document. All premiums are paid before the month of coverage, and once paid, are non-refundable. The only exception to this rule is if the Subscriber cancels coverage prior to the coverage effectuation date. Any payments that are refundable for canceled coverage will be refunded to you following the month of cancelation.

1.8 RENEWAL

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

SECTION 2. TERMINATION

2.1 TERMINATION BY LIBERTY

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

- Failure to maintain eligibility requirements as set forth in Section 1.
- Non-payment by Subscriber. Payment is due on the first day of each month that you are insured by LIBERTY. LIBERTY will provide notice of delinquent payments. LIBERTY will provide notice of delinquent payments. The subscriber will be terminated on the 1st day following the grace period, if payment has not been received by LIBERTY.
    - There is a 90 day grace period for payment to be received by LIBERTY for an individual eligible to receive APTC.
    - There is a 30 day grace period for payment to be received by LIBERTY for individuals not eligible to receive APTC.
- With thirty (30) days written notice if you or your dependents allow your LIBERTY ID card to be used by any other person or if you or your dependents use another person's card. You will be liable to LIBERTY for all costs incurred as a result of the misuse of the LIBERTY ID card.
- If any information given to LIBERTY by you on your Enrollment Form is fraudulent or contains intentional misrepresentations of fact, LIBERTY has the right to declare the coverage under the Plan null and void as of the original Effective Date of coverage if the discovery is made within two (2) years of the document being received by LIBERTY.
- When you or your dependents move the primary residence outside of the Service Area and/or no longer has a place of work within the Service Area. You must notify LIBERTY and Healthcare.gov within thirty-one (31) days of the change. LIBERTY will request proof of the change of residence and/or place of work.

2.2 TERMINATION BY THE SUBSCRIBER

You have the right to terminate your coverage under the Plan by providing notice to Healthcare.gov or directly to LIBERTY. For the purposes of this section, reasonable or appropriate notice is defined as fourteen (14) days from the requested effective date of termination. Termination notice must be reported to LIBERTY by Healthcare.gov or by the Subscriber for termination to take place.

2.3 REINSTATEMENT

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

2.4 TERMINATION BY Healthcare.gov

During the course of the benefit plan year Healthcare.gov may need to terminate Subscriber's coverage in the Plan. The following events may trigger a termination:

- Voluntary Termination – Subscriber provides notice to Healthcare.gov that Subscriber would like to terminate coverage.
- Loss of Eligibility – Subscriber is no longer eligible for coverage through Healthcare.gov;
- Non-payment – Subscriber fails to pay premiums by the appropriate deadlines and the following grace periods have been exhausted:
    - For an individual eligible to receive APTC, the 3-month grace period provided by Healthcare.gov has been exhausted; and
    - For individuals not eligible to receive APTC, the 30 day grace period has been exhausted;
- Rescission – Your coverage is rescinded by LIBERTY;
- Withdrawal of Product or Decertification – The Plan is withdrawn by LIBERTY and terminates or is decertified by Healthcare.gov; or
- You change from one plan to another during an annual open enrollment period or special enrollment period.

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

- The termination date specified by Subscriber, if Subscriber provides reasonable notice.
- Fourteen days after the termination is requested by Subscriber, if Subscriber does not provide reasonable notice.
- On a date determined by LIBERTY, if LIBERTY is able to complete the termination in fewer than fourteen days and Subscriber requests an earlier termination effective date.
- If the enrollee is newly eligible for Medicaid, Medicare, or CHIP, the last day of coverage is the day before such coverage begins.

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

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

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

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

2.5 EFFECT OF TERMINATION

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

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

SECTION 3. USING THIS PLAN

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

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

3.1 REFERRAL TO A SPECIALIST

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

The pre-authorization submission will be processed within five (5) business days of receipt, unless urgent. Requests for urgent or emergency services will be processed within 72 hours.

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

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

SECTION 4. COVERED SERVICES

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

4.1 BENEFITS AVAILABLE

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

4.2 CLAIM PAYMENTS

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

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

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

4.3 LIABILITY FOR PAYMENT

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

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

IMPORTANT: Prior to providing you with non-covered services, your contracted dentist should provide you a treatment plan that includes each anticipated service and the estimated cost. To avoid any financial misunderstandings, you may wish to obtain a written disclosure of all services proposed or received, whether covered or not.

Unless pre-approved by LIBERTY, if you have services from a non-contracted dentist or facility, you are responsible for that dentist's usual fee. If a pre-authorization was required and you did not have the treatment pre-authorized, you are responsible for the provider's usual fee. Emergency services may be

available out-of-network or without pre-authorization in some situations (see Emergency Dental Care section below).

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

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

4.4 EMERGENCY SERVICES

In the event of an emergency outside of LIBERTY's service, the Member should contact LIBERTY at (866) 609-0417. LIBERTY will direct you to an available Plan Provider if possible. Should no Plan Provider be available in a fifty (50) mile radius you can seek treatment from an out-of-network provider. In such an event, the Plan will reimburse you for the cost of qualified emergency services received from an out-of-network provider up to a maximum of seventy-five dollars ($75), less any applicable member co-payments based on the In-Network Benefits.

LIBERTY provides coverage for emergency dental services only if the services are required to alleviate severe pain or bleeding or if an enrollee reasonably believes that the condition, if not diagnosed or treated, may lead to disability, dysfunction or death.

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

4.5 SECOND OPINIONS

At no cost to you, you may request a second dental opinion when appropriate, by directly contacting Member Services either by calling the toll-free number (866) 609-0417 or by writing to: LIBERTY Dental Plan of Nevada, 6385 S. Rainbow Blvd. Suite 200, Las Vegas, NV, 89118. Your primary care dentist may also request a second dental opinion on your behalf by submitting a Standard Specialty or Orthodontic Referral form with appropriate x-rays. All requests for a second dental opinion are approved by LIBERTY Dental Plan within 72 hours of receipt of such request. Upon approval, LIBERTY Dental Plan will make the appropriate second dental opinion arrangements and advise the attending dentist of your concerns. You will then be advised of the arrangement so an appointment can be scheduled. Upon request, you may obtain a copy of LIBERTY Dental Plan's policy description for a second dental opinion.

SECTION 5. PEDIATRIC BENEFITS, EXCLUSIONS AND LIMITATIONS

5.1 PEDIATRIC BENEFITS

The following is a list of Essential Pediatric Benefits covered by this Plan. For a list of copayments that apply, please refer to the Schedule of Benefits.

Diagnostic Services

D0120 Periodic oral evaluation
D0145 Oral evaluation under age 3
D0150 Comprehensive oral evaluation
D0140 Limited oral evaluation
D0160 Oral evaluation, problem focused
D0170 Re-evaluation, limited, problem focused
D0171 Re-evaluation, post-operative office visit
D0210 Intraoral, complete series of radiographic images
D0220 Intraoral, periapical, first radiographic image
D0230 Intraoral, periapical, each add 'l radiographic image
D0240 Intraoral, occlusal radiographic image
D0270 Bitewing, single radiographic image
D0272 Bitewings, two radiographic images
D0273 Bitewings, three radiographic images
D0274 Bitewings, four radiographic images
D0277 Vertical bitewings, 7 to 8 radiographic images
D0322 Tomographic survey
D0330 Panoramic radiographic image
D0340 2D cephalometric radiographic image, measurement and analysis
D0350 2D oral/facial photographic image, intra-orally/extra-orally
D0351 3D photographic image
D0415 Collection of microorganisms for culture
D0416 Viral culture
D0460 Pulp vitality tests
D0470 Diagnostic casts
D0486 Accession of transepithelial cytologic sample, prep, written report
D0502 Other oral pathology procedures, by report
D0601 Caries risk assessment and documentation, low risk
D0602 Caries risk assessment and documentation, moderate risk
D0603 Caries risk assessment and documentation, high risk

Preventive Services

D1110 Prophylaxis, adult
D1120 Prophylaxis, child
D1206 Topical application of fluoride varnish
D1208 Topical application of fluoride, excluding varnish
D1310 Nutritional counseling for control of dental disease

D1330 Oral hygiene instruction
D1351 Sealant, per tooth
D1352 Preventive resin restoration, permanent tooth
D1353 Sealant repair, per tooth
D1510 Space maintainer, fixed, unilateral
D1515 Space maintainer, fixed, bilateral
D1520 Space maintainer, removable, unilateral
D1525 Space maintainer, removable, bilateral
D1550 Re-cement or re-bond space maintainer
D1555 Removal of fixed space maintainer
D1575 Distal shoe space maintainer, fixed, unilateral

Basic Restorative Services

D2140 Amalgam, one surface, primary or permanent
D2150 Amalgam, two surfaces, primary or permanent
D2160 Amalgam, three surfaces, primary or permanent
D2161 Amalgam, four or more surfaces, primary or permanent
D2330 Resin-based composite, one surface, anterior
D2331 Resin-based composite, two surfaces, anterior
D2332 Resin-based composite, three surfaces, anterior
D2335 Resin-based composite, four or more surfaces, involving incisal angle
D2390 Resin-based composite crown, anterior
D2391 Resin-based composite, one surface, posterior
D2392 Resin-based composite, two surfaces, posterior
D2393 Resin-based composite, three surfaces, posterior
D2394 Resin-based composite, four or more surfaces, posterior

Major Restorative Services

D2712 Crown, ¾ resin-based composite (indirect)
D2721 Crown, resin with predominantly base metal
D2740 Crown, porcelain/ceramic
D2751 Crown, porcelain fused to predominantly base metal
D2781 Crown, ¾ cast predominantly base metal
D2791 Crown, full cast predominantly base metal
D2910 Re-cement or re-bond inlay, onlay, veneer, or partial coverage
D2915 Re-cement or re-bond indirectly fabricated/prefabricated post & core
D2920 Re-cement or re-bond crown
D2930 Prefabricated stainless steel crown, primary tooth
D2931 Prefabricated stainless steel crown, permanent tooth
D2932 Prefabricated resin crown
D2933 Prefabricated stainless steel crown with resin window
D2940 Protective restoration

D2950 Core buildup, including any pins when required
D2951 Pin retention, per tooth, in addition to restoration
D2952 Post & core in addition to crown, indirect fabricated
D2953 Each additional indirect fabric. post, same tooth
D2954 Prefabricated post & core in addition to crown
D2955 Post removal
D2957 Each additional prefabricated post, same tooth
D2960 Labial veneer (resin laminate), chairside
D2961 Labial veneer (resin laminate), laboratory
D2962 Labial veneer (porcelain laminate), laboratory
D2975 Coping
D2980 Crown repair necessitated by restorative material failure

Endodontic Services

D3110 Pulp cap, direct (excluding final restoration)
D3120 Pulp cap, indirect (excluding final restoration)
D3220 Therapeutic pulpotomy (excluding final restoration)
D3222 Partial pulpotomy, apexogenesis, permanent tooth, incomplete root
D3230 Pulpal therapy, anterior, primary tooth (excluding final restoration)
D3240 Pulpal therapy, posterior, primary tooth (excluding finale restoration)
D3310 Endodontic therapy, anterior tooth (excluding final restoration)
D3320 Endodontic therapy, premolar tooth (excluding final restoration)
D3330 Endodontic therapy, molar tooth (excluding final restoration)
D3331 Treatment of root canal obstruction; non-surgical access
D3332 Incomplete endodontic therapy; inoperable, unrestorable, fractured tooth
D3351 Apexification/recalcification, initial visit
D3352 Apexification/recalcification, interim medication replacement
D3353 Apexification/recalcification, final visit
D3410 Apicoectomy, anterior
D3421 Apicoectomy, premolar (first root)
D3425 Apicoectomy, molar (first root)
D3426 Apicoectomy, (each additional root)
D3427 Periradicular surgery without apicoectomy
D3430 Retrograde filling, per root
D3450 Root amputation, per root
D3460 Endodontic endosseous implant
D3920 Hemisection, not including root canal therapy
D3950 Canal preparation and fitting of preformed dowel or post

Periodontal Services

D4210 Gingivectomy or gingivoplasty, four or more teeth per quadrant
D4211 Gingivectomy or gingivoplasty, one to three teeth per quadrant

D4230 Anatomical crown exposure, four or more teeth per quadrant
D4231 Anatomical crown exposure, one to three teeth per quadrant
D4240 Gingival flap procedure, four or more teeth per quadrant
D4241 Gingival flap procedure, one to three teeth per quadrant
D4249 Clinical crown lengthening, hard tissue
D4260 Osseous surgery, four or more teeth per quadrant
D4261 Osseous surgery, one to three teeth per quadrant
D4263 Bone replacement graft, retained natural tooth, first site, quadrant
D4264 Bone replacement graft, retained natural tooth, each additional site
D4265 Biologic materials to aid in soft and osseous tissue regeneration
D4266 Guided tissue regeneration, resorbable barrier, per site
D4267 Guided tissue regeneration, non-resorbable barrier, per site
D4270 Pedicle soft tissue graft procedure
D4273 Autogenous connective tissue graft procedure, first tooth
D4274 Mesial/distal wedge procedure, single tooth
D4277 Free soft tissue graft, first tooth
D4278 Free soft tissue graft, each additional tooth
D4320 Provisional splinting, intracoronal
D4321 Provisional splinting, extracoronal
D4341 Periodontal scaling and root planing, four or more teeth per quadrant
D4342 Periodontal scaling and root planing, one to three teeth per quadrant
D4346 Scaling in presence of moderate or severe inflammation, full mouth after evaluation
D4355 Full mouth debridement
D4381 Localized delivery of antimicrobial agent/per tooth
D4910 Periodontal maintenance

Removable Prosthodontic Services

D5110 Complete denture, maxillary
D5120 Complete denture, mandibular
D5130 Immediate denture, maxillary
D5140 Immediate denture, mandibular
D5211 Maxillary partial denture, resin base
D5212 Mandibular partial denture, resin base
D5213 Maxillary partial denture, cast metal, resin base
D5214 Mandibular partial denture, cast metal, resin base
D5281 Removable unilateral partial denture, one piece cast metal
D5410 Adjust complete denture, maxillary
D5411 Adjust complete denture, mandibular
D5421 Adjust partial denture, maxillary
D5422 Adjust partial denture, mandibular
D5511 Repair broken complete denture base, mandibular
D5512 Repair broken complete denture base, maxillary

D5520 Replace missing or broken teeth, complete denture
D5611 Repair resin partial denture base, mandibular
D5612 Repair resin partial denture base, maxillary
D5621 Repair cast partial framework, mandibular
D5622 Repair cast partial framework, maxillary
D5630 Repair or replace broken clasp, per tooth
D5640 Replace broken teeth, per tooth
D5650 Add tooth to existing partial denture
D5660 Add clasp to existing partial denture, per tooth
D5670 Replace all teeth & acrylic on cast metal frame, maxillary
D5671 Replace all teeth & acrylic on cast metal frame, mandibular
D5730 Reline complete maxillary denture, chairside
D5731 Reline complete mandibular denture, chairside
D5740 Reline maxillary partial denture, chairside
D5741 Reline mandibular partial denture, chairside
D5750 Reline complete maxillary denture, laboratory
D5751 Reline complete mandibular denture, laboratory
D5760 Reline maxillary partial denture, laboratory
D5761 Reline mandibular partial denture, laboratory
D5820 Interim partial denture, maxillary
D5821 Interim partial denture, mandibular
D5850 Tissue conditioning, maxillary
D5851 Tissue conditioning, mandibular
D5862 Precision attachment, by report

Fixed Prosthodontic Services

D6930 Re-cement or re-bond fixed partial denture

Oral & Maxillofacial Services

D7111 Extraction, coronal remnants, primary tooth
D7140 Extraction, erupted tooth or exposed root
D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth
D7220 Removal of impacted tooth, soft tissue
D7230 Removal of impacted tooth, partially bony
D7240 Removal of impacted tooth, completely bony
D7241 Removal impacted tooth, complete bony, complication
D7250 Removal of residual tooth roots (cutting procedure)
D7260 Oroantral fistula closure
D7261 Primary closure of a sinus perforation
D7270 Tooth reimplantation and/or stabilization, accident
D7280 Exposure of an unerupted tooth
D7283 Placement, device to facilitate eruption, impaction

D7285 Incisional biopsy of oral tissue, hard (bone, tooth)
D7286 Incisional biopsy of oral tissue, soft
D7287 Exfoliative cytological sample collection
D7288 Brush biopsy, transepithelial sample collection
D7290 Surgical repositioning of teeth
D7291 Transseptal fiberotomy/supra crestal fiberotomy, by report
D7292 Placement of temporary anchorage device (screw retained plate) requiring flap
D7293 Placement of temporary anchorage device requiring flap; includes device removal
D7294 Placement of temporary anchorage device without flap; includes device removal
D7310 Alveoloplasty with extractions, four or more teeth per quadrant
D7311 Alveoloplasty with extractions, one to three teeth per quadrant
D7320 Alveoloplasty, w/o extractions, four or more teeth per quadrant
D7321 Alveoloplasty, w/o extractions, one to three teeth per quadrant
D7410 Excision of benign lesion, up to 1.25 cm
D7411 Excision of benign lesion, greater than 1.25 cm
D7412 Excision of benign lesion, complicated
D7440 Excision of malignant tumor, up to 1.25 cm
D7441 Excision of malignant tumor, greater than 1.25 cm
D7450 Removal, benign odontogenic cyst/tumor, up to 1.25 cm
D7451 Removal, benign odontogenic cyst/tumor, greater than 1.25 cm
D7460 Removal, benign nonodontogenic cyst/tumor, up to 1.25 cm
D7461 Removal, benign nonodontogenic cyst/tumor, greater than 1.25 cm
D7465 Destruction of lesion(s) by physical or chemical method, by report
D7472 Removal of torus palatinus
D7473 Removal of torus mandibularis
D7490 Radical resection of maxilla or mandible
D7510 Incision & drainage of abscess, intraoral soft tissue
D7511 Incision & drainage of abscess, intraoral soft tissue, complicated
D7520 Incision & drainage of abscess, extraoral soft tissue
D7521 Incision & drainage of abscess, extraoral soft tissue, complicated
D7530 Remove foreign body, mucosa, skin, tissue
D7540 Removal of reaction producing foreign bodies, musculoskeletal system
D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone
D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body
D7610 Maxilla, open reduction (teeth immobilized, if present)
D7620 Maxilla, closed reduction (teeth immobilized, if present)
D7630 Mandible, open reduction (teeth immobilized, if present)
D7640 Mandible, closed reduction (teeth immobilized, if present)
D7650 Malar and/or zygomatic arch, open reduction
D7660 Malar and/or zygomatic arch, closed reduction
D7670 Alveolus, closed reduction, may include stabilization of teeth
D7671 Alveolus, open reduction, may include stabilization of teeth
D7680 Facial bones, complicated reduction with fixation, multiple surgical approaches

D7710 Maxilla, open reduction
D7720 Maxilla, closed reduction
D7730 Mandible, open reduction
D7740 Mandible, closed reduction
D7750 Malar and/or zygomatic arch, open reduction
D7760 Malar and/or zygomatic arch, closed reduction
D7770 Alveolus, open reduction stabilization of teeth
D7771 Alveolus, closed reduction stabilization of teeth
D7780 Facial bones, complicated reduction with fixation and multiple approaches
D7910 Suture of recent small wounds up to 5 cm
D7911 Complicated suture, up to 5 cm
D7912 Complicated suture, greater than 5 cm
D7940 Osteoplasty, for orthognathic deformities
D7941 Osteotomy, mandibular rami
D7943 Osteotomy, mandibular rami with bone graft; includes obtaining the graft
D7944 Osteotomy, segmented or subapical
D7945 Osteotomy, body of mandible
D7946 LeFort I (maxilla, total)
D7947 LeFort I (maxilla, segmented)
D7948 LeFort II or LeFort III, without bone graft
D7949 LeFort II or LeFort III, with bone graft
D7951 Sinus augmentation with bone or bone substitutes via a lateral open approach
D7953 Bone replacement graft for ridge preservation, per site
D7955 Repair of maxillofacial soft and/or hard tissue defect
D7960 Frenulectomy (frenectomy or frenotomy), separate procedure
D7963 Frenuloplasty
D7970 Excision of hyperplastic tissue, per arch
D7971 Excision of pericoronal gingiva
D7980 Surgical sialolithotomy
D7981 Excision of salivary gland, by report
D7982 Sialodochoplasty
D7983 Closure of salivary fistula
D7990 Emergency tracheotomy
D7991 Coronoidectomy
D7996 Implant-mandible for augmentation purposes, by report
D7998 Intraoral placement of a fixation device not in conjunction with a fracture

Medically Necessary Orthodontic Services

For Pediatric Dental EHB, orthodontic treatment is a benefit of this Dental Plan ONLY when the patient's orthodontic needs meet medically necessary requirements as determined by a verified score of 26 or higher (or other qualifying conditions) on HLD Index analysis. All treatment must be prior authorized by the Plan prior to banding.

D8080 Comprehensive orthodontic treatment of the adolescent dentition
D8090 Comprehensive orthodontic treatment of the adult dentition
D8660 Pre-orthodontic treatment examination to monitor growth and development
D8670 Periodic orthodontic treatment visit
D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s))
D8690 Orthodontic treatment (alternative billing to a contract fee)
D8693 Re-cement or re-bond fixed retainer
D8694 Repair of fixed retainers, includes reattachment

Adjunctive General Services

D9110 Palliative (emergency) treatment, minor procedure
D9120 Fixed partial denture sectioning
D9210 Local anesthesia not in conjunction, operative or surgical procedures
D9212 Trigeminal division block anesthesia
D9215 Local anesthesia in conjunction with operative or surgical procedures
D9219 Evaluation for deep sedation or general anesthesia
D9222 Deep sedation/general anesthesia – first 15 minutes
D9223 Deep sedation/general anesthesia, each subsequent 15 minute increment
D9230 Inhalation of nitrous oxide/analgesia, anxiolysis
D9239 Intravenous moderate (conscious) sedation/analgesia, first 15 minutes
D9243 Intravenous moderate (conscious) sedation/analgesia, each subsequent 15 minute increment
D9248 Non-intravenous (conscious) sedation, includes non-IV minimal and moderate sedation
D9310 Consultation, other than requesting dentist
D9410 House/extended care facility call
D9420 Hospital or ambulatory surgical center call
D9430 Office visit, observation, regular hours, no other services
D9440 Office visit, after regularly scheduled hours
D9610 Therapeutic parenteral drug, single administration
D9612 Therapeutic parenteral drugs, two or more administrations, different meds.
D9630 Drugs or medicaments dispensed in the office for home use
D9930 Treatment of complications, post-surgical, unusual, by report
D9932 Cleaning and inspection of removable complete denture, maxillary
D9933 Cleaning and inspection of removable complete denture, mandibular
D9934 Cleaning and inspection of removable partial denture, maxillary
D9935 Cleaning and inspection of removable partial denture, mandibular
D9940 Occlusal guard, by report
D9942 Repair and/or reline of occlusal guard
D9950 Occlusion analysis, mounted case
D9951 Occlusal adjustment, limited
D9952 Occlusal adjustment, complete

5.2 EXCLUSIONS

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

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

5.3 LIMITATIONS

The following limitations are also identified in the Benefits Schedule; this section tells you when LIBERTY's duty to provide or arrange for services is limited.

- Periodic, Comprehensive or Comprehensive periodontal oral evaluations are limited to two (2) per plan year.
- Complete series of x-rays (full mouth x-rays) is limited to one (1) per eleven (11) month period.
- Panoramic Image is limited to one (1) per three (3) plan years.
- Occlusal radiographic image is limited to two (2) per 12 month period.
- Bitewings, single, two (2), three (3), four (4) and vertical (7 to 8) radiographic images are limited to one (1) per six (6) month period for members nineteen (19) and older.
- Bitewings, single, two (2), and four (4) radiographic images are limited to one (1) per six (6) month period for children through age eighteen (18).
- Prophylaxis or scaling in the presence of inflammation procedures are covered two (2) per plan year.
- Fluoride treatments are covered two (2) per plan year.
- Sealants are covered only on the first and second permanent molars, limited to one (1) per tooth per lifetime for children through age eighteen (18).
- Sealant repairs are covered only on the first and second permanent molars, limited to one (1) per tooth per lifetime for children through age eighteen (18).
- Space maintainers are covered two (2) per twelve (12) month period, limited to four (4) units per lifetime for children through age eighteen (18).
- Fillings are limited to one (1) per tooth per surface per twelve (12) month period. If replacement restoration is less than twelve (12) months performed by same dental office or provider it is not chargeable to the plan or member.
- Resin-based composite crown are covered one (1) per twelve (12) month period.
- Crowns, Inlays, Onlays, or fixed partial dentures (bridgework), per unit, are limited to one (1) per permanent tooth per sixty (60) month period.

- Prefabricated Stainless Steel Crowns, primary teeth is limited to one (1) per tooth per 36 month period, permanent teeth is limited to one (1) per tooth in a lifetime.

- Labial veneers limited to one (1) per permanent tooth when medically necessary for children through age eighteen (18) and limited to one (1) per permanent tooth per five (5) year period for members nineteen (19) and older.

- Periodontal scaling & root planing is limited to one (1) per site or quadrant per 12 month period.

- Periodontal maintenance and scaling in presence of moderate or severe inflammation, full mouth after evaluation are limited to two (2) (D1110, D1120, D4346, D4910) per plan year, and includes prophylaxis.

- Other surgical periodontal procedures (D4210-D4285) limited to one (1) surgical procedure per quadrant per sixty (60) month period

- Full mouth debridement is covered one (1) per 24 month period for members nineteen (19) and older.

- Full Dentures and/or Partial Dentures are limited to one (1) per arch per sixty (60) month period. Members must meet medical necessity as determined by a dentist.

- Removable partial dentures are limited to one (1) per sixty (60) month period. Members must meet medical necessity as determined by a dentist.

- Denture and/or Partial denture adjustments are limited to one (1) per arch per six (6) month period for children through age eighteen (18), one (1) per arch per twelve (12) month period for adults.

- Denture and/or Partial Relines are limited to one (1) per arch per six (6) month period.

- Partial Interim Dentures are limited to one (1) per arch per sixty (60) month period. Member must meet medical necessity as determined by a dentist.

- Pontics, retainer inlays, onlays and crowns are limited to one (1) per permanent tooth per five (5) year period for members nineteen (19) and older. Must meet medical necessity as determined by a dentist.

- Orthodontic treatment is a benefit for children through age eighteen (18) only when the patient's orthodontic needs meet medically necessary requirements as determined by a verified score of 26 or higher (or other qualifying conditions) on the HLD Index analysis. All treatment must be prior authorized by the Plan prior to banding.

- Deep Sedation/General Anesthesia is a plan benefit only in conjunction with covered oral surgery procedures and covered pedodontic procedures.
- Procedures that appear to have a poor prognosis as determined by a licensed LIBERTY dental consultant are not covered.

SECTION 6. GENERAL PROVISIONS

6.1 RELATIONSHIP OF PARTIES

The relationship between LIBERTY and Plan Providers is an independent contractor relationship. Plan Providers are not agents or employees of LIBERTY, nor is LIBERTY or any employee of LIBERTY an employee or agent of a Plan Provider. LIBERTY is not liable for any claim or demand on account of damages as a result of, or in any manner connected with, any injury suffered by a Member while receiving care from any Plan Provider or in any Plan Provider's facility. LIBERTY is not bound by statements or promises made by its Plan Providers.

6.2 ENTIRE AGREEMENT

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

6.3 CONTESTABILITY

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

6.4 AUTHORITY TO CHANGE THE FORM OR CONTENT OF EOC

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

6.5 IDENTIFICATION CARD

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

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

6.6 NOTICE

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

LIBERTY Dental Plan of Nevada, Inc.
6385 S. Rainbow Blvd., Suite 200
Las Vegas, NV 89118

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

6.7 ASSIGNMENT

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

6.8 MODIFICATIONS

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

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

6.9 CLERICAL ERROR

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

6.10 POLICIES AND PROCEDURES

LIBERTY may adopt reasonable policies, procedures, rules and Interpretations to promote the orderly and efficient administration of this EOC with which Members shall comply. These policies and procedures are maintained by LIBERTY at its offices. Such policies and procedures may have bearing on whether dental service and/or supply are covered. These policies include claims payment policies and practices, periodic financial disclosures, data on rating practices, information on cost-sharing and payments for out-of-network coverage, and information on enrollee rights under Title I of the Affordable Care Act. LIBERTY will make these policies available in an accurate and timely manner to Members upon request.

6.11 OVERPAYMENTS

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

6.12 RELEASE OF RECORDS

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

6.13 GENDER REFERENCES

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

6.14 AVAILABILITY OF PROVIDERS

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

6.15 GOVERNING LAW

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

6.16 NO WAIVER

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

SECTION 7. APPEALS AND GRIEVANCES

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

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

LIBERTY considers complaints, grievances and appeals as the same.

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

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

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

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

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

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

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

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

7.1 INFORMAL REVIEW

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

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

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

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

7.2 FIRST LEVEL FORMAL APPEAL

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

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

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

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

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

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

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

1st Level Formal Appeals will be decided by a Grievance Review Committee.

If the 1st Level Formal Appeal results in an Adverse Benefit Determination, the Member will be informed in writing of the following:

- The specific reason or reasons for upholding the Adverse Benefit Determination;
- Reference to the specific Plan provisions on which the determination is based;
- A statement that the Member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's Claim for Benefits used by LIBERTY in the processing of a grievance or appeal;
- A statement describing any voluntary appeal procedures offered by LIBERTY and the Member's right to receive additional information describing such procedures;
- A statement that any internal rule, guideline, protocol or other similar criteria that was relied on in making the determination is available free of charge upon the Member's request; and

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

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

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

7.3 EXPEDITED APPEAL

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

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

- LIBERTY's receipt of the specified information, or
- The end of the period afforded the Member to provide the specified information.

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

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

7.4 SUBSEQUENT APPEALS

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

Exhaustion of the 1st Level Formal Appeal procedure is a precondition to filling a subsequent Formal Appeal. A subsequent Formal Appeal not filed in a timely manner will be deemed waived with respect to the Adverse Benefit Determination to which it relates. The subsequent 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 used in the processing of the previous grievance or appeal as referenced above under the 1st Level Formal Appeal.

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

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

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

- consider the Appeal;
- schedule and conduct a formal presentation if applicable;
- obtain additional information from the Member and/or staff as it deems appropriate; and

- make a decision and communicate its decision to the Member within thirty (30) days following LIBERTY's receipt of the request for a subsequent Formal Appeal.

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

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

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

7.5 APPEALS Regarding a Healthcare.gov or Marketplace Decision

If a member is dissatisfied with a decision made by Healthcare.gov, an appeal may be filed directly through Healthcare.gov. For instructions on how to file an appeal through Healthcare.gov use the following link: https://www.healthcare.gov/can-i-appeal-a-marketplace-decision/

SECTION 8. OTHER PROVISIONS

8.1 COORDINATION OF BENEFITS

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

8.2 THIRD PARTY LIABILITY

If services otherwise covered by virtue of this Plan are deemed to be necessary due to a work-related injury or are the liability of another third party, you agree to cooperate in LIBERTY's processes to be reimbursed for these services.

8.3 ACCESS TO PATIENT RECORDS

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

8.4 NON DISCRIMINATION

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

8.5 Filing Claims

As stated throughout this document, you are not required to file claims directly with LIBERTY. Your general dental services are arranged with the participating general dentist who submits claims or encounters on your behalf. Your specialty care services are reported to LIBERTY via the specialist. If you receive services out-of-network due to an emergency after-hours or out-of-area situation, consult the section above for submitting your expenses to LIBERTY to receive reimbursement (see Section 4.4 Emergency Services above).

SECTION 9. GLOSSARY

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

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

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

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

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

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

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

"**Contract Year**" means the twelve (12) months beginning with and following the Effective Date of the Group Enrollment Agreement (GEA).

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

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

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

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

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

- meets the eligibility requirements of the Plan as set forth in Section 1 of this EOC, including services pursuant to the plan purchased through Healthcare.gov;
- is enrolled under this Plan; and
- for whom premiums have been paid.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"**Plan**" means the LIBERTY Dental Plan of Nevada, Inc. dental care plan.

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

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

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

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

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

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

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

- Both the Subscriber and the Domestic Partner are at least 18 years of age;
- The Subscriber and the Domestic Partner have chosen to share one another's lives in an intimate and committed relationship of mutual caring;
- Subscriber and the Domestic Partner have entered into a domestic partnership out of their own free will;
- Subscriber and Domestic Partner are competent to consent to the domestic partnership;
- Subscriber and Domestic Partner have a common residence;
- Subscriber and the Domestic Partner have filed the required affidavits for the formation of a Domestic Partnership under the laws of the State of Nevada with the Secretary of State for the State of Nevada;
- The Subscriber and the Domestic Partner are unmarried to each other or any other person;
- The Subscriber and the Domestic Partner are not in any other domestic partnership; and
- The Subscriber and the Domestic Partner are not related by blood to a degree that would prohibit them from being married to each other in Nevada.

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

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

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

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

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

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

SECTION 10. NOTICE OF NON-DISCRIMINATION

Discrimination is against the law. LIBERTY Dental Plan ("LIBERTY") complies with all applicable Federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, or sex.

LIBERTY provides free aids and services to people with disabilities, and free language services to people whose primary language is not English, such as:

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

If you need these services, please contact us at 1-888-401-1128.

If you believe LIBERTY has failed to provide these services or has discriminated on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with LIBERTY's Civil Rights Coordinator:

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

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Online at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

LIBERTY DENTAL PLAN

Notice of Language Assistance

If you, or someone you support, have questions about LIBERTY Dental Plan, you have the right to get help and information in your language at no cost. To speak to an interpreter, call 1-888-401-1128.

እርስዎ፣ ወይም እርስዎ የሚያግዙት ግለሰብ፣ ስለ LIBERTY Dental Plan ጥያቄ ካላቸሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላቸሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-888-401-1128 ይደውሉ።). (Amarhic)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص LIBERTY Dental Plan فلديك الحق
في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 1-888-401-1128 (Arabic)

如果您，或您正在幫助的人，有關於LIBERTY Dental Plan 方面的問題，您有權利免費以您的母語得到幫助和訊息 想要跟一位翻譯員通話，請致電 1-888-401-1128. (Chinese)

اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد LIBERTY Dental Plan -
داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایکان دریافت نمایید. 1-888-401-1128
تماس حاصل نمایید.(Farsi)

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de LIBERTY Dental Plan, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-888-401-1128. (French)

Falls Sie oder jemand, dem Sie helfen, Fragen zum LIBERTY Dental Plan haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-888-401-1128 an. (German)

No dakayo, wenno maysa a tao a tultulunganyo, ket adda kayatyo a saludsoden maipanggep iti LIBERTY Dental Plan, adda karbenganyo a dumawat iti tulong ken impormasion iti bukodyo a pagsasao nga awan ti bayadanyo. Tapno makipatang iti maysa a mangipatarus iti pagsasao, tumawag iti numero nga 1-888-401-1128. (Ilocano)

ご本人様、またはお客様の身の回りの方でもLIBERTY Dental Plan についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合1-888-401-1128までお電話ください (Japanese)

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 LIBERTY Dental Plan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-888-401-1128 로 전화하십시오.。(Korean)

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу LIBERTY Dental Plan, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-888-401-1128. (Russian)

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de LIBERTY Dental Plan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-888-401-1128. (Spanish)

‘Afai olo’o iai se fesili iate oe, po o se tasi olo’o e fesoasoani i ai, e uiga i le LIBERTY Dental Plan polokalame, o iai iate oe le aia tatau e maua atu ai i se fesoasoani po o se fa’atamalaga e uiga i lena polokalame i le gagana fa’asamoa, auno ma se togiga o tupe. Ina ia talatalanoa i se tagata ua malamalama ai i le gagana fa’asoma, po o se tagata fa’aliliu gagana, vili atu e lau telefoni 1-888-401-1128. (Samoan)

Notice of Language Assistance

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa LIBERTY Dental Plan may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-888-401-1128. (Tagalog)

หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ LIBERTY Dental Plan,

คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 1-888-401-1128. (Thai)

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về LIBERTY Dental Plan, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-888-401-1128. (Vietnamese)