LIBERTY Dental Plan of California, Inc.
Family Dental HMO
Individual Market Place

Individual Out of Pocket Maximum: $350 per 2017 Calendar Year (applies to Pediatric only)
Family Out of Pocket Maximum: $700 per 2017 Calendar Year (applies to Pediatric only)
Individual Deductible: None - Family Deductible: None

Waiting Period: None — Annual Benefit Limit: None
Office Visit Copay: No Charge — Actuarial Value: 83.2%

✓ Members must select, and be assigned to, LIBERTY Dental Plan contracted dental office to utilize covered benefits. Your dental office will initiate a treatment plan or will initiate the specialty referral process with LIBERTY Dental Plan if the services are dentally necessary and outside the scope of general dentistry.

✓ Member Co-payments are payable to the dental office at the time services are rendered, and are subject to Out-of-Pocket Maximums. Pediatric benefits apply for Enrollees ages 0 to the age of 19. Adult benefits are not subject to Out-of-Pocket Maximums. There may be other costs incurred for optional, and non-covered services that do not apply toward Out-of-Pocket Maximums.

✓ This Benefit Schedule does not guarantee benefits. All services are subject to eligibility, exclusions and limitations must be determined to be dentally necessary at the time you receive the service. Additional requests, beyond the stated frequency limitations shall be considered for prior authorization when documented dental necessity is provided as required by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit.

✓ Dental procedures not listed on this Benefit Schedule may be available at the dental office's usual and customary fees.

CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Diagnostic Services				
D0120	Periodic oral evaluation	no charge	no charge	1 every 6 months, per provider	1 every 6 months, per provider
D0140	Limited oral evaluation	no charge	no charge	1 per patient per provider	1 per patient per provider
D0145	Oral evaluation under age 3	no charge	not covered		
D0150	Comprehensive oral evaluation	no charge	no charge	1 per patient per provider for initial evaluation	1 per patient per provider for initial evaluation
D0160	Oral evaluation, problem focused	no charge	no charge	1 per patient per provider	1 per patient per provider
D0170	Re-evaluation, limited, problem focused	no charge	no charge	up to 6 in a 3 month period, no more than 12 in a 12 months	1 every 6 months
D0180	Comprehensive periodontal evaluation	no charge	no charge	only be billed as D0150	1 every 6 months
D0190	Screening of a patient	not covered	no charge		
D0191	Assessment of a patient	not covered	no charge		
D0210	Intraoral, complete series of radiographic images	no charge	no charge	1 every 36 months per provider	1 every 36 months per provider
D0220	Intraoral, periapical, first radiographic image	no charge	no charge	20 of (D0220, D0230)PA's in a 12 month period by the same provider	20 of(D0220, D0230)PA's in a 12 month period by the same provider
D0230	Intraoral, periapical, each add 'l radiographic image	no charge	no charge		
D0240	Intraoral, occlusal radiographic image	no charge	no charge	2 per 6 months per provider	2 per 6 months per provider
D0250	Extra-oral 2D projection radiographic image, stationary radiation source	no charge	no charge	1 per date of service	1 every 6 months
D0270	Bitewing, single radiographic image	no charge	no charge	1 per date of service	1 of (D0270, D0272, D0273, D0277) every 6 months
D0272	Bitewings, two radiographic images	no charge	no charge	1 per 6 months per provider	
D0273	Bitewings, three radiographic images	no charge	no charge	downcode to D0270 and D0272	
D0274	Bitewings, four radiographic images	no charge	no charge	1 per 6 months per provider, age 10 and over	1 per 6 months per provider
D0277	Vertical bitewings, 7 to 8 radiographic images	no charge	no charge	downcode to D0274	1 of (D0270, D0272, D0273, D0277) every 6 months
D0290	Posterior-anterior, lateral skull & facial bone survey	no charge	not covered	3 per date of service	
D0310	Sialography	no charge	not covered		
D0320	TMJ arthrogram, including injection	no charge	not covered	3 per date of service	
D0322	Tomographic survey	no charge	not covered	2 every 12 months per provider	
D0330	Panoramic radiographic image	no charge	no charge	1 every 36 months per provider	1 every 36 months per provider
D0340	2D cephalometric radiographic image, measurement and analysis	no charge	not covered	2 every 12 months per provider	
D0350	2D oral/facial photographic image, intra-orally/extra-orally	no charge	not covered	4 per date of service	
D0460	Pulp vitality tests	no charge	no charge		
D0470	Diagnostic casts	no charge	no charge	1 per provider, only a benefit with covered Orthodontic services, for permanent dentition	1 per provider

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	Diagnostic Services (continued)				
D0502	Other oral pathology procedures, by report	no charge	not covered		
D0601	Caries risk assessment and documentation, low risk	no charge	not covered		
D0602	Caries risk assessment and documentation, moderate risk	no charge	not covered		
D0603	Caries risk assessment and documentation, high risk	no charge	not covered		
D0999	Unspecified diagnostic procedure, by report	no charge	not covered		
	Preventive Services				
D1110	Prophylaxis, adult	no charge	no charge	1 of (D1110, D1120) every 6 months. Additional requests, beyond the stated frequency limitations, for prophylaxis procedures (D1110 and D1120) shall be considered for prior authorization when documented medical necessity is provided as required by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit.	1 of (D1110, D4910) every 6 months
D1120	Prophylaxis, child	no charge	not covered		
D1206	Topical application of fluoride varnish	no charge	not covered	1 of (D1206, D1208) every 6 months. Additional requests, beyond the stated frequency limitations, for fluoride procedures (D1206 and D1208) shall be considered for prior authorization when documented medical necessity is provided as required by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit.	
D1208	Topical application of fluoride, excluding varnish	no charge	not covered		
D1310	Nutritional counseling for control of dental disease	no charge	not covered		
D1320	Tobacco counseling, control/prevention oral disease	no charge	not covered		
D1330	Oral hygiene instruction	no charge	no charge		
D1351	Sealant, per tooth	no charge	not covered	1 of (D1351,D1352) every 36 months 1st, 2nd, 3rd molars	
D1352	Preventive resin restoration, permanent tooth	no charge	not covered		
D1510	Space maintainer, fixed, unilateral	no charge	not covered	1 of (D1510, D1520) per quadrant per patient, under age 18	
D1515	Space maintainer, fixed, bilateral	no charge	not covered	1 of (D1515, D1525) per arch under age 18	
D1520	Space maintainer, removable, unilateral	no charge	not covered	1 of (D1510, D1520) per quadrant per patient	
D1525	Space maintainer, removable, bilateral	no charge	not covered	1 of (D1515, D1525) per arch under age 18	
D1550	Re-cement or re-bond space maintainer	no charge	not covered	1 per quad/arch every 12 months under age 18	
D1555	Removal of fixed space maintainer	no charge	not covered		
	Restorative Services				
D2140	Amalgam, one surface, primary or permanent	$25	$25	primary teeth - 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 12 months permanent teeth - 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 36 months	1 of (D2140-D2335, D2391-D2394) every 36 months
D2150	Amalgam, two surfaces, primary or permanent	$30	$30		
D2160	Amalgam, three surfaces, primary or permanent	$40	$40		
D2161	Amalgam, four or more surfaces, primary or permanent	$45	$45		
D2330	Resin-based composite, one surface, anterior	$30	$30		
D2331	Resin-based composite, two surfaces, anterior	$45	$45		
D2332	Resin-based composite, three surfaces, anterior	$55	$55		
D2335	Resin-based composite, four or more surfaces, involving incisal angle	$60	$60		
D2390	Resin-based composite crown, anterior	$50	$50	primary teeth - 1 per tooth every 12 months permanent teeth - 1 per tooth every 36	1 per tooth every 36 months

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	Restorative Services (continued)				
D2391	Resin-based composite, one surface, posterior	$30	$30	primary teeth - 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 12 months permanent teeth - 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 36 months	1 of (D2140-D2335, D2391-D2394) every 36 months
D2392	Resin-based composite, two surfaces, posterior	$40	$40		
D2393	Resin-based composite, three surfaces, posterior	$50	$50		
D2394	Resin-based composite, four or more surfaces, posterior	$70	$70		

***GUIDELINES for Single Crowns - Applies to Adult Dental Only**

The total maximum amount chargeable to the member for elective upgraded procedures (explained below) is $250.00 per tooth. Providers are required to explain covered benefits as well as any elective differences in materials and fees prior to providing an elective upgraded procedure.

1. **Brand name restorations:** (e.g. Sunrise, Captek, Vitadure-N, Hi-Ceram, Optec, HSP, In-Ceram, Empress, Cerec, AllCeram, Procera, Lava, etc.) may be considered elective upgraded procedures if their related CDT procedure codes are not listed as covered benefits.
2. **Benefits for anterior and bicuspid teeth:** Resin, porcelain and any resin to base metal or porcelain to base metal crowns are covered benefits for anterior and bicuspid teeth. Adding a porcelain margin may be considered an elective upgraded procedure.
3. **Benefits for molar teeth:** Cast base metal restorations are covered benefits for molar teeth. Resin-based composite and porcelain to metal crowns may be considered elective upgraded procedures. Adding a porcelain margin may be considered an elective upgraded procedure.
4. **Base metal is the benefit:** If elected, a)noble, b)high noble metal, or c) titanium may be considered an elective upgraded procedure.

CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
D2542	Onlay, metallic, two surfaces	not covered	$185		1 of (D2542-D2792, D6205-D6791) per tooth per 5 year period
D2543	Onlay, metallic, three surfaces	not covered	$200		
D2544	Onlay, metallic, four or more surfaces	not covered	$215		
D2642	Onlay, porcelain/ceramic, two surfaces*	not covered	$250		
D2643	Onlay, porcelain/ceramic, three surfaces*	not covered	$275		
D2644	Onlay, porcelain/ceramic, four or more surfaces*	not covered	$300		
D2662	Onlay, resin-based composite, two surfaces	not covered	$160		
D2663	Onlay, resin-based composite, three surfaces	not covered	$180		
D2664	Onlay, resin-based composite, four or more surfaces	not covered	$200		
D2710	Crown, resin-based composite (indirect)	$140	$140	1 of (D2710-D2791, D6211-D6791) per tooth per 5 year period age 13 and over	
D2712	Crown, ¾ resin-based composite (indirect)	$190	not covered		
D2720	Crown, resin with high noble metal*	not covered	$300		
D2721	Crown, resin with predominantly base metal*	$300	$300		
D2722	Crown, resin with noble metal*	not covered	$300		
D2740	Crown, porcelain/ceramic substrate*	$300	$300		
D2750	Crown, porcelain fused to high noble metal*	not covered	$300		
D2751	Crown, porcelain fused to predominantly base metal*	$300	$300		
D2752	Crown, porcelain fused to noble metal*	not covered	$300		
D2780	Crown, ¾ cast high noble metal*	not covered	$300		
D2781	Crown, ¾ cast predominantly base metal	$300	$300		
D2782	Crown, ¾ cast noble metal*	not covered	$300		
D2783	Crown, ¾ porcelain/ceramic substrate*	$310	not covered		
D2790	Crown, full cast high noble metal*	not covered	$300		
D2791	Crown, full cast predominantly base metal	$300	$300		
D2792	Crown, full cast noble metal*	not covered	$300		
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	$25	$25	1 per tooth every 12 months, per provider	
D2915	Re-cement or re-bond indirectly fabricated/prefabricated post & core	$25	$25		
D2920	Re-cement or re-bond crown	$25	$15	after 12 months of initial placement with same provider	
D2929	Prefabricated porcelain/ceramic crown, primary tooth	$95	not covered	1 of (D2929, D2930, D2934) per tooth every 12 months	
D2930	Prefabricated stainless steel crown, primary tooth	$65	not covered		
D2931	Prefabricated stainless steel crown, permanent tooth	$75	$75	1 per tooth every 36 months	1 per tooth every 36 months

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CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Restorative Services (continued)				
D2932	Prefabricated resin crown	$75	not covered	primary - 1 of (D2932, D2933) per tooth every 12 months	
D2933	Prefabricated stainless steel crown with resin window	$80	not covered	permanent - 1 of (D2932, D2933) per tooth every 36 months	
D2940	Protective restoration	$25	$20	1 per tooth every 6 months, per provider	1 per tooth every 6 months, per provider
D2950	Core buildup, including any pins when required	$20	$20		
D2951	Pin retention, per tooth, in addition to restoration	$25	$20	1 per tooth	
D2952	Post and core in addition to crown, indirectly fabricated	$100	$60	1 per tooth	
D2953	Each additional indirectly fabricated post, same tooth	$30	$30		
D2954	Prefabricated post and core in addition to crown	$90	$60	1 per tooth	
D2955	Post removal	$60	not covered		
D2957	Each additional prefabricated post, same tooth	$35	$35		
D2971	Additional procedure to construct new crown, existing partial denture frame	$35	not covered		
D2980	Crown repair necessitated by restorative material failure	$50	$50	after 12 months of initial crown placement with same provider	
D2999	Unspecified restorative procedure, by report	$40	not covered		
	Endodontic Services				
D3110	Pulp cap, direct (excluding final restoration)	$20	$20		
D3120	Pulp cap, indirect (excluding final restoration)	$25	$25		
D3220	Therapeutic pulpotomy (excluding final restoration)	$40	$35	1 per primary tooth	
D3221	Pulpal debridement, primary and permanent teeth	$40	not covered	1 per tooth	
D3222	Partial pulpotomy, apexogenesis, permanent tooth, incomplete root	$60	not covered	1 per tooth	
D3230	Pulpal therapy, anterior, primary tooth (excluding final restoration)	$55	not covered	1 of (D3230, D3240) per tooth	
D3240	Pulpal therapy, posterior, primary tooth (excluding finale restoration)	$55	not covered		
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$195	$200	1 of (D3310, D3320, D3330) per tooth	
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	$235	$235		
D3330	Endodontic therapy, molar (excluding final restoration)	$300	$300		
D3331	Treatment of root canal obstruction; non-surgical access	$50	$50		
D3332	Incomplete endodontic therapy; inoperable, unrestorable, fractured tooth	$100	$85		
D3333	Internal root repair of perforation defects	$80	not covered		
D3346	Retreatment of previous root canal therapy, anterior	$240	$245	1 of (D3346-D3348) after 12 months of initial treatment	1 of (D3346-D3348) per tooth per lifetime
D3347	Retreatment of previous root canal therapy, bicuspid	$295	$295		
D3348	Retreatment of previous root canal therapy, molar	$365	$365		
D3351	Apexification/recalcification, initial visit	$85	not covered	1 per tooth	
D3352	Apexification/recalcification, interim medication replacement	$45	not covered	1 per tooth	
D3410	Apicoectomy, anterior	$240	$240		
D3421	Apicoectomy, bicuspid (first root)	$250	$250		
D3425	Apicoectomy, molar (first root)	$275	$275		
D3426	Apicoectomy, (each additional root)	$110	$110		
D3430	Retrograde filling, per root	$90	$90		
D3450	Root amputation, per root	not covered	$110		
D3910	Surgical procedure for isolation of tooth with rubber dam	$30	not covered		
D3920	Hemisection, not including root canal therapy	not covered	$120		
D3950	Canal preparation and fitting of preformed dowel or post	not covered	$60		
D3999	Unspecified endodontic procedure, by report	$100	not covered		

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	Periodontal Services				
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	$150	$150	1 of (D4210, D4211, D4260, D4261) per site/quad every 36 months, age 13 and over	1 of (D4210-D4273, D4283) per site quad every 36 months
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant	$50	$50		
D4240	Gingival flap procedure, four or more teeth per quadrant	not covered	$135		
D4241	Gingival flap procedure, one to three teeth per quadrant	not covered	$70		
D4249	Clinical crown lengthening, hard tissue	$165	not covered		
D4260	Osseous surgery, four or more teeth per quadrant	$265	$265	1 of (D4210, D4211, D4260, D4261) per site/quad every 36 months, age 13 and over	
D4261	Osseous surgery, one to three teeth per quadrant	$140	$140		
D4263	Bone replacement graft, first site in quadrant	not covered	$105		
D4264	Bone replacement graft, each additional site, quadrant	not covered	$75		
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$80	not covered		
D4266	Guided tissue regeneration, resorbable barrier, per site	not covered	$145		
D4267	Guided tissue regeneration, non-resorbable barrier, per site	not covered	$175		
D4270	Pedicle soft tissue graft procedure	not covered	$155		
D4273	Autogenous connective tissue graft procedure, first tooth	not covered	$220		
D4283	Autogenous connective tissue graft procedure, each additional tooth	not covered	$220		
GUIDELINE: No more than two (2) quadrants of periodontal scaling and root planing per appointment/ per day are allowable.					
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	$55	$55	1 of (D4341, D4342) per site quad, every 24 months, age 13 and over	1 of (D4341, D4342) per site quad, every 24 months
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	$30	$25		
D4355	Full mouth debridement	$40	$40		1 every 24 months
D4381	Localized delivery of antimicrobial agent/per tooth	$10	not covered		
D4910	Periodontal maintenance	$30	$30	1 every 3 months	1 of (D1110, D4910) every 6 months
D4920	Unscheduled dressing change (other than treating dentist or staff)	$15	not covered	1 per patient per provider, age 13 and over	
D4999	Unspecified periodontal procedure, by report	$350	not covered		
	Removable Prosthodontic Services				
D5110	Complete denture, maxillary	$300	$400	1 of (D5110-D5214, D5863-D5865) per arch every 5 year period	1 of (D5110-D5226, D5281, D5863-D5866) per arch every 5 year period
D5120	Complete denture, mandibular	$300	$400		
D5130	Immediate denture, maxillary	$300	$400	1 of (D5130, D5140) per arch per patient	
D5140	Immediate denture, mandibular	$300	$400		
D5211	Maxillary partial denture, resin base	$300	$325	1 of (D5110-D5214, D5863-D5865) per arch every 5 year period	
D5212	Mandibular partial denture, resin base	$300	$325		
D5213	Maxillary partial denture, cast metal, resin base	$335	$375		
D5214	Mandibular partial denture, cast metal, resin base	$335	$375		
D5225	Maxillary partial denture, flexible base	not covered	$375		
D5226	Mandibular partial denture, flexible base	not covered	$375		
D5281	Removable unilateral partial denture, one piece cast metal	not covered	$250		
D5410	Adjust complete denture, maxillary	$20	$20	2 of (D5410-D5422) per arch every 12 months, 1 per arch per date of service per provider	2 of (D5410-D5422) per arch every 12 months, per provider
D5411	Adjust complete denture, mandibular	$20	$20		
D5421	Adjust partial denture, maxillary	$20	$20		
D5422	Adjust partial denture, mandibular	$20	$20		
D5510	Repair broken complete denture base	$40	$30	1 per arch, per date of service per provider, twice in a 12 month period per provider	1 per arch, per date of service per provider, twice in a 12 month period per provider
D5520	Replace missing or broken teeth, complete denture	$40	$30	up to 4 per arch per date of service per provider, twice per arch in a 12 month period per provider	up to 4 per arch per date of service per provider, twice per arch in a 12 month period per provider

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	Removable Prosthodontic Services (continued)				
D5610	Repair resin denture base	$40	$30	2 per arch per provider every 12 months, 1 per arch per date of service per provider	2 per arch per provider every 12 months, 1 per arch per date of service per provider
D5620	Repair cast framework	$40	$35	2 per arch per provider every 12 months, 1 per arch per date of service per provider	2 per arch per provider every 12 months, 1 per arch per date of service per provider
D5630	Repair or replace broken clasp, per tooth	$50	$30	3 per arch per provider every 12 months, 1 per arch per date of service per provider	3 per arch per provider every 12 months, 1 per arch per date of service per provider
D5640	Replace broken teeth, per tooth	$35	$30	4 per arch per provider every 12 months, 1 per arch per date of service per provider	4 per arch per provider every 12 months, 1 per arch per date of service per provider
D5650	Add tooth to existing partial denture	$35	$35	3 per arch per provider per date of service, 1 per tooth	3 per arch per provider per date of service, 1 per tooth
D5660	Add clasp to existing partial denture, per tooth	$60	$45	3 per date of service per provider, 2 per arch per provider every 12 months	3 per date of service per provider, 2 per arch per provider every 12 months
D5670	Replace all teeth & acrylic on cast metal frame, maxillary	not covered	$195		1 (of D5670, D5671) per arch every 36 months
D5671	Replace all teeth & acrylic on cast metal frame, mandibular	not covered	$195		
D5710	Rebase complete maxillary denture	not covered	$155		1 of (D5710-D5721) per arch every 12 months
D5711	Rebase complete mandibular denture	not covered	$155		
D5720	Rebase maxillary partial denture	not covered	$150		
D5721	Rebase mandibular partial denture	not covered	$150		
D5730	Reline complete maxillary denture, chairside	$60	$80	1 of (D5730-D5761) every 12 months. Covered 6 months after initial placement of appliance if extractions were required, 12 months after initial placement of appliance if extractions were not required.	1 of (D5730-D5761) every 12 months. Covered 6 months after initial placement of appliance if extractions were required, 12 months after initial placement of appliance if extractions were not required.
D5731	Reline complete mandibular denture, chairside	$60	$80		
D5740	Reline maxillary partial denture, chairside	$60	$75		
D5741	Reline mandibular partial denture, chairside	$60	$75		
D5750	Reline complete maxillary denture, laboratory	$90	$120		
D5751	Reline complete mandibular denture, laboratory	$90	$120		
D5760	Reline maxillary partial denture, laboratory	$80	$110		
D5761	Reline mandibular partial denture, laboratory	$80	$110		
D5850	Tissue conditioning, maxillary	$30	$35	2 of (D5850, D5851) per arch every 36 months	1 of (D5850, D5851) per arch every 36 months
D5851	Tissue conditioning, mandibular	$30	$35		
D5862	Precision attachment, by report	$90	not covered		
D5863	Overdenture, complete, maxillary	$300	not covered	1 of (D5110-D5226, D5863-D5865) per arch every 5 year period	
D5865	Overdenture, complete, mandibular	$300	not covered		
D5899	Unspecified removable prosthodontic procedure, by report	$350	not covered		
	Maxillofacial Prosthetic Services				
D5911	Facial moulage (sectional)	$285	not covered		
D5912	Facial moulage (complete)	$350	not covered		
D5913	Nasal prosthesis	$350	not covered		
D5914	Auricular prosthesis	$350	not covered		
D5915	Orbital prosthesis	$350	not covered		
D5916	Ocular prosthesis	$350	not covered		
D5919	Facial prosthesis	$350	not covered		
D5922	Nasal septal prosthesis	$350	not covered		
D5923	Ocular prosthesis, interim	$350	not covered		
D5924	Cranial prosthesis	$350	not covered		
D5925	Facial augmentation implant prosthesis	$200	not covered		
D5926	Cranial prosthesis	$200	not covered		

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	Maxillofacial Prosthetic Services (continued)				
D5927	Auricular prosthesis, replacement	$200	not covered		
D5928	Orbital prosthesis, replacement	$200	not covered		
D5929	Facial prosthesis, replacement	$200	not covered		
D5931	Obturator prosthesis, surgical	$350	not covered		
D5932	Obturator prosthesis, definitive	$350	not covered		
D5933	Obturator prosthesis, modification	$150	not covered	2 every 12 months	
D5934	Mandibular resection prosthesis with guide flange	$350	not covered		
D5935	Mandibular resection prosthesis without guide flange	$350	not covered		
D5936	Obturator prosthesis, interim	$350	not covered		
D5937	Trismus appliance (not for TMD treatment)	$85	not covered		
D5951	Feeding aid	$135	not covered	under age 18	
D5952	Speech aid prosthesis, pediatric	$350	not covered	under age 18	
D5953	Speech aid prosthesis, adult	$350	not covered	age 18 and over	
D5954	Palatal augmentation prosthesis	$135	not covered		
D5955	Palatal lift prosthesis, definitive	$350	not covered		
D5958	Palatal lift prosthesis, interim	$350	not covered		
D5959	Palatal lift prosthesis, modification	$145	not covered	2 every 12 months	
D5960	Speech aid prosthesis, modification	$145	not covered	2 every 12 months	
D5982	Surgical stent	$70	not covered		
D5983	Radiation carrier	$55	not covered		
D5984	Radiation shield	$85	not covered		
D5985	Radiation cone locator	$135	not covered		
D5986	Fluoride gel carrier	$35	not covered		
D5987	Commissure splint	$85	not covered		
D5988	Surgical splint	$95	not covered		
D5991	Vesiculobullous disease medicament carrier	$70	not covered		
D5999	Unspecified maxillofacial prosthesis, by report	$350	not covered		
	Implant Services				
D6010	Surgical placement of implant body: endosteal implant	$350	not covered	Only a Plan Benefit when exceptional medical conditions are met	
D6040	Surgical placement: eposteal implant	$350	not covered		
D6050	Surgical placement: transosteal implant	$350	not covered		
D6055	Connecting bar, implant supported or abutment supported	$350	not covered		
D6056	Prefabricated abutment, includes modification and placement	$135	not covered		
D6057	Custom fabricated abutment, includes placement	$180	not covered		
D6058	Abutment supported porcelain/ceramic crown	$320	not covered		
D6059	Abutment supported porcelain fused to high noble crown	$315	not covered		
D6060	Abutment supported porcelain fused to base metal crown	$295	not covered		
D6061	Abutment supported porcelain fused to noble metal crown	$300	not covered		
D6062	Abutment supported cast metal crown, high noble	$315	not covered		
D6063	Abutment supported cast metal crown, base metal	$300	not covered		
D6064	Abutment supported cast metal crown, noble metal	$315	not covered		
D6065	Implant supported porcelain/ceramic crown	$340	not covered		
D6066	Implant supported porcelain fused to high noble crown	$335	not covered		
D6067	Implant supported metal crown	$340	not covered		
D6068	Abutment supported retainer, porcelain/ceramic FPD	$320	not covered		
D6069	Abutment supported retainer, metal FPD, high noble	$315	not covered		

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	Implant Services (continued)				
D6070	Abutment supported retainer, porcelain fused to metal FPD, base metal	$290	not covered	Only a Plan Benefit when exceptional medical conditions are met	
D6071	Abutment supported retainer, porcelain fused to metal FPD, noble	$300	not covered		
D6072	Abutment supported retainer, cast metal FPD, high noble	$315	not covered		
D6073	Abutment supported retainer, cast metal FPD, base metal	$290	not covered		
D6074	Abutment supported retainer, cast metal FPD, noble	$320	not covered		
D6075	Implant supported retainer for ceramic FPD	$335	not covered		
D6076	Implant supported retainer for porcelain fused metal FPD	$330	not covered		
D6077	Implant supported retainer for cast metal FPD	$350	not covered		
D6080	Implant maintenance procedures, prosthesis removed/reinserted, including cleansing	$30	not covered		
D6090	Repair implant supported prosthesis, by report	$65	not covered		
D6091	Replacement of semi-precision, precision attachment, implant/abutment supported prosthesis, per attachment	$40	not covered		
D6092	Re-cement or re-bond implant/abutment supported crown	$25	not covered		
D6093	Re-cement or re-bond implant/abutment supported FPD	$35	not covered		
D6094	Abutment supported crown, titanium	$295	not covered		
D6095	Repair implant abutment, by report	$65	not covered		
D6100	Implant removal, by report	$110	not covered		
D6110	Implant/abutment supported removable denture, maxillary	$350	not covered		
D6111	Implant/abutment supported removable denture, mandibular	$350	not covered		
D6112	Implant/abutment supported removable denture, partial, maxillary	$350	not covered		
D6113	Implant/abutment supported removable denture, partial, mandibular	$350	not covered		
D6114	Implant/abutment supported fixed denture, maxillary	$350	not covered		
D6115	Implant/abutment supported fixed denture, mandibular	$350	not covered		
D6116	Implant/abutment supported fixed denture for partial, maxillary	$350	not covered		
D6117	Implant/abutment supported fixed denture for partial, mandibular	$350	not covered		
D6190	Radiographic/surgical implant index, by report	$75	not covered		
D6194	Abutment supported retainer crown, FPD, titanium	$265	not covered		
D6199	Unspecified implant procedure, by report	$350	not covered		
	Fixed Prosthodontic Services				

***GUIDELINES for Pontics, Onlays, Crowns: Applies to Adult Dental Only**

The total maximum amount chargeable to the member for elective upgraded procedures (explained below) is $250.00 per tooth. Providers are required to explain covered benefits as well as any elective differences in materials and fees prior to providing an elective upgraded procedure.

1. Brand name restorations: (e.g. Sunrise, Captek, Vitadure-N, Hi-Ceram, Optec, HSP, In-Ceram, Empress, Cerec, AllCeram, Procera, Lava, etc.) may be considered elective upgraded procedures if their related CDT procedure codes are not listed as covered benefits.

2. Benefits for anterior and bicuspid teeth: Resin, porcelain and any resin to base metal or porcelain to base metal crowns are covered benefits for anterior and bicuspid teeth. Adding a porcelain margin may be considered an elective upgraded procedure.

3. Benefits for molar teeth: Cast base metal restorations are covered benefits for molar teeth. Resin-based composite and porcelain to metal crowns may be considered elective upgraded procedures. Adding a porcelain margin may be considered an elective upgraded procedure.

4. Base metal is the benefit: If elected, a)noble, b)high noble metal, or c) titanium may be considered an elective upgraded procedure.

CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
D6205	Pontic, indirect resin based composite*	not covered	$165		1 of (D2542-D2792, D6205-D6791) per tooth per 5 year period
D6210	Pontic, cast high noble metal*	not covered	$300		
D6211	Pontic, cast predominantly base metal	$300	$300	1 of (D2710-D2791, D6211-D6791) per tooth per 5 year period age 13 and over	
D6212	Pontic, cast noble metal*	not covered	$300		
D6214	Pontic, titanium*	not covered	$300		

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CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Fixed Prosthodontic Services (continued)				
D6241	Pontic, porcelain fused to predominantly base metal*	$300	$300	1 of (D2710-D2791, D6211-D6791) per tooth per 5 year period age 13 and over	1 of (D2542-D2792, D6205-D6791) per tooth per 5 year period
D6242	Pontic, porcelain fused to noble metal*	not covered	$300		
D6245	Pontic, porcelain/ceramic*	$300	$300		
D6250	Pontic, resin with high noble metal*	not covered	$300		
D6251	Pontic, resin with predominantly base metal*	$300	$300		
D6252	Pontic, resin with noble metal*	not covered	$300		
D6545	Retainer, cast metal for resin bonded fixed prosthesis	not covered	$130		
D6548	Retainer, porcelain/ceramic, resin bonded fixed prosthesis*	not covered	$145		
D6608	Retainer onlay, porcelain/ceramic, two surfaces*	not covered	$200		
D6609	Retainer onlay, porcelain/ceramic, three or more surfaces*	not covered	$200		
D6610	Retainer onlay, cast high noble metal, two surfaces*	not covered	$200		
D6611	Retainer onlay, cast high noble metal, three or more surfaces*	not covered	$200		
D6612	Retainer onlay, cast base metal, two surfaces	not covered	$200		
D6613	Retainer onlay, cast base metal, three or more surfaces	not covered	$200		
D6614	Retainer onlay, cast noble metal, two surfaces*	not covered	$200		
D6615	Retainer onlay, cast noble metal three or more surfaces*	not covered	$200		
D6634	Retainer onlay, titanium*	not covered	$200		
D6710	Retainer crown, indirect resin based composite	not covered	$200		
D6720	Retainer crown, resin with high noble metal*	not covered	$300		
D6721	Retainer crown, resin with predominantly base metal	$300	$300	1 of (D2710-D2791, D6211-D6791) per tooth per 5 year period age 13 and over	
D6722	Retainer crown, resin with noble metal*	not covered	$300		
D6740	Retainer crown, porcelain/ceramic*	$300	$300		
D6751	Retainer crown, porcelain fused to predominantly base metal*	$300	$300		
D6781	Retainer crown, ¾ cast predominantly base metal	$300	$300		
D6782	Retainer crown, ¾ cast noble metal*	not covered	$300		
D6783	Retainer crown, ¾ porcelain/ceramic*	$300	$300		
D6791	Retainer crown, full cast predominantly base metal	$300	$300		
D6930	Re-cement or re-bond fixed partial denture	$40	$40		
D6980	Fixed partial denture repair, restorative material failure	$95	$95		
D6999	Unspecified fixed prosthodontic procedure, by report	$350	not covered		
	Oral & Maxillofacial Services				
GUIDELINE: The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists					
D7111	Extraction, coronal remnants, deciduous tooth	$40	$40		
D7140	Extraction, erupted tooth or exposed root	$65	$65		
D7210	Surgical removal of erupted tooth	$120	$115		
D7220	Removal of impacted tooth, soft tissue	$95	$85		
D7230	Removal of impacted tooth, partially bony	$145	$145		
D7240	Removal of impacted tooth, completely bony	$160	$160		
D7241	Removal impacted tooth, complete bony, complication	$175	$175		
D7250	Surgical removal residual tooth roots, cutting procedure	$80	$75		
D7260	Oroantral fistula closure	$280	$280		
D7261	Primary closure of a sinus perforation	$285	not covered		
D7270	Tooth reimplantation and/or stabilization, accident	$185	not covered	1 per arch	
D7280	Surgical access of an unerupted tooth	$220	not covered		
D7283	Placement, device to facilitate eruption, impaction	$85	not covered		

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CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Oral & Maxillofacial Services (continued)				
D7285	Incisional biopsy of oral tissue, hard (bone, tooth)	$180	not covered	1 per arch per date of service	
D7286	Incisional biopsy of oral tissue, soft	$110	$110	up to 3 per date of service	
D7287	Exfoliative cytological sample collection	not covered	$35		
D7288	Brush biopsy, transepithelial sample collection	not covered	$35		
D7290	Surgical repositioning of teeth	$185	not covered	1 per arch, for active orthodontic treatment only	
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$80	not covered	1 per arch, for active orthodontic treatment only	
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	$85	$85		
D7311	Alveoloplasty with extractions, one to three teeth per quadrant	$50	$50		
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant	$120	$120		
D7321	Alveoloplasty, w/o extractions, one to three teeth per quadrant	$65	$65		
D7340	Vestibuloplasty, ridge extension (2nd epithelialization)	$350	not covered	1 per arch per 5 year period	
D7350	Vestibuloplasty, ridge extension	$350	not covered	1 per arch	
D7410	Excision of benign lesion, up to 1.25 cm	$75	not covered		
D7411	Excision of benign lesion, greater than 1.25 cm	$115	not covered		
D7412	Excision of benign lesion, complicated	$175	not covered		
D7413	Excision of malignant lesion, up to 1.25 cm	$95	not covered		
D7414	Excision of malignant lesion, greater than 1.25 cm	$120	not covered		
D7415	Excision of malignant lesion, complicated	$255	not covered		
D7440	Excision of malignant tumor, up to 1.25 cm	$105	not covered		
D7441	Excision of malignant tumor, greater than 1.25 cm	$185	not covered		
D7450	Removal, benign odontogenic cyst/tumor, up to 1.25 cm	$180	not covered		
D7451	Removal, benign odontogenic cyst/tumor, greater than 1.25 cm	$330	not covered		
D7460	Removal, benign nonodontogenic cyst/tumor, up to 1.25 cm	$155	not covered		
D7461	Removal, benign nonodontogenic cyst/tumor, greater than 1.25 cm	$250	not covered		
D7465	Destruction of lesion(s) by physical or chemical method, by report	$40	not covered		
D7471	Removal of lateral exostosis, maxilla or mandible	$140	$140	1 per quadrant	
D7472	Removal of torus palatinus	$145	$140	1 per lifetime	
D7473	Removal of torus mandibularis	$140	$140	1 per quadrant	
D7485	Surgical reduction of osseous tuberosity	$105	not covered	1 per quadrant	
D7490	Radical resection of maxilla or mandible	$350	not covered		
D7510	Incision & drainage of abscess, intraoral soft tissue	$70	$55	1 per quadrant, same date of service	
D7511	Incision & drainage of abscess, intraoral soft tissue, complicated	$70	$69	1 per quadrant, same date of service	
D7520	Incision & drainage of abscess, extraoral soft tissue	$70	not covered		
D7521	Incision & drainage of abscess, extraoral soft tissue, complicated	$80	not covered		
D7530	Remove foreign body, mucosa, skin, tissue	$45	not covered	1 per date of service	
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$75	not covered	1 per date of service	
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$125	$125	1 per quadrant per date of service	
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235	not covered		
D7610	Maxilla, open reduction (teeth immobilized, if present)	$140	not covered		
D7620	Maxilla, closed reduction (teeth immobilized, if present)	$250	not covered		
D7630	Mandible, open reduction (teeth immobilized, if present)	$350	not covered		
D7640	Mandible, closed reduction (teeth immobilized, if present)	$350	not covered		
D7650	Malar and/or zygomatic arch, open reduction	$350	not covered		
D7660	Malar and/or zygomatic arch, closed reduction	$350	not covered		

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CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Oral & Maxillofacial Services (continued)				
D7670	Alveolus, closed reduction, may include stabilization of teeth	$170	not covered		
D7671	Alveolus, open reduction, may include stabilization of teeth	$230	not covered		
D7680	Facial bones, complicated reduction with fixation, multiple surgical approaches	$350	not covered		
D7710	Maxilla, open reduction	$110	not covered		
D7720	Maxilla, closed reduction	$180	not covered		
D7730	Mandible, open reduction	$350	not covered		
D7740	Mandible, closed J reduction	$290	not covered		
D7750	Malar and/or zygomatic arch, open reduction	$220	not covered		
D7760	Malar and/or zygomatic arch, closed reduction	$350	not covered		
D7770	Alveolus, open reduction stabilization of teeth	$135	not covered		
D7771	Alveolus, closed reduction stabilization of teeth	$160	not covered		
D7780	Facial bones, complicated reduction with fixation, multiple surgical approaches	$350	not covered		
D7810	Open reduction of dislocation	$350	not covered		
D7820	Closed reduction of dislocation	$80	not covered		
D7830	Manipulation under anesthesia	$85	not covered		
D7840	Condylectomy	$350	not covered		
D7850	Surgical discectomy, with/without implant	$350	not covered		
D7852	Disc repair	$350	not covered		
D7854	Synovectomy	$350	not covered		
D7856	Myotomy	$350	not covered		
D7858	Joint reconstruction	$350	not covered		
D7860	Arthrotomy	$350	not covered		
D7865	Arthroplasty	$350	not covered		
D7870	Arthrocentesis	$90	not covered		
D7871	Non-arthroscopic lysis and lavage	$150	not covered		
D7872	Arthroscopy, diagnosis, with or without biopsy	$350	not covered		
D7873	Arthroscopy, surgical: lavage and lysis of adhesions	$350	not covered		
D7874	Arthroscopy, surgical: disc repositioning and stabilization	$350	not covered		
D7875	Arthroscopy, surgical: synovectomy	$350	not covered		
D7876	Arthroscopy, surgical: discectomy	$350	not covered		
D7877	Arthroscopy, surgical: debridement	$350	not covered		
D7880	Occlusal orthotic device, by report	$120	not covered		
D7899	Unspecified TMD therapy, by report	$350	not covered		
D7910	Suture of recent small wounds up to 5 cm	$35	not covered		
D7911	Complicated suture, up to 5 cm	$55	not covered		
D7912	Complicated suture, greater than 5 cm	$130	not covered		
D7920	Skin graft (identify defect covered, location and type of graft)	$120	not covered		
D7940	Osteoplasty, for orthognathic deformities	$160	not covered		
D7941	Osteotomy, mandibular rami	$350	not covered		
D7943	Osteotomy, mandibular rami with bone graft; includes obtaining the graft	$350	not covered		
D7944	Osteotomy, segmented or subapical	$275	not covered		
D7945	Osteotomy, body of mandible	$350	not covered		
D7946	LeFort I (maxilla, total)	$350	not covered		
D7947	LeFort I (maxilla, segmented)	$350	not covered		
D7948	LeFort II or LeFort III, without bone graft	$350	not covered		
D7949	LeFort II or LeFort III, with bone graft	$350	not covered		

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	Oral & Maxillofacial Services (continued)				
D7950	Osseous, osteoperiosteal, cartilage graft, mandible or maxilla, by report	$190	not covered		
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$290	not covered		
D7952	Sinus augmentation via a vertical approach	$175	not covered		
D7955	Repair of maxillofacial soft and/or hard tissue defect	$200	not covered		
D7960	Frenulectomy (frenectomy or frenotomy), separate procedure	$120	$120	1 per arch per date of service	
D7963	Frenuloplasty	$120	$120	1 per arch per date of service	
D7970	Excision of hyperplastic tissue, per arch	$175	$176	1 per arch per date of service	
D7971	Excision of pericoronal gingiva	$80	$80		
D7972	Surgical reduction of fibrous tuberosity	$100	not covered	1 per quadrant per date of service	
D7980	Sialolithotomy	$155	not covered		
D7981	Excision of salivary gland, by report	$120	not covered		
D7982	Sialodochoplasty	$215	not covered		
D7983	Closure of salivary fistula	$140	not covered		
D7990	Emergency tracheotomy	$350	not covered		
D7991	Coronoidectomy	$345	not covered		
D7995	Synthetic graft, mandible or facial bones, by report	$150	not covered		
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	$60	not covered	1 per arch per date of service	
D7999	Unspecified oral surgery procedure, by report	$350	not covered		
	Orthodontic Services				
For Pediatric Dental, 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 qualify conditions) on Handicapping Labio-Lingual Deviation (HLD) Index analysis. All treatment must be prior authorized by the Plan prior to banding.					
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$350 per course of treatment, regardless of plan year	not covered	age 13 and over	
D8210	Removable appliance therapy		not covered	1 per patient, age 6 through 12	
D8220	Fixed appliance therapy		not covered	1 per patient, age 6 through 12	
D8660	Pre-orthodontic treatment examination to monitor growth and development		not covered	1 every 3 months for a maximum of 6	
D8670	Periodic orthodontic treatment visit		not covered	1 per calendar quarter	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))		not covered	1 per arch for each authorized phase of orthodontic treatment	
D8691	Repair of orthodontic appliance		not covered	1 per appliance	
D8692	Replacement of lost or broken retainer		not covered	1 per arch	
D8693	Re-cement or re-bond fixed retainer		not covered	1 per provider	
D8999	Unspecified orthodontic procedure, by report		not covered		
	Adjunctive General Services				
D9110	Palliative (emergency) treatment, minor procedure	$30	$28	1 per date of service	
D9120	Fixed partial denture sectioning	$95	$95		
D9210	Local anesthesia not in conjunction, operative or surgical procedures	$10	$10	1 per date of service	
D9211	Regional block anesthesia	$20	$20		
D9212	Trigeminal division block anesthesia	$60	$60		
D9215	Local anesthesia in conjunction with operative or surgical procedures	$15	$15		
GUIDELINE: Deep Sedation and IV Conscious Sedation are covered benefits only in conjunction with covered oral surgery procedures when dispensed in a dental office by a practitioner acting within the scope of his/her licensure. Patient apprehension and/or nervousness are not of themselves sufficient justification.					
D9223	Deep sedation/general anesthesia, each 15 minute increment	$45	$45		
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$15	not covered		
D9243	Intravenous moderate (conscious) sedation/analgesia, each 15 minute increment	$60	$45		

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	Adjunctive General Services (continued)				
D9248	Non-intravenous (conscious) sedation, includes non-IV minimal and moderate sedation	$65	not covered		
D9310	Consultation, other than requesting dentist	$50	$45		
D9410	House/extended care facility call	$50	not covered		
D9420	Hospital or ambulatory surgical center call	$135	not covered		
D9430	Office visit, observation, regular hours, no other services	$20	$12	1 per date of service per provider	1 per date of service per provider
D9440	Office visit, after regularly scheduled hours	$45	$40	1 per date of service per provider	1 per date of service per provider
D9450	Case presentation, detailed & extensive treatment	not covered	no charge		
D9610	Therapeutic parenteral drug, single administration	$30	not covered	4 per date of service	
D9612	Therapeutic parenteral drugs, two or more administrations, different meds.	$40	not covered	4 per date of service	
D9910	Application of desensitizing medicament	$20	$22	1 per tooth every 12 months, for permanent teeth only	
D9930	Treatment of complications, post surgical, unusual, by report	$35	not covered	1 per date of service per provider	
D9940	Occlusal guard, by report	not covered	$115		1 per 5 year period
D9942	Repair and/or reline of occlusal guard	not covered	$35		
D9950	Occlusion analysis, mounted case	$120	not covered	1 per 12 months, age 13 and over	
D9951	Occlusal adjustment, limited	$45	$45	1 per quadrant every 12 months per provider, age 13 and over	1 per quadrant every 12 months per provider, age 13 and over
D9952	Occlusal adjustment, complete	$210	$210	1 per 12 months, age 13 and over	
D9999	Unspecified adjunctive procedure, by report	no charge	not covered		

Pediatric Benefits – Children to the age of 19[1]

Adult Benefits – Benefits for eligible members age 19 and over[2]

The Out-of-Pocket Maximum is the maximum amount of money that a covered Pediatric Enrollee can pay in copays for all allowable expenses, including orthodontic copayments, in any Calendar Year. A single Pediatric Enrollee will have an out-of-pocket maximum of $350. A family with two (2) or more Pediatric Enrollees will have a combined Out-of-Pocket Maximum of $700.

Once the amount paid by all Pediatric Enrollee(s) equals the Out-of-Pocket Maximum shown above, no further payment will be required by any of the Pediatric Enrollee(s) for the remainder of the Calendar Year for covered services. Adult benefits are not subject to Out-of-Pocket Maximums.

Payment for services that are Optional or that are not covered under the Policy will not count toward the Out-of-Pocket Maximum, and payment for such services still applies after the annual Out-of-Pocket Maximum is met.

Record of payment for covered procedures should be kept by the Responsible Party. When the Out-of-Pocket Maximum has been reached; contact the Customer Service department at 888-844-3344 for instruction on how to submit. Proof that the Out-of-Pocket Maximum has been reached must be submitted to the Plan.

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General Exclusions:

1. Services which, in the opinion of the attending dentist, are not necessary to the member's dental health.
2. Procedures, appliances, or restoration to correct congenital or developmental malformations are not covered benefits unless specifically listed in the Benefits section above.
3. Cosmetic dental care.
4. Experimental procedures or investigational services, including any treatment, therapy, procedure or drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional standards or for which the safety and efficiency have not been determined for use in the treatment for which the item in service in question is recommended or prescribed.
5. Services that were provided without cost to the Member by State government or an agency thereof, or any municipality, county or other subdivisions.
6. Hospital charges of any kind are not covered by the Dental Plan. Refer to your Health Plan's Evidence of Coverage for benefit information.
7. Major surgery for fractures and dislocations.
8. Loss or theft of dentures or bridgework.
9. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Member became eligible for such services.
10. Any service that is not specifically listed as a covered benefit.
11. Malignancies.
12. Dispensing of drugs not normally supplied in a dental office.
13. Additional treatment costs incurred because a dental procedure is unable to be preformed in the dentists office due to the general health and physical limitations of the patient.
14. Services of a pedodontist/pediatric dentist, except when the Member is unable to be treated by his or her panel provider, or treatment by a pedodontist/pediatric dentist is Medically Necessary, or his or her plan provider is a pedodontist/pediatric dentist.
15. Dental Services that are received in an Emergency Care setting for conditions that are not emergencies if the subscriber reasonable should have known that an Emergency Care situation did not exist.

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CALIFORNIA
INDIVIDUAL PLAN
COMBINED EVIDENCE OF COVERAGE
AND DISCLOSURE FORM

Contains information for Enrollees covered by an Individual Plan from LIBERTY Dental Plan of California, Inc.

Interpretation and translation services may be available for Members with limited English proficiency, including translation of documents into certain threshold languages. To ask for language services call 888-844-3344.

Spanish (Español)
IMPORTANTE: ¿Puede leer esta noticia? Si no, alguien le puede ayudar a leerla. Además, es posible que reciba esta noticia escrita en su propio idioma. Para obtener ayuda gratuita, llame ahora mismo al 1-888-844-3344.

Hereinafter in this document, LIBERTY Dental Plan of California, Inc. may be referred to as "LIBERTY" or "the Plan."

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.

A specimen of the dental plan contract will be furnished upon request.

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

Section I of this document contains a Benefit Matrix for general reference and comparison of Your Benefits under this plan followed by an Overview of Your Dental Benefit Plan.

Section II of this document contains definitions of terms used throughout this document.

I. GENERAL INFORMATION – OVERVIEW OF YOUR DENTAL BENEFIT PLAN

BENEFITS MATRIX

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM AND THE PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

(A) Deductibles	None
(B) Lifetime Maximums	None
(C) Professional services	An Enrollee may be required to pay a Copayment amount for each procedure as shown in the Description of Benefits and Copayments, subject to the Limitations and Exclusions. Copayments range by category of service. Examples are as follows: • Diagnostic Services .... No Cost • Preventive Services .... No Cost • Restorative Services........ $25.00 - $300.00 • Periodontic Services .... $10.00 - $350.00 • Prosthodontic Services .... $20.00 - $375.00 • Oral and Maxillofacial Surgery .... $40.00 - $350.00 • Orthodontic Services .... $350.00 **Note:** Some services may not be covered. Certain services may be covered only if provided by specified Dentists, or may be subject to additional charges. Limitations apply to the frequency with which some services may be obtained. For example: bitewing x-rays in conjunction with periodic examinations are limited to one series of four films in any 6 consecutive month period; Full upper and/or lower denture are not to be replaced within 36 consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair.
(D) Outpatient Services	Not Covered
(E) Hospitalization Services	Not Covered
(F) Emergency Dental Coverage	The Enrollee may receive a maximum Benefit of up to $75 per emergency for out-of-area Emergency Services.
(G) Ambulance Services	Not Covered
(H) Prescription Drug Services	Not Covered
(I) Durable Medical Equipment	Not Covered
(J) Mental Health Services	Not Covered
(K) Chemical Dependency Services	Not Covered
(L) Home Health Services	Not Covered
(M) Other	Not Covered

Each individual procedure within each category listed above that is covered under the Program has a specific Copayment, which is shown in the Schedule of Benefits and in the Combined Evidence of Coverage.

A. HOW TO USE YOUR LIBERTY DENTAL PLAN

This booklet is Your Evidence of Coverage (EOC). It explains what LIBERTY covers and does not cover. Also read Your Schedule of Benefits (on page 18), which lists co-pays and other fees. Your LIBERTY Dental Plan is an Individual dental plan. To be eligible for this coverage, You must meet the eligibility requirements as stated in this document.

B. HOW TO CONTACT LIBERTY

Our Member Services Department is here to help You. Call us if You have a question or a problem:

LIBERTY Dental Plan of California, Inc.
P.O. Box 26110
Santa Ana, CA 92799-6110
Member Services (Toll-Free): (888) 844-3344
Website: www.LIBERTYDentalPlan.com

C. LIBERTY'S SERVICE AREA

LIBERTY has a Service Area, which is the entire state of California. This is the area in which LIBERTY provides dental coverage. You must live or work in the Service Area. You must receive all dental service services within the Service Area, unless You need emergency or Urgent Care. If You move out of the Service Area You must tell LIBERTY.

D. LIBERTY'S NETWORK

Our network is all the General Dentists and dental Specialists that LIBERTY has contracted with to provide services to our Members. You must get Your dental services from Your Primary Care Provider and other Providers who are in the network. Call 888-844-3344 to ask for a LIBERTY Provider Directory or use the website.

If You go to Providers outside the network, You will have to pay all the cost, unless You received pre-approval from LIBERTY or You had an emergency or You needed Urgent Care away from home. If You are new to LIBERTY or LIBERTY ends Your Provider's contract, You can continue to see Your current dentist in some cases. This is called *continuity of care* *(see page 9).*

E. YOUR PRIMARY CARE PROVIDER (see page 6)

When You join LIBERTY, in most cases You need to choose a Primary Care Provider to whom You will be assigned. This is usually a General Dentist who provides Your basic care and coordinates the care You need from other dental specialty Providers.

EXCEPTION: Some LIBERTY plans do not require You to choose and be assigned to a Primary Care Provider. On those plans, You may access services from any contracted Primary Care Provider in the network. Refer to Your Schedule of Benefits to determine if Your plan requires You to choose and be assigned to a Primary Care Provider.

F. LANGUAGE AND COMMUNICATION ASSISTANCE (see page 16)

If English is not Your first language, LIBERTY provides interpretation services and translation of certain written materials in Your preferred language. To ask for language services call 888-844-3344. If You have a preferred language, please notify us of Your personal language needs by calling 888-844-3344.

G. HOW TO GET DENTAL CARE WHEN YOU NEED IT

Call Your Primary Care Provider first for all Your care, unless it is an emergency.

- You usually need a referral and pre-approval to get care from a Provider other than Your Primary Care Provider. See the next section.
- The care must be medically necessary for Your health. Your dentist and LIBERTY follow guidelines and policies to decide if the care is medically necessary. If You disagree with LIBERTY about whether a service You want is medically necessary, You can file a Grievance or, in some cases, You may request an Independent Medical Review (see page 15).
- The care must be a service that LIBERTY covers. Covered dental services are also called Benefits. To see what services LIBERTY covers, see the Schedule of Benefits in Appendix I.

H. REFERRALS AND PRE-AUTHORIZATIONS (see page 8)

You need a referral from Your Primary Care Provider and pre-approval from LIBERTY for services to be provided by a Specialist or to receive a second opinion or to see a dentist who is not in LIBERTY's network. Pre-approval is also called Pre-Authorization.

- Make sure Your Primary Care Provider gives You a referral and gets pre-approval if it is required.
- If You do not have a referral and pre-approval when it is required, You will have to pay all of the cost of the service.

You do **not** need a referral and pre-approval to see Your Primary Care Provider, or to get emergency care or Urgent Care.

I. EMERGENCY CARE (see page 8)

Emergency care is covered anywhere in the world. If it is an emergency, call 9-1-1 or go to the nearest hospital. It is an emergency if You reasonably believe that not getting immediate care could be dangerous to Your life or to a part of Your body. Emergency care may include care for a bad injury, severe pain, or a sudden serious dental illness. Go to Your Primary Care Provider for follow-up care. Do not go back to the emergency room for follow-up care.

J. URGENT CARE (see page 7)

Urgent care is care that You need soon to prevent a serious health problem. Urgent care is covered anywhere in the world.

K. CARE WHEN YOU ARE OUT OF THE LIBERTY SERVICE AREA (see page 7)

Only Emergency and Urgent Care is covered outside of the LIBERTY Service Area.

L. COSTS (see the "SCHEDULE OF BENEFITS" in Appendix I and "What You Pay" on page 9)

- The Premium is what You pay to LIBERTY to keep coverage.
- A Co-payment is the amount that You must pay to the Provider for a particular covered procedure.

After You pay Your Co-payments, LIBERTY pays for the rest of any covered service.

M. IF YOU HAVE A COMPLAINT ABOUT YOUR LIBERTY DENTAL PLAN (see page 13)

LIBERTY provides a Grievance resolution process. You can file a complaint (also called an *appeal* or a *grievance*) with LIBERTY for any dissatisfaction You have with LIBERTY, Your Benefits, a claim determination, a benefit or coverage determination, Your Provider or any aspect of Your dental Benefit Plan. If You disagree with LIBERTY's decision about Your complaint, You can get help from the State of California's HMO Help Center. In some cases, the HMO Help Center can help You apply for an Independent Medical Review (IMR) or file a complaint. IMR is a review of Your case by doctors who are not part of Your health plan.

N. FISCAL SEPARATION OF DECISION MAKING

It is LIBERTY's policy that all clinical review decisions made by staff and or contractors are based solely on appropriateness of care and services and the existence of coverage. LIBERTY does not reward or incentivize reviewers for issuing denials for coverage or care, nor provide incentives that would encourage decisions that result in underutilization.

LIBERTY's Utilization Management staff annually signs an attestation that review decisions were made based solely on appropriateness of care and services and existence of coverage.

II. DEFINITIONS OF USEFUL TERMS CONTAINED IN THIS DOCUMENT

The following terms are used in this EOC document:

Authorization: The notification of approval by LIBERTY that You may proceed with treatment requested.

Benefits: Services covered by Your LIBERTY dental plan.

Benefit Plan: The LIBERTY dental product that You purchased to provide coverage for dental services.

Benefit Year: The year of coverage of Your LIBERTY dental plan.

Capitation: Pre-paid payments made by LIBERTY to a Contracted General Dentist Provider to provide services to assigned Members.

Charges: The fees requested for proposed services or services rendered.

Contracting Dentist: A dentist with LIBERTY Members in accordance with LIBERTY's rules and regulations.

Covered Services: Services listed in this document as a benefit of this dental plan.

Co-payment: Any amount charged to a Member at the time of service for Covered Services. Fixed co-payment amounts are listed in the Schedule of Benefits.

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: Any eligible Member of a Subscriber's family who is enrolled in LIBERTY Dental Plan.

Dental Necessity or Dentally Necessary: A Covered Service that meets Plan guidelines for appropriateness and reasonableness by virtue of a clinical review of submitted information. Covered Services may be reviewed for Dental Necessity prior to o has signed a contract to provide services to or after rendering. Payment for services occurs for Covered Services that are deemed Dentally Necessary by the Plan.

Disputed Dental Service: Any service that is the subject of a dispute filed by either Member or Provider.

Domestic Partner: A person that is in a committed life-sharing relationship with the Member.

Emergency Care / Emergency Dental Service: Emergency Dental Service and care include (and are covered by LIBERTY Dental Plan) 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 and in order to alleviate any emergency symptoms in a dental office. Medical emergencies are not covered by LIBERTY Dental Plan if the services are rendered in a hospital setting which are covered by a Medical Plan, or if LIBERTY Dental Plan determines the services were not dental in nature.

Enrollee: see Member.

Exclusion: A statement describing one or more services or situations where coverage is not provided for dental services by the Plan.

General Dentist: A licensed dentist who provides general dental services and who does not identify as a Specialist.

Grievance: Any expression of dissatisfaction; also known as a complaint. See Grievance Section of EOC for pertinent rules, regulations and processes.

Independent Medical Review (IMR): A California program where certain denied services may be subject to an external review. For Individual Plans, IMR is only available for medical services.

Individual Plan: A dental Benefit Plan providing coverage for an individual person. A spouse or covered Dependent may also be included on the same Individual Plan as the Subscriber.

In-Network Benefits: Benefits available to You when You receive services from a Contracted Provider

Member: Subscriber or eligible Dependent(s) who are actually enrolled in the Plan. Also known as Enrollee.

Non-Participating Provider: A dentist that has no contract to provide services for LIBERTY.

Out-of-Area Coverage: Benefits provided when You are out of the Plan's Service Area, or away from Your Primary Care Provider.

Our-of-Area Urgent Care: Urgent services that are needed while You are located out of the Service Area or away from Your Primary Care Provider.

Participating Dental Group, Dental Office, or Provider: A dental facility and its dentists that are under contract to provide services to LIBERTY Members in accordance with LIBERTY's rules and regulations.

Plan: LIBERTY Dental Plan of California, Inc.

Pre-Authorization: A document submitted in Your behalf requesting an advance determination and approval to render desired treatment services for You.

Premium: The fee paid to LIBERTY for this Benefit Plan.

Primary Care Provider: A dentist affiliated with LIBERTY to provide services to covered Members of the Plan. The Primary Care Dentist is responsible to provide or arrange for needed dental services.

Professional Services: Dental services or procedures provided by a licensed dentist or approved auxiliaries.

Provider: A contracted dentist providing services under contract with the Plan.

Specialist: A Dentist that has received advanced training in one of the dental specialties approved by the American Dental Association as a dental specialty, and practices as a Specialist. Examples are Endodontists, Oral and Maxillofacial Surgeon, Periodontists and Pediatric Dentist.

Subscriber: Member, Enrollee or "You" are equivalent in this document.

Surcharge: An amount charged in addition to a listed Co-payment for a requested service or feature

Terminated Provider: A dentist that formerly delivered services under contract that is no longer associated with the Plan.

Service Area: The counties in California where LIBERTY provides coverage.

Urgent Care: See Emergency Care

Usual Charges: A dentist's usual charge for a service

You: Pertains to Individual Members.

III. ACCESS TO SERVICES – SEEING A DENTIST

LIBERTY Dental Plan contracts with General Dentists and Specialists to provide services covered by Your Plan. Contact us toll-free at **(888) 844-3344** or via our website, **www.LIBERTYdentalplan.com**, to find a dentist in Your area. All services and Benefits described in this publication are covered only if provided by a contracted Primary Care 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" or "Urgent Care."

A. FACILITIES

LIBERTY makes available Primary Care Providers (General Dentist) and Specialists throughout the state of California within a reasonable distance from Your home or workplace. Contact LIBERTY toll-free at **888-844-3344** or via website at www.LIBERTYdentalplan.com to find a dentist in Your area.

Our goal is to provide You 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 participating dentist must adhere to strict contractual guidelines. All dentists are pre-screened and reviewed on a regular basis. We conduct a quality assessment program which includes ongoing contract management to assure compliance with continuing education, accessibility for Members, appropriate diagnosis and treatment planning. Your Primary Care Dentist will provide for all of Your dental care needs including referring You to a Specialist, should it be necessary. All Enrollees shall have a residence or workplace within thirty (30) minutes or fifteen (15) miles of a Primary Care Dental office.

B. DENTAL HEALTH EDUCATION

For further information on using Your dental Benefits, please see the website at www.LIBERTYdentalplan.com. The website contains other helpful information on dental and oral health information to assist You in assessing Your risk of future dental disease, home care measures You can take to keeping Your teeth and mouth healthy. Further, the condition of Your teeth, gums and mouth can have profound effect on Your total overall health. Information on how Your oral health can affect Your overall health conditions such as cardiovascular conditions, diabetes, obesity, pregnancy and pre- and peri-natal health as well as other health conditions can be found on the website.

C. CHOICE OF PROVIDERS

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHAT PROVIDER DENTAL SERVICES MAY BE OBTAINED

1. **General Dentistry/Primary Care Dentistry**: Except as noted below under Exception, when You join LIBERTY Dental Plan, You must choose a Primary Care Dentist to which You will be assigned. Your assigned Primary Care Provider is responsible for coordinating any specialty care dental services You might need. You must

obtain general dental services from Your assigned Primary Care Provider. Your assigned Primary Care Provider will share information with any Specialist to coordinate Your overall care.

Unless otherwise noted in the Exception below, if You do not select a Primary Care Provider, one will be chosen for You by LIBERTY upon Your enrollment and You will be notified of this assignment.

2. **Changing Primary Care Dentists**: You may contact LIBERTY at any time to change Your Primary Care Provider. Contact our Member Services Department toll-free at (888) 844-3344 (during regular business hours) or submit a change request in writing to: LIBERTY Dental Plan, P.O. Box 26110, Santa Ana, CA, 92799-6110. Your requested change to a Primary Care Dentist will be in effect on the first (1st) day of the following month if the change is received by LIBERTY Dental Plan prior to the twentieth (20th) of the current month. Your request to change dentists will not be processed if You have an outstanding balance with Your current dentist.

3. **Exception:** To determine if Your plan requires provider office pre-assignment, please refer to the first page of Your Schedule of Benefits beginning on page 18. If Your plan does not require provider office pre-assignment, in order to access care under one of those plans, contact a LIBERTY Dental Plan provider who is contracted to provide services under Your selected plan for an appointment. The Primary Care Provider will then contact LIBERTY Dental Plan to verify Your eligibility. You may obtain information on contracted providers by phone or website. Refer to Your Schedule of Benefits to determine if Your plan requires You to choose and be assigned to a Primary Care Provider, or if You may access services from any contracted Primary Care Provider in the network.

4. **Care from a Dental Specialist:** You may only obtain care from a dental Specialist only after Your referral to a Specialist has been submitted by Your assigned Primary Care Provider to LIBERTY for approval. You may only receive services from a dental Specialist that have been Pre-Authorized for You by LIBERTY. Your Specialist will submit a Pre-Authorization for services to LIBERTY for Pre-Authorization.

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

D. URGENT CARE

Urgent care is care You need within 24 to 72 hours, and are services needed to prevent the serious deterioration of Your dental health resulting from an unforeseen illness or injury for which treatment cannot be delayed. The Plan provides coverage for urgent 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. Contact Your assigned Primary Care Provider for Your urgent needs during business hours or after hours. If You are out of the area, You may contact LIBERTY for referral to another contracted dentist that can treat Your urgent condition. For after-hours Urgent Care outside the Service Area, You may proceed to find a dentist who can assist You. LIBERTY will reimburse You for covered dental expenses up to a maximum of seventy-five dollars ($75) less applicable Co-payments per calendar year. You should notify LIBERTY as soon as possible after receipt of Urgent Care services preferable within 48 hours. If it is determined that Your treatment was not due to a dental emergency, the services of any non-contracted dentist will not be covered.

E. EMERGENCY DENTAL CARE

All affiliated LIBERTY Dental Plan Primary Care Dental offices provide availability of Emergency Dental Services twenty-four (24) hours per day, seven (7) days per week. 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. If You encounter a dental emergency condition or situation 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, You may also wish to consider contacting the "911" emergency response system. The use of such system should be done so responsibly.

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

If Your Primary Care Dentist is not available, or if You are out of the area and cannot contact LIBERTY to redirect You to another contracted Dental Office, contact any licensed dentist to receive emergency care. LIBERTY will reimburse You for covered dental expenses up to a maximum of seventy-five dollars ($75), less applicable Co-payments. You should notify LIBERTY as soon as possible after receipt of Emergency Dental Services, preferably within 48 hours. If it is determined that Your treatment was not due to a dental emergency, the services of any non-contracted dentist will not be covered.

Emergency Dental Service *(covered by Your LIBERTY Dental Plan)* is defined in the California Health & Safety Code, to include a dental screening, examination, evaluation by dentist or Specialist to determine if an emergency dental condition exists, and to provide care that would be acknowledged as within professionally recognized standards of dental care and in order to alleviate any emergency symptoms in a dental office.

Reimbursement for Emergency Dental Care: If the requirements in the section titled "Emergency Dental Care" are satisfied, LIBERTY will cover up to $75 of such services per calendar year. If You pay a bill for covered Emergency Dental Care, submit a copy of the paid bill to LIBERTY Dental Plan, Claims Department, P.O. Box 26110, Santa Ana, CA, 92799-6110. Please include a copy of the claim from the Provider's office or a legible statement of services/invoice. Please forward to LIBERTY Dental Plan with the following information:

- Your membership information.
- Individual's name that received the Emergency Dental Services.
- Name and address of the dentist providing the Emergency Dental Service.
- A statement explaining the circumstances surrounding the emergency visit.

If additional information is needed, You will be notified in writing. If any part of Your claim is denied You will receive a written explanation of benefits (EOB) within 30 days of LIBERTY 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. You may also refer to the EOC section, GRIEVANCE PROCEDURES below.

F. SECOND OPINION

At no cost to You, You may request a second dental opinion diagnosis for services covered under Your plan when appropriate, by directly contacting Member Services either by calling the toll-free number (888) 844-3344 or by writing to: LIBERTY Dental Plan, P.O. Box 26110, Santa Ana, CA, 92799-6110. Your Primary Care 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 processed by LIBERTY Dental Plan within five (5) business days of receipt of the request, or within 72 hours of receipt for cases involving an an imminent and serious threat to Your health including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. Upon approval, LIBERTY 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.

G. 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 responded to within five (5) business days of receipt, unless urgent.

If Your specialty referral Pre-Authorization is denied or You are dissatisfied with the Pre-Authorization, 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.

H. AUTHORIZATION, MODIFICATION OR DENIAL OF SERVICES

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

Referral to a Specialist is the responsibility of Your assigned contracted Primary Care Provider (see Referral to a Specialist above).

Specialty services proposed by any Specialist to whom You are referred must be Pre-Authorized prior to rendering care, except for Emergency Dental Services (Emergency Dental Care and Urgent Care services described above).

You or Your Providers may call Member Services toll-free at 1-888-844-3344 for information on Pre-Authorization of services policies, procedures or the status of a particular referral or Pre-Authorization.

Specialty referral and Pre-Authorization of specialty services proposed by the Specialist is processed within 5 days of receipt of all information necessary to make the determination. When LIBERTY is unable to make the determination within the 5-day requirement, LIBERTY will notify Your Provider and You of the information needed to complete the review and the anticipated date when the determination will be made.

Any denial, delay or modification of services will contain a clear and concise description of the utilization review criteria, guideline, clinical reason or contractual section of the coverage documentation used to make such a determination. Such determinations will include the name and telephone number of the health care professional responsible for the determination and information on how You can

Determinations to deny, delay or modify treatment requested on Your behalf will contain information on how You may file a Grievance based on this determination.

Urgent requests: If You or Your Primary Care Dentist encounter an urgent condition in which there is an imminent and serious threat to Your health including but not limited to, the potential loss of life, limb, or other major body function, or the normal timeframe for the decision making process as described above would be detrimental to Your life or health, the response to the request for referral should not exceed seventy-two (72) hours from the time of receipt of such information, based on the nature of the urgent or emergent condition.

The decision to approve, modify or deny will be communicated to the Primary Care Dentist within twenty-four (24) hours of the decision. In cases where the review is retrospective (services already provided), the decision shall be communicated to the Enrollee within thirty (30) days of the receipt of the information.

I. CONTINUITY OF CARE

Current Members: Current Members may have the right to the benefit of completion of care with their Terminated Provider for certain specified acute or serious chronic dental conditions. Please call the Plan at 1-888-844-3344 to see if You may be eligible for this benefit. You may request a copy of the Plan's Continuity of Care Policy. You must make a specific request to continue under the care of Your Terminated Provider. We are not required to continue Your care with that Provider if You are not eligible under our policy or if we cannot reach agreement with Your Terminated Provider on the terms regarding Your care in accordance with California law.

New Members: A New Member may have the right to the qualified benefit of completion of care with their Non-Participating Provider for certain specified acute or serious chronic dental conditions. Please call the Plan at 1-888-844-3344 to see if You may be eligible for this benefit. You may request a copy of the Plan's Continuity of Care Policy. You must make a specific request to continue under the care of Your current Provider. We are not required to continue Your care with that Provider if You are not eligible under our policy or if we cannot reach agreement with Your Provider on the terms regarding Your care in accordance with California law. This policy does not apply to new Members of an individual Subscriber contract.

J. LANGUAGE ASSISTANCE

Interpretation and translation services may be available for Members with limited English proficiency, including translation of documents into certain threshold languages. To ask for language services call 888-844-3344.

IV. FEES AND CHARGES – WHAT YOU PAY

A. PREMIUMS AND PREPAYMENT FEES

Premiums are due to LIBERTY Dental Plan prior to the month of coverage.

Your Premium and payment terms are listed in Appendix 2, including mailing address for payments.

Premiums must be paid for the period in which services are received.

B. CHANGES TO BENEFITS AND PREMIUMS

LIBERTY Dental Plan may change the covered Benefits, Co-payments, and Premium rates from time to time. LIBERTY Dental Plan will not decrease the covered Benefits or increase the Premium rates during the term of the agreement without giving notice to You at least sixty (60) days before the proposed change.

At renewal, LIBERTY may change the Premium and may provide 60 days' notice of any Premium change.

C. OTHER CHARGES

You are responsible only for Premiums and listed Co-payments for Covered Services. You may be responsible for other Charges for non-covered or optional services as described in this Evidence of Coverage document. You should discuss any Charges for non-covered

or optional services directly with Your Provider. In order to be certain which services on Your treatment plan are covered benefits of Your plan and which services, if any, are non-covered or optional services (for which You may be responsible for paying out-of-pocket), You may wish to obtain a written disclosure of all services proposed or received, whether covered or not.

If You receive services that require Pre-Authorization without the necessary authorization (other than emergent or Urgent Care services as medically necessary), You will be responsible for full payment of the Provider's usual fee to the Provider for any such services.

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 for any third party payment organizations as agreed upon mutually by You and Your Provider as per business arrangements and disclosures made by LIBERTY or the treating Provider.

D. 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 are responsible for the treating dentist's usual fee in the following situations:

- For non-covered services. If You have services from a non-contracted dentist or facility
- If a Pre-Authorization was required and You did not have the treatment Pre-Authorized
- Services received out of area that are later deemed to not qualify as emergency or Urgent Care services, such as (but not limited to) routine treatment beyond the stabilization of the emergency situation

Emergency services may be available out-of-network or without Pre-Authorization in some situations (see Emergency Dental Care section above).

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. If You would like more information about dental coverage options, You may contact our Member Services Department at 888-844-3344.

In no event are You ever responsible for any sums owed to a Contracted Dentist by LIBERTY. In the event that LIBERTY fails to pay a Non-Participating Provider, You may be liable to the Non-Participating Provider for the cost of services You received.

IMPORTANT: If You opt to receive dental services that are not covered services under this plan, a participating dental provider may charge You his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If You would like more information about dental coverage options, You may call member services at (888) 844-3344 or Your insurance broker. To fully understand Your coverage, You may wish to carefully review this evidence of coverage document.

E. PROVIDER REIMBURSEMENT

LIBERTY pays for Covered Services to Contracted Dentists via a variety of arrangements including Capitation, fee-for-service and supplemental surpayments in addition to Capitation. Reimbursement varies by geographic area, general dentist, specialty dentist and procedure code. For more information on reimbursement, You may address a request in writing to LIBERTY at the address shown above.

V. ELIGIBILITY AND ENROLLMENT

A. WHO IS ENTITLED TO BENEFITS

If LIBERTY Dental Plan receives Your completed enrollment form payment by the 20th day of the month, You are eligible to receive care on the first day of the following month. You may call Your selected dentist at any time after the effective date of Your coverage. 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 Evidence of Coverage or the Schedule of Benefits and applicable Limitations and Exclusions in Appendix 1 with You when You go to Your appointment. You can then reference Benefits and applicable Co-payments which are the out-of-pocket costs associated with Your plan, as well as any non-covered treatment.

B. WHO IS ELIGIBLE TO ENROLL

You and Your eligible dependents are eligible to enroll in a LIBERTY dental plan. You must live or work in the Plan Service Area.

- You may enroll Your spouse.
- Unmarried dependent children (including adopted) who are under the age of twenty-six (26).
- Disabled children dependent upon You for support and are not able to support themselves due to physical or mental handicap. You must provide proof of disability or handicap at the time You enroll.
- New dependents such as new spouse, children placed with You for adoption, and newborns.

VI. COVERED SERVICES

You are covered for the dental services and procedures listed below when necessary for Your dental health in accordance with professionally recognized standards of practice, subject to the limitations and Exclusions described for each category and for all services. Please see Schedule of Benefits (Appendix 1) for a detailed listing of specific Covered Services and the Co-payments applicable to each, and a list of the Exclusions and limitations that are applicable to all dental services covered under Your LIBERTY Dental Plan.

A. DIAGNOSTIC DENTAL SERVICES

Diagnostic dental services are those that are used to diagnose Your dental condition and evaluate necessary dental treatment, when deemed necessary for Your dental health in accordance with professionally recognized standards of practice.

You are covered for the Diagnostic dental services listed in Appendix 1, together with related limitations and Exclusions.

B. PREVENTIVE DENTAL SERVICES

Preventive dental services are those that are used to maintain good dental condition or to prevent deterioration of dental condition, when deemed necessary for Your dental health in accordance with professionally recognized standards of practice:

You are covered for the Preventive dental services listed in Appendix 1, together with related limitations and Exclusions.

C. RESTORATIVE DENTAL SERVICES

Restorative dental services are those that are used to repair and restore the natural teeth to healthy condition, when deemed necessary for Your dental health in accordance with professionally recognized standards of practice:

You are covered for the Restorative dental services listed in Appendix 1, together with related limitations and Exclusions.

D. ENDODONTIC SERVICES

Endodontic dental services are procedures that involve treatment of the pulp, root canal and roots when deemed necessary for Your dental health in accordance with professionally recognized standards of practice:

You are covered for the Endodontic dental services listed in Appendix 1, together with related limitations and Exclusions.

E. PERIODONTIC SERVICES

Periodontic dental services are those procedures that involve the treatment of the gum and bone supporting the teeth and the management of gingivitis (gum inflammation) and periodontitis (gum disease), when deemed necessary for Your dental health in accordance with professionally recognized standards of practice:

You are covered for the Periodontic dental services listed in Appendix 1, together with related limitations and Exclusions.

F. PROSTHODONTIC SERVICES

Removable prosthodontics is the replacement of lost teeth by a removable prosthesis and the maintenance of those appliances. Fixed prosthodontics is the replacement of lost teeth by a fixed prosthesis.

You are covered for the Prosthodontic dental services listed in Appendix 1, together with related limitations and Exclusions.

G. ORAL SURGERY SERVICES

Oral surgery services are procedures that involve the extraction of teeth and other surgical procedures as listed in the Schedule of Benefits.

You are covered for the Oral Surgery dental services listed in Appendix 1, together with related limitations and Exclusions.

H. ADJUNCTIVE DENTAL SERVICES

Adjunctive Dental Services are ancillary services such as anesthesia during dental services, bleaching, mouthguards, etc.

You are covered for the Adjunctive dental services listed in Appendix 1,together with related limitations and Exclusions.

I. ORTHODONTIC SERVICES

Orthodontic services are procedures that involve straightening teeth and treating discrepancies in the bite relationship of the teeth and jaws. See Appendix 1 for a list of any covered orthodontic services provided in Your Benefit Plan, and any pertinent limitations and Exclusions.

J. URGENT AND EMERGENCY SERVICES

See information provided above in this Evidence of Coverage document for a description of coverage for Emergency Dental Services, including out of area urgent services, and how to access them.

K. SERVICES PROVIDED BY A SPECIALIST

See information provided above in this Evidence of Coverage document for a description of coverage for services available performed by a Specialist, including a list of the types of dental Specialists covered and how to access services from a Specialist.

VII. LIMITATIONS, EXCLUSIONS, EXCEPTIONS, REDUCTIONS

See Appendix 1 for limitations to covered procedures and Exclusions to Your plan Benefits.

A. GENERAL EXCLUSIONS

LIBERTY will not cover:

- Care You get from a doctor who is not in the LIBERTY network, unless You have pre-approval from LIBERTY, or You need Urgent Care and are outside the LIBERTY Service Area.
- Care that is not medically necessary
- Exams that You need only to get work, go to school, play a sport, or get a license or professional certification.
- Services that are ordered for You by a court, unless they are medically necessary and covered by LIBERTY.
- The cost of copying Your medical records. (This cost is usually a small fee per page)
- Expenses for travel, such as taxis and bus fare, to see a doctor or get health care.
- Other Exclusions are listed in Appendix 1.

B. MISSED APPOINTMENTS

LIBERTY strongly recommends that if You need to cancel or reschedule an appointment with Your Provider that You notify the Dental Office as far in advance as possible. This will allow the LIBERTY and the Provider to accommodate another person in need of attention. Providers may charge a fee for missed or broken appointments with less than the recommended notice.

VIII. TERMINATION, RESCISSION AND CANCELLATION OF COVERAGE

A. TERMINATION OF BENEFITS

1. Termination Due to Loss of Eligibility

Your LIBERTY Plan coverage may end if You no longer live or work in the LIBERTY service area or if LIBERTY no longer offers Your dental plan.

2. Termination Due to Non-Payment of Premium

If premiums are not paid according to the agreement, termination will be effective on midnight of the last day of the month for which premiums were last received, subject to compliance with notice requirements accepted by LIBERTY Dental Plan.

Termination by LIBERTY will comply with Health and Safety Code, Section 1365(a) as amended and any associated guidance or regulation in force at that time.

3. Completion of Treatment In Progress After Termination

If You terminate from the Plan while the contract between You and LIBERTY Dental Plan is in effect, Your Primary Care Provider or Specialist must complete any procedure in progress that was started before Your termination, abiding by the terms and conditions of the Plan.

If You terminate coverage from the Plan after the start of orthodontic treatment, You will be responsible for any Charges on any remaining orthodontic treatment.

4. Termination Due to Fraud

If a Subscriber permits any other person to use their Member ID card to obtain services under this dental plan, or otherwise engages in fraud or deception in the provision of incomplete or incorrect "material" information to LIBERTY or to the Provider that would affect enrollment information, for use of the services or facilities of the plan or knowingly permits such fraud or deception by another, termination will be effective immediately upon notice from LIBERTY Dental Plan.

5. Termination Due to Health Status

LIBERTY does not terminate based on any health status. If You believe that Your coverage has been terminated based on Your health status or requirements for health care services, You may request a review to be performed by the Director of the Department of Managed Health Care. If the Director determines that a proper complaint exists under the provisions of this section, the Director shall notify the plan. Within 15 days after receipt of such notice, the plan shall either request a hearing or reinstate the Enrollee or Subscriber. A reinstatement shall be retroactive to time of cancellation or failure to renew and the plan shall be liable for the expenses incurred by the Subscriber or Enrollee for covered health care services from the date of cancellation or non-renewal to and including the date of reinstatement. You can contact the Department of Managed Health Care at (1-888-HMO-2219) or on a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's Internet web site is http://www.hmohelp.ca.gov.

B. EFFECTIVE DATE OF TERMINATION

Coverage may be terminated, cancelled or non-renewed following 15 days since the date of notification of termination, except for fraud or deception as stated above, which is effective immediately upon notification.

C. DISENROLLMENT

You may disenroll from the plan by contacting LIBERTY by phone or in writing. Disenrollment is effective as of the end of the last day of the period for which Premium was paid.

D. RESCISSION

Rescission means that LIBERTY may cancel Your coverage as if no coverage ever existed. Rescission may be elected by LIBERTY only in the event of fraud or intentional misrepresentation of material fact such as if You intentionally submitted incomplete or incorrect material information in Your enrollment application that would have affected our decision to accept You as a covered Member. You have the right to appeal any decision to rescind Your membership. Appeal procedures will be provided to You in the notice of rescission.

IX. RENEWAL AND REINSTATEMENT OF COVERAGE

Your coverage will be automatically renewed at the same terms and conditions unless LIBERTY notifies You in writing at least 30 days before the end of Your coverage term describing any changes in the Premium, coverage or other terms or conditions of Your coverage.

X. GRIEVANCE PROCEDURES

If You are dissatisfied with Your selected Primary Care Dentist, personnel, facilities, specialty referral, Pre-Authorization, claim, or the dental care You receive, You have the right to complain to the dental plan. A Complaint is the same as a Grievance. Grievance Forms may be requested by contacting LIBERTY Dental Plan's Member Services Department at (888) 844-3344. Grievance Forms are also available on our website, www.libertydentalplan.com, or by calling LIBERTY Member Services or by asking Your Provider. Grievance Forms are not necessary. LIBERTY will investigate a Grievance submitted in any format. Your complaint or Grievances may be:

- Sent in writing to: LIBERTY Dental Plan, P.O. Box 26110, Santa Ana, CA, 92799-6110, or
- Sent by facsimile to: LIBERTY Dental Plan's Member Services Department facsimile at (949) 223-0011, or
- Submitted verbally: LIBERTY Dental Plan Member Services Representative at LIBERTY's toll-free number: (888) 844-3344, or
- Submitted using our website online Grievance filing process by visiting www.libertydentalplan.com.

You may use a "patient advocate" to help You file a Grievance. For Grievances involving minors or incapacitated or incompetent individuals, the parent, guardian, conservator, relative or other designee of the Member, as appropriate may submit the Grievance to LIBERTY, or to the DMHC for urgent matters (see "Urgent Grievances" below)

If You have limited English proficiency, visual or other communication impairment, LIBERTY will assist You in filing a Grievance. Assistance may include translation of Grievance procedures, forms and LIBERTY's responses, and may also include access to interpreters, telephone relay systems to aid disabled individuals to communicate.

You will not be discriminated against in any way by LIBERTY or Your Provider for filing a Grievance.

You may file a Grievance for at least 180 calendar days following any incident or action that is the subject of Your dissatisfaction.

LIBERTY Dental Plan's representatives will review the problem with You and take appropriate steps for a quick resolution. You will receive acknowledgement of Your Grievance within five (5) calendar days of receipt. Grievances will be resolved within 30 days.

Grievances Exempt from Written Acknowledgement and Response: In some cases Grievances that are received by telephone, facsimile, e-mail or through a website that are not coverage disputes, or are not involving Dental Necessity and are resolved by the next business day do not require a written acknowledgement or response. In these cases You will be contacted by the same method by which You submitted the Grievance or otherwise discussed with You at the time You reported Your complaint.

The following information is required by the State of California pertaining to Your dental plan.

A. STATE OF CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE (DMHC) COMPLAINT PROCEDURE

The DMHC has established a toll-free number for You as a Member to utilize should You have a complaint against a health care service plan, or requests for review of cancellations, rescissions and non-renewals under Health and Safety Code section 1365(b) and related guidance and rules. This number is **888-HMO-2219**. As a Member You may file a complaint against LIBERTY Dental Plan; however, You may only do so after contacting Your plan directly to utilize its complaint resolution process.

A Member may immediately file a complaint with the California DMHC in the event of a dental emergency situation. In addition a Member may also file a complaint in the event that the plan does not satisfactorily resolve the complaint (grievance) within thirty (30) days of filing with your health care service plan.

California Required Statement: The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your Health Plan, you should first telephone your Health Plan at **1-888-844-3344** and use your Health Plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your Health Plan, or a grievance that remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a Health Plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-HMO-2219)** and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The Department's Internet web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

Grievance Resolutions and Responses: For Grievances related to requested services that were denied, delayed or modified based in whole or in part on a finding that the proposed health care service is not a covered benefit, the response will indicated the exact document, page and provision applicable to the Grievance response.

For Grievances related to requested health care services that were denied, delayed or modified in whole or in part based on a determination that the service is not medically (dentally) necessary, the response will indicate the criteria, clinical guideline or policy used in reaching the determination.

Urgent Grievances: For cases involving an imminent and serious threat to Your health including, but not limited to, severe pain, potential loss of life, limb, or major bodily function, LIBERTY will expedite the processing of Your Grievance upon notification of this urgent condition. LIBERTY will resolve to the urgent condition within 3 calendar days of receipt of the Grievance, or sooner, based on the condition. In the case of urgent Grievances, You are not required to await the determination by LIBERTY before accessing the DMHC as noted above.

If You are not satisfied with the resolution initially provided, You may contact the DMHC as noted above. You may also submit additional materials for additional consideration to LIBERTY Dental Plan's Quality Management Department. Your requests must be in writing with a detailed summary and should be directed to:

LIBERTY Dental Plan, Inc.
Quality Management Department
P.O. Box 26110
Santa Ana, CA 92799-6110

Any additional information will be processed as a new Grievance.

B. MEDIATION

You may also request voluntary mediation with LIBERTY before exercising Your right to submit a Grievance to the DMHC. The use of mediation does not preclude Your right to submit a Grievance to the DMHC upon completion of mediation. In order to initiate mediation, You or Your agent must voluntarily agree to the mediation process. Expenses for mediation will be borne equally by You and LIBERTY.

C. INDEPENDENT MEDICAL REVIEW (IMR)

In cases which result in the denial of the Pre-Authorization request for Covered Services by a LIBERTY Dental Plan Provider, and are considered the practice of medicine or are provided pursuant to a contract between LIBERTY and a health plan (that covers hospital, medical or surgical benefits) may be eligible for the DMHC Independent Medical Review (IMR) program. Subscribers may request a form for the independent medical review of their case by contacting LIBERTY Dental Plan at 888-844-3344 or writing to: LIBERTY Dental Plan, P.O. Box 26110, Santa Ana, CA, 92799-6110. You may also request the forms from the Department of Managed Health Care. The Department of Managed Health Care may be reached at 1-888-HMO-2219 or by visiting their website at: **http://www.hmohelp.ca.gov**. Independent Medical Review is only available for certain medical services.

D. ARBITRATION

If You or one of Your eligible Dependents is not satisfied with the results of LIBERTY Dental Plan's complaint resolution process, and all the complaint resolution procedures have been exhausted, the matter can be submitted to arbitration for resolution. If You, or one of Your eligible Dependents, believe that some conduct arising from or relating to Your participation as a LIBERTY Dental Plan Member, including contract or medical liability, the matter shall be settled by arbitration. The arbitration will be conducted according to the American Arbitration Association rules and regulations in force at the time of the occurrence of the Grievance (dispute or controversy) and subject to Section 1295 of the California code of Civil Procedure..

XI. MISCELLANEOUS PROVISIONS

A. 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.

B. THIRD PARTY LIABILITY

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

C. OPPORTUNITY TO PARTICIPATE IN LIBERTY'S PULBIC POLICY COMMITTEE

If You wish to participate in LIBERTY's Public Policy Committee, which reviews plan performance and assists in establishing LIBERTY's public policies, please contact Member Services Department at (888) 844-3344, or contact Quality Management Department at qm@libertydentalplan.com

D. NON DISCRIMINATION

LIBERTY and contracted Providers provide care in a non-discriminatory environment. 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.

E. 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 Primary Care Provider who submits claims or encounters on Your behalf. Services provided by a Specialist 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 Reimbursement for Emergency Dental Services section above).

F. ORGAN DONATION

LIBERTY is required by DMHC to inform You that organ donation options are available to You. Organ donation has many benefits to society, and You may wish to consider this option in the event of any health situation that may lead to the option to do so. You may find more information about organ donation at http://donatelife.net/

G. LANGUAGE ASSISTANCE

Interpretation and translation services may be available for Members with limited English proficiency, including translation of documents into certain threshold languages. See statements below:

IMPORTANT: Can You read this document? If not, we can have somebody help You read it.
You may also be able to get this letter written in Your language. For free help, please call
right away at 1-888-844-3344.

Spanish (Español)

IMPORTANTE: ¿Puede leer esta noticia? Si no, alguien le puede ayudar a leerla. Además,
es posible que reciba esta noticia escrita en su propio idioma. Para obtener ayuda gratuita,
llame ahora mismo al 1-888-844-3344.

H. LIBERTY DENTAL PLAN MEMBER SERVICES DEPARTMENT

LIBERTY Dental Plan Member Services provides toll-free customer service support Monday through Friday 8:00 a.m. to 5:00 p.m. on normal business days to assist Members with simple inquiries and resolution of dissatisfactions. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers 1-800-735-2929 (TTY) or 1-888-877-5378 (TTY) to contact the department. Our toll-free number is (888) 844-3344.

I. MEMBER RIGHTS

As a Member, You have the right to:

- Be treated with respect, dignity and recognition of Your need for privacy and confidentiality
- Express a complaint and be informed of the Grievance process
- Have access and availability to care
- Access Your Dental Records
- Participate in decision-making regarding Your course of treatment
- Be provided information regarding a Provider
- Be provided information regarding the organization's services, Benefits and specialty referral process.

LIBERTY Dental Plan Policies and Procedures for preserving the confidentiality of medical records are available and will be furnished to You upon request.

J. MEMBER RESPONSIBILITIES

As a Member, You have the responsibility to:

- Pay the Premium for Your coverage on time
- Identify yourself to Your selected Dental Office as a Liberty Dental Plan Member
- Treat the Primary Care Dentist, office staff and Liberty Dental Plan staff with respect and courtesy
- Keep scheduled appointments or contact the Dental Office twenty-four (24) hours in advance to cancel an appointment
- Cooperate with the Primary Care Dentist in following a prescribed course of treatment
- Make Co-payments 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

LIBERTY Dental Plan of California, Inc.

P.O. Box 26110

Santa Ana, CA 92799-6110

(888) 844-3344

Appendix 1:
SCHEDULE OF BENEFITS
COVERED SERVICES

Refer to the benefit schedule issued to You at the time of enrollment. You may also obtain a copy by contacting our Member Services department toll free at (888) 844-3344, Monday through Friday, from 8:00 am to 6:00 pm Pacific Standard Time.

Appendix 2:

PREMIUM, PRE-PAYMENT FEES
AND CHARGES

IMPORTANT: You can get an interpreter at no cost to talk to your doctor or health plan. To get an interpreter or to request written information (in your language or in a different format, such as Braille or larger font), first call your health plan's phone number at 1-888-844-3344. Someone who speaks (your language) can help you. If you need more help, call the HMO Help Center at 1-888-466-2219.

IMPORTANTE: Puede obtener la ayuda de un intérprete sin costo alguno para hablar con su médico o con su plan de salud. Para obtener la ayuda de un intérprete o pedir información escrita (en su idioma o en algún formato diferente, como Braille o tipo de letra más grande), primero llame al número de teléfono de su plan de salud al 1-888-844-3344. Alguien que habla español puede ayudarle. Si necesita ayuda adicional, llame al Centro de ayuda de HMO al 1-888-466-2219. (Spanish)

重要提示： 您與您的醫生或保健計劃工作人員交談時，可獲得免費口譯服務。如需口譯員服務或索取（用給您的語言或布萊葉盲文或大字體等不同格式提供的）書面資料，請先打電話給您的保健計劃，電話號碼 1-888-844-3344。會講（您的語言）的人士將為您提供協助。 如需更多協助，請打電話給 HMO 協助中心，電話號碼 1-888-466-2219。 (Cantonese or Mandarin)

هام: يمكنك الحصول على خدمات مترجم فوري مجاناً للتحدث مع طبيبك أو خطتك الصحية. للحصول على مترجم فوري أو لطلب معلومات مكتوبة (بلغتك أو بصيغة أخرى، مثل طريقة برايل أو بخط كبير)، اتصل أولاً برقم هاتف الخطة الصحية على 1-888-844-3344. سيساعدك شخص ما يتحدث (نفس لغتك). إذا كنت تريد المزيد من المساعدة، اتصل بمركز مساعدة HMO على الرقم 1-888-466-2219. (Arabic)

ԿԱՐԵՎՈՐ ՏԵՂԵԿՈՒԹՅՈՒՆ. Դուք կարող եք խոսել Ձեր բժշկի կամ առողջապահական ծրագրի հետ՝ օգտվելով թարգմանչի ծառայություններից առանց որևէ վճարի: Թարգմանիչ ունենալու կամ գրավոր տեղեկություն խնդրելու համար (հայերենով կամ մեկ այլ ձևաչափով, օրինակ՝ Բրայլը կամ մեծ տառաչափը), նախ զանգահարեք առողջապահական ծրագրի հեռախոսահամարով՝ 1-888-844-3344: Ցանկացած մեկը, ով խոսում է հայերեն, կարող է օգնել Ձեզ: Եթե Ձեզ լրացուցիչ օգնություն է անհրաժեշտ, ապա զանգահարեք Առողջապահական օժանդակության կազմակերպության (HMO) Օգնության կենտրոն՝ 1-888-466-2219 հեռախոսահամարով: (Armenian)

សារៈសំខាន់: អ្នកអាចទទួលអ្នកបកប្រែផ្ទាល់មាត់ដោយឥតគិតថ្លៃ ដើម្បីនិយាយទៅកាន់វេជ្ជបណ្ឌិត ឬគំរោងសុខភាពរបស់អ្នក។ ដើម្បីទទួលអ្នកបកប្រែផ្ទាល់មាត់ ឬស្នើសុំព័ត៌មានជាលាយល័ក្ខណ៍អក្សរ (ជាភាសាខ្មែរ ឬជាទំរង់ផ្សេងទៀត ដូចជាអក្សរប្រ៊ៃល ឬអក្សរពុម្ពធំៗ) សូមទូរស័ព្ទទៅគំរោងសុខភាពរបស់អ្នក តាមលេខ 1-888-844-3344 ជាមុនសិន។ អ្នកនិយាយភាសាខ្មែរ អាចជួយអ្នកបាន។ បើសិនអ្នកត្រូវការជំនួយបន្ថែម សូមទូរស័ព្ទទៅមជ្ឈមណ្ឌលជំនួយអង្គការថែរក្សាសុខភាព HMO តាមលេខ 1-888-466-2219។ (Khmer)

مهم: برای گفتگو با پزشک معالج یا طرح بیمه می توانید بطور رایگان مترجم حضوری داشته باشید. برای درخواست مترجم حضوری یا برای دریافت اطلاعات بصورت کتبی (به زبان خود، یا با فرمت های دیگر مانند بریل یا چاپ درشت) ابتدا با شماره تلفن طرح خود یعنی 1-888-844-3344 تماس حاصل نمایید. فردی که (زبان شما را) صحبت می کند، می تواند شما را یاری دهد. اگر به کمک بیشتر نیاز دارید با مرکز کمک رسانی اچ ام او (HMO) به شماره 1-888-466-2219 تماس حاصل نمایید. (Farsi)

TSEEM CEEB: Muaj tus neeg txhais lus pub dawb rau koj kom koj tham tau nrog koj tus kws kho mob los yog nrog lub chaw pab them nqi kho mob rau koj. Yog xav tau ib tug neeg txhais lus los yog xav tau cov ntaub ntawv (sau ua koj yam lus los sis ua lwm yam ntawv, zoo li ua lus Braille los sis ua ntawv loj loj), xub hu rau koj lub chaw pab them nqi kho mob tus xov tooj ntawm 1-888-844-3344. Yuav muaj ib tug neeg hais lus Hmoob pab tau koj. Yog koj xav tau kev pab ntxiv, hu rau HMO Qhov Chaw Txais Tos Pab Neeg ntawm 1-888-466-2219. (Hmong)

중요: 의사나 건강 플랜과 대화하실 때 무료 통역 서비스를 받으실 수 있습니다. 통역을 구하시거나 문자 정보(한국어 번역본 또는 점자나 큰 글자 같이 다른 형식으로 된 정보)를 요청하시려면, 가입하신 건강 플랜에 1-888-844-3344 로 먼저 전화하십시오. 한국어를 하는 사람이 도와드릴 수 있습니다. 도움이 더 필요하시면 HMO 도움 센터에 1-888-466-2219 로 연락하십시오. (Korean)

ВАЖНО: Вы можете бесплатно воспользоваться услугами переводчика во время обращения к врачу или в страховой план. Чтобы запросить услуги переводчика или письменную информацию (на русском языке или в другом формате, например, шрифтом Брайля или крупным шрифтом), позвоните в свой страховой план по телефону 1-888-844-3344. Вам окажет помощь русскоговорящий сотрудник. Если вам нужна помощь в других вопросах, позвоните в справочный центр Организации медицинского обеспечения (HMO) по телефону 1-888-466-2219. (Russian)

MAHALAGA: Maaari kang kumuha ng isang tagasalin nang walang bayad upang makipag-usap sa iyong doktor o planong pangkalusugan. Upang makakuha ng isang tagasalin o upang humiling ng nakasulat na impormasyon (sa iyong wika o sa ibang anyo, tulad ng Braille o malalaking letra), tawagan muna ang numero ng telepono ng iyong planong pangkalusugan sa 1-888-844-3344. Ang isang tao na nakapagsasalita ng Tagalog ay maaaring tumulong sa iyo. Kung kailangan mo ng karagdagang tulong, tawagan ang Sentro ng Pagtulong ng HMO sa 1-888-466-2219. (Tagalog)

LƯU Ý QUAN TRỌNG: Quý vị có thể được cấp dịch vụ thông dịch miễn phí khi đi khám tại văn phòng bác sĩ hoặc khi cần liên lạc với chương trình bảo hiểm sức khỏe của quý vị. Để được cấp dịch vụ thông dịch hoặc yêu cầu văn bản thông tin bằng tiếng Việt hoặc bằng một hình thức khác như chữ nổi hoặc bản in bằng chữ khổ lớn, trước tiên hãy gọi số điện thoại của chương trình bảo hiểm sức khỏe của quý vị tại 1-888-844-3344. Sẽ có người nói tiếng Việt giúp đỡ quý vị. Nếu quý vị cần được giúp đỡ thêm, vui lòng gọi Trung tâm Hỗ trợ HMO theo số 1-888-466-2219. (Vietnamese)

ENPÒTAN: Ou kapab jwenn yon moun pou entèprete pou ou gratis pou w ka pale avèk doktè ou oswa plan sante ou. Pou jwenn yon entèprèt oswa mande enfòmasyon ekri (nan lang kreyòl ayisyen oswa yon diferan fòma tankou ekriti Bray oswa pi gwo lèt), rele nimewo telefòn plan sante ou a ki se 1-888-844-3344. Yon moun ki pale kreyòl ayisyen kapab ede ou. Si ou bezwen plis asistans, rele HMO Help Center nan nimewo 1-888-466-2219. (Haitian Creole)

IMPORTANTE: Você pode usar um intérprete gratuitamente para falar com seu médico ou comunicar-se com seu plano de saúde. Para pedir um intérprete ou solicitar informações por escrito (no seu idioma ou em outro formato, como em Braille ou em letras grandes), primeiramente, ligue para o telefone de seu plano de saúde no número 1-888-844-3344. Uma pessoa que fala português irá atendê-lo. Se precisar de mais ajuda, ligue para o HMO Help Center no telefone 1-888-466-2219. (Portuguese)

ਮਹੱਤਵਪੂਰਨ: ਤੁਸੀਂ ਆਪਣੇ ਡਾਕਟਰ ਜਾਂ ਸਿਹਤ ਯੋਜਨਾ ਲਈ ਗੱਲ ਕਰਨ ਵਾਸਤੇ ਮੁਫਤ ਅਨੁਵਾਦਕ ਪਾ ਸਕਦੇ ਹੋ| ਅਨੁਵਾਦਕ ਪਾਉਣ ਲਈ ਜਾਂ ਲਿਖਤੀ ਜਾਣਕਾਰੀ (ਆਪਣੀ ਭਾਸ਼ਾ ਜਾਂ ਵੱਖਰੇ ਫਾਰਮੈਟ ਵਿੱਚ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਜਾਂ ਵੱਡੇ ਅੱਖਰ) ਦੀ ਬੇਨਤੀ ਕਰਨ ਲਈ, ਪਹਿਲਾਂ 1-888-844-3344 'ਤੇ ਆਪਣੀ ਸਿਹਤ ਯੋਜਨਾ ਦੇ ਫੋਨ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ| ਜੋ ਵੀ (ਤੁਹਾਡੀ ਭਾਸ਼ਾ) ਬੋਲੇਦਾ ਹੈ, ਉਹ ਤੁਹਾਡੀ ਸਹਾਇਤਾ ਕਰ ਸਕਦਾ ਹੈ| ਜੇਕਰ ਤੁਹਾਨੂੰ ਹੋਰ ਸਹਾਇਤਾ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ 1-888-466-2219 'ਤੇ HMO Help Center (ਐਚ.ਐਮ.ਓ. ਸਹਾਇਤਾ ਸੈਂਟਰ) ਨੂੰ ਕਾਲ ਕਰੋ| (Punjabi)

重要 通訳を通して医師や医療保険会社とお話しいただけます。料金はかかりません。日本語でサポートを受けたり、日本語で書かれた情報を入手するには、あなたの医療保険会社（1-888-844-3344）までお電話ください。日本語が話せるスタッフがお手伝いします。さらなるサポートが必要な場合は、HMO Help Center（1-888-466-2219）までお電話ください。 (Japanese)