



**CALIFORNIA  
SMALL GROUP PLAN  
COMBINED EVIDENCE OF COVERAGE (EOC)  
AND DISCLOSURE FORM**

**Plan LS200**

Your employer group arranges for your dental benefits coverage to be provided by LIBERTY Dental Plan of California.

**ANNOUNCEMENTS**

**Availability of 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 877-873-2241.

**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 1-877-873-2241.

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) Out of Pocket Maximums	None
(D) Professional services	<p>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.</p> <p>Copayments range by category of service. Examples are as follows:</p> <ul style="list-style-type: none"> <li>• Diagnostic Services .....No Cost</li> <li>• Preventive Services .....No Cost - \$45.00</li> <li>• Restorative Services .....\$5.00 - \$425.00</li> <li>• Periodontic Services .....No Cost - \$400.00</li> <li>• Prosthodontic Services .....No Cost - \$180.00</li> <li>• Oral and Maxillofacial Surgery .....No Cost - \$152.00</li> <li>• Orthodontic Services .....No Cost - \$1,695.00</li> </ul> <p><b>Note:</b> 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.</p>
(E) Outpatient Services	Not Covered
(F) Hospitalization Services	Not Covered
(G) Emergency Dental Coverage	The Enrollee may receive a maximum Benefit of up to \$75 per emergency for out-of-area Emergency Services.
(H) Ambulance Services	Not Covered
(I) Prescription Drug Services	Not Covered
(J) Durable Medical Equipment	Not Covered
(K) Mental Health Services	Not Covered
(L) Chemical Dependency Services	Not Covered
(M) Home Health Services	Not Covered
(N) 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.

## **OVERVIEW OF YOUR DENTAL BENEFIT PLAN**

### **A. How to Use Your LIBERTY Dental Plan**

This booklet is your group's Evidence of Coverage. It explains what LIBERTY covers and does not cover. Your comprehensive Schedule of Benefits, which lists copays and other fees, is provided with this document at the inception of the contract, and is available separately upon request. Your LIBERTY Dental Plan is a group dental plan. Group plans are provided through a group, such as an employer. Your group or employer is purchasing this dental benefit for You. To be eligible for this coverage, You must be employed or affiliated with the group or employer purchasing dental Benefits from LIBERTY.

### **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): (877) 873-2241**  
**Website: [www.LIBERTYDentalPlan.com](http://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 Primary Care Providers and 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 877-873-2241 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 10).

### **E. Your Primary Care Provider (see page 7)**

When You join LIBERTY, in most cases You need to choose a Primary Care Provider to whom You will be assigned, unless otherwise stated below. The first page of your Schedule of Benefits indicates if you must choose, and become assigned to a Primary Care Provider. Your Primary Care Provider is usually a General Dentist who provides your basic care and coordinates the care You need from other dental specialty Providers.

### **F. Language and Communication Assistance (see page 21)**

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 877-873-2241. If You have a preferred language, please notify us of your personal language needs by calling 877-873-2241.

### **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 20).

- 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. Your comprehensive Schedule of Benefits is provided with this document at the inception of the contract, and is also available separately upon request from Member Services or via the LIBERTY website.

**H. Referrals and Pre-approvals** (see page 9)

You need a referral from your Primary Care Provider and pre-approval from LIBERTY for specialty services or to receive a second opinion or to see a dentist who is not in LIBERTY’s network. Pre-approval is also called *prior 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, get Emergency Care or Urgent Care.

**I. Emergency Care** (see page 8)

Emergency Care is covered anywhere in the world. 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. You should seek emergency care from your Primary Care Provider whenever possible. If you are unable to access your Primary Care Provider or are out of the service area and it is an emergency, call 9-1-1 or go to the nearest hospital or emergency room. Go to your Primary Care Provider for follow-up care. Do not go back to the emergency room for follow-up care. Coverage for Urgent Care and Emergency Care is explained fully on page 8.

**J. Urgent Care** (see page 8)

Urgent care is care that You need soon to prevent a serious health problem. Urgent care is covered anywhere in the world. Coverage for Urgent Care and Emergency Care is explained fully on page 8.

**K. Care When You Are Out of the LIBERTY Service Area** (see page 7)

Only emergency and Urgent Care is covered.

**L. Costs** (see the “Fees and Charges – What You Pay” section on page 10)

- The premium is what You and/or your employer group pays to LIBERTY to keep coverage.
- A co-pay (Co-payment) is the amount that You must pay for a particular covered procedure.

**M. If You Have a Complaint About Your LIBERTY Dental Plan** (see page 18)

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.

**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

**Cal-COBRA:** State law requiring an individual in a small group of 2-19 members to purchase continuing coverage at the termination of employment or at the termination of employer group-sponsored health coverage

**Capitation:** Pre-paid payments made by LIBERTY to a Contracted Primary Care Provider to provide services to assigned Members

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

**COBRA:** Federal law requiring an individual to purchase continuing coverage at the termination of employment or at the termination of employer group-sponsored health coverage

**Contracting Dentist:** A dentist who has signed a contract to provide services to 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 or after rendering. Payment for services occurs for Covered Services that are deemed Dentally Necessary by the Plan

**Dental Office:** A dental facility and its dentists that are under contract to provide services to LIBERTY Members in accordance with LIBERTY's rules and regulations

**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.

**Enrollee:** see Member

**Emergency Care / Emergency Dental Service:** Emergency Dental Service and care include (and are covered by LIBERTY Dental Plan) dental screening, examination, evaluation by dentist or dental Specialist to determine if an emergency dental condition exists, and to provide care that would be acknowledged as within professionally recognized standards of care and in order to alleviate any emergency symptoms in a Dental Office. Medical 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.

**EPDB: Essential Pediatric Dental Benefit:** Refers to benefits required by the Affordable Care Act to provide essential pediatric dental Benefits to children.

**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. IMR is only available for medical services or services that are available due to enrollment in a related full-service medical plan

**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

**Open Enrollment Period:** A period of time where enrollment in a dental plan may be started or changed

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

**Out-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

**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 received by LIBERTY, paid by You or your employer to LIBERTY for this Benefit Plan

**Primary Care Provider:** A General Dentist affiliated with LIBERTY to provide general dental services to covered members of the Plan. The Primary Care Provider is responsible to provide or arrange for needed dental services. Primary Care Provider may include one or more General Dentists or Specialists in the same facility

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

**Provider:** A contracted dentist providing services under this 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 Members who are the beneficiary of this dental Benefit Plan

### **III. ACCESS TO SERVICES – SEEING A DENTIST**

LIBERTY Dental Plan contracts with Primary Care Providers and Specialists to provide services covered by your Plan. Contact us toll-free at (877) 873-2241 or via our website, [www.LIBERTYdentalplan.com](http://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 (General Dentist) and specialty care dental facilities throughout the state of California within a reasonable distance from your home or workplace. Contact LIBERTY toll-free at 877-873-2241 or via website at [www.LIBERTYdentalplan.com](http://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 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 Provider will provide for all of your dental care needs including referring You to a Specialist, should it be necessary. Most Enrollees should 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](http://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 when You join LIBERTY Dental Plan, You must choose a Primary Care Provider to whom You will be assigned. The first page of your Schedule of Benefits indicates if you must choose, and become assigned to a Primary Care Provider. 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 facility will share information with any Specialist to coordinate your overall care.

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 Providers:** You may contact LIBERTY at any time to change your Primary Care Provider. Contact our Member Services Department toll-free at (877) 873-2241 (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 Provider 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. **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-approved for You. Your Specialist will submit a Pre-Authorization for services to LIBERTY for pre-approval.

#### **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, 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.

#### **E. EMERGENCY DENTAL CARE**

All affiliated LIBERTY Dental Plan Primary Care Providers provide availability of emergency dental care 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 Provider to schedule an immediate appointment. For urgent or unexpected dental conditions that occur after-hours or on weekends, contact your Primary Care Provider for instructions on how to proceed.

If your Primary Care Provider 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 per calendar year. You should notify LIBERTY as soon as possible after receipt of emergency 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 dental 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. Medical and/or psychiatric emergencies are not covered by LIBERTY Dental Plan and are generally covered by a Medical Plan. LIBERTY does not cover services that LIBERTY determines the services were not dental in nature.

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

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



If additional information is needed, You will be notified in writing. If any part of your claim is denied You will receive a written Explanation of Benefits (EOB) within 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 when appropriate, by directly contacting Member Services either by calling the toll-free number (877) 873-2241 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 approved by LIBERTY Dental Plan within 72 hours of receipt of such request. Upon approval, LIBERTY Dental Plan will make the appropriate second dental opinion arrangements and advise the attending dentist of your concerns. You will then be advised of the arrangement so an appointment can be scheduled. Upon request, You may obtain a copy of LIBERTY Dental Plan's policy description for a second dental opinion.

#### **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 Provider 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 Provider 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 Provider. The Primary Care Provider has the authority to make most coverage determinations. The coverage determinations are achieved through comprehensive oral evaluations which are covered by your plan. Your Primary Care Provider 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 services (Emergency Dental Care and Urgent Care services described above).

You or your Providers may call Member Services toll-free at 1-877-873-2241 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 Provider encounter an urgent condition in which there is an imminent and serious threat to your health including but not limited to, the potential loss of life, limb, or other major body function, or the normal timeframe for the decision making process as described above would be detrimental to your life or health, the response to the request for referral should not exceed seventy-two (72) hours from the time of receipt of such information, based on the nature of the urgent or emergent condition.

The decision to approve, modify or deny will be communicated to the Primary Care Provider 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 1-877-873-2241 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 1-877-873-2241 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 877-873-2241.

### **IV. FEES AND CHARGES – WHAT YOU PAY**

#### **A. PREMIUMS AND PREPAYMENT FEES**

In most cases, your employer will make payments of your premium directly to LIBERTY. In some cases, You will make payments to your employer (see COBRA and Cal-COBRA) or will arrange for a payroll deduction to pay the premium. Your employer will provide to LIBERTY the collected premium.

Your Premium and payment terms, including mailing address for payments, are provided directly to your employer or group administrator.

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 annually. 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 your employer will provide 60 days' notice of any premium change that may affect You.

### **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 to 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**

In most cases, your employer will make payments of your premium directly to LIBERTY. In some cases, You will make payments to your employer (see COBRA and Cal-COBRA) or will arrange for a payroll deduction to pay the premium. You are responsible for listed Co-payments for any 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 877-873-2241.

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

### **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**

Your LIBERTY Dental Plan is provided by your employer or group and coordinated through LIBERTY. If LIBERTY 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 with You when You go to your appointment. Your comprehensive Schedule of Benefits, which lists copays and other fees, is provided with this document at the inception of the contract, and is available separately upon request. 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**

**For all plans other than EPDB plans:** As an Employee or Group Member, You and your eligible Dependents are eligible to enroll in LIBERTY Dental Plan. You must live in the plan Service Area. Prospective Group Subscribers must also meet their employer's eligibility requirements. You may enroll:

- Your spouse.
- Your Domestic Partner. A Domestic Partner is any person whose domestic partnership is currently registered with a governmental body pursuant to state or local law. This includes both same-sex and opposite-sex couples.
- Unmarried Dependent children (including adopted) who are under the age of twenty-six (26) and other Dependent children if your group provides Benefits for those Dependents.
- 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 the Schedule of Benefits for a detailed listing of specific covered dental procedures 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. Schedules of Benefits are provided with this document at the inception of the contract and are available separately upon request from LIBERTY Dental Plan by contacting Member Services at (Toll-Free): (877) 873-2241, or from the LIBERTY Dental Website at [www.LIBERTYDentalPlan.com](http://www.LIBERTYDentalPlan.com). When required, the Schedule of Benefits may also be included in Appendix 1 of this document.

### **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 Your comprehensive Schedule of Benefits provided with this document at the inception of the contract, and available separately upon request, 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 Your comprehensive Schedule of Benefits provided with this document at the inception of the contract, and available separately upon request, 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 Your comprehensive Schedule of Benefits provided with this document at the inception of the contract, and available separately upon request, 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 following types of Endodontic dental services listed in Your comprehensive Schedule of Benefits provided with this document at the inception of the contract, and available separately upon request, 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 Your comprehensive Schedule of Benefits provided with this document at the inception of the contract, and available separately upon request, 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 Your comprehensive Schedule of Benefits provided with this document at the inception of the contract, and available separately upon request, 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 Your comprehensive Schedule of Benefits provided with this document at the inception of the contract, and available separately upon request, 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 Your comprehensive Schedule of Benefits provided with this document at the inception of the contract, and available separately upon request, 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. Orthodontic services are not a required covered category of dental service. See Your comprehensive Schedule of Benefits provided with this document at the inception of the contract, and available separately upon request, for a list of any covered orthodontic services provided in your Benefit Plan, and any pertinent relevant 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 Specialist services.

## **VII. LIMITATIONS, EXCLUSIONS, EXCEPTIONS, REDUCTIONS**

See Your comprehensive Schedule of Benefits provided with this document at the inception of the contract, and available separately upon request, for limitations to covered procedures and Exclusions to your plan Benefits as part of the Schedule of 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 or Emergency Care and are outside the LIBERTY Service Area.
- Care that is not medically necessary
- Procedures that are not listed or included in the Schedule of Benefits.
- 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 Your comprehensive Schedule of Benefits provided with this document at the inception of the contract, and available separately upon request.

### **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 may be terminated by your Employer or Group that subscribes to LIBERTY for dental coverage. If this happens, You will receive notice through your employer or group administrator at least 30 days before the change takes effect. Coverage for your Dependents will also end.

Your LIBERTY Plan coverage may also end if your job ends or You no longer work enough hours to be on your employer's plan. In this case coverage for your Dependents also ends.

Your LIBERTY Plan coverage may also end if You no longer live or work in the LIBERTY Service Area or if your Employer or Group stops offering any dental plan.

#### **2. Termination Due to Non-Payment of Premium**

If your employer or group does not pay the premium, LIBERTY will send a notice to your employer or group saying that the premium is overdue.

If premiums are not paid according to the agreement, termination will be effective on midnight 30 days after the last day of the month for which premiums were last received, subject to compliance with notice requirements accepted

by LIBERTY Dental Plan. This is equivalent to a minimum of a 30-day grace period. 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**

Existing in-force coverage may be terminated by LIBERTY if LIBERTY can demonstrate that a Subscriber has performed and act of practice constituting fraud or made an intentional misrepresentation of material fact. Fraudulent practices or acts include, but are not limited to, permitting 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. In such cases, Subscriber will receive a letter via certified mail at least 30 days prior to the effective date of the termination explaining the reason for the intended termination, and the notice of appeal rights. A Subscriber who alleges that an enrollment has been or will be improperly canceled, rescinded, or not renewed may request a review by the Director of the DMHC. Upon notice of completion of the appeal process, termination will be effective immediately upon such 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 is has been terminated, improperly canceled, rescinded or not renewed 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 30 days since the date of notification of termination, except for fraud and intentional misrepresentation of material fact, 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, but not limited to, if You intentionally submitted incomplete or incorrect material information in your enrollment application. You have the right to appeal any decision to rescind your membership. Appeal procedures will be provided to You in the notice of rescission. A Subscriber who alleges that an enrollment has been or will be improperly canceled, rescinded, or not renewed may request a review by the Director of the DMHC. Upon notice of completion of the appeal process, termination will be effective immediately upon such notice from LIBERTY Dental Plan. Except as provided by law, LIBERTY may not rescind Your coverage after 24 months from the issuance of the coverage contract.

## **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. INDIVIDUAL CONTINUATION OF DENTAL COVERAGE (COBRA, CAL-COBRA, CONVERSION COVERAGE AND HIPAA)**

### **A. COBRA**

For more information on COBRA, call the Federal Employee Benefits Security Administration (EBSA), toll-free, at 1-866-444-3272.

- COBRA is a U.S. law that applies to employers who have 20 or more employees in their group health plan.
- COBRA may allow You and your Dependents to keep LIBERTY coverage for up to 18 or 36 months, depending on the qualifying event and other circumstances. If You are no longer eligible for COBRA after 18 months, You may be able to keep your Benefits through Cal-COBRA. See below.
- Each qualified person may independently elect/enroll in COBRA coverage. A parent or legal guardian may elect COBRA for a minor child.
- With COBRA, You have the same Benefits as current Members with LIBERTY coverage.
- You have to pay all of the monthly premium.

#### **Important deadlines for electing/enrolling in COBRA with LIBERTY Dental Plan:**

It is important to meet the following deadlines. If You do not, You lose your right to COBRA coverage.

1. **Notification of qualifying event:** Employers must notify LIBERTY within 30 days after the following qualifying events:
  - The employee's job ends
  - The employee's hours of employment are reduced
  - The employee becomes eligible to receive Medicare Benefits
  - The employee diesYou or your Dependent must notify LIBERTY in writing within 60 days after any of the following qualifying events:
  - The employee divorces or legally separates
  - A child or other Dependent no longer qualifies as a Dependent under plan rules
2. **Election notice:** Generally, You must be sent an election notice not later than 14 days after your Employer receives notice that a qualifying event has occurred.
3. **Election period:** You have 60 days to notify your employer in writing that You want to elect/enroll in COBRA coverage. The 60 days starts on the later of the following two dates:
  - The date You receive the election notice.
  - The date your coverage ended.
4. **Premium payment:** You must pay the premiums for your COBRA coverage as per instructions provided by your Employer. LIBERTY must receive your first premium within 45 days after You enroll in COBRA. This first premium covers the time from the date your coverage ended because of the qualifying event up to the day You signed up for COBRA. You must then pay a monthly premium as instructed by your Employer and/or LIBERTY as long as You stay on COBRA.

#### **If your COBRA is ending, You may be able to elect/enroll in Cal-COBRA:**

When your 18 months of COBRA ends, You may be able to keep LIBERTY coverage for up to 18 more months under Cal-COBRA. If You were on COBRA for 36 months, You cannot get Cal-COBRA for any additional period of time.



Your employer should send You an enrollment form. You must fill out the enrollment form, and return it to your employer as instructed, and pay your premium no more than 30 days after You receive the enrollment form.

**You will lose COBRA if:**

- You do not pay your premiums on time.
- You move outside the LIBERTY Service Area.
- Your former employer no longer offers any health plan.
- You become eligible for Medicare.
- You sign up for another health plan.
- You commit fraud, which means that You intentionally deceive LIBERTY or You misrepresent yourself or allow someone else to do so in order to get health care services.

**B. Cal-COBRA**

Cal-COBRA is a California law that applies to Employers who have between 2 and 19 employees in their group health plan.

- Cal-COBRA may allow You, your Dependents, and former Dependents to keep LIBERTY coverage for up to 36 months.
- You have the same Benefits as current Members with LIBERTY coverage.
- You have to pay all of the monthly premium.

**Important deadlines for electing/enrolling in Cal-COBRA with LIBERTY:**

It is important to meet the following deadlines. If You do not, You lose your right to Cal-COBRA coverage.

1. **Notification of qualifying event:** Employers must notify LIBERTY within 30 days after the following qualifying events:
  - The employee's job ends
  - The employee's hours of employment are reduced

You or your Dependent must notify your employer and LIBERTY in writing within 60 days after any of the following qualifying events:

- The employee dies
  - The employee divorces or legally separates
  - A child or other Dependent no longer qualifies as a Dependent under plan rules
  - The employee becomes eligible to receive Medicare Benefits
2. **Election notice:** Generally, You must be sent an election notice not later than 14 days after your employer receives notice that a qualifying event has occurred.
  3. **Election period:** You have 60 days to notify your employer and/or LIBERTY in writing that You want to elect/enroll in Cal-COBRA continuation coverage. The 60 days starts on the later of the following two dates:
    - The date You receive the election notice.
    - The date your coverage ended.
  4. **Premium payment:** You must pay the premiums for your Cal-COBRA coverage as instructed by your employer. LIBERTY must receive your first premium from your employer within 45 days after You enroll in Cal-COBRA. This first premium covers the time from the date your coverage ended because of the qualifying event up to the day You signed up for Cal-COBRA. You must then pay a monthly premium as instructed by your employer as long as You stay on Cal-COBRA.

**If your former employer stops offering LIBERTY when You are on Cal-COBRA:**

- You can elect/enroll in Cal-COBRA with the new health plan offered by your employer.

- You must enroll and pay your first premium as instructed by your employer with the new health plan no more than 30 days after You receive notice that LIBERTY is no longer being offered. If You do not meet this deadline, your Cal-COBRA Benefits end.

**You will lose Cal-COBRA if:**

- You do not pay your premiums on time.
- You move outside the LIBERTY Service Area.
- Your former employer no longer offers any health plan.
- You sign up for or become eligible for Medicare.
- You sign up for another health plan. (However, if your new plan has a waiting period for pre-existing conditions and You have not used up all of your Cal-COBRA, You can keep your Cal-COBRA until the waiting period is over.)
- You commit fraud, which means that You intentionally deceive LIBERTY or You misrepresent yourself or allow someone else to do so in order to get health care services.

## **XI. GRIEVANCE PROCEDURES**

If You are dissatisfied with your selected Primary Care Provider, 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 (877) 873-2241. Grievance Forms are also available on our website, [www.libertydentalplan.com](http://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 to: LIBERTY Dental Plan Member Services Representative at LIBERTY’s toll-free number: (877) 873-2241, or
- Submitted using our website online Grievance filing process by visiting [www.libertydentalplan.com](http://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 **1-877-873-2241** 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 indicate 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 877-873-2241 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.

## **XII. 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. However, any Covered California coverage that you have that is embedded into a full service health plan will act as the primary payor when you have a supplemental pediatric dental benefit through a family benefit plan.

#### **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 PUBLIC 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 (877) 873-2241, or contact Quality Management Department at [qm@libertydentalplan.com](mailto:qm@libertydentalplan.com)

#### **D. REPORTING POSSIBLE FRAUD**

LIBERTY has established a specific fraud hotline number: (877) 873-2241. The Fraud Hotline provides the opportunity to report reasonable and good faith fraud suspicions or concerns in an anonymous/confidential manner. This hotline is monitored by a designated Member of the LIBERTY Corporate Compliance Committee. All

information reported on the anonymous hotline is then forwarded to LIBERTY Dental Plan's Quality Management team for full investigation.

The Chairman of the Committee and the Chief Compliance Officer, in conjunction with Legal Counsel, determine whether LIBERTY shall take any additional action, which may include, without limitation:

- The provision of information, for purposes of education, to the participating Provider describing the incident involving suspected fraudulent activity;
- Seek restitution from the participating Provider for any amounts paid by LIBERTY in connection with the incident involving suspected fraudulent activity;
- Termination of the Provider agreement in effect between LIBERTY and the participating Provider; and/or
- Referral of the matter to an appropriate governmental agency, including, without limitation, the State Board of Dental Examiners and Centers for Medicare and Medicaid Services.

#### **E. 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.

#### **F. 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. Your specialty care services are reported to LIBERTY via the Specialist. If You receive services out-of-network due to an emergency after-hours or out-of-area situation, consult the section above for submitting your expenses to LIBERTY to receive reimbursement (see Reimbursement for Emergency Dental Services section above).

#### **G. 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>

#### **H. 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 1-877- 873-2241.

#### **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 1-877- 873-2241.

#### **I. 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 (877) 873-2241.

#### **J. 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 Grievances 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.

#### **K. MEMBER RESPONSIBILITIES**

As a Member, You have the responsibility to:

- Identify yourself to your selected Dental Office as a LIBERTY Dental Plan Member
- Treat the Primary Care Provider, office staff and LIBERTY Dental Plan staff with respect and courtesy
- Keep scheduled appointments or contact the Dental Office twenty-four (24) hours in advance to cancel an appointment
- Cooperate with the Primary Care Provider 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

(877) 873-2241



**Appendix 1:**

**SCHEDULE OF BENEFITS  
COVERED SERVICES**



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# LIBERTY Dental Plan of California, Inc.

## LS200 PLAN SCHEDULE OF BENEFITS Covered Benefits, Member Co-payments, Limitations & Exclusions

### No Annual Deductible No Annual Dollar Amount Maximum

- Members must select, and be assigned to, a LIBERTY Dental Plan contracted dental office to utilize covered benefits. Your assigned 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.
- This Schedule does not guarantee benefits. All services are subject to eligibility and dental necessity at the time of service.
- Dental procedures not listed as covered benefits are available at the dental office's usual and customary fee.
- For a complete description of your Plan, please refer to the Evidence of Coverage in addition to this Schedule.

CDT Code	Description	Member Co-payment
<b>Diagnostic Services</b>		
D0120	Periodic oral evaluation	\$0.00
D0140	Limited oral evaluation	\$0.00
D0145	Oral evaluation under age 3	\$0.00
D0150	Comprehensive oral evaluation	\$0.00
D0160	Oral evaluation, problem focused	\$0.00
D0170	Re-evaluation, limited, problem focused	\$0.00
D0171	Re-evaluation, post operative office visit	\$0.00
D0180	Comprehensive periodontal evaluation	\$0.00
D0210	Intraoral, complete series of radiographic images	\$0.00
D0220	Intraoral, periapical, first radiographic image	\$0.00
D0230	Intraoral, periapical, each add 1 radiographic image	\$0.00
D0240	Intraoral, occlusal radiographic image	\$0.00
D0250	Extra-oral 2D projection radiographic image, stationary radiation source	\$0.00
D0251	Extra-oral posterior dental radiographic image	\$0.00
D0270	Bitewing, single radiographic image	\$0.00
D0272	Bitewings, two radiographic images	\$0.00
D0273	Bitewings, three radiographic images	\$0.00
D0274	Bitewings, four radiographic images	\$0.00
D0277	Vertical bitewings, 7 to 8 radiographic images	\$0.00
D0330	Panoramic radiographic image	\$0.00
D0415	Collection of microorganisms for culture	\$0.00
D0425	Caries susceptibility tests	\$0.00
D0460	Pulp vitality tests	\$0.00
D0470	Diagnostic casts	\$0.00
D0472	Accession of tissue, gross exam, prep & report	\$0.00

CDT Code	Description	Member Co-payment
D0474	Accession of tissue, gross/micro. exam, report	\$0.00
<b>Preventive Services</b>		
D1110	Prophylaxis, adult	\$0.00
	Prophylaxis, adult (additional prophylaxis)	\$45.00
D1120	Prophylaxis, child	\$0.00
	Prophylaxis, child (additional prophylaxis)	\$35.00
D1206	Topical application of fluoride varnish	\$0.00
D1208	Topical application of fluoride, excluding varnish up to the 18th birthday (additional fluoride)	\$10.00
D1310	Nutritional counseling for control of dental disease	\$0.00
D1320	Tobacco counseling, control/prevention oral disease	\$0.00
D1330	Oral hygiene instruction	\$0.00
D1351	Sealant, per tooth	\$10.00
D1352	Preventive resin restoration, permanent tooth	\$10.00
D1353	Sealant repair, per tooth	\$0.00
D1510	Space maintainer, fixed, unilateral	\$25.00
D1515	Space maintainer, fixed, bilateral	\$25.00
D1520	Space maintainer, removable, unilateral	\$25.00
D1525	Space maintainer, removable, bilateral	\$25.00
D1550	Re-cement or re-bond space maintainer	\$10.00
D1555	Removal of fixed space maintainer	\$10.00
<b>Restorative Services</b>		
D2140	Amalgam, one surface, primary or permanent	\$5.00
D2150	Amalgam, two surfaces, primary or permanent	\$10.00
D2160	Amalgam, three surfaces, primary or permanent	\$17.00
D2161	Amalgam, four or more surfaces, primary or permanent	\$20.00

CDT Code	Description	Member Co-payment
<b>Restorative Services (continued)</b>		
D2330	Resin-based composite, one surface, anterior	\$10.00
D2331	Resin-based composite, two surfaces, anterior	\$17.00
D2332	Resin-based composite, three surfaces, anterior	\$26.00
D2335	Resin-based composite, four or more surfaces, involving incisal angle	\$37.00
D2390	Resin-based composite crown, anterior	\$50.00
D2391	Resin-based composite, one surface, posterior	\$55.00
D2392	Resin-based composite, two surfaces, posterior	\$60.00
D2393	Resin-based composite, three surfaces, posterior	\$70.00
D2394	Resin-based composite, four or more surfaces, posterior	\$80.00
<p><b>*GUIDELINES for Inlays, Onlays, and Single Crowns:</b>  <b>The total maximum amount chargeable to the member for elective upgraded procedures</b> (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.</p> <p><b>1. Brand name restorations:</b> (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.</p> <p><b>2. Benefits for anterior and bicuspid teeth:</b> 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.</p> <p><b>3. Benefits for molar teeth:</b> 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.</p> <p><b>4. Base metal is the benefit:</b> If elected, a)noble, b)high noble metal, or c) titanium may be considered an elective upgraded procedure.</p>		
D2510	Inlay, metallic, one surface	\$120.00
D2520	Inlay, metallic, two surfaces	\$140.00
D2530	Inlay, metallic, three or more surfaces	\$145.00
D2542	Onlay, metallic, two surfaces	\$145.00
D2543	Onlay, metallic, three surfaces	\$155.00

CDT Code	Description	Member Co-payment
D2544	Onlay, metallic, four or more surfaces	\$160.00
D2610	Inlay, porcelain/ceramic, one surface	\$130.00*
D2620	Inlay, porcelain/ceramic, two surfaces	\$140.00*
D2630	Inlay, porcelain/ceramic, three or more surfaces	\$145.00*
D2642	Onlay, porcelain/ceramic, two surfaces	\$155.00*
D2643	Onlay, porcelain/ceramic, three surfaces	\$160.00*
D2644	Onlay, porcelain/ceramic, four or more surfaces	\$170.00*
D2650	Inlay, resin-based composite, one surface	\$130.00*
D2651	Inlay, resin-based composite, two surfaces	\$135.00*
D2652	Inlay, resin-based composite, three or more surfaces	\$150.00*
D2662	Onlay, resin-based composite, two surfaces	\$145.00*
D2663	Onlay, resin-based composite, three surfaces	\$160.00*
D2664	Onlay, resin-based composite, four or more surfaces	\$165.00*
D2710	Crown, resin-based composite (indirect)	\$85.00*
D2712	Crown, ¼ resin-based composite (indirect)	\$85.00*
D2720	Crown, resin with high noble metal	\$90.00*
D2721	Crown, resin with predominantly base metal	\$90.00*
D2722	Crown, resin with noble metal	\$90.00*
D2740	Crown, porcelain/ceramic substrate	\$100.00*
D2750	Crown, porcelain fused to high noble metal	\$115.00*
D2751	Crown, porcelain fused to predominantly base metal	\$115.00*
D2752	Crown, porcelain fused to noble metal	\$115.00*
D2780	Crown, ¾ cast high noble metal	\$115.00*
D2781	Crown, ¾ cast predominantly base metal	\$100.00
D2782	Crown, ¾ cast noble metal	\$100.00*
D2783	Crown, ¾ porcelain/ceramic	\$100.00*
D2790	Crown, full cast high noble metal	\$100.00*
D2791	Crown, full cast predominantly base metal	\$100.00
D2792	Crown, full cast noble metal	\$100.00*
D2794	Crown, titanium	\$100.00*
D2799	Provisional crown	\$65.00
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	\$5.00
D2915	Re-cement or re-bond indirectly fabricated/prefabricated post & core	\$5.00
D2920	Re-cement or re-bond crown	\$5.00
D2930	Prefabricated stainless steel crown, primary tooth	\$25.00
D2931	Prefabricated stainless steel crown, permanent tooth	\$25.00
D2932	Prefabricated resin crown	\$30.00
D2933	Prefabricated stainless steel crown with resin window	\$20.00
D2934	Prefabricated esthetic coated stainless steel crown, primary tooth	\$10.00
D2940	Protective restoration	\$0.00
D2950	Core buildup, including any pins when required	\$20.00

CDT Code	Description	Member Co-payment
<b>Restorative Services (continued)</b>		
D2951	Pin retention, per tooth, in addition to restoration	\$10.00
D2952	Post and core in addition to crown, indirectly fabricated	\$30.00
D2953	Each additional indirectly fabricated post, same tooth	\$25.00
D2954	Prefabricated post and core in addition to crown	\$30.00
D2955	Post removal	\$15.00
D2957	Each additional prefabricated post, same tooth	\$15.00
D2960	Labial veneer (resin laminate), chairside	\$200.00
D2961	Labial veneer (resin laminate), laboratory	\$325.00
D2962	Labial veneer (porcelain laminate), laboratory	\$425.00
D2971	Additional procedure to construct new crown, existing partial denture frame	\$30.00
D2980	Crown repair necessitated by restorative material failure	\$25.00
<b>Endodontic Services</b>		
D3110	Pulp cap, direct (excluding final restoration)	\$0.00
D3120	Pulp cap, indirect (excluding final restoration)	\$0.00
D3220	Therapeutic pulpotomy (excluding final restoration)	\$10.00
D3221	Pulpal debridement, primary and permanent teeth	\$15.00
D3230	Pulpal therapy, anterior, primary tooth (excluding final restoration)	\$25.00
D3240	Pulpal therapy, posterior, primary tooth (excluding final restoration)	\$25.00
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	\$50.00
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	\$90.00
D3330	Endodontic therapy, molar (excluding final restoration)	\$115.00
D3331	Treatment of root canal obstruction; non-surgical access	\$80.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable, fractured tooth	\$70.00
D3333	Internal root repair of perforation defects	\$90.00
D3346	Retreatment of previous root canal therapy, anterior	\$75.00
D3347	Retreatment of previous root canal therapy, bicuspid	\$100.00
D3348	Retreatment of previous root canal therapy, molar	\$175.00
D3351	Apexification/recalcification, initial visit	\$85.00
D3352	Apexification/recalcification, interim medication replacement	\$65.00
D3353	Apexification/recalcification, final visit	\$65.00
D3410	Apicoectomy, anterior	\$70.00
D3421	Apicoectomy, bicuspid (first root)	\$70.00
D3425	Apicoectomy, molar (first root)	\$70.00
D3426	Apicoectomy, (each additional root)	\$30.00
D3430	Retrograde filling, per root	\$30.00
D3450	Root amputation, per root	\$60.00
D3910	Surgical procedure for isolation of tooth with rubber dam	\$35.00
D3920	Hemisection, not including root canal therapy	\$105.00
D3950	Canal preparation and fitting of preformed dowel or post	\$10.00

CDT Code	Description	Member Co-payment
<b>Periodontal Services</b>		
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	\$70.00
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant	\$30.00
D4212	Gingivectomy or gingivoplasty, restorative procedure, per tooth	\$0.00
D4240	Gingival flap procedure, four or more teeth per quadrant	\$115.00
D4241	Gingival flap procedure, one to three teeth per quadrant	\$115.00
D4245	Apically positioned flap	\$125.00
D4249	Clinical crown lengthening, hard tissue	\$175.00
D4260	Osseous surgery, four or more teeth per quadrant	\$250.00
D4261	Osseous surgery, one to teeth per quadrant	\$125.00
D4263	Bone replacement graft, first site in quadrant	\$120.00
D4264	Bone replacement graft, each additional site, quadrant	\$64.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration	\$115.00
D4266	Guided tissue regeneration, resorbable barrier, per site	\$290.00
D4267	Guided tissue regeneration, non-resorbable barrier, per site	\$375.00
D4270	Pedicle soft tissue graft procedure	\$216.00
D4273	Autogenous connective tissue graft procedure, first tooth	\$400.00
D4274	Distal or proximal wedge procedure	\$105.00
D4275	Non-autogenous connective tissue graft, first tooth	\$425.00
D4277	Free soft tissue graft, first tooth	\$216.00
D4278	Free soft tissue graft, each additional tooth	\$216.00
D4283	Autogenous connective tissue graft procedure, each additional tooth, per site	\$400.00
D4285	Non-autogenous connective tissue graft procedure, each additional tooth, per site	\$425.00
D4320	Provisional splinting, intracoronal	\$72.00
D4321	Provisional splinting, extracoronal	\$72.00
<b>GUIDELINE:</b> 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	\$30.00
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	\$15.00
D4355	Full mouth debridement	\$30.00
D4381	Localized delivery of antimicrobial agent/per tooth	\$18.00
D4910	Periodontal maintenance	\$40.00
D4920	Unscheduled dressing change (other than treating dentist or staff)	\$5.00
<b>Removable Prosthodontic Services</b>		
D5110	Complete denture, maxillary	\$175.00
D5120	Complete denture, mandibular	\$175.00
D5130	Immediate denture, maxillary	\$175.00
D5140	Immediate denture, mandibular	\$175.00
D5211	Maxillary partial denture, resin base	\$120.00
D5212	Mandibular partial denture, resin base	\$120.00
D5213	Maxillary partial denture, cast metal, resin base	\$180.00
D5214	Mandibular partial denture, cast metal, resin base	\$180.00

CDT Code	Description	Member Co-payment
<b>Removable Prosthodontic Services (continued)</b>		
D5221	Immediate maxillary partial denture, resin base	\$120.00
D5222	Immediate mandibular partial denture, resin base	\$120.00
D5223	Immediate maxillary partial denture, cast metal framework, resin denture base	\$180.00
D5224	Immediate mandibular partial denture, cast metal framework, resin denture base	\$180.00
D5225	Maxillary partial denture, flexible base	\$180.00
D5226	Mandibular partial denture, flexible base	\$180.00
D5281	Removable unilateral partial denture, one piece cast metal	\$145.00
D5410	Adjust complete denture, maxillary	\$0.00
D5411	Adjust complete denture, mandibular	\$0.00
D5421	Adjust partial denture, maxillary	\$0.00
D5422	Adjust partial denture, mandibular	\$0.00
D5510	Repair broken complete denture base	\$15.00
D5520	Replace missing or broken teeth, complete denture	\$10.00
D5610	Repair resin denture base	\$15.00
D5620	Repair cast framework	\$15.00
D5630	Repair or replace broken clasp, per tooth	\$10.00
D5640	Replace broken teeth, per tooth	\$10.00
D5650	Add tooth to existing partial denture	\$10.00
D5660	Add clasp to existing partial denture, per tooth	\$10.00
D5670	Replace all teeth & acrylic on cast metal frame, maxillary	\$105.00
D5671	Replace all teeth & acrylic on cast metal frame, mandibular	\$105.00
D5710	Rebase complete maxillary denture	\$75.00
D5711	Rebase complete mandibular denture	\$75.00
D5720	Rebase maxillary partial denture	\$75.00
D5721	Rebase mandibular partial denture	\$75.00
D5730	Reline complete maxillary denture, chairside	\$16.00
D5730	Reline complete maxillary denture, chairside	\$16.00

CDT Code	Description	Member Co-payment
D5731	Reline complete mandibular denture, chairside	\$16.00
D5740	Reline maxillary partial denture, chairside	\$16.00
D5741	Reline mandibular partial denture, chairside	\$16.00
D5750	Reline complete maxillary denture, laboratory	\$50.00
D5751	Reline complete mandibular denture, laboratory	\$50.00
D5760	Reline maxillary partial denture, laboratory	\$50.00
D5761	Reline mandibular partial denture, laboratory	\$50.00
D5810	Interim complete denture, maxillary	\$100.00
D5811	Interim complete denture, mandibular	\$100.00
D5820	Interim partial denture, maxillary	\$40.00
D5821	Interim partial denture, mandibular	\$40.00
D5850	Tissue conditioning, maxillary	\$0.00
D5851	Tissue conditioning, mandibular	\$0.00
<b>Implant Services</b>		
<b>GUIDELINE:</b>		
Implants and all services associated with implants are listed at the actual member co-payment amount. No additional fee is allowable for porcelain, noble metal, high noble metal, or titanium for implants and procedures associated with implants.		
D6010	Surgical placement of implant body, endosteal	\$2,000.00
D6056	Prefabricated abutment, includes modification and placement	\$210.00
D6058	Abutment supported porcelain/ceramic crown	\$1,110.00
D6059	Abutment supported porcelain fused to high noble crown	\$1,096.00
D6060	Abutment supported porcelain fused to base metal crown	\$1,035.00
D6061	Abutment supported porcelain fused to noble metal crown	\$1,056.00
D6062	Abutment supported cast metal crown, high noble	\$1,003.00
D6063	Abutment supported cast metal crown, base metal	\$861.00
D6064	Abutment supported cast metal crown, noble metal	\$912.00
D6094	Abutment supported crown, titanium	\$670.00
D6065	Implant supported porcelain/ceramic crown	\$1,040.00
D6066	Implant supported porcelain fused to high noble crown	\$1,013.00
D6067	Implant supported metal crown	\$984.00
D6068	Abutment supported retainer, porcelain/ceramic FPD	\$1,110.00
D6069	Abutment supported retainer, metal FPD, high noble	\$1,096.00
D6070	Abutment supported retainer, porcelain fused to metal FPD, base metal	\$1,035.00
D6071	Abutment supported retainer, porcelain fused to metal FPD, noble	\$1,056.00
D6072	Abutment supported retainer, cast metal FPD, high noble	\$1,028.00
D6073	Abutment supported retainer, cast metal FPD, base metal	\$930.00
D6074	Abutment supported retainer, cast metal FPD, noble	\$1,005.00
D6194	Abutment supported retainer crown, FPD, titanium	\$670.00
D6075	Implant supported retainer for ceramic FPD	\$1,092.00
D6076	Implant supported retainer for porcelain fused metal FPD	\$1,064.00

CDT Code	Description	Member Co-payment
<b>Implant Services (continued)</b>		
D6077	Implant supported retainer for cast metal FPD	\$984.00
D6092	Re-cement or re-bond implant/abutment supported crown	\$45.00
D6093	Re-cement or re-bond implant/abutment supported FPD	\$65.00
<b>Fixed Prosthodontic Services</b>		
*GUIDELINES for Pontics, Retainer Crowns, Retainer Inlays, Retainer Onlays:		
<p><b>The total maximum amount chargeable to the member for elective upgraded procedures</b> (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.</p> <p><b>1. Brand name restorations:</b> (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.</p> <p><b>2. Benefits for anterior and bicuspid teeth:</b> 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.</p> <p><b>3. Benefits for molar teeth:</b> 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.</p> <p><b>4. Base metal is the benefit:</b> If elected, a) noble, b) high noble metal, or c) titanium may be considered an elective upgraded procedure.</p>		
D6205	Pontic, indirect resin based composite	\$85.00*
D6210	Pontic, cast high noble metal	\$100.00*
D6211	Pontic, cast predominantly base metal	\$100.00
D6212	Pontic, cast noble metal	\$100.00*
D6214	Pontic, titanium	\$100.00*
D6240	Pontic, porcelain fused to high noble metal	\$115.00*
D6241	Pontic, porcelain fused to predominantly base metal	\$115.00*
D6242	Pontic, porcelain fused to noble metal	\$115.00*
D6245	Pontic, porcelain/ceramic	\$100.00*
D6250	Pontic, resin with high noble metal	\$90.00*
D6251	Pontic, resin with predominantly base metal	\$90.00*
D6252	Pontic, resin with noble metal	\$90.00*
D6253	Provisional pontic	\$90.00*
D6545	Retainer, cast metal for resin bonded fixed prosthesis	\$90.00*
D6548	Retainer, porcelain/ceramic, resin bonded fixed prosthesis	\$80.00*
D6549	Resin retainer, for resin bonded fixed prosthesis	\$80.00
D6600	Retainer inlay, porcelain/ceramic, two surfaces	\$140.00*
D6601	Retainer inlay, porcelain/ceramic, three or more surfaces	\$150.00*
D6602	Retainer inlay, cast high noble metal, two surfaces	\$140.00*
D6603	Retainer inlay, cast high noble metal, three or more surfaces	\$145.00*
D6604	Retainer inlay, cast base metal, two surfaces	\$140.00
D6605	Retainer inlay, cast base metal, three or more surfaces	\$145.00
D6606	Retainer inlay, cast noble metal, two surfaces	\$135.00*
D6607	Retainer inlay, cast noble metal, three or more surfaces	\$145.00*
D6624	Retainer inlay, titanium	\$145.00*
D6608	Retainer onlay, porcelain/ceramic, two surfaces	\$160.00*

CDT Code	Description	Member Co-payment
D6609	Retainer onlay, porcelain/ceramic, three or more surfaces	\$165.00*
D6610	Retainer onlay, cast high noble metal, two surfaces	\$155.00*
D6611	Retainer onlay, cast high noble metal, three or more surfaces	\$155.00*
D6612	Retainer onlay, cast base metal, two surfaces	\$145.00
D6613	Retainer onlay, cast base metal, three or more surfaces	\$155.00
D6614	Retainer onlay, cast noble metal, two surfaces	\$145.00*
D6615	Retainer onlay, cast noble metal three or more surfaces	\$150.00*
D6634	Retainer onlay, titanium	\$155.00*
D6710	Retainer crown, indirect resin based composite	\$85.00*
D6720	Retainer crown, resin with high noble metal	\$90.00*
D6721	Retainer crown, resin with predominantly base metal	\$90.00*
D6722	Retainer crown, resin with noble metal	\$90.00*
D6740	Retainer crown, porcelain/ceramic	\$100.00*
D6750	Retainer crown, porcelain fused to high noble metal	\$115.00*
D6751	Retainer crown, porcelain fused to predominantly base metal	\$115.00*
D6752	Retainer crown, porcelain fused to noble metal	\$115.00*
D6780	Retainer crown, ¾ cast high noble metal	\$115.00*
D6781	Retainer crown, ¾ cast predominantly base metal	\$100.00
D6782	Retainer crown, ¾ cast noble metal	\$100.00*
D6783	Retainer crown, ¾ porcelain/ceramic	\$100.00*
D6790	Retainer crown, full cast high noble metal	\$100.00*
D6791	Retainer crown, full cast predominantly base metal	\$100.00
D6792	Retainer crown, full cast noble metal	\$100.00*
D6793	Provisional retainer crown	\$65.00
D6794	Retainer crown, titanium	\$100.00*
D6930	Re-cement or re-bond fixed partial denture	\$0.00
D6940	Stress breaker	\$15.00
D6980	Fixed partial denture repair, restorative material failure	\$24.00
<b>Oral &amp; Maxillofacial Services</b>		
D7111	Extraction, coronal remnants, deciduous tooth	\$0.00
D7140	Extraction, erupted tooth or exposed root	\$8.00
D7210	Surgical removal of erupted tooth	\$20.00
D7220	Removal of impacted tooth, soft tissue	\$68.00
D7230	Removal of impacted tooth, partially bony	\$100.00
D7240	Removal of impacted tooth, completely bony	\$130.00
D7241	Removal impacted tooth, complete bony, complication	\$140.00
D7250	Surgical removal residual tooth roots, cutting procedure	\$45.00
D7261	Primary closure of a sinus perforation	\$152.00
D7270	Tooth reimplantation and/or stabilization, accident	\$75.00
D7280	Surgical access of an unerupted tooth	\$105.00

CDT Code	Description	Member Co-payment
<b>Oral &amp; Maxillofacial Services (continued)</b>		
D7282	Mobilization of erupted/malpositioned tooth	\$48.00
D7283	Placement, device to facilitate eruption, impaction	\$45.00
D7285	Incisional biopsy of oral tissue, hard (bone, tooth)	\$15.00
D7286	Incisional biopsy of oral tissue, soft	\$15.00
D7287	Exfoliative cytological sample collection	\$20.00
D7288	Brush biopsy, transepithelial sample collection	\$20.00
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	\$45.00
D7311	Alveoloplasty with extractions, one to three teeth per quadrant	\$40.00
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant	\$50.00
D7321	Alveoloplasty, w/o extractions, one to three teeth per quadrant	\$60.00
D7340	Vestibuloplasty, ridge extension (2nd epithelialization)	\$64.00
D7350	Vestibuloplasty, ridge extension	\$88.00
D7450	Removal, benign odontogenic cyst/tumor, up to 1.25 cm	\$70.00
D7451	Removal, benign odontogenic cyst/tumor, greater than 1.25 cm	\$144.00
D7460	Removal, benign nonodontogenic cyst/tumor, up to 1.25 cm	\$80.00
D7461	Removal, benign nonodontogenic cyst/tumor, greater than 1.25 cm	\$112.00
D7471	Removal of lateral exostosis, maxilla or mandible	\$85.00
D7472	Removal of torus palatinus	\$65.00
D7473	Removal of torus mandibularis	\$65.00
D7485	Surgical reduction of osseous tuberosity	\$40.00
D7510	Incision & drainage of abscess, intraoral soft tissue	\$10.00
D7511	Incision & drainage of abscess, intraoral soft tissue, complicated	\$15.00
D7520	Incision & drainage of abscess, extraoral soft tissue	\$10.00
D7521	Incision & drainage of abscess, extraoral soft tissue, complicated	\$12.00
D7530	Remove foreign body, mucosa, skin, tissue	\$12.00

CDT Code	Description	Member Co-payment
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	\$40.00
D7960	Frenulectomy (frenectomy or frenotomy), separate procedure	\$0.00
D7963	Frenuloplasty	\$0.00
D7970	Excision of hyperplastic tissue, per arch	\$45.00
D7971	Excision of pericoronal gingiva	\$40.00
<b>Adjunctive General Services</b>		
D9110	Palliative (emergency) treatment, minor procedure	\$10.00
D9120	Fixed partial denture sectioning	\$0.00
D9210	Local anesthesia not in conjunction, operative or surgical procedures	\$0.00
D9211	Regional block anesthesia	\$0.00
D9212	Trigeminal division block anesthesia	\$0.00
D9215	Local anesthesia in conjunction with operative or surgical procedures	\$0.00
<b>**GUIDELINE:</b> Deep sedation/general anesthesia is a covered benefit only when in conjunction with covered oral surgery and pedodontic procedures when dispensed in a dental office by a practitioner acting within the scope of his/her licensure; and when warranted by documented conditions that local anesthetic and contraindicated. General anesthesia, as used for dental pain control, means the elimination of all sensations accompanied by a state of unconsciousness. Patient apprehension and/or nervousness are not of themselves sufficient justification for deep sedation/general anesthesia or intravenous conscious sedation/analgesia.		
D9219	Evaluation for deep sedation or general anesthesia	\$0.00
D9223	Deep sedation/general anesthesia, each 15 minute increment	\$110.00**
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	\$30.00
D9243	Intravenous moderate (conscious) sedation/analgesia, each 15 minute increment	\$90.00**
D9248	Non-intravenous (conscious) sedation, includes non-IV minimal and moderate sedation	\$100.00
D9310	Consultation, other than requesting dentist	\$0.00
D9430	Office visit, observation, regular hours, no other services	\$0.00
D9440	Office visit, after regularly scheduled hours	\$30.00
D9450	Case presentation, detailed & extensive treatment	\$0.00
D9630	Other drugs and/or medicaments, by report	\$20.00
D9910	Application of desensitizing medicament	\$0.00
D9911	Application of desensitizing resin for cervical, root surface, per tooth	\$0.00
D9930	Treatment of complications, post surgical, unusual, by report	\$5.00
D9940	Occlusal guard, by report	\$115.00
D9942	Repair and/or reline of occlusal guard	\$50.00
D9950	Occlusion analysis, mounted case	\$0.00
D9951	Occlusal adjustment, limited	\$15.00
D9952	Occlusal adjustment, complete	\$20.00
D9971	Odontoplasty one to two teeth; includes removal of enamel projections	\$5.00

CDT Code	Description	Member Co-payment
<b>Adjunctive General Services (continued)</b>		
D9972	External bleaching, per arch, performed in office	\$185.00
D9986	Missed appointment	\$20.00
D9987	Cancelled appointment	\$0.00
	Office visit, per visit	\$0.00

LIBERTY Dental Plan of California, Inc.  
 Questions, please call:  
 P.O. Box 26110  
 2241  
 Santa Ana CA, 92799-6110  
 please call:

Members with  
 Member Services (877) 873-  
 Providers with Questions,  
 Professional Services (800)268-9012



## **Limitations:**

1. Prophylaxis procedures are covered once every 6 consecutive months.
2. Complete series of x-rays (full mouth x-rays) or panoramic films are covered once every 36 consecutive months.
3. Fluoride treatments are covered once every 6 consecutive months.
4. Sealants are covered only on the first and second permanent molars with no caries (decay) for dependent children up to the 14th birth date. Limited to once per tooth per 36 month period.
5. Scaling and root planing per quadrant/site is covered once every 24 consecutive months.
6. Replacement of crowns, labial veneers or fixed partial dentures (bridgework), per unit, are limited to once every 5 year period.
7. Replacement of an existing full and partial denture is covered once per arch every 5 years if the appliance cannot be made functional through relines or repair.
8. Denture relines are covered twice every 12 consecutive months.
9. Fabricated crowns, onlays and inlays may be covered when a tooth with a good prognosis requires restoration but has insufficient remaining structure to reliably retain a filling. Coverage for these procedures limited to members age 16 and over.
10. The replacement of an amalgam or resin restoration in less than twelve months by the same contracted dentist or office is not chargeable to the Plan or the member.
11. Procedures that appear to have a poor prognosis as determined by a licensed LIBERTY dentist consultant are not covered.
12. Localized delivery of antimicrobial agents may be covered 4-6 weeks after the completion of scaling and root planing as an adjunctive procedure for 2 non-responsive sites in a quadrant with 5mm pockets or deeper plus inflammation.
13. For treatment plans involving 7 or more units of crowns and/or fixed partial dentures (bridges), contracted providers may charge an additional \$200 co-payment per unit. In such cases, the first 6 units, as described in limitation #6 above, are covered at the specified member co-payment amount only, as documented in this Schedule of Benefits.
14. Fixed partial dentures (bridges) are covered when: replacing a "like-for-like" existing fixed partial denture with identical pontics and abutment teeth with good prognosis; abutment teeth qualify for crowns on their own merit, as described in limitation #6 above; there is only one missing permanent tooth in a full arch and the bridge would have opposing teeth in the opposite arch.
15. Surgical periodontal services are limited to once every 36 month period.
16. Full mouth debridement is limited to once in a 24 month period.
17. Pediatric referrals, if authorized by LIBERTY, are covered only for dependent children through the age of 6 unless the child qualifies under the American with Disabilities Act (ADA).

## **Exclusions:**

1. Any procedure not specifically listed as a Covered Benefit.
2. Replacement of lost or stolen prosthetics or appliances including partial dentures, full dentures, and orthodontic appliances.
3. General anesthesia, analgesia, intravenous/intramuscular sedation or the services of an anesthesiologist other than those situations described in the Schedule of Benefits (\*\*).
4. Treatment started prior to coverage or after termination of coverage.
5. Procedures, appliances, or restorations to treat temporomandibular joint dysfunctions (e.g. adjustments/corrections to the facial bones), congenital or developmental situations (including supernumerary teeth) or medically induced dental disorders, including but not limited to: myofunctional treatment (e.g. speech therapy), or myoskeletal dysfunctions, unless otherwise covered as an orthodontic benefit.
6. Services for cosmetic purposes or for conditions that are a result of hereditary developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.
7. Procedures which are determined not to be dentally necessary consistent with professionally recognized standards of dental practice.
8. Procedures performed on natural teeth solely to increase vertical dimension or restore occlusion.
9. Any service performed outside of your assigned dental office, unless expressly authorized by LIBERTY Dental Plan, or unless as outlined and covered in the "Emergency Dental Care" section of the Evidence of Coverage.
10. The removal of asymptomatic, unerupted third molars (or other teeth) that appear to have an unimpeded pathway to eruption and no active pathology.
11. Procedures or appliances that are provided by a dentist who specializes in prosthodontic services.
12. Services for restoring tooth structure lost from wear (abrasion, erosion, attrition or abfraction), for rebuilding occlusion or maintaining chewing surfaces or teeth that are out of alignment or for stabilizing teeth. Examples of such treatment are equilibration and periodontal splinting.
13. Any routine dental services performed by a dentist or dental specialist in an inpatient/outpatient hospital setting.
14. Consultations for non-covered services.

# LIBERTY Dental Plan of California, Inc.

## LS200 ORTHODONTIC RIDER

### Principal Benefits and Coverage

Primary Dentition:	Teeth developed and erupted first in order of time
Transitional Dentition:	The final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.
Adolescent Dentition:	The dentition that is present after the normal loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment.
Adult Dentition:	The dentition that is present after the cessation of growth that would affect orthodontic treatment. <b>Treatment must be provided by a LIBERTY Dental Plan contracted orthodontic provider.</b> <b>Any procedure not listed is available at the provider's usual and customary fee</b>

ADA Code	Description	Pay	Co-
<b>Orthodontic Diagnostic Records</b>			
D0340	2D cephalometric radiographic image, measurement and analysis	\$100.00	
D0470	Diagnostic casts	\$75.00	
D9310	Consultation, other than requesting dentist		no charge
<b>Limited Orthodontic Treatment</b>			
D8010	Limited orthodontic treatment of the primary dentition	\$1300.00	
D8020	Limited orthodontic treatment of the transitional dentition	\$1300.00	
D8030	Limited orthodontic treatment of the adolescent dentition	\$1300.00	
D8040	Limited orthodontic treatment of the adult dentition	\$1300.00	
<b>Interceptive Orthodontic Treatment</b>			
D8050	Interceptive orthodontic treatment of the primary dentition	\$500.00	
D8060	Interceptive orthodontic treatment of the transitional dentition	\$500.00	
<b>Comprehensive Orthodontic Treatment (24 months of Usual and Customary Orthodontic Treatment)</b>			
D8070	Comprehensive orthodontic treatment of the transitional dentition	\$1550.00	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	\$1550.00	
D8090	Comprehensive orthodontic treatment of the adult dentition	\$1695.00	
<b>Minor Treatment to Control Harmful Habits</b>			
D8210	Removable appliance therapy	\$350.00	
D8220	Fixed appliance therapy	\$350.00	
<b>Other Orthodontic Services</b>			
D8660	Pre-orthodontic treatment examination to monitor growth and development		no charge
D8670	Periodic orthodontic treatment visit		no charge
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	\$250.00	
D9986	Missed appointment		\$20.00
D9987	Cancelled appointment		no charge

### Orthodontic Exclusions

1. Replacement of lost or stolen orthodontic appliances.
2. Lost, stolen or broken appliances.
3. Orthodontic treatment started prior to member's effective date of coverage unless covered through an orthodontic takeover provision.
4. Extractions for orthodontic purposes, (will not be applied if extraction is consistent with professionally recognized standards of dental practice or arises in the context of an emergency dental condition).
5. Treatment in progress at the time of eligibility, unless included as an orthodontic rider to the groups benefits.
6. Temporomandibular joint syndrome (TMJ) surgical orthodontics.
7. Myofunctional therapy.
8. Treatment of cleft palate.
9. Treatment of micrognathia.
10. Treatment of macroglossia.
11. Changes in orthodontic treatment necessitated by accident of any kind.
12. Orthodontic coverage is limited to 24 months of treatment, followed by 24 months of retention office visits.
13. Services provided after the 24th month of treatment and/or retention is the responsibility of the patient at a fee not to exceed \$130 per month.
14. In the event of termination the patient is responsible for the usual fee of the treating dentist pro-rated over the remainder of treatment and/or retention.