LIBERTY DENTAL PLAN FAMILY DENTAL HMO CALIFORNIA INDIVIDUAL PLAN COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

Contains information for members covered by a COVERED CALIFORNIA Individual Essential Pediatric Dental Benefit (EPDB) Plan, including the "LIBERTY Dental Plan Family Dental HMO" plan.

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 at no cost to You. To ask for language services call 1-888-844-3344. Make sure to notify your provider (Dentist) of Your personal language needs upon your initial dental visit.

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 sin ningún costo a usted. Para obtener ayuda gratuita, llame ahora mismo al 1-888-844-3344.

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

This COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM constitutes only a summary of the dental plan. The dental plan contract must be consulted to determine the exact terms and conditions of coverage.

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

A STATEMENT DESCRIBING LIBERTY'S 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

THIS BENEFITS 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.

LIBERTY Dental Plan Family Dental HMO			
Copay Plan			
Member Cost Share amounts describe the Member' out-of-pocket costs.			
Benefit Type		**Pediatric Dental EHB**	**Adult Dental**
Age		**Up to Age 19**	**Age 19 and Older**
Actuarial Value		84.80%	Not Calculated
Network Type		**In-Network**	**In-Network**
Individual Deductible		None	None
Family Deductible (Two or more children)		Not applicable	Not Applicable
Individual Out of Pocket Maximum		$350	Not Applicable
Family Out-of-Pocket Maximum (Two or More Children)		$700	Not Applicable
Office Copay		$0	$0
Waiting Period		None	None
Annual Benefit Limit (the maximum amount the dental plan will pay in the benefit year)		None	None
Procedure Category	**Service Type**	**Member Cost Share**	**Member Cost Share**
Diagnostic & Preventive	Oral Exam	No Charge	No Charge if Covered
	Preventive - Cleaning	No Charge	No Charge if Covered
	Preventive - X-ray	No Charge	No Charge if Covered
	Sealants per Tooth	No Charge	No Charge if Covered
	Topical Fluoride Application	No Charge	No Charge if Covered
	Space Maintainers - Fixed	No Charge	No Charge if Covered
Basic Services	Restorative Procedures	$25-$310	$25-$310
	Periodontal Maintenance	$30	$30
Major Services	Periodontics (other than maintenance)	$10-$350	$10-$350
	Endodontics	$20-$365	$20-$365
	Crowns and Casts	$20-$310	$20-$310
	Prosthodontics	$35-$350	$35-$400
	Oral Surgery	$40-$350	$35-$350
Orthodontia	Medically Necessary Orthodontia	$350	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 Appendix I of the Combined Evidence of Coverage.

OVERVIEW OF YOUR DENTAL BENEFIT PLAN

A. HOW TO USE YOUR LIBERTY DENTAL PLAN

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

B. HOW TO CONTACT LIBERTY

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

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

C. LIBERTY'S SERVICE AREA

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

D. LIBERTY'S NETWORK

Our network includes General Dentists and Specialists with which LIBERTY has contracted to provide Covered Services to Members under the Benefit Plan. To use Your Benefits, Covered Services must be performed by Your PCD and other Participating Providers. Call 888-844-3344 to ask for a LIBERTY Provider Directory or use the website.

If You go a Non-Participating Provider, You will have to pay all the cost, unless You received pre-approval from LIBERTY, or You require Emergency/Urgent Care or Out-of-Area Urgent Care. 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 11).*

E. YOUR PRIMARY CARE DENTIST (PCD) (see page 8)

You do not need to choose a PCD. You may access services from any contracted General Dentist in the network.

F. LANGUAGE AND COMMUNICATION ASSISTANCE

Interpretation and translation services are available for members with limited English proficiency, including translation of documents into certain threshold languages. If English is not Your first language, LIBERTY provides interpretation services and translation of certain written materials in Your preferred language. If You have a preferred language, please notify us of Your personal language needs by completing an online survey at https://www.libertydentalplan.com/Members/Member-Language-Survey.aspx or calling 888-844-3344. Make sure to notify your provider (Dentist) of Your personal language needs upon your initial dental visit.

LIBERTY provides language assistance services at all points of contact, including at your dental appointment(s). If your PCD, dental specialist, or their office staff, cannot communicate with you in your preferred language, LIBERTY can arrange for interpretation services at your appointment at no cost to you. LIBERTY makes these services available to you even if you are accompanied by a family member or friend that can assist with interpretation. Please call LIBERTY's Member Services at 888-844-3344 to arrange for an in-person interpreter as far in advance of your appointment time as possible but no less than 72 hours from the time of your appointment.

G. HOW TO GET DENTAL CARE WHEN YOU NEED IT

Call Your PCD first for all Your care, unless it is an emergency.

- You usually need a referral and pre-approval to get care from a dentist other than your PCD. 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 (IMR) (see page 21).
- The dental care must be a service that LIBERTY covers. Covered dental services are also called benefits. To see what services LIBERTY covers, see the Schedule of Benefits in Appendix I.

H. Timely Access to Care

You are entitled to schedule an appointment with your PCD within a reasonable time that is appropriate to your condition:

- Emergency appointments should be available 24 hours a day, 7 days a week. Contact your PCD for an immediate appointment or in the event of a life-threatening situation, call "911"
- Urgent appointments should be scheduled within 72 hours. Discuss your individual needs with your PCD to determine how soon you can be seen
- Non-Urgent Appointment should be offered within 36 business days.
- Preventive dental care appointments should be offered within 40 business days.

If for any reason you are unable to schedule an appointment within these timeframes, please call Member Services at 888-844-3344 for assistance.

I. SPECIALTY REFERRALS AND PRE-AUTHORIZATIONS (see page 10)

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

IMPORTANT: You do **not** need a referral and pre-approval to see Your PCD, or to get Emergency Care or Urgent Care.

J. EMERGENCY CARE (see page 9)

Emergency Care is a Covered Service, anywhere in the world. A condition may be considered an emergency if, without treatment, Your health may be in serious jeopardy, You may experience serious impairment to bodily functions or serious dysfunction of any bodily organ or part. Emergency Care may include care for a bad injury, severe pain, or a sudden serious dental illness. Emergency Care may include care for a bad injury, severe pain, or a sudden serious dental illness. If You receive Emergency Care, go to your PCD for follow-up care. Do not return to the emergency room for follow-up care.

K. URGENT CARE (see page 9)
Urgent Care is covered anywhere in the world. Urgent Care may be needed to prevent a serious health problem that requires prompt attention.

L. CARE WHEN YOU ARE OUT OF THE LIBERTY SERVICE AREA (see page 9)
Only Emergency and Urgent Care is covered outside of the LIBERTY Service Area.

M. COSTS (see the "SCHEDULE OF BENEFITS" and "What You Pay" on page 12)
Premium is what You pay to LIBERTY to keep coverage.

- A Co-payment is the amount that You must pay to the PCD or Specialist for a particular covered procedure.
- The yearly deductible is the amount You pay directly to PCD or Specialist for certain services, before LIBERTY starts to pay.
- The yearly out-of-pocket maximum is the most money You have to pay for Your covered dental care in a year.
- After You pay Your Co-payments, LIBERTY pays for the rest of any covered service.
- After You have reached the yearly out-of-pocket maximum, LIBERTY pays the rest of the cost of the services for that year, as long as the service You get is a covered benefit.

N. IF YOU HAVE A GRIEVANCE ABOUT YOUR LIBERTY DENTAL PLAN (see page 18)
LIBERTY provides a Grievance resolution process You can file a Grievance (also called complaint or appeal) with LIBERTY for any dissatisfaction You have with LIBERTY, Your Benefits, a claim determination, a benefit or coverage determination, Your PCD, Specialist or any aspect of Your dental Benefit Plan.

If You disagree with LIBERTY's decision about Your grievance, 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:

- **Appeal:** A request made to LIBERTY by a member, a provider acting on behalf of a member, or other authorized designee to review an action by the Plan to delay, modify or deny services.
- **Authorization:** The notification of approval by LIBERTY that You may proceed with treatment requested.
- **Benefits:** Services covered by Your LIBERTY Dental Plan.
- **Benefit Plan:** The LIBERTY dental product that You purchased to provide coverage for dental services.
- **Benefit Year:** The year of coverage of Your LIBERTY Dental Plan.
- **Capitation:** Pre-paid payments made by LIBERTY to a Contracting General Dentist to provide services to assigned Members.
- **Charges:** The fees requested for proposed services or services rendered.
- **Contracting General 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 x-ray(s), written treatment records, 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.
- **Disputed Dental Service:** Any service that is the subject of a dispute filed by either Member, a Provider acting on behalf of a member, or other authorized designee
- **Domestic Partner:** A person that is in a committed life-sharing relationship with the Member.
- **Emergency Care/Emergency Dental Service:** Emergency Dental Service and Care include, dental screening, examination, evaluation by a PCD or dental Specialist to determine if an emergency dental condition exists. A condition may be considered an emergency if, without treatment, Your health may be in serious jeopardy, You may experience serious impairment to bodily functions or serious dysfunction of any bodily organ or part. Medical emergencies are not covered by LIBERTY if the services are rendered in a hospital setting which are covered by a Medical Plan, or if LIBERTY determines the services were not dental in nature.
- **Enrollee:** See definition for Member below.
- **Essential Pediatric Dental Benefit (EPDB):** Refers to plans mandated 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. For Individual Plans, IMR is only available for medical services.
- **Individual Plan:** A dental Benefit Plan providing coverage for an individual person. A spouse or covered Dependent may also be included on the same Individual Plan as the Subscriber.
- **In-Network Benefits:** Benefits available to You when You receive services from a Contracted PCD or Specialist
- **Medical Necessity or Medically 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 Medical Necessity prior to or after rendering. Payment for services occurs for Covered Services that are deemed Medically Necessary by the Plan.
- **Member:** Subscriber or eligible Dependent(s) who are actually enrolled with LIBERTY. Also known as Enrollee.
- **Non-Participating Provider:** A PCD or Specialist that is not contract with LIBERTY to provide service to members.
- **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 PCD.
- **Out-of-Area Urgent Care:** Urgent services that are needed while You are located out of the Service Area or away from Your PCD.
- **Participating Dental Group, Dental Office, or Provider:** A dental facility, dentists and dental office staff that are under contract to provide services to LIBERTY Members in accordance with LIBERTY's rules and regulations.
- **Plan:** LIBERTY Dental Plan of California, Inc.
- **Pre-Authorization:** A request for services, submitted on Your behalf, asking for an advance determination and approval. Also known as a pre-approval.
- **Premium:** The fee paid to LIBERTY for this Benefit Plan.

- **Primary Care Dentist (PCD):** Normally, a General Dentist affiliated with LIBERTY to provide services to covered Members of the Plan. The PCD is responsible for providing or arranging for needed dental services.
- **Professional Services:** Dental services or procedures provided by a licensed dentist or approved auxiliaries.
- **Provider:** A contracted dentist providing services under contract with LIBERTY
- **Specialist:** A Dentist that has received advanced training in one of the dental specialties approved by the American Dental Association (ADA) 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 contracted with LIBERTY to provide services to members of the Plan.
- **Service Area:** The counties in California where LIBERTY provides coverage.
- **Urgent Care:** Care that You need soon to prevent a serious health problem.
- **Usual Charges:** A dentist's usual charge for a service
- **You:** Pertains to Individual Members including covered Dependent children on the Essential Pediatric Benefit Individual Plans who are the beneficiary of this dental Benefit Plan.

III. ACCESS TO SERVICES – SEEING A DENTIST

LIBERTY contracts with general dentists and specialists to provide services covered by your plan. Contact us toll-free at 888-844-3344 or you can go to our website, www.libertydentalplan.com, to find a dentist in your area. All services and benefits described in this publication are covered only if provided by a contracted PCD 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. DENTAL OFFICES FACILITIES

LIBERTY makes available PCDs and Specialists throughout the state of California within a reasonable distance from your home or workplace. Contact LIBERTY toll-free at 888-844-3344 or you can go to our website,**www.libertydentalplan.com**, to find a dentist in your area.

Our goal is to provide You with appropriate dental benefits, delivered by highly-qualified dental professionals in a comfortable setting. All of LIBERTY Dental Plan's contracted private practice dentists must meet LIBERTY's credentialing criteria, prior to joining our network. In addition, each participating dentist must adhere to strict contractual guidelines. All dentists are pre-screened and reviewed on a regular basis.

LIBERTY 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 PCD will provide all your dental care needs including referring you to a specialist, should it be necessary. All members shall have a residence or workplace within thirty (30) minutes or fifteen (15) miles of a PCD office.

B. DENTAL HEALTH EDUCATION

For more information on using Your dental Benefits, please go to our website at www.libertydentalplan.com. The website contains other helpful information on dental and oral health information to assist You in assessing your risk of future dental disease, home care measures You can take to keeping Your teeth and mouth healthy. It is important to know the condition of Your teeth, gums and

mouth can affect 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 post pregnancy 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 Dentist (PCD)**: You do not need to select a Primary Care Dentist at the point of enrollment. Simply contact a General Dentist who is contracted to provide services under Your selected plan for an appointment. The contracting General Dentist will then contact LIBERTY to verify Your eligibility. You may obtain information on Providers in these counties by phone or website. In these counties You are not assigned to this Provider and may change to a different contracting General Dentist at any time.

   You can obtain information on contracted providers by calling Member Services at (888) 703-6999 or you can go to our website, **www.libertydentalplan.com**. You can also refer to your Schedule of Benefits to determine if your plan requires assignment to a PCD, or if you can access services from any contracted PCD in the network.

2. **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 PCD to LIBERTY for approval. You may only receive services from a dental Specialist that has been Pre-Authorized for You by LIBERTY. Your Specialist will submit a Pre-Authorization for services to LIBERTY for Pre-Authorization.

   All services and Benefits described in this publication are covered only if provided by a contracted LIBERTY PCD or Specialist. Services received by a Non-Participating Provider are not covered. The only time You may receive care outside the network is for Emergency Dental Services as described herein under "**Emergency Dental Care**".

D. TELE-DENTISTRY

Tele-dentistry is a Virtual Dental Service, available twenty-four (24) hours per day, seven (7) days per week, as an alternative solution to help You monitor your oral health, especially when You and the dentist cannot be in the same physical location. Dentists are available by phone and computer from anywhere to address emergency and urgent dental needs. LIBERTY covers tele-dentistry services to help improve access and continuity of dental care for our members. There is no difference in your dental coverage for tele-dentistry. The same benefits are available with tele-dentistry as it would be for in-person visits.

You dentist can determine through consultation whether you have an emergency dental problem and can provide instructions on how to treat conditions. If you have a cracked or chipped tooth, soft tissue lesion (bump on your gums), small cavity, jaw pain or similar non-emergency condition, a tele-dentistry consultation through phone or video may work. If you need urgent treatment, it must be scheduled for an onsite visit.

You can set up an appointment with your dental office, by phone or online to discuss regular dental services, dental problems, and instructions on how to treat conditions. Contact your PCD if You are experiencing dental pain or a potential dental emergency. If your PCD is not available, contract LIBERTY toll-free for assistance with the Tele-dentistry program. If an in-person visit is required, dental emergency visits are coordinated by LIBERTY's Member Services Department.

If you are experiencing a life-threatening emergency, immediately contact 911.

E. URGENT CARE

Urgent Care is care You need within 72 hours, and to prevent the serious worsening of Your dental health due to an unforeseen illness or injury for which treatment cannot be delayed. LIBERTY provides coverage for urgent dental services only if the services are required to alleviate severe pain or bleeding or if a Member reasonably believes that the condition, if not diagnosed or treated, may lead to disability, dysfunction or death.

Contact Your PCD 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 LIBERTY determine that Your treatment was not due to a dental emergency, the services of any a Non-Participating Provider will not be covered, and you will not be eligible for reimbursement.

F. EMERGENCY DENTAL CARE

All affiliated LIBERTY PCD offices provide availability of Emergency Dental Services twenty-four (24) hours per day, seven (7) days per week. LIBERTY provides coverage for Emergency Dental Services if, without treatment, Your health may be in serious jeopardy, You may experience serious impairment to bodily functions or serious dysfunction of any bodily organ or part. Emergency Care may include care for a bad injury, severe pain, or a sudden serious dental illness. You may also wish to consider contacting the "911" emergency response system.

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

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

Emergency Dental Service (covered by your LIBERTY dental plan) is defined in by California laws, to include a dental screenings, examinations, evaluations by dentist or Specialist to determine if an emergency dental condition exists, and to provide care that would be considered within professionally recognized standards of dental care and in order to alleviate any emergency symptoms in a dental office/clinic setting and emergency department in a hospital.

Emergency dental services may be an allowable benefit, in accordance with the schedule of benefits. LIBERTY will provide benefits for such emergency dental services and shall ensure the availability of a provider in the event that an on-call network provider is unavailable in a dental setting or hospital. LIBERTY does not cover services that LIBERTY determines 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 per calendar year. If you pay a bill for

covered Emergency Dental Care, submit a copy of the paid bill to LIBERTY Dental Plan, Claims Department, P.O. Box 26110, Santa Ana, CA, 92799-6110.

Please include a copy of the claim from the Provider's office or a legible statement of services/invoice. Please forward to LIBERTY Dental Plan with the following information:

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

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

- The reason for the denial.
- Reference to the pertinent EOC 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.

G. SECOND OPINION

You may request a second dental opinion, at no cost to you, for services covered under your plan, by calling the Member Services Department toll-free number (888) 844-3344 or by writing to: LIBERTY Dental Plan, P.O. Box 26110, Santa Ana, CA, 92799-6110. Your PCD may also request a second dental opinion on Your behalf by submitting a Standard Specialty or Orthodontic Referral form with appropriate x-rays. All requests for a second dental opinion are processed by LIBERTY within five (5) business days of receipt of the request, or 72 hours of receipt 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.

Upon approval, LIBERTY 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's policy description for a second dental opinion.

H. REFERRAL TO A SPECIALIST

In the event that You need to be seen by a Specialist, LIBERTY requires your PCD obtains Pre-Authorization. The Pre-Authorization submission will be responded to within five (5) business days of receipt, unless urgent. In the case of an urgent request, your PCD can call LIBERTY's Referral Unit at (800) 268-9012 to submit a request for prior authorization to a specialist.

- If your request for a specialty pre-authorization is denied or you are dissatisfied with the pre-authorization, you have the right to file a grievance. See EOC Section X, "GRIEVANCE PROCEDURES", on page 18.
- If your PCD has difficulty locating a specialist in your area, contact LIBERTY Member Services for assistance in locating a specialist.
- Specialty services and treatment plans that are pre-authorized, and found to be necessary, by LIBERTY, are only available with the specialist who requested the services. Treatment plans and specialty services are not transferrable from one specialist to another specialist, unless both specialist agree with the proposed treatment plan.
- If you are unable to access in-network specialty services in a reasonable time period or location (as determined by published access requirement), you may contact Member Services for assistance in

finding another in-network specialist, or to make arrangements to access care from an out-of-network specialist.

- All specialty care must be pre-authorized to determine coverage, benefits, medical necessity and/or appropriateness to the presenting conditions. You would only be financially responsible for the listed co-payment amounts for covered services. You would also be financially responsible for the specialist's usual fee for any non-covered, elective services, or for services not deemed to be medically necessary upon review by LIBERTY.

I. AUTHORIZATION, MODIFICATION OR DENIAL OF SERVICES

Prior authorization is required in order to receive dental services from your PCD. The PCD has the authority to make most coverage determinations. The benefit determinations are achieved through comprehensive oral evaluations, which are covered by Your plan. Your PCD 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 PCD (see Referral to a Specialist above).

Any service(s) recommended by a Specialty, that You were referred to, must be Pre-Authorized before rendering care, except for Emergency Dental Services (Emergency Dental Care and Urgent Care services described above).

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

Specialty referral(s) and Pre-Authorization of specialty services are processed within 5 calendar days of receipt of all information necessary to make the determination. When LIBERTY is unable to make the determination within the 5 calendar day requirement, LIBERTY will notify Your PCD or Specialist 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 be provided in writing and 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 file an Appeal.

J. Urgent requests

If You or Your PCD 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 PCD within twenty-four (24) hours of the decision. In cases where the review is retrospective (services already provided), the decision shall be communicated to You in writing within thirty (30) days of the receipt of the information.

K. 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 Member

Services at 1-888-844-3344 to see if You may be eligible for this benefit. You may request a copy of the LIBERTY'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 Member Services at 1-888-844-3344 to see if You may be eligible for this benefit. You may request a copy of the LIBERTY'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.

IV. FEES AND CHARGES – WHAT YOU PAY

A. PREMIUMS AND PREPAYMENT FEES

- If You purchased Your Individual Plan from Covered California, You must make the first payment ("initial binder payment") directly to LIBERTY to ensure your effective date, and all remaining payments to LIBERTY at the address provided in Appendix 2.
- Your initial binder payment is due to LIBERTY by the 15th of the effective month. Once Your initial binder payment has been received, Your monthly payments will be due as billed and must be received prior to the 30-day grace period.
- Your Dental Plan provides a "grace period" to allow You time to make Your premium payment without losing Your dental coverage. "Grace Period" means a period of 30 days beginning on the first day after the last day of paid coverage. If LIBERTY does not receive Premium payment in full before the end of the Grace Period, this EOC and all coverage afforded under it may be terminated by LIBERTY in accordance with the Termination provisions in this EOC.
- Your Premium and payment terms are listed in Appendix 2, including mailing address for payments.
- Premiums must be paid for the period in which services are received.

B. CHANGES TO BENEFITS AND PREMIUMS

LIBERTY Dental Plan may change the covered Benefits, Co-payments, and Premium rates from time to time. LIBERTY 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.

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 EOC document. You should discuss any Charges for non-covered or optional services directly with Your PCD or Specialist. To avoid any financial misunderstandings, 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 PCD's or Specialist's usual fee for any such services.

IMPORTANT: You may be responsible for additional fees for returned or dishonored checks, cancelled credit card payments, broken or missed appointments. Charges are as agreed upon mutually by You and

Your PCD or Specialist as per business arrangements and disclosures made by the treating Provider. LIBERTY does not have jurisdiction over internal office policies or business arrangements mutually agreed upon by You and Your PCD or Specialist.

D. LIABILITY FOR PAYMENT

You are responsible for payment of Premiums and listed Co-payments for any Covered Services subject to the limitations and Exclusions of Your plan.

You are responsible for the PCD's or Specialist usual fee in the following situations:

- Non-covered services
- Services completed with a non-contracted office, PCD or Specialist
- Services completed prior to or without a require a pre-authorization from LIBERTY
- Services completed out-of-area, which LIBERTY determined to not qualify as emergency or urgent care services, including, but not limited to, routine treatment that was not completed to treat an emergency dental 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 PCD or Specialist should provide You a treatment plan that includes each recommended service and the estimated cost. If You would like more information about dental coverage options, call the Member Services Department at 888-844-3344.

You will not be held financially responsible for any monies owed to a LIBERTY contracted PCD or Specialist. In the event that LIBERTY fails to pay a Non-Participating Provider, You may be liable for the cost of services You received.

IMPORTANT: If you elect to receive dental services that are not covered services under this plan, the PCD or specialist may charge you the usual and customary rate for those services. Prior to providing a member with dental services that are not a covered benefit, the PCD or specialist should provide you with treatment plan that includes each recommended service and the estimated cost of each service. If you would like more information about dental coverage options, call the Member Services Department at 888-844-3344 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

E. PROVIDER REIMBURSEMENT

LIBERTY pays for Covered Services to Contracted PCDs and Specialists via a variety of arrangements including Capitation, fee-for-service and supplemental surpayments. 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 LIBERTY Dental Plan, P.O. Box 26110, Santa Ana, CA, 92799-6110.

V. ELIGIBILITY AND ENROLLMENT

Eligibility and Enrollment processes are determined by Covered California. To apply for coverage, you must enroll through Covered California, who will then determine whether you are eligible. For more details on the process, please visit www.coveredca.com.

A. WHO IS ELIGIBLE TO ENROLL

You and Your enrolled eligible dependents must live or work in the plan's Service Area. The following dependents must be considered eligible by Covered California to be enrolled on Your Dental Plan:

- Your spouse
- New dependents such as new spouse, children placed with You for adoption, and newborns who become eligible after Your effective date of coverage.
- Your dependent children, including adopted and newborns, who are under the age of twenty-six (26); Please note: An enrolled Dependent child who reaches age 26 shall have their coverage end on the last day of the birthday month during which the Dependent child becomes ineligible, unless both of the following are true:
    - The dependent is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition; AND
    - The dependent is chiefly dependent upon the subscriber for support and maintenance

If you wish to continue coverage for your dependent who qualifies, you will be asked to submit supporting documentation.

B. WHO IS ENTITLED TO BENEFITS

If LIBERTY receives Your completed dental application from Covered California and Your initial binder payment by the 15th day of the effective month, You may receive care on the day You are considered eligible by Covered California. 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 when You call the dentist for an appointment. We also suggest that You take this EOC or the Schedule of Benefits and applicable Limitations and Exclusions in Appendix 1 to your appointment. You can then reference Benefits and applicable Co-payments which are the out-of-pocket costs associated with Your plan, as well as any non-covered treatment.

VI. COVERED SERVICES

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

A. DIAGNOSTIC DENTAL SERVICES

Diagnostic dental services are those that are used to diagnose your dental condition and help determine medically necessary treatment, in accordance with professionally recognized standards of practice.

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

B. PREVENTIVE DENTAL SERVICES

Preventive dental services are those that are used to maintain good dental condition or to prevent the worsening of Your dental condition, when determined medically necessary, in accordance with professionally recognized standards of practice:

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

C. RESTORATIVE DENTAL SERVICES

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

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

D. ENDODONTIC SERVICES

Endodontic dental services, include root canal procedures, that involve treatment of the pulp, canals and roots when determined medically necessary, in accordance with professionally recognized standards of practice:

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

E. PERIODONTAL SERVICES

Periodontal dental services involve the treatment and management of the gums and bone supporting the teeth, when determined medically necessary, in accordance with professionally recognized standards of practice:

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

F. PROSTHODONTIC SERVICES

Prosthodontics dental services includes the replacement of lost teeth by a removable (removable denture) or fixed (fixed bridge) appliance and the maintenance of those appliances.

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

G. ORAL SURGERY SERVICES

Oral surgery dental services include the extraction of teeth and other surgical procedures as listed in the Schedule of Benefits.

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

H. ADJUNCTIVE DENTAL SERVICES

Adjunctive dental services include deep sedation (anesthesia) during approved dental services, mouthguards, and other procedures s listed in the Schedule of Benefits.

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

I. ORTHODONTIC SERVICES

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

VII. LIMITATIONS, EXCLUSIONS, EXCEPTIONS, REDUCTIONS

See Appendix 1 for limitations to covered procedures and exclusions to your plan Benefits.

A. GENERAL EXCLUSIONS

LIBERTY will not cover:

- Care You get from a PCD or specialist who is not contracted with LIBERTY, unless You have pre-approval from LIBERTY, or You need Emergency or Urgent Care outside the LIBERTY Service Area
- Care that is not Medically Necessary
- Exams that You need only to get work, go to school, play a sport, or get a license or professional certification
- Services that are ordered for You by a court, unless they are Medically Necessary and covered by LIBERTY
- The cost of copying Your dental records with your PCD or Specialist
- 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.

IMPORTANT: If You elect receive dental services that are not covered services under this plan, a PCD or Specialist may charge You the usual and customary rate for those services. Prior to completing any services that are not covered under this Plan, the PCD or Specialist should provide You with a treatment plan that includes the recommended service to be completed and the estimated cost of each service. If you would like more information about dental coverage options, call Member Services at (888) 844-3344 or speak with Your insurance broker. To fully understand Your coverage, carefully review this EOC.

B. MISSED APPOINTMENTS

LIBERTY strongly recommends that if You need to cancel or reschedule an appointment with Your PCD or Specialist that You notify the Dental Office as far in advance as possible but no later than 72 hours prior to your appointment. This will allow the PCD or Specialist to accommodate another person in need of attention. Dental offices 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 coverage may end if You no longer live or work in the service area or if LIBERTY no longer offers Your dental plan, or if Covered California finds You are no longer eligible for coverage.

2. Termination Due to Non-Payment of Premium

If premiums are not paid according to the agreement, termination will be effective on midnight of the last day of 30-day grace period, subject to compliance with notice requirements accepted by LIBERTY. Members are given a grace period of at least 30 consecutive days, beginning on the date specified in the Notice of Start of Grace Period.

Coverage shall continue uninterrupted under the Plan contract during the grace period. If premiums are not paid, coverage shall terminate after the completion of the grace period followed by a written notice of the cancellation to the subscriber. The written notice will state the reason for the cancellation and the time period when the cancellation became effective.

3. **Completion of Treatment In Progress After Termination**
   If You terminate from the Plan while the contract between You and LIBERTY is in effect, Your PCD or Specialist must complete any procedure in progress that was started before Your termination, abiding by the terms and conditions of the Plan.

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

4. **Termination Due to Fraud**
   If a member permits any other person to use their identification 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 dental office that would affect enrollment information, for use of the services or facilities of the plan or knowingly permits such fraud or deception by another, termination will be effective immediately upon notice from LIBERTY Dental Plan.

5. **Termination Due to Health Status**
   LIBERTY does not terminate based on any health status. If You believe that Your coverage has been terminated based on Your health status or requirements for health care services, You may request a review to be performed by the Director of the Department of Managed Health Care (DMHC). 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, LIBERTY will either request a hearing or reinstate the Member coverage. The reinstatement will be retroactive to time of cancellation or failure to renew.

   LIBERTY will be responsible for the expenses incurred by the Member for covered dental care services from the date of cancellation or non-renewal to and including the date of reinstatement. You can contact the DMHC at 1-888-466-2219 or on a TDD line at 1-877-688-9891 for the hearing and speech impaired. The DMHC's web site is www.dmhc.ca.gov.

B. EFFECTIVE DATE OF TERMINATION

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

C. DISENROLLMENT

You may disenroll at any time from LIBERTY, with at least a fourteen (14) calendar day advance notice, by contacting Covered California or LIBERTY by phone or in writing. Disenrollment is effective on the date specified or fourteen (14) days after termination is requested, if reasonable notice is not provided.

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 facts. This includes, but is not limited to, the intentional submission of incomplete or incorrect information on Your enrollment application that would have affected our decision to accept You as a covered Member.

You have the right to appeal any decision to rescind Your membership. Appeal procedures will be provided to You in the notice of rescission.

IX. RENEWAL AND REINSTATEMENT OF COVERAGE

Your coverage will be automatically renewed on the same terms and conditions unless Covered California notifies us that You are no longer eligible for coverage. LIBERTY will notify You in writing at least 30 calendar days before the end of Your coverage term describing any changes in the Premium, coverage or other terms or conditions of Your coverage.

X. YOUR RIGHT TO SUBMIT A GRIEVANCE REGARDING CANCELLATION, RESCISSION, OR NON-RENEWAL OF YOUR PLAN ENROLLEMENT

YOUR RIGHT TO SUBMIT A GRIEVANCE REGARDING CANCELLATION, RESCISSION, OR NONRENEWAL OF YOUR PLAN ENROLLMENT

If you believe your dental plan coverage has been, or will be, improperly cancelled, rescinded, or not renewed, you have the right to file a grievance with LIBERTY and/or the DMHC.

Option (1) - You may submit a grievance to LIBERTY

You may submit a grievance to LIBERTY by calling (888) 844-3344 or use TDD/TTY 800-735-2929, go online to www.libertydentalplan.com, fax your written grievance to 833-250-1814 or mail your written grievance to LIBERTY Dental Plan, Grievances and Appeals, P.O. Box 26610, Santa Ana, CA 92799-6110.

You may want to submit your grievance to LIBERTY first if you believe your cancellation, rescission or nonrenewal is the result of a mistake. Grievances should be submitted as soon as possible after you receive the Notice of Cancellation, Rescission, or Nonrenewal.

We will resolve your grievance or provide a pending status within three (3) calendar days of receipt. If you do not receive a response form LIBERTY three (3) calendar days, or if you are not satisfied in any way with the LIBERTY's response, you may submit a grievance to the DMHC as detailed under Option 2, below.

Option (2) - You may submit a grievance to the DMHC.

You may submit a grievance directly to the DMHC without first submitting it to LIBERTY or after you have received our decision on your grievance.

- You may submit a grievance to the DMHC online at: www.dmhc.ca.gov
- You may submit a grievance to the DMHC by mailing your written grievance to:

  HELP CENTER
  DEPARTMENT OF MANAGED HEALTH CARE
  980 NINTH STREET, SUITE 500
  SACRAMENTO, CALIFORNIA 95814-2725
- You may contact the DMHC for more information on filing at grievance at:

  PHONE: 1-888-466-2219
  TDD: 1-877-688-9891
  FAX: 1-916-255-5241

XI. GRIEVANCE AND APPEALS PROCEDURES

If You are dissatisfied with Your selected PCD, specialist, personnel, facilities, specialty referral, Pre-Authorization, claim, or the dental care You receive, You have the right to submit a grievance to LIBERTY. A Grievance is the same as a complaint. Grievance Forms may be requested from your dental office or by contacting LIBERTY's Member Services at (888) 844-3344. Grievance Forms are also available on our website, www.libertydentalplan.com. LIBERTY does not require a grievance form; we will investigate a grievance submitted in any format. You can submit your grievance to any of the following:

- In writing to: LIBERTY Dental Plan, P.O. Box 26110, Santa Ana, CA, 92799-6110
- By fax to: LIBERTY's Grievances and Appeals at (833)250-1814
- By telephone to: LIBERTY's Member Services Department at (888) 844-3344
- Online: LIBERTY's website by visiting www.libertydentalplan.com

You may use a "patient advocate" to help you file a Grievance. For Grievances involving minors, dependents or members with a disability who are incapacitated, the parent, guardian, conservator, relative or other designee with the authority to act on behalf of the member, may submit the grievance to LIBERTY or to the DMHC for urgent matters (see "Urgent Grievances and Appeals" below). LIBERTY will request written proof of active guardianship, when necessary.

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 PCD or Specialist 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'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 thirty (30) calendar days.

Grievances Exempt from Written Acknowledgement and Response: In some cases, LIBERTY's Member Services can help resolve Grievances received over the telephone within twenty-four (24) hours of receipt but no later than the close of the next business day. Grievances resolved by Member Services within the time frame mentioned above do not require a written acknowledgement or response. The following categories cannot be resolved by Member Services and must addressed through the standard Grievance process: coverage disputes, appeals, experimental or investigational treatment, unsanitary office conditions or procedures, potential discrimination, and quality of completed treatment.

Urgent Grievances and Appeals: You can request an urgent or expedited review of your Grievance or Appeal when you feel there could an imminent and serious threat to your health, including, but not limited to, severe pain, potential loss of life or major bodily function. A LIBERTY licensed dentist will review your request to determine if you meet the expedited review criteria. Upon review and determination that your case does quality for expedited review, LIBERTY will resolve your grievance or appeal within three (3) calendar days of receipt, or sooner, based on Your condition.

IMPORTANT: You are not required to wait for a determination from LIBERTY, before contacting the DMHC for urgent cases. You can contact the DMHC as noted below, at any time.

If you are not satisfied with the resolution provided by LIBERTY, you may contact the DMHC as noted below. You may also submit additional materials for additional consideration to LIBERTY's Grievances and Appeals Department, at the address listed below.

LIBERTY Dental Plan of California, Inc.
Grievances and Appeals
P.O. Box 26110
Santa Ana, CA 92799-6110

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 **(888-466-2219)** and a TDD line **(1-877-688-9891)** that You can utilize should you have a complaint against LIBERTY, or requests for review of cancellations, rescissions and non-renewals under California laws and related rules. Except in cases of emergency dental situations as described below, you must file your grievance with LIBERTY first; if you are not satisfied with the outcome of your grievance or you do not receive a written response within thirty (30) calendar days, you can contact the DMHC to file a complaint against LIBERTY. Please note: DMHC complaints can only be filed once you have exhausted your grievance rights with LIBERTY.

IMPORTANT: You may immediately file a complaint with the DMHC without having to file a grievance to LIBERTY first in the event of an emergency dental situation.

California Required Statement: The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If You have a grievance against your health plan, you should first telephone your health plan at **1-888-844-3344** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that remained unresolved for more than 30 days, you may call the DMHC 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 **(1-888-466-2219)** and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The Department's Internet web site **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

Your Right to File an Appeal:

Appeal Resolutions and Responses: An Appeal is a request by a member, a provider acting on behalf of a member, or other authorized individual to review an action by LIBERTY that delayed, modified, or denied services, in whole or in part. The written appeal responses for services denied based on medical necessity, not a covered benefit or another criteria, will include clear and easily understood language, the reason, criteria, and dental policies for the action along with the applicable provision and page numbers from your EOC.

If You are not satisfied with LIBERTY's determination, You have up to 180 calendar days from the date listed on the notice of determination to file an appeal. An appeal allows You to submit additional information that is relevant to Your claim and ask that LIBERTY review it.

You may include documents, records, or other written information with Your appeal. You may also request, free of charge, copies of all documents, records and other information from LIBERTY that are relevant to Your claim. LIBERTY will review the information that You submit and will reconsider Your claim. As part of Your appeal, You may request from LIBERTY the name of any medical expert or other individual that LIBERTY sought advice from while reconsidering Your claim.

You may send Your written grievance and/or appeal to:

LIBERTY Dental Plan of California, Inc.
Attn: Grievances and Appeals
Quality Management Department
P.O. Box 26110, Santa Ana, CA 92799-6110
Fax: 833-250-1814
Online: www.libertydentalplan.com

Or You may contact LIBERTY's Member Services Department by telephone at (877) 877-1893

If Your situation meets the definition of urgent under the law, LIBERTY's review of Your appeal will be conducted as expeditiously as possible. Generally, an urgent situation is one in which Your health may be in serious jeopardy or, in the opinion of Your physician, You may experience severe pain that cannot be adequately controlled while You wait for a decision on the external review of Your claim. If You believe Your situation is urgent, You may request an expedited external review by contacting LIBERTY's Member Services at (877) 877-1893.

You may submit Your grievance for arbitration, which will allow a neutral arbiter to review Your situation and determine whether LIBERTY is responsible for any further services or payments. You may contact LIBERTY's Member Services at (877) 877-1893 in order to initiate the arbitration process. You also have the right to bring a civil action under the Employee Retirement Income Security Act in response to an unsuccessful 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 equally shared by You and LIBERTY.

C. INDEPENDENT MEDICAL REVIEW (IMR)

Cases denied by LIBERTY, for covered services that are found not to be medically necessary, may be eligible for the DMHC Independent Medical Review (IMR) program. Members may request a form for the IMR of their case by contacting LIBERTY at 888-844-3344, going online to LIBERTY's website, www.libertydentalplan.com or writing to: LIBERTY Dental Plan, P.O. Box 26110, Santa Ana, CA, 92799-6110. You may also request the forms from the DMHC. The DMHC may be reached at 1-888-466-2219 or by visiting their website at: **www.dmhc.ca.gov.** IMR is only available for certain medical services. You can read more on the IMR process, under the **California Required Statement** listed on the previous page.

D. ARBITRATION

If You or one of Your eligible Dependents is not satisfied with the results of LIBERTY's grievance resolution process, and all the grievance 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 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 California laws and related codes.

XII. MISCELLANEOUS PROVISIONS

A. COORDINATION OF BENEFITS

As a LIBERTY Member, You will always receive Your 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 PULBIC POLICY COMMITTEE

LIBERTY's Public Policy Committee is a group of members, support staff and our Dental Director. The Public Policy Committee discusses ways LIBERTY can better serve our members and how to improve our policies and programs. Joining this group is voluntary and you will be financially compensated for attending. If you wish to participate in LIBERTY's Public Policy Committee, please contact our Quality Management Department at qm@libertydentalplan.com or call 888-844-3344.

D. NOTICE OF NON-DISCRIMINATION

Discrimination is against the law. LIBERTY follows all state and federal civil rights laws. LIBERTY does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identify or sexual orientation.

LIBERTY provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - ✓ Qualified sign language interpreters
  - ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:

✓ Qualified interpreters
✓ Information written in other languages

If you need these services, please contact us between 8 a.m. to 5 p.m. (PST) by calling (888) 844-3344. Or, if you cannot hear or speak well, please call (800) 735-2929.

HOW TO FILE A GRIEVANCE

If you believe that LIBERTY has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with LIBERTY's Civil Rights Coordinator. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Call LIBERTY's Civil Rights Coordinator, Monday through Friday, 8 a.m. to 5 p.m. (PST) by calling 888-704-9833. Or if you cannot hear or speak well, please call (800) 735-2929.
- In writing: Fill out a complaint form or write a letter and send it to:
  P.O. Box 26110
  Santa Ana, CA 92799
- In person: Visit your doctor's office or LIBERTY Dental Plan and say you want to file a grievance.
- Electronically: Visit LIBERTY Dental Plan website at https://www.libertydentalplan.com.

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- By phone: Call **916-440-7370**. If you cannot speak or hear well, please call **711 (Telecommunications Relay Service)**.
- In writing: Fill out a complaint form or send a letter to:

  Michele Villados
  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Complaint forms are available at http://www.dhcs.ca.gov/Pages/Language_Access.aspx.

- Electronically: Send an email to CivilRights@dhcs.ca.gov.

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.
- In writing: Fill out a complaint form or send a letter to:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

E. FILING CLAIMS

As stated throughout this document, You are not required to file claims directly with LIBERTY. Your general dental services are arranged with the participating PCD who submits claims or encounters on Your behalf. Services provided by a Specialist are reported to LIBERTY via the Specialist. If You receive services out-of-network due to an emergency after-hours or Out-of-Area situation, consult the section above for submitting Your expenses to LIBERTY to receive reimbursement (see Reimbursement for Emergency Dental Services section above).

F. ORGAN DONATION

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

G. LIBERTY DENTAL PLAN MEMBER SERVICES DEPARTMENT

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

H. MEMBER RIGHTS

As a Member, You have the right to:

- To be treated with respect, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information.
- To be provided with information about the plan and its services, including Covered Services.
- To be able to choose a PCD within LIBERTY's network.
- To participate in decision making regarding your own health care, including the right to refuse treatment.
- To voice grievances, either verbally or in writing, about the organization or the care received.
- To receive care coordination.
- To request an appeal of decisions to deny, defer or limit services or benefits.
- To receive oral interpretation services for their language.
- To formulate advance directives.
- To disenroll upon request.
- To access Minor Consent Services.
- To receive written member-informing materials in alternative formats (such as braille, large-size print and audio format) upon request and in a timely fashion appropriate for the format being requested and in accordance with California laws and related codes.

- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand;
- To have access to and receive a copy of your medical records, and request that they be amended or corrected, in accordance with Federal laws.

Freedom to exercise these rights without adversely affecting how you are treated by LIBERTY, your providers or the State.

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

I. MEMBER RESPONSIBILITIES

As a Member, You have the responsibility to:

- Pay the Premium for Your coverage on time;
- Identify yourself to your selected Dental Office as a LIBERTY Dental Plan Member;
- Treat the PCD, 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 PCD in following a prescribed course of treatment;
- Make Co-payments at the time of service;
- Notify your PCD of Your personal language needs;
- Notify LIBERTY Dental Plan of changes in family status
- Be aware of and follow the organization's guidelines in seeking dental care;
- Having treatment completed with your assigned PCD;
- Following all of the dental office's rules about care and conduct;
- Following the referral process for specialty care;
- Giving your PCD, to the best of your knowledge, correct information about your physical and dental health;
- Telling your PCD if you have any sudden changes to your physical and dental health;
- Telling your PCD or specialist that you understand the treatment plan and what is of you required of you;
- Staying with the treatment plan that you understood and agreed to with your PCD or specialist;
- Your own actions if you refuse treatment or do not follow your PCD's or specialist's treatment plan, instructions and advise; and
- Understanding your dental benefits, including what is and is not covered.

J. FISCAL SEPARATION OF DECISION MAKING

It is LIBERTY's policy that all clinical review decisions made by staff and or contractors are based solely on appropriateness of care and services and the existence of coverage. Services may only be denied for Dental Necessity by an appropriately licensed and qualified dentist working within LIBERTY's written clinical criteria guidelines and with due consideration of the individual member needs as well as the characteristics of the local delivery system. LIBERTY does not reward or incentivize reviewers for issuing denials for coverage or care, nor provide incentives that would encourage barriers to care/services or decisions that result in underutilization.

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

XII COMPLIANCE PLAN

A. COMPLIANCE PLAN OBJECTIVE:

LIBERTY is dedicated to ensuring that it complies with all applicable Federal and state laws, rules, regulations and procedures, including Health Insurance Marketplace requirements, in a timely and effective manner. All LIBERTY Board Members, officers, employees, contractors, providers and members are expected to meet these various legal requirements.
For these reasons, LIBERTY has developed and instituted a Corporate Compliance Plan. The Plan is designed to ensure LIBERTY Dental Plan fulfills all statutory and contractual obligations in a fair, accurate and consistent manner.

The compliance plan not only addresses health care fraud, waste and abuse, but the requirements and obligations set forth by the Centers for Medicare and Medicaid (CMS), employment, whistleblower and insurance laws.

A. Definitions

- **Fraud** – includes, but is not limited to, "knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit." Fraud also includes fraud or misrepresentation by a member with respect to coverage of individuals and fraud or deception in the use of the services or facilities of LIBERTY or knowingly permitting such fraud or deception by another.
- **Waste** – means the thoughtless or careless expenditure, consumption, mismanagement, use, or squandering of resources. Waste also includes incurring unnecessary costs because of inefficient or ineffective practices, systems, or controls. Waste does not normally lead to an allegation of "fraud", but it could.
- **Abuse** – means the excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive use so to abuse one's position or authority. "Abuse" does not necessarily lead to an allegation of "fraud", but it could.

B. POLICY:

It is the policy of LIBERTY to review and investigate all allegations of fraud, waste, and abuse, whether internal or external, to take corrective action for any supported allegation and to report confirmed misconduct to the appropriate parties both internal and external.

C. REPORTING POSSIBLE FRAUD

LIBERTY has established a specific fraud hotline number: (888) 704-9833. 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's Quality Management team for full investigation.

- LIBERTY's Corporate Compliance Hotline: (888) 704-9833
- LIBERTY's Compliance Unit email: compliance@libertydentalplan.com

- LIBERTY's Special Investigations Unit Hotline: (888) 704-9833
- LIBERTY's Special Investigations Unit email: SIU@libertydentalplan.com

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.

LIBERTY Dental Plan of California, Inc.

P.O. Box 26110

Santa Ana, CA 92799-6110

(888) 844-3344

Appendix 1:

SCHEDULE OF BENEFITS
COVERED SERVICES

LIBERTY Dental Plan Family Dental HMO
Individual Market Place

Individual Out of Pocket Maximum: $350 per 2021 Calendar Year (applies to Pediatric only)
Family Out of Pocket Maximum: $700 per 2021 Calendar Year (applies to Pediatric only)
Individual Deductible: None - Family Deductible: None
Waiting Period: None Annual Benefit Limit: None
Office Visit Copay: No Charge Actuarial Value: 84.8%

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

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

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

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

CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Diagnostic Services				
D0120	Periodic oral evaluation	no charge	no charge	1 (D0120) every 6 months per provider	1 (D0120) every 6 months per provider
D0140	Limited oral evaluation	no charge	no charge	1 (D0140) per patient per provider	1 (D0140) per patient per provider
D0145	Oral evaluation under age 3	no charge	not covered		
D0150	Comprehensive oral evaluation	no charge	no charge	1 (D0150) per patient per provider for initial evaluation	1 (D0150) per patient per provider for initial evaluation
D0160	Oral evaluation, problem focused	no charge	no charge	1 (D0160) per patient per provider	1 (D0160) per patient per provider
D0170	Re-evaluation, limited, problem focused	no charge	no charge	up to 6 of (D0170, D0171)in a 3 month period, no more than 12 in a 12 months	1 of (D0170, D0171) every 6 months
D0171	Re-evaluation, post operative office visit	no charge	no charge		
D0180	Comprehensive periodontal evaluation	no charge	no charge	only be billed as D0150	1 (D0180) every 6 months
D0190	Screening of a patient	not covered	no charge		
D0191	Assessment of a patient	not covered	no charge		
D0210	Intraoral, complete series of radiographic images	no charge	no charge	1 (D0210) every 36 months per provider	1 (D0210) every 36 months per provider
D0220	Intraoral, periapical, first radiographic image	no charge	no charge	20 of (D0220, D0230) PA's in a 12 month period by the same provider	20 of (D0220, D0230) PA's in a 12 month period by the same provider
D0230	Intraoral, periapical, each add 'l radiographic image	no charge	no charge		
D0240	Intraoral, occlusal radiographic image	no charge	no charge	2 (D0240) every 6 months per provider	2 (D0240) every 6 months per provider
D0250	Extra-oral 2D projection radiographic image, stationary radiation source	no charge	no charge	1 (D0250) per date of service	1 (D0250) every 6 months
D0251	Extra-oral posterior dental radiographic image	no charge	not covered	1 (D0251) per date of service	1 (D0251) every 6 months
D0270	Bitewing, single radiographic image	no charge	no charge	1 (D0270) per date of service	1 (D0270) per date of service
D0272	Bitewings, two radiographic images	no charge	no charge	1 (D0272) every 6 months per provider	1 of (D0272-D0277) every 6 months per provider
D0273	Bitewings, three radiographic images	no charge	no charge	downcode to D0270 and D0272	
D0274	Bitewings, four radiographic images	no charge	no charge	1 (D0274) every 6 months per provider, age 10 and over	
D0277	Vertical bitewings, 7 to 8 radiographic images	no charge	no charge	downcode to D0274	
D0310	Sialography	no charge	no charge		
D0320	TMJ arthrogram, including injection	no charge	no charge	3 (D0320) per date of service	3 (D0320) per date of service
D0322	Tomographic survey	no charge	no charge	2 (D0322) every 12 months per provider	2 (D0322) every 12 months per provider
D0330	Panoramic radiographic image	no charge	no charge	1 (D0330) every 36 months per provider	1 (D0330) every 36 months per provider
D0340	2D cephalometric radiographic image, measurement and analysis	no charge	no charge	2 (D0340) every 12 months per provider	2 (D0340) every 12 months per provider
D0350	2D oral/facial photographic image, intra-orally/extra-orally	no charge	no charge	4 (D0350) per date of service	4 (D0350) per date of service
D0351	3D photographic image	no charge	no charge		
D0419	Assessment of salivary flow by measurement	not covered	no charge	1 (D0419) every 12 months	1 (D0419) every 12 months
D0431	Adjunctive pre-diagnostic test	not covered	no charge		
D0460	Pulp vitality tests	no charge	no charge		
D0470	Diagnostic casts	no charge	no charge	1 (D0470) per provider, only a benefit with covered Orthodontic services, for permanent	1 (D0470) per provider
D0502	Other oral pathology procedures, by report	no charge	no charge		
D0601	Caries risk assessment and documentation, low risk	no charge	no charge		
D0602	Caries risk assessment and documentation, moderate risk	no charge	no charge		
D0603	Caries risk assessment and documentation, high risk	no charge	no charge		

LIBERTY Dental Plan Family Dental HMO
Individual Market Place

CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Diagnostic Services (continued)				
D0999	Unspecified diagnostic procedure, by report	no charge	no charge		
	Preventive Services				
D1110	Prophylaxis, adult	no charge	no charge	1 of (D1110, D1120, D4346) every 6 months	1 of (D1110, D4346, D4910) every 6 months
D1120	Prophylaxis, child	no charge	not covered		
D1206	Topical application of fluoride varnish	no charge	no charge	1 of (D1206, D1208) every 6 months	1 of (D1206, D1208) every 6 months
D1208	Topical application of fluoride, excluding varnish	no charge	no charge		
D1310	Nutritional counseling for control of dental disease	no charge	no charge		
D1320	Tobacco counseling, control/prevention oral disease	no charge	no charge		
D1330	Oral hygiene instruction	no charge	no charge		
D1351	Sealant, per tooth	no charge	not covered	1 of (D1351,D1352) every 36 months 1st, 2nd, 3rd molars	
D1352	Preventive resin restoration, permanent tooth	no charge	not covered		
D1353	Sealant repair, per tooth	no charge	not covered	1 (D1353) every 36 months 1st, 2nd, 3rd molars	
D1354	Interim caries arresting medicament application, per tooth	no charge	no charge	1 (D1354) per tooth every 6 months, subject to medical necessity review for the first treatment only	1 (D1354) per tooth every 6 months, subject to medical necessity review for the first treatment only
D1510	Space maintainer, fixed, unilateral, per quadrant	no charge	not covered	1 of (D1510, D1520) per quadrant per patient,	
D1516	Space maintainer, fixed, bilateral, maxillary	no charge	not covered	1 of (D1516, D1526) under age 18	
D1517	Space maintainer, fixed, bilateral, mandibular	no charge	not covered	1 of (D1517, D1527) under age 18	
D1520	Space maintainer, removable, unilateral, per quadrant	no charge	not covered	1 of (D1510, D1520) per quadrant per patient under age 18	
D1526	Space maintainer, removable, bilateral, maxillary	no charge	not covered	1 of (D1516, D1526) under age 18	
D1527	Space maintainer, removable, bilateral, mandibular	no charge	not covered	1 of (D1517, D1527) under age 18	
D1551	Re-cement or re-bond bilateral space maintainer, maxillary	no charge	not covered	1 of (D1551, D1552) per arch every 12 months under age 18	
D1552	Re-cement or re-bond bilateral space maintainer, mandibular	no charge	not covered		
D1553	Re-cement or re-bond unilateral space maintainer, per quadrant	no charge	not covered	1 (D1553) per quad every 12 months under age 18	
D1556	Removal of fixed unilateral space maintainer, per quadrant	no charge	not covered		
D1557	Removal of fixed bilateral space maintainer, maxillary	no charge	not covered		
D1558	Removal of fixed bilateral space maintainer, mandibular	no charge	not covered		
D1575	Distal shoe space maintainer, fixed, per quadrant	no charge	not covered		
	Restorative Services				
D2140	Amalgam, one surface, primary or permanent	$25	$25	primary teeth - 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 12 months permanent teeth - 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 36 months	1 of (D2140-D2335, D2391-D2394) every 36 months
D2150	Amalgam, two surfaces, primary or permanent	$30	$30		
D2160	Amalgam, three surfaces, primary or permanent	$40	$40		
D2161	Amalgam, four or more surfaces, primary or permanent	$45	$45		
D2330	Resin-based composite, one surface, anterior	$30	$30		
D2331	Resin-based composite, two surfaces, anterior	$45	$45		
D2332	Resin-based composite, three surfaces, anterior	$55	$55		
D2335	Resin-based composite, four or more surfaces, involving incisal angle	$60	$60		
D2390	Resin-based composite crown, anterior	$50	$50	primary teeth - 1 (D2390) per tooth every 12 months permanent teeth - 1 (D2390) per tooth every 36 months	1 (D2390) per tooth every 36 months
D2391	Resin-based composite, one surface, posterior	$30	$30	primary teeth - 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 12 months permanent teeth - 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 36 months	1 of (D2140-D2335, D2391-D2394) every 36 months
D2392	Resin-based composite, two surfaces, posterior	$40	$40		
D2393	Resin-based composite, three surfaces, posterior	$50	$50		
D2394	Resin-based composite, four or more surfaces, posterior	$70	$70		

LIBERTY Dental Plan Family Dental HMO
Individual Market Place

CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Restorative Services (continued)				
	***GUIDELINES for Single Crowns - Applies to Adult Dental Only** **The total maximum amount chargeable to the member for elective upgraded procedures** (explained below) is $250.00 per tooth. Providers are required to explain covered benefits as well as any elective differences in materials and fees prior to providing an elective upgraded procedure. **1. Brand name restorations:** (e.g. Sunrise, Captek, Vitadure-N, Hi-Ceram, Optec, HSP, In-Ceram, Empress, Cerec, AllCeram, Procera, Lava, etc.) may be considered elective upgraded procedures if their related CDT procedure codes are not listed as covered benefits. **2. Benefits for anterior and bicuspid teeth:** Resin, porcelain and any resin to base metal or porcelain to base metal crowns are covered benefits for anterior and bicuspid teeth. Adding a porcelain margin may be considered an elective upgraded procedure. **3. Benefits for molar teeth:** Cast base metal restorations are covered benefits for molar teeth. Resin-based composite and porcelain to metal crowns may be considered elective upgraded procedures. Adding a porcelain margin may be considered an elective upgraded procedure. **4. Base metal is the benefit:** If elected, a)noble, b)high noble metal, or c) titanium may be considered an elective upgraded procedure.				
D2542	Onlay, metallic, two surfaces	not covered	$185		1 of (D2542-D2794 D6205-D6794) per tooth every 5 year period
D2543	Onlay, metallic, three surfaces	not covered	$200		
D2544	Onlay, metallic, four or more surfaces	not covered	$215		
D2642	Onlay, porcelain/ceramic, two surfaces*	not covered	$250		
D2643	Onlay, porcelain/ceramic, three surfaces*	not covered	$275		
D2644	Onlay, porcelain/ceramic, four or more surfaces*	not covered	$300		
D2662	Onlay, resin-based composite, two surfaces	not covered	$160		
D2663	Onlay, resin-based composite, three surfaces	not covered	$180		
D2664	Onlay, resin-based composite, four or more surfaces	not covered	$200		
D2710	Crown, resin-based composite (indirect)	$140	$140	1 of (D2710-D2791, D6211-D6791) per tooth every 5 year period age 13 and over	
D2712	Crown, ¾ resin-based composite (indirect)	$190	$200		
D2720	Crown, resin with high noble metal*	not covered	$300		
D2721	Crown, resin with predominantly base metal*	$300	$300		
D2722	Crown, resin with noble metal*	not covered	$300		
D2740	Crown, porcelain/ceramic*	$300	$300		
D2750	Crown, porcelain fused to high noble metal*	not covered	$300		
D2751	Crown, porcelain fused to predominantly base metal*	$300	$300		
D2752	Crown, porcelain fused to noble metal*	not covered	$300		
D2753	Crown, porcelain fused to titanium and titanium alloys*	not covered	$300		
D2780	Crown, ¾ cast high noble metal*	not covered	$300		
D2781	Crown, ¾ cast predominantly base metal	$300	$300		
D2782	Crown, ¾ cast noble metal*	not covered	$300		
D2783	Crown, ¾ porcelain/ceramic substrate*	$310	$310		
D2790	Crown, full cast high noble metal*	not covered	$300		
D2791	Crown, full cast predominantly base metal	$300	$300		
D2792	Crown, full cast noble metal*	not covered	$300		
D2794	Crown, titanium and titanium alloys*	not covered	$300		
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	$25	$25	1 (D2910) per tooth every 12 months, per provider	
D2915	Re-cement or re-bond indirectly fabricated/prefabricated post & core	$25	$25		
D2920	Re-cement or re-bond crown	$25	$15	after 12 months of initial placement with same provider	
D2921	Reattachment of tooth fragment, incisal edge or cusp	$45	$45		
D2929	Prefabricated porcelain/ceramic crown, primary tooth	$95	not covered	1 of (D2929, D2930) per tooth every 12 months	
D2930	Prefabricated stainless steel crown, primary tooth	$65	not covered		
D2931	Prefabricated stainless steel crown, permanent tooth	$75	$75	1 (D2931) per tooth every 36 months	1 (D2931) per tooth every 36 months
D2932	Prefabricated resin crown	$75	not covered	primary - 1 of (D2932, D2933) per tooth every 12 months permanent - 1 of (D2932, D2933) per tooth every 36 months	
D2933	Prefabricated stainless steel crown with resin window	$80	not covered		
D2940	Protective restoration	$25	$20	1 (D2940) per tooth every 6 months, per provider	1 (D2940) per tooth every 6 months, per provider
D2941	Interim therapeutic restoration, primary dentition	$30	not covered		

LIBERTY Dental Plan Family Dental HMO
Individual Market Place

CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Restorative Services (continued)				
D2949	Restorative foundation for an indirect restoration	$45	not covered		
D2950	Core buildup, including any pins when required	$20	$20		
D2951	Pin retention, per tooth, in addition to restoration	$25	$20	1 (D2951) per tooth	
D2952	Post and core in addition to crown, indirectly fabricated	$100	$60	1 (D2952) per tooth	
D2953	Each additional indirectly fabricated post, same tooth	$30	$30		
D2954	Prefabricated post and core in addition to crown	$90	$60	1 (D2954) per tooth	
D2955	Post removal	$60	not covered		
D2957	Each additional prefabricated post, same tooth	$35	$35		
D2971	Additional procedure to construct new crown, existing partial denture frame	$35	not covered		
D2980	Crown repair necessitated by restorative material failure	$50	$50	after 12 months of initial crown placement with same provider	
D2999	Unspecified restorative procedure, by report	$40	$40		
	Endodontic Services				
D3110	Pulp cap, direct (excluding final restoration)	$20	$20		
D3120	Pulp cap, indirect (excluding final restoration)	$25	$25		
D3220	Therapeutic pulpotomy (excluding final restoration)	$40	$35	1 (D3220) per primary tooth	
D3221	Pulpal debridement, primary and permanent teeth	$40	$50	1 (D3221) per tooth	1 (D3221) per tooth
D3222	Partial pulpotomy, apexogenesis, permanent tooth, incomplete root	$60	not covered	1 (D3222) per tooth	
D3230	Pulpal therapy, anterior, primary tooth (excluding final restoration)	$55	not covered	1 of (D3230, D3240) per tooth	
D3240	Pulpal therapy, posterior, primary tooth (excluding finale restoration)	$55	not covered		
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$195	$200	1 of (D3310, D3320, D3330) per tooth	
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$235	$235		
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$300	$300		
D3331	Treatment of root canal obstruction; non-surgical access	$50	$50		
D3332	Incomplete endodontic therapy; inoperable, unrestorable, fractured tooth	not covered	$85		
D3333	Internal root repair of perforation defects	$80	$80		
D3346	Retreatment of previous root canal therapy, anterior	$240	$245	1 of (D3346-D3348) after 12 months of initial treatment	1 of (D3346-D3348) per tooth per lifetime
D3347	Retreatment of previous root canal therapy, premolar	$295	$295		
D3348	Retreatment of previous root canal therapy, molar	$365	$365		
D3351	Apexification/recalcification, initial visit	$85	$85	1 (D3351) per tooth	1 (D3351) per tooth
D3352	Apexification/recalcification, interim medication replacement	$45	$50	1 (D3352) per tooth	1 (D3352) per tooth
D3410	Apicoectomy, anterior	$240	$240		
D3421	Apicoectomy, premolar (first root)	$250	$250		
D3425	Apicoectomy, molar (first root)	$275	$275		
D3426	Apicoectomy, (each additional root)	$110	$110		
D3430	Retrograde filling, per root	$90	$90		
D3450	Root amputation, per root	not covered	$110		
D3501	Surgical exposure of root surface w/out apicoectomy or root resorption, anterior	$160	$160		
D3502	Surgical exposure of root surface w/out apicoectomy or root resorption, premolar	$160	$160		
D3503	Surgical exposure of root surface w/out apicoectomy or root resorption, molar	$160	$160		
D3910	Surgical procedure for isolation of tooth with rubber dam	$30	$50		
D3920	Hemisection, not including root canal therapy	not covered	$120		
D3950	Canal preparation and fitting of preformed dowel or post	not covered	$60		
D3999	Unspecified endodontic procedure, by report	$100	not covered		
	Periodontal Services				
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	$150	$150	1 of (D4210, D4211, D4260, D4261) per site/quad every 36 months, age 13 and over	1 of (D4210-D4275) per site quad every 36 months
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant	$50	$50		
D4240	Gingival flap procedure, four or more teeth per quadrant	not covered	$135		
D4241	Gingival flap procedure, one to three teeth per quadrant	not covered	$70		
D4249	Clinical crown lengthening, hard tissue	$165	$200		
D4260	Osseous surgery, four or more teeth per quadrant	$265	$265	1 of (D4210, D4211, D4260, D4261) per site/quad every 36 months, age 13 and over	
D4261	Osseous surgery, one to three teeth per quadrant	$140	$140		

LIBERTY Dental Plan Family Dental HMO
Individual Market Place

CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Periodontal Services (continued)				
D4263	Bone replacement graft, retained natural tooth, first site, quadrant	not covered	$105		1 of (D4210-D4275) per site quad every 36 months
D4264	Bone replacement graft, retained natural tooth, each additional site	not covered	$75		
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$80	not covered		
D4266	Guided tissue regeneration, resorbable barrier, per site	not covered	$145		
D4267	Guided tissue regeneration, non-resorbable barrier, per site	not covered	$175		
D4270	Pedicle soft tissue graft procedure	not covered	$155		
D4273	Autogenous connective tissue graft procedure, first tooth	not covered	$220		
D4275	Non-autogenous connective tissue graft, first tooth	not covered	$190		
GUIDELINE: No more than two (2) quadrants of periodontal scaling and root planing per appointment/ per day are allowable.					
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	$55	$55	1 of (D4341, D4342) per site quad, every 24 months, age 13 and over	1 of (D4341, D4342) per site quad, every 24 months
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	$30	$25		
D4346	Scaling in presence of moderate or severe inflammation, full mouth after evaluation	$40	$40	1 of (D1110, D1120, D4346) every 6 months	1 of (D1110, D4346, D4910) every 6 months
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis, subsequent visit	$40	$40		1 every 24 months
D4381	Localized delivery of antimicrobial agent/per tooth	$10	$10		
D4910	Periodontal maintenance	$30	$30	1 (D4910) every 3 months	1 of (D1110, D4346, D4910) every 6 months
D4920	Unscheduled dressing change (other than treating dentist or staff)	$15	not covered	1 (D4920) per patient per provider, age 13 and over	
D4999	Unspecified periodontal procedure, by report	$350	$350		
	Removable Prosthodontic Services				
D5110	Complete denture, maxillary	$300	$400	1 of (D5110-D5120, D5211-D5214, D5863-D5866) per arch every 5 year period. A benefit once in a five year period from a previous complete, immediate or overdenture - complete denture.	1 of (D5110-D5214, D5225-D5226, D5282, D5283) per arch every 5 year period.
D5120	Complete denture, mandibular	$300	$400		
D5130	Immediate denture, maxillary	$300	$400	1 (D5130) per patient. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.	
D5140	Immediate denture, mandibular	$300	$400	1 (D5140) per patient. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.	
D5211	Maxillary partial denture, resin base	$300	$325	1 of (D5110-D5120, D5211-D5214, D5863-D5866) per arch every 5 year period. A benefit once in a five year period from a previous complete, immediate or overdenture - complete denture.	
D5212	Mandibular partial denture, resin base	$300	$325		
D5213	Maxillary partial denture, cast metal, resin base	$335	$375		
D5214	Mandibular partial denture, cast metal, resin base	$335	$375		
D5221	Immediate maxillary partial denture, resin base	$275	$300	1 of (D5221-D5224) per arch per patient. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.	
D5222	Immediate mandibular partial denture, resin base	$275	$300		
D5223	Immediate maxillary partial denture, cast metal framework, resin denture base	$330	$375		
D5224	Immediate mandibular partial denture, cast metal framework, resin denture base	$330	$375		
D5225	Maxillary partial denture, flexible base	not covered	$375		
D5226	Mandibular partial denture, flexible base	not covered	$375		
D5282	Removable unilateral partial denture, one piece cast metal, maxillary	not covered	$250		
D5283	Removable unilateral partial denture, one piece cast metal, mandibular	not covered	$250		
D5284	Removable unilateral partial denture, one piece flexible base, per quadrant	not covered	$250		1 of (D5284, D5286) per arch every 5 year period
D5286	Removable unilateral partial denture, one piece resin, per quadrant	not covered	$250		
D5410	Adjust complete denture, maxillary	$20	$20	2 of (D5410-D5422) per arch every 12 months, 1 per arch per date of service per provider	2 of (D5410-D5422) per arch every 12 months, 1 per arch per date of service per provider
D5411	Adjust complete denture, mandibular	$20	$20		
D5421	Adjust partial denture, maxillary	$20	$20		
D5422	Adjust partial denture, mandibular	$20	$20		

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CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Removable Prosthodontic Services (continued)				
D5511	Repair broken complete denture base, mandibular	$40	$30	1 (D5511) per date of service per provider, 2 every 12 months per provider	1 (D5511) per date of service per provider, 2 every 12 months per provider
D5512	Repair broken complete denture base, maxillary	$40	$30	1 (D5512) per date of service per provider, 2 every 12 months per provider	1 (D5512) per date of service per provider, 2 every 12 months per provider
D5520	Replace missing or broken teeth, complete denture	$40	$30	up to 4 (D5520) per arch per date of service per provider, 2 per arch every 12 months per provider	up to 4 (D5520) per arch per date of service per provider, 2 per arch every 12 months per provider
D5611	Repair resin partial denture base, mandibular	$40	$30	1 (D5611) per date of service per provider, 2 every 12 months per provider	1 (D5611) per date of service per provider, 2 every 12 months per provider
D5612	Repair resin partial denture base, maxillary	$40	$30	1 (D5612) per date of service per provider, 2 every 12 months per provider	1 (D5612) per date of service per provider, 2 every 12 months per provider
D5621	Repair cast partial framework, mandibular	$40	$35	1 (D5621) per date of service per provider, 2 every 12 months per provider	1 (D5621) per date of service per provider, 2 every 12 months per provider
D5622	Repair cast partial framework, maxillary	$40	$35	1 (D5622) per date of service per provider, 2 every 12 months per provider	1 (D5622) per date of service per provider, 2 every 12 months per provider
D5630	Repair or replace broken retentive clasping materials, per tooth	$50	$30	3 (D5630) per arch per date of service per provider, 2 per arch every 12 months per provider	3 (D5630) per arch per date of service per provider, 2 per arch every 12 months per provider
D5640	Replace broken teeth, per tooth	$35	$30	4 (D5640) per arch per date of service per provider, 2 per arch every 12 months per provider	4 (D5640) per arch per date of service per provider, 2 per arch every 12 months per provider
D5650	Add tooth to existing partial denture	$35	$35	3 (D5650) per arch per provider per date of service, 1 per tooth	3 (D5650) per arch per provider per date of service, 1 per tooth
D5660	Add clasp to existing partial denture, per tooth	$60	$45	3 (D5660) per date of service per provider, 2 per arch every 12 months per provider	3 (D5660) per date of service per provider, 2 per arch every 12 months per provider
D5670	Replace all teeth & acrylic on cast metal frame, maxillary	not covered	$195		1 (D5670) every 36 months
D5671	Replace all teeth & acrylic on cast metal frame, mandibular	not covered	$195		1 (D5671) every 36 months
D5710	Rebase complete maxillary denture	not covered	$155		1 of (D5710, D5720) every 12 months
D5711	Rebase complete mandibular denture	not covered	$155		1 of (D5711, D5721) every 12 months
D5720	Rebase maxillary partial denture	not covered	$150		1 of (D5710, D5720) every 12 months
D5721	Rebase mandibular partial denture	not covered	$150		1 of (D5711, D5721) every 12 months
D5730	Reline complete maxillary denture, direct	$60	$80	1 of (D5730-D5761) every 12 months. Covered 6 months after initial placement of appliance if extractions were required, 12 months after initial placement of appliance if extractions were not required.	1 of (D5730-D5761) every 12 months. Covered 6 months after initial placement of appliance if extractions were required, 12 months after initial placement of appliance if extractions were not required.
D5731	Reline complete mandibular denture, direct	$60	$80		
D5740	Reline maxillary partial denture, direct	$60	$75		
D5741	Reline mandibular partial denture, direct	$60	$75		
D5750	Reline complete maxillary denture, indirect	$90	$120		
D5751	Reline complete mandibular denture, indirect	$90	$120		
D5760	Reline maxillary partial denture, indirect	$80	$110		
D5761	Reline mandibular partial denture, indirect	$80	$110		
D5850	Tissue conditioning, maxillary	$30	$35	2 (D5850) every 36 months	1 (D5850) every 36 months
D5851	Tissue conditioning, mandibular	$30	$35	2 (D5851) every 36 months	1 (D5851) every 36 months
D5862	Precision attachment, by report	$90	not covered		
D5863	Overdenture, complete, maxillary	$300	not covered	1 of (D5110-D5120, D5211-D5214, D5863-D5866) per arch every 5 year period. A benefit once in a five year period from a previous complete, immediate or overdenture - complete denture.	
D5864	Overdenture, partial, maxillary	$300	not covered		
D5865	Overdenture, complete, mandibular	$300	not covered		
D5866	Overdenture, partial, mandibular	$300	not covered		
D5876	Add metal substructure to acrylic full denture (per arch)	not covered	$30		
D5899	Unspecified removable prosthodontic procedure, by report	$350	$400		
	Maxillofacial Prosthetic Services				
D5911	Facial moulage (sectional)	$285	not covered		
D5912	Facial moulage (complete)	$350	not covered		
D5913	Nasal prosthesis	$350	not covered		
D5914	Auricular prosthesis	$350	not covered		
D5915	Orbital prosthesis	$350	not covered		

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CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Maxillofacial Prosthetic Services (continued)				
D5916	Ocular prosthesis	$350	not covered		
D5919	Facial prosthesis	$350	not covered		
D5922	Nasal septal prosthesis	$350	not covered		
D5923	Ocular prosthesis, interim	$350	not covered		
D5924	Cranial prosthesis	$350	not covered		
D5925	Facial augmentation implant prosthesis	$200	not covered		
D5926	Nasal prosthesis, replacement	$200	not covered		
D5927	Auricular prosthesis, replacement	$200	not covered		
D5928	Orbital prosthesis, replacement	$200	not covered		
D5929	Facial prosthesis, replacement	$200	not covered		
D5931	Obturator prosthesis, surgical	$350	not covered		
D5932	Obturator prosthesis, definitive	$350	not covered		
D5933	Obturator prosthesis, modification	$150	not covered	2 (D5933) every 12 months	
D5934	Mandibular resection prosthesis with guide flange	$350	not covered		
D5935	Mandibular resection prosthesis without guide flange	$350	not covered		
D5936	Obturator prosthesis, interim	$350	not covered		
D5937	Trismus appliance (not for TMD treatment)	$85	not covered		
D5951	Feeding aid	$135	not covered	under age 18	
D5952	Speech aid prosthesis, pediatric	$350	not covered	under age 18	
D5953	Speech aid prosthesis, adult	$350	not covered	age 18 and over	
D5954	Palatal augmentation prosthesis	$135	not covered		
D5955	Palatal lift prosthesis, definitive	$350	not covered		
D5958	Palatal lift prosthesis, interim	$350	not covered		
D5959	Palatal lift prosthesis, modification	$145	not covered	2 (D5959) every 12 months	
D5960	Speech aid prosthesis, modification	$145	not covered	2 (D5960) every 12 months	
D5982	Surgical stent	$70	not covered		
D5983	Radiation carrier	$55	not covered		
D5984	Radiation shield	$85	not covered		
D5985	Radiation cone locator	$135	not covered		
D5986	Fluoride gel carrier	$35	not covered		
D5987	Commissure splint	$85	not covered		
D5988	Surgical splint	$95	not covered		
D5991	Vesiculobullous disease medicament carrier	$70	not covered		
D5999	Unspecified maxillofacial prosthesis, by report	$350	not covered		
	Implant Services				
D6010	Surgical placement of implant body, endosteal	$350	not covered	Only a Plan Benefit when exceptional medical conditions are met	
D6011	Surgical access to an implant body (second stage implant surgery)	$350	not covered		
D6013	Surgical placement of mini implant	$350	not covered		
D6040	Surgical placement: eposteal implant	$350	not covered		
D6050	Surgical placement: transosteal implant	$350	not covered		
D6052	Semi-precision attachment abutment	$350	not covered		
D6055	Connecting bar, implant supported or abutment supported	$350	not covered		
D6056	Prefabricated abutment, includes modification and placement	$135	not covered		
D6057	Custom fabricated abutment, includes placement	$180	not covered		
D6058	Abutment supported porcelain/ceramic crown	$320	not covered		
D6059	Abutment supported porcelain fused to high noble crown	$315	not covered		
D6060	Abutment supported porcelain fused to base metal crown	$295	not covered		
D6061	Abutment supported porcelain fused to noble metal crown	$300	not covered		
D6062	Abutment supported cast metal crown, high noble	$315	not covered		
D6063	Abutment supported cast metal crown, base metal	$300	not covered		
D6064	Abutment supported cast metal crown, noble metal	$315	not covered		

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CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Implant Services (continued)				
D6065	Implant supported porcelain/ceramic crown	$340	not covered		
D6066	Implant supported crown, porcelain fused to high noble alloys	$335	not covered		
D6067	Implant supported crown, high noble alloys	$340	not covered		
D6068	Abutment supported retainer, porcelain/ceramic FPD	$320	not covered		
D6069	Abutment supported retainer, metal FPD, high noble	$315	not covered		
D6070	Abutment supported retainer, porcelain fused to metal FPD, base metal	$290	not covered		
D6071	Abutment supported retainer, porcelain fused to metal FPD, noble	$300	not covered		
D6072	Abutment supported retainer, cast metal FPD, high noble	$315	not covered		
D6073	Abutment supported retainer, cast metal FPD, base metal	$290	not covered		
D6074	Abutment supported retainer, cast metal FPD, noble	$320	not covered		
D6075	Implant supported retainer for ceramic FPD	$335	not covered		
D6076	Implant supported retainer for FPD, porcelain fused to high noble alloys	$330	not covered		
D6077	Implant supported retainer for metal FPD, high noble alloys	$350	not covered		
D6080	Implant maintenance procedures, prosthesis removed/reinserted, including cleansing	$30	not covered		
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant	$30	not covered		
D6082	Implant supported crown, porcelain fused to predominantly base alloys	$335	not covered		
D6083	Implant supported crown, porcelain fused to noble alloys	$335	not covered		
D6084	Implant supported crown, porcelain fused to titanium and titanium alloys	$335	not covered		
D6085	Provisional implant crown	$300	not covered		
D6086	Implant supported crown, predominantly base alloys	$340	not covered		
D6087	Implant supported crown, noble alloys	$340	not covered		
D6088	Implant supported crown, titanium and titanium alloys	$340	not covered		
D6090	Repair implant supported prosthesis, by report	$65	not covered		
D6091	Replacement of replaceable part of semi-precision, precision attachment, implant/abutment supported prosthesis, per attachment	$40	not covered	Only a Plan Benefit when exceptional medical conditions are met	
D6092	Re-cement or re-bond implant/abutment supported crown	$25	not covered		
D6093	Re-cement or re-bond implant/abutment supported FPD	$35	not covered		
D6094	Abutment supported crown, titanium, and titanium alloys	$295	not covered		
D6095	Repair implant abutment, by report	$65	not covered		
D6096	Remove broken implant retaining screw	$60	not covered		
D6097	Abutment supported crown, porcelain fused to titanium and titanium alloys	$315	not covered		
D6098	Implant supported retainer, porcelain fused to predominantly base alloys	$330	not covered		
D6099	Implant supported retainer for FPD, porcelain fused to noble alloys	$330	not covered		
D6100	Implant removal, by report	$110	not covered		
D6110	Implant/abutment supported removable denture, maxillary	$350	not covered		
D6111	Implant/abutment supported removable denture, mandibular	$350	not covered		
D6112	Implant/abutment supported removable denture, partial, maxillary	$350	not covered		
D6113	Implant/abutment supported removable denture, partial, mandibular	$350	not covered		
D6114	Implant/abutment supported fixed denture, maxillary	$350	not covered		
D6115	Implant/abutment supported fixed denture, mandibular	$350	not covered		
D6116	Implant/abutment supported fixed denture for partial, maxillary	$350	not covered		
D6117	Implant/abutment supported fixed denture for partial, mandibular	$350	not covered		
D6120	Implant supported retainer, porcelain fused to titanium and titanium alloys	$330	not covered		
D6121	Implant supported retainer for metal FPD, predominantly base alloys	$350	not covered		
D6122	Implant supported retainer for metal FPD, noble alloys	$350	not covered		
D6123	Implant supported retainer for metal FPD, titanium and titanium alloys	$350	not covered		
D6190	Radiographic/surgical implant index, by report	$75	not covered		
D6194	Abutment supported retainer crown for FPD titanium, titanium and titanium alloys	$265	not covered		
D6195	Abutment supported retainer, porcelain fused to titanium and titanium alloys	$315	not covered		
D6199	Unspecified implant procedure, by report	$350	not covered		

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CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Fixed Prosthodontic Services				
***GUIDELINES for Pontics, Onlays, Crowns: Applies to Adult Dental Only** **The total maximum amount chargeable to the member for elective upgraded procedures** (explained below) is $250.00 per tooth. Providers are required to explain covered benefits as well as any elective differences in materials and fees prior to providing an elective upgraded procedure. **1. Brand name restorations:** (e.g. Sunrise, Captek, Vitadure-N, Hi-Ceram, Optec, HSP, In-Ceram, Empress, Cerec, AllCeram, Procera, Lava, etc.) may be considered elective upgraded procedures if their related CDT procedure codes are not listed as covered benefits. **2. Benefits for anterior and bicuspid teeth:** Resin, porcelain and any resin to base metal or porcelain to base metal crowns are covered benefits for anterior and bicuspid teeth. Adding a porcelain margin may be considered an elective upgraded procedure. **3. Benefits for molar teeth:** Cast base metal restorations are covered benefits for molar teeth. Resin-based composite and porcelain to metal crowns may be considered elective upgraded procedures. Adding a porcelain margin may be considered an elective upgraded procedure. **4. Base metal is the benefit:** If elected, a)noble, b)high noble metal, or c) titanium may be considered an elective upgraded procedure.				
D6205	Pontic, indirect resin based composite*	not covered	$165		
D6210	Pontic, cast high noble metal*	not covered	$300		
D6211	Pontic, cast predominantly base metal	$300	$300	1 of (D2710-D2791, D6211-D6791) per tooth every 5 year period age 13 and over	
D6212	Pontic, cast noble metal*	not covered	$300		
D6214	Pontic, titanium, and titanium alloys*	not covered	$300		
D6240	Pontic, porcelain fused to high noble metal*	not covered	$300		
D6241	Pontic, porcelain fused to predominantly base metal*	$300	$300		
D6242	Pontic, porcelain fused to noble metal*	not covered	$300		
D6243	Pontic, porcelain fused to titanium and titanium alloys*	not covered	$300		
D6245	Pontic, porcelain/ceramic*	$300	$300		
D6250	Pontic, resin with high noble metal*	not covered	$300		
D6251	Pontic, resin with predominantly base metal*	$300	$300		
D6252	Pontic, resin with noble metal*	not covered	$300		
D6545	Retainer, cast metal for resin bonded fixed prosthesis	not covered	$130		
D6548	Retainer, porcelain/ceramic, resin bonded fixed prosthesis*	not covered	$145		
D6549	Resin retainer, for resin bonded fixed prosthesis	not covered	$130		
D6608	Retainer onlay, porcelain/ceramic, two surfaces*	not covered	$200		
D6609	Retainer onlay, porcelain/ceramic, three or more surfaces*	not covered	$200		
D6610	Retainer onlay, cast high noble metal, two surfaces*	not covered	$200		
D6611	Retainer onlay, cast high noble metal, three or more surfaces*	not covered	$200		
D6612	Retainer onlay, cast base metal, two surfaces	not covered	$200		
D6613	Retainer onlay, cast base metal, three or more surfaces	not covered	$200		
D6614	Retainer onlay, cast noble metal, two surfaces*	not covered	$200		
D6615	Retainer onlay, cast noble metal three or more surfaces*	not covered	$200		
D6634	Retainer onlay, titanium*	not covered	$200		
D6710	Retainer crown, indirect resin based composite	not covered	$200		
D6720	Retainer crown, resin with high noble metal*	not covered	$300		
D6721	Retainer crown, resin with predominantly base metal	$300	$300	1 of (D2710-D2791, D6211-D6791) per tooth every 5 year period age 13 and over	
D6722	Retainer crown, resin with noble metal*	not covered	$300		
D6740	Retainer crown, porcelain/ceramic*	$300	$300		
D6751	Retainer crown, porcelain fused to predominantly base metal*	$300	$300		
D6752	Retainer crown, porcelain fused to noble metal*	not covered	$300		
D6753	Retainer crown, porcelain fused to titanium and titanium alloys*	not covered	$300		
D6781	Retainer crown, ¾ cast predominantly base metal	$300	$300		
D6782	Retainer crown, ¾ cast noble metal*	not covered	$300		
D6783	Retainer crown, ¾ porcelain/ceramic*	$300	$300		
D6784	Retainer crown ¾, titanium and titanium alloys*	$300	$300		
D6791	Retainer crown, full cast predominantly base metal	$300	$300		
D6794	Retainer crown, titanium and titanium alloys*	not covered	$300		
D6930	Re-cement or re-bond fixed partial denture	$40	$40		
D6980	Fixed partial denture repair, restorative material failure	$95	$95		

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CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Fixed Prosthodontic Services (continued)				
D6999	Unspecified fixed prosthodontic procedure, by report	$350	$400		
	Oral & Maxillofacial Services				
GUIDELINE: The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists					
D7111	Extraction, coronal remnants, primary tooth	$40	$40		
D7140	Extraction, erupted tooth or exposed root	$65	$65		
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth	$120	$115		
D7220	Removal of impacted tooth, soft tissue	$95	$85		
D7230	Removal of impacted tooth, partially bony	$145	$145		
D7240	Removal of impacted tooth, completely bony	$160	$160		
D7241	Removal impacted tooth, complete bony, complication	$175	$175		
D7250	Removal of residual tooth roots (cutting procedure)	$80	$75		
D7260	Oroantral fistula closure	$280	$280		
D7261	Primary closure of a sinus perforation	$285	$285		
D7270	Tooth reimplantation and/or stabilization, accident	$185	$185	1 (D7270) per arch	
D7280	Exposure of an unerupted tooth	$220	$220		
D7283	Placement, device to facilitate eruption, impaction	$85	$85		
D7285	Incisional biopsy of oral tissue, hard (bone, tooth)	$180	$180	1 (D7285) per arch per date of service	1 (D7285) per arch per date of service
D7286	Incisional biopsy of oral tissue, soft	$110	$110	up to 3 (D7286) per date of service	
D7287	Exfoliative cytological sample collection	not covered	$35		
D7288	Brush biopsy, transepithelial sample collection	not covered	$35		
D7290	Surgical repositioning of teeth	$185	not covered	1 (D7290) per arch, for active orthodontic treatment only	
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$80	not covered	1 (D7291) per arch, for active orthodontic treatment only	
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	$85	$85		
D7311	Alveoloplasty with extractions, one to three teeth per quadrant	$50	$50		
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant	$120	$120		
D7321	Alveoloplasty, w/o extractions, one to three teeth per quadrant	$65	$65		
D7340	Vestibuloplasty, ridge extension (2nd epithelialization)	$350	$350	1 (D7340) per arch every 5 year period	1 (D7340) per arch every 5 year period
D7350	Vestibuloplasty, ridge extension	$350	$350	1 (D7350) per arch	1 (D7350) per arch
D7410	Excision of benign lesion, up to 1.25 cm	$75	not covered		
D7411	Excision of benign lesion, greater than 1.25 cm	$115	not covered		
D7412	Excision of benign lesion, complicated	$175	not covered		
D7413	Excision of malignant lesion, up to 1.25 cm	$95	not covered		
D7414	Excision of malignant lesion, greater than 1.25 cm	$120	not covered		
D7415	Excision of malignant lesion, complicated	$255	not covered		
D7440	Excision of malignant tumor, up to 1.25 cm	$105	not covered		
D7441	Excision of malignant tumor, greater than 1.25 cm	$185	not covered		
D7450	Removal, benign odontogenic cyst/tumor, up to 1.25 cm	$180	$180		
D7451	Removal, benign odontogenic cyst/tumor, greater than 1.25 cm	$330	$330		
D7460	Removal, benign nonodontogenic cyst/tumor, up to 1.25 cm	$155	$180		
D7461	Removal, benign nonodontogenic cyst/tumor, greater than 1.25 cm	$250	$250		
D7465	Destruction of lesion(s) by physical or chemical method, by report	$40	not covered		
D7471	Removal of lateral exostosis, maxilla or mandible	$140	$140	1 (D7471) per quadrant	
D7472	Removal of torus palatinus	$145	$140	1 (D7472) per lifetime	
D7473	Removal of torus mandibularis	$140	$140	1 (D7473) per quadrant	
D7485	Reduction of osseous tuberosity	$105	$105	1 (D7485) per quadrant	
D7490	Radical resection of maxilla or mandible	$350	not covered		
D7510	Incision & drainage of abscess, intraoral soft tissue	$70	$55	1 (D7510) per quadrant, same date of service	
D7511	Incision & drainage of abscess, intraoral soft tissue, complicated	$70	$69	1 (D7511) per quadrant, same date of service	

LIBERTY Dental Plan Family Dental HMO
Individual Market Place

CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Oral & Maxillofacial Services (continued)				
D7520	Incision & drainage of abscess, extraoral soft tissue	$70	$70		
D7521	Incision & drainage of abscess, extraoral soft tissue, complicated	$80	$80		
D7530	Remove foreign body, mucosa, skin, tissue	$45	$45	1 (D7530) per date of service	1 (D7530) per date of service
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$75	not covered	1 (D7540) per date of service	
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$125	$125	1 (D7550) per quadrant per date of service	
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235	$235		
D7610	Maxilla, open reduction (teeth immobilized, if present)	$140	not covered		
D7620	Maxilla, closed reduction (teeth immobilized, if present)	$250	not covered		
D7630	Mandible, open reduction (teeth immobilized, if present)	$350	not covered		
D7640	Mandible, closed reduction (teeth immobilized, if present)	$350	not covered		
D7650	Malar and/or zygomatic arch, open reduction	$350	not covered		
D7660	Malar and/or zygomatic arch, closed reduction	$350	not covered		
D7670	Alveolus, closed reduction, may include stabilization of teeth	$170	not covered		
D7671	Alveolus, open reduction, may include stabilization of teeth	$230	not covered		
D7680	Facial bones, complicated reduction with fixation, multiple surgical approaches	$350	not covered		
D7710	Maxilla, open reduction	$110	not covered		
D7720	Maxilla, closed reduction	$180	not covered		
D7730	Mandible, open reduction	$350	not covered		
D7740	Mandible, closed reduction	$290	not covered		
D7750	Malar and/or zygomatic arch, open reduction	$220	not covered		
D7760	Malar and/or zygomatic arch, closed reduction	$350	not covered		
D7770	Alveolus, open reduction stabilization of teeth	$135	not covered		
D7771	Alveolus, closed reduction stabilization of teeth	$160	not covered		
D7780	Facial bones, complicated reduction with fixation and multiple approaches	$350	not covered		
D7810	Open reduction of dislocation	$350	not covered		
D7820	Closed reduction of dislocation	$80	not covered		
D7830	Manipulation under anesthesia	$85	not covered		
D7840	Condylectomy	$350	not covered		
D7850	Surgical discectomy, with/without implant	$350	not covered		
D7852	Disc repair	$350	not covered		
D7854	Synovectomy	$350	not covered		
D7856	Myotomy	$350	not covered		
D7858	Joint reconstruction	$350	not covered		
D7860	Arthrotomy	$350	not covered		
D7865	Arthroplasty	$350	not covered		
D7870	Arthrocentesis	$90	not covered		
D7871	Non-arthroscopic lysis and lavage	$150	not covered		
D7872	Arthroscopy, diagnosis, with or without biopsy	$350	not covered		
D7873	Arthroscopy: lavage and lysis of adhesions	$350	not covered		
D7874	Arthroscopy: disc repositioning and stabilization	$350	not covered		
D7875	Arthroscopy: synovectomy	$350	not covered		
D7876	Arthroscopy: discectomy	$350	not covered		
D7877	Arthroscopy: debridement	$350	not covered		
D7880	Occlusal orthotic device, by report	$120	not covered		
D7881	Occlusal orthotic device adjustment	$30	not covered		
D7899	Unspecified TMD therapy, by report	$350	not covered		
D7910	Suture of recent small wounds up to 5 cm	$35	not covered		
D7911	Complicated suture, up to 5 cm	$55	not covered		

LIBERTY Dental Plan Family Dental HMO
Individual Market Place

CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Oral & Maxillofacial Services (continued)				
D7912	Complicated suture, greater than 5 cm	$130	not covered		
D7920	Skin graft (identify defect covered, location and type of graft)	$120	not covered		
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot, stabilization, per site	$80	$80		1 (D7922) per tooth in a lifetime
D7940	Osteoplasty, for orthognathic deformities	$160	not covered		
D7941	Osteotomy, mandibular rami	$350	not covered		
D7943	Osteotomy, mandibular rami with bone graft; includes obtaining the graft	$350	not covered		
D7944	Osteotomy, segmented or subapical	$275	not covered		
D7945	Osteotomy, body of mandible	$350	not covered		
D7946	LeFort I (maxilla, total)	$350	not covered		
D7947	LeFort I (maxilla, segmented)	$350	not covered		
D7948	LeFort II or LeFort III, without bone graft	$350	not covered		
D7949	LeFort II or LeFort III, with bone graft	$350	not covered		
D7950	Osseous, osteoperiosteal, cartilage graft, mandible or maxilla, by report	$190	not covered		
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$290	not covered		
D7952	Sinus augmentation via a vertical approach	$175	not covered		
D7955	Repair of maxillofacial soft and/or hard tissue defect	$200	not covered		
D7961	Buccal/labial frenectomy (frenulectomy)	$120	$120	1 (D7961) per arch per date of service	
D7962	Lingual frenectomy (frenulectomy)	$120	$120	1 (D7962) per arch per date of service	
D7963	Frenuloplasty	$120	$120	1 (D7963) per arch per date of service	
D7970	Excision of hyperplastic tissue, per arch	$175	$176	1 (D7970) per arch per date of service	
D7971	Excision of pericoronal gingiva	$80	$80		
D7972	Surgical reduction of fibrous tuberosity	$100	not covered	1 (D7972) per arch per date of service	
D7979	Non – surgical sialolithotomy	$155	$350		
D7980	Surgical Sialolithotomy	$155	not covered		
D7981	Excision of salivary gland, by report	$120	not covered		
D7982	Sialodochoplasty	$215	not covered		
D7983	Closure of salivary fistula	$140	not covered		
D7990	Emergency tracheotomy	$350	not covered		
D7991	Coronoidectomy	$345	not covered		
D7995	Synthetic graft, mandible or facial bones, by report	$150	not covered		
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	$60	not covered	1 (D7997) per arch per date of service	
D7999	Unspecified oral surgery procedure, by report	$350	not covered		
	Orthodontic Services				
For Pediatric Dental, orthodontic treatment is a benefit of this Dental Plan ONLY when the patient's orthodontic needs meet medically necessary requirements as determined by a verified score of 26 or higher (or other qualify conditions) on Handicapping Labio-Lingual Deviation (HLD) Index analysis. All treatment must be prior authorized by the Plan prior to banding.					
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$350 per course of treatment, regardless of plan year, as long as member remains enrolled in the plan	not covered	age 13 and over	
D8210	Removable appliance therapy		not covered	1 (D8210) per patient, age 6 through 12	
D8220	Fixed appliance therapy		not covered	1 (D8220) per patient, age 6 through 12	
D8660	Pre-orthodontic treatment examination to monitor growth and development		not covered	1 (D8660) every 3 months for a maximum of 6	
D8670	Periodic orthodontic treatment visit		not covered	1 (D8670) per calendar quarter	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))		not covered	1 (D8680) per arch for each authorized phase of orthodontic treatment	
D8681	Removable orthodontic retainer adjustment		not covered		
D8696	Repair of orthodontic appliance, maxillary		not covered	1 of (D8696, D8697) per arch	
D8697	Repair of orthodontic appliance, mandibular		not covered		
D8698	Re-cement or re-bond fixed retainer, maxillary		not covered	1 of (D8698, D8699) per arch per provider	
D8699	Re-cement or re-bond fixed retainer, mandibular		not covered		
D8701	Repair of fixed retainer, includes reattachment, maxillary		not covered		
D8702	Repair of fixed retainer, includes reattachment, mandibular		not covered		

LIBERTY Dental Plan Family Dental HMO
Individual Market Place

CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Orthodontic Services (continued)				
D8703	Replacement of lost or broken retainer, maxillary	$350 per course of treatment, regardless of plan year, as long as member remains enrolled in the plan	not covered	1 of (D8703, D8704) per arch	
D8704	Replacement of lost or broken retainer, mandibular		not covered		
D8999	Unspecified orthodontic procedure, by report		not covered		
	Adjunctive General Services				
D9110	Palliative (emergency) treatment, minor procedure	$30	$28	1 (D9110) per date of service	
D9120	Fixed partial denture sectioning	$95	$95		
D9210	Local anesthesia not in conjunction, operative or surgical procedures	$10	$10	1 (D9210) per date of service	
D9211	Regional block anesthesia	$20	$20		
D9212	Trigeminal division block anesthesia	$60	$60		
D9215	Local anesthesia in conjunction with operative or surgical procedures	$15	$15		
PEDIATRIC GUIDELINE: Deep Sedation and IV Conscious Sedation are covered benefits when it is documented local anesthesia is not possible, in such cases as a severe mental or physical handicap, extensive surgical procedures, an uncooperative child, an acute infection at the injection site, or a failure of a local anesthetic to control pain. Services covered when dispensed in a dental office by a practitioner acting within the scope of his/her licensure. Patient apprehension and/or nervousness are not of themselves sufficient justification. **ADULT GUIDELINE:** Deep Sedation and IV Conscious Sedation are covered benefits only in conjunction with covered oral surgery procedures when dispensed in a dental office by a practitioner acting within the scope of his/her licensure. Patient apprehension and/or nervousness are not of themselves sufficient justification.					
D9222	Deep sedation/general anesthesia, first 15 minute increment	$45	$45		
D9223	Deep sedation/general anesthesia, each subsequent 15 minute increment	$45	$45		
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$15	not covered		
D9239	Intravenous moderate (conscious) sedation/analgesia, first 15 minute increment	$60	$45		
D9243	Intravenous moderate (conscious) sedation/analgesia, each subsequent 15 minute increment	$60	$45		
D9248	Non-intravenous (conscious) sedation, includes non-IV minimal and moderate sedation	$65	not covered		
D9310	Consultation, other than requesting dentist	$50	$45		
D9311	Consultation with a medical health care professional	no charge	no charge		
D9410	House/extended care facility call	$50	not covered		
D9420	Hospital or ambulatory surgical center call	$135	not covered		
D9430	Office visit, observation, regular hours, no other services	$20	$12	1 (D9430) per date of service per provider	1 (D9430) per date of service per provider
D9440	Office visit, after regularly scheduled hours	$45	$40	1 (D9440) per date of service per provider	1 (D9440) per date of service per provider
D9450	Case presentation, detailed & extensive treatment	not covered	no charge		
D9610	Therapeutic parenteral drug, single administration	$30	not covered	4 (D9610) per date of service	
D9612	Therapeutic parenteral drugs, two or more administrations, different meds.	$40	not covered	4 (D9612) per date of service	
D9910	Application of desensitizing medicament	$20	$22	1 (D9910) per tooth every 12 months, for permanent teeth only	
D9930	Treatment of complications, post surgical, unusual, by report	$35	$50	1 (D9930) per date of service per provider	1 (D9930) per date of service per provider
D9942	Repair and/or reline of occlusal guard	not covered	$35		
D9943	Occlusal guard adjustment	not covered	$35		
D9944	Occlusal guard, hard appliance, full arch	not covered	$115		1 of (D9944-D9946) every 5 year period
D9945	Occlusal guard, soft appliance, full arch	not covered	$115		
D9946	Occlusal guard, hard appliance, partial arch	not covered	$115		
D9950	Occlusion analysis, mounted case	$120	not covered	1 (D9950) every 12 months, age 13 and over	

LIBERTY Dental Plan Family Dental HMO
Individual Market Place

CDT Code	Description	Pediatric[1] Copay	Adult[2] Copay	Pediatric Limitation[1]	Adult Limitation[2]
	Adjunctive General Services (continued)				
D9951	Occlusal adjustment, limited	$45	$45	1 (D9951) per quad every 12 months per provider, age 13 and over	1 (D9951) per quad every 12 months per provider
D9952	Occlusal adjustment, complete	$210	$210	1 (D9952) every 12 months, age 13 and over	
D9995	Teledentistry, synchronous; real-time encounter	no charge	no charge		
D9996	Teledentistry, asynchronous; information stored and forwarded to dentist for subsequent	no charge	no charge		
D9997	Dental case management, patients with special health care needs	no charge	no charge		1 (D9997) per date of service
D9999	Unspecified adjunctive procedure, by report	no charge	no charge		

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

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

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

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

Copayments made by each individual child for in-network services contribute to the Out-of-Pocket Maximum. Out-of-network services are not covered and do not accumulate to the Out-of-Pocket Maximum.

Only copayments for services provided by a contracted provider will count toward the Out-of-Pocket Maximum. Payment for services that are Optional, performed by a non-contracted provider, or that are not covered under the Policy will not count toward the Out-of-Pocket Maximum, and payment for such services still applies after the annual Out-of-Pocket Maximum is met.

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

LIBERTY Dental Plan Family Dental HMO
Individual Market Place

General Exclusions:

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

Appendix 2:

PREMIUM, PRE-PAYMENT FEES AND CHARGES

Region and County	Covered Child (1)*	Adult Per Member Per Month (PMPM)*
Region 1 – Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yuba	$38.52	$47.18
Region 2 – Marin, Napa, Solano, Sonoma	$22.24	$21.86
Region 3 – El Dorado, Placer, Sacramento, Yolo	$14.52	$8.45
Region 4 – San Francisco	$14.52	$8.45
Region 5 – Contra Costa	$22.24	$21.86
Region 6 – Alameda	$14.52	$8.45
Region 7 – Santa Clara	$14.52	$8.45
Region 8 – San Mateo	$22.24	$21.86
Region 9 – Monterey, San Benito, Santa Cruz	$22.24	$21.86
Region 10 – Mariposa, Merced, San Joaquin, Stanislaus, Tulare	$24.37	$24.84
Region 11 – Fresno, Kings, Madera	$22.24	$21.86
Region 12 – San Luis Obispo, Santa Barbara, Ventura	$24.43	$25.63
Region 13 – Imperial, Inyo, Mono	$37.90	$44.87
Region 14 – Kern	$12.49	$7.66
Region 15 – Los Angeles ZIP Codes: 906-912, 915, 917, 918, 935	$12.49	$7.66
Region 16 – Los Angeles, all other ZIP Codes	$12.49	$7.66
Region 17 – Riverside, San Bernardino	$12.49	$7.66
Region 18 – Orange	$12.49	$7.66
Region 19 – San Diego	$12.49	$7.66

***A maximum rate of three (3) child dependents under the age of 19 will be applied to each family. The adult rate will be applied to each number of adults 19 and older in a family.**

Discrimination is against the law. LIBERTY Dental Plan ("LIBERTY") follows State and Federal civil rights laws. LIBERTY does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

LIBERTY provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - ✓ Qualified sign language interpreters
  - ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - ✓ Qualified interpreters
  - ✓ Information written in other languages

If you need these services, please contact us between 8 a.m. to 5 p.m (PST) by calling (888) 844-3344. Or, if you cannot hear or speak well, please call (800) 735-2929

HOW TO FILE A GRIEVANCE

If you believe that LIBERTY has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with LIBERTY's Civil Rights Coordinator. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact LIBERTY's Civil Rights Coordinator, Monday through Friday, 8 a.m to 5 p.m (PST) by calling 888-704-9833. Or if you cannot hear or speak well, please call (800) 735-2929.
- In writing: Fill out a complaint form or write a letter and send it to:
  P.O. Box 26110
  Santa Ana, CA 92799
- In person: Visit your doctor's office or LIBERTY Dental Plan and say you want to file a grievance.
- Electronically: Visit LIBERTY Dental Plan website at https://www.libertydentalplan.com.

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- By phone: Call **916-440-7370**. If you cannot speak or hear well, please call **711 (Telecommunications Relay Service)**.
- In writing: Fill out a complaint form or send a letter to:

  Michele Villados
  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Complaint forms are available at http://www.dhcs.ca.gov/Pages/Language_Access.aspx.
- Electronically: Send an email to CivilRights@dhcs.ca.gov.

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.
- In writing: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

LIBERTY's HIPAA Privacy Notice provides you with information about your rights and our legal duties and privacy practices with respect to Protected Health Information (PHI), including how we use and disclose your PHI. You can always request a written copy of our most current privacy notice from LIBERTY's Privacy Officer by calling 888.704.9833, or online at: www.libertydentalplan.com/HIPAA-Privacy-Notice.

LIBERTY DENTAL PLAN

Notice of Language Assistance

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

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

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

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

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

សារ:សំខាន់: អ្នកអាចទទួលអ្នកបកប្រែផ្ទាល់មាត់ដោយឥតគិតថ្លៃ ដើម្បីនិយាយទៅកាន់វេជ្ជបណ្ឌិត ឬគំរោងសុខភាពរបស់អ្នក។ ដើម្បីទទួលអ្នកបកប្រែផ្ទាល់មាត់ ឬស្នើសុំព័ត៌មានជាលាយលក្ខណ៍អក្សរ (ជាភាសាខ្មែរ ឬជាទំរង់ផ្សេងទៀត ដូចជាអក្សរប្រ៊ែល ឬអក្សរពុម្ពធំៗ) សូមទូរស័ព្ទទៅគំរោងសុខភាពរបស់អ្នក តាមលេខ 1-888-844-3344 ជាមុនសិន។ អ្នកនិយាយភាសាខ្មែរ អាចជួយអ្នកបាន។ បើសិនអ្នកត្រូវការជំនួយបន្ថែម សូមទូរស័ព្ទទៅមជ្ឈមណ្ឌលជំនួយអង្គការថែរក្សាសុខភាព HMO តាមលេខ 1-888-466-2219។ (Khmer)

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

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

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

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

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

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

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

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

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

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