



CALIFORNIA INDIVIDUAL FAMILY PLAN COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

This EOC contains information for members covered by the LIBERTY Dental Plan commercial individual and family plans.

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 888-703-6999/TTY: 877-855-8039. Make sure to notify your primary care dentist or specialty 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 888-703-6999/TTY: 877-855-8039.

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 is only a summary of the dental plan. The dental plan contract must be consulted to determine the exact terms and conditions of coverage. A copy of the dental plan contract is available 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.

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Confidential Communications

California law states that you can ask for confidential communications regarding the receipt of sensitive services. These types of services can include:

- Bills and attempts to collect payment.
- A Notice of Adverse Benefit Determination(s)
- An Explanation of Benefit notice(s)
- A Plan's request for additional information regarding a claim
- A notice of a contested claim
- The name and address of a provider, description of services received, and other information related to a visit.
- Any verbal, written or electronic communications from the Plan that contain protected health information.

To request confidential communications from LIBERTY for any of the services listed above, please call member services or you can submit a request in writing by mail or fax to any of the following:

- **Online:** LIBERTY's website by visiting www.libertydentalplan.com
- **By mail to:** LIBERTY Dental Plan, P.O. Box 26110, Santa Ana, CA 92799-6110
- **By fax to** 877-831-6019
- **By telephone to:** LIBERTY's Member Services at 888-703-6999
- **By TDD/TTY:** 877-855-8039

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 Benefit Matrix	
Copayment Plan	
(A) Deductibles	None
(B) Lifetime Maximums	A member has a lifetime maximum copayment of \$ 2,200 - 2,300 for 24 months of covered comprehensive orthodontic treatment. Applies to adults and children.
(C) Out of Pocket Maximums	None
(D) Professional services	<p>A member may be required to pay a copayment amount for each procedure as shown in the Description of Benefits and Copayments, subject to the Limitations and Exclusions.</p> <p>Copayments range by category of service. Examples are as follows:</p> <ul style="list-style-type: none"> • Diagnostic ServicesNo Cost - \$85.00 • Preventive ServicesNo Cost - \$258.00 • Restorative ServicesNo Cost - \$560.00 • Endodontic Services.....No Cost - \$580.00 • Periodontic ServicesNo Cost - \$685.00 • Prosthodontic Services\$10.00 - \$850.00 • Oral and Maxillofacial Surgery.....\$8.00 - \$2,625.00 • Implant Services.....No Cost - \$2,300.00 • Adjunctive General Services..... No Cost - \$210.00 • Orthodontic ServicesNo Cost - \$2,300.00
(E) Outpatient Services	Not Covered
(F) Hospitalization Services	Not Covered
(G) Emergency Dental Coverage	The member may receive a maximum benefit of up to \$75 per calendar year for out-of-area emergency services.
(H) Ambulance Services	Not Covered
(I) Prescription Drug Services	Not Covered
(J) Durable Medical Equipment	Not Covered
(K) Mental Health Services	Not Covered
(L) Chemical Dependency Services	Not Covered
(M) Home Health Services	Not Covered
(N) Other	Not Covered

Each individual procedure within each category listed above that is covered under the Program has a specific copayment, which is shown in the Schedule of Benefits (Appendix 1) included in the welcome packet issued during your initial enrollment with LIBERTY.

A copy of your combined Evidence of Coverage will be made available yearly or upon request and will include any changes about your dental benefits or LIBERTY's member public policies.

II. 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 Important Contact Information			
Hours: Monday - Friday 8:00 a.m. to 5:00 p.m.	Website: www.libertydentalplan.com	Mailing Address: LIBERTY Dental Plan, P.O. Box 26110 Santa Ana, CA 92799-6110	Member Services: 888-703-6999 TTY: 877-855-8039

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 888-703-6999/TTY: 877-855-8039 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 receive 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.

E. YOUR PRIMARY CARE DENTIST (PCD)

You do not need to choose a PCD. You may access services from any contracted general dentist in the network. When you join LIBERTY, in most cases you need to choose a PCD. This is usually a general dentist who provides your basic care and coordinates the care you need from other dental specialty providers.

EXCEPTION: Some LIBERTY plans do not require you to choose and be assigned to a primary care provider. On those plans, you may access services from any contracted primary care provider in the network. Refer to your Schedule of Benefits to determine if your plan requires you to choose and be assigned to a primary care provider.

F. LANGUAGE ASSISTANCE SERVICES

Interpretation and translation services are available at no cost for members that speak limited English, including translation of documents into certain threshold languages and/or alternative formats. If English is not your first language, LIBERTY provides interpretation services and translation of some written materials in your preferred language. To ask for language assistance service call 888-703-6999/TTY: 877-855-8039.

You can report your race, ethnicity, and language preferences to us to assist in meeting your healthcare needs. you can complete an online member demographic survey at <https://www.libertydentalplan.com/Members/Member-Language-Survey.aspx> or by calling 888-703-6999/TTY: 877-855-8039.

Make sure to notify your PCD or specialty dentist of your preferred language needs at your first dental visit. LIBERTY provides language assistance services for all 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 certified interpretation services available to you at no cost and does not recommend using family members, minors, or friend to assist you. Please call our member services to arrange for telephonic or 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. If you have an emergency/urgent care appointment, LIBERTY can provide you with interpretation services over the phone, to help you talk to the office staff in your preferred language.

G. HOW TO GET DENTAL CARE WHEN YOU NEED IT

Call your PCD first for all your care unless it is an emergency. If you are having a medical emergency call your primary care physician, 911, or go to the closest emergency room.

- 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 for your health. If you disagree with LIBERTY about whether a service you want is medically

necessary for your health, you can request an appeal, file a grievance or, in some cases, you may request an Independent Medical Review (IMR).

- 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. Your Schedule of Benefits is provided with this document at the start of your plan, is available anytime on the LIBERTY website at www.libertydentalplan.com, through our mobile app on your smartphone, or upon request from our member services.

H. TIMELY ACCESS TO CARE

California law says that you have the right to schedule an appointment within a reasonable time based on your oral needs. The table below shows the type of appointment and timeframes:

Type of Appointment	Condition/Type of Services	Appointment Wait Time
Emergency Care	Severe pain, swelling, bleeding	24 hours a day, 7 days a week
Urgent Care	Broken filling/lost crown	72 hours
Initial	Exam, x-rays	36 business days
Routine Care (Non-Emergency)	Restorative care (fillings/crowns)	36 business days
Preventive Care	Cleanings	40 business days
Specialty Dentist	Oral Surgeon, Endodontist, etc.	30 calendar days
In-Office Wait Time	Scheduled appointments only	Not to exceed 30 minutes
Telephone Wait Time	To answer incoming calls	Within 30 seconds
Return Call Wait Time	Returning calls from voicemails	Within 30 minutes

If for any reason you are unable to schedule an appointment within these timeframes, please call member services at 888-703-6999/TTY: 877-855-8039 for assistance.

I. SPECIALTY REFERRALS AND PRE-AUTHORIZATIONS

You need a referral from the PCD and pre-approval from LIBERTY for services to be provided by a dental 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 give you a referral and get 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 costs for the services.

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

A condition may be considered an emergency if you have severe pain, swelling, or bleeding. A condition is also considered any emergency, if you reasonably think that your condition, without treatment, could cause your health or body to be in serious danger and lead to death.

Emergency care is covered 24 hours a day, 7 days a week, anywhere in the world. If you require emergency care, contact your PCD, including unexpected dental conditions that take place after normal business hours or on weekends. 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.

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. If you are having a medical emergency call your primary care physician, 911, or go to the nearest emergency room.

K. URGENT CARE

Urgent care is covered anywhere in the world. Urgent care may be needed to prevent a serious health problem that requires prompt attention.

Urgent care is covered, anywhere in the world and appointment should be scheduled within 72 hours. If you require urgent care, contact your PCD, including unexpected dental conditions that take place after normal business hours or on weekends.

L. CARE WHEN YOU ARE OUT OF THE LIBERTY SERVICE AREA

Only emergency and urgent care is covered outside of the LIBERTY service area.

M. COSTS (see the “SCHEDULE OF BENEFITS” and “What You Pay”)

- 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. LIBERTY pays the rest of that covered service.
- There can be other costs incurred for optional, non-covered, and upgraded material services.

- To verify your dental benefits, please visit our website at www.libertydentalplan.com, download our mobile app on your smart phone, or call LIBERTY's member services, toll-free at 888-703-6999/TTY: 877-855-8039.

N. IF YOU HAVE A GRIEVANCE ABOUT YOUR LIBERTY DENTAL PLAN

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 pre-estimate 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 California Department of Managed Health Care help center. In some cases, the Department of Managed Health Care 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.

III. 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 the member with written consent, or other authorized designee to review an action by the Plan to delay, modify, or deny services.
- **Applicable:** To have an effect on someone or something.
- **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.
- **Consultation:** A meeting with a specialty dentist to determine care and a treatment plan, as needed.
- **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 actively enrolled in LIBERTY. Also known as an enrollee, member, or subscriber.
- **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:** Any person whose domestic partnership is currently registered with a governmental body pursuant to state or local law. This includes both same-sex and opposite-sex couples.
- **Emergency Care:** A dental screening, examination, or evaluation by a LIBERTY provider to determine if an emergency dental condition exists, and to provide care to treat any emergency symptoms within the capability of the facility within professionally recognized standards of care.
- **Emergency Dental Service:** A dental condition that if not treated immediately could reasonably be expected to result in placing the person's health in jeopardy, causing severe pain or impairing function.
- **Endodontist:** A specialty dentist who specifically treats disease and injuries to the pulp and root of the tooth. Also known as a root canal specialist.
- **Enrollee:** LIBERTY considers an enrollee to mean the same as a member, dependent or subscriber who are actively enrolled in the plan.
- **Exclusion:** Refers to any dental procedure or service that is not available under your LIBERTY Dental Plan.
- **Explanation of Benefits (EOB):** A written statement from LIBERTY about a claim, showing what was covered under your dental plan, what was paid for by the Plan, and what you must pay for.
- **General Dentist:** A licensed dentist who provides general dental services and who does not identify as a specialist. Also, known as your primary care dentist.
- **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.

- **Maximum Contract Allowance:** The reimbursement under the dental plan against what LIBERTY calculates as payment and the member's financial obligation.
- **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:** LIBERTY considers a member to mean that same as an enrollee, subscriber, or dependent who are actively enrolled with LIBERTY.
- **Non-Participating Provider:** A PCD or specialist that is not contracted with LIBERTY to provide service to members. Also, known as out-of-network provider.
- **Oral Surgeon:** A specialty dentist who treats diseases, injuries, deformities, and appearance of the mouth, jaws, and face.
- **Orthodontist:** A specialty dentist who treats problems in the way the upper and lower teeth fit together in biting or chewing.
- **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.
- **Pediatric Dentist:** A specialty dentist who treats children from birth to adolescence, providing primary and full range of preventive care treatment.
- **Periodontist:** A specialty dentist who treats diseases of the gums and tissue around the teeth
- **Plan:** LIBERTY Dental Plan of California, Inc., also known as "LIBERTY."
- **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.
- **Referral:** A request from your primary care dentist to direct you to a specialty dentist for evaluation and services as needed.
- **Service Area:** The counties in California where LIBERTY provides coverage.

- **Schedule of Benefits:** A document that outlines the type of dental procedures covered by your LIBERTY Dental Plan, including any copayments, deductibles, out-of-pocket maximums, exclusions, and limitations.
- **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:** LIBERTY considers a subscriber to mean that same as an enrollee, member, or dependent who are actively enrolled with LIBERTY.
- **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.
- **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 spouses and dependent children.

IV. ACCESS TO SERVICES – SEEING A DENTIST

LIBERTY contracts with general dentists and specialists to provide services covered by your plan. To find a dentist in your area, you can go to our website at www.libertydentalplan.com, download the LIBERTY mobile app on your smart phone, or call us toll-free at 888-703-6999/TTY: 877-855-8039.

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

LIBERTY makes available PCDs and specialists throughout the state of California within a reasonable distance from your home or workplace. You can find a dentist in your area by going to our website, www.libertydentalplan.com, downloading our mobile app on your smart phone, or calling us toll-free at 888-703-6999/TTY: 877-855-8039.

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 conducts 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 30 minutes or 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): Except as noted below under Exception, when you join LIBERTY Dental Plan, you must choose a PCD to which you will be assigned. Your assigned PCD is responsible for coordinating any specialty care dental services you might need. You must obtain general dental services from your assigned PCD. Your assigned PCD will share information with any specialist to coordinate your overall care.

You can locate a LIBERTY contracted provider by going online to our website at www.libertydentalplan.com, downloading our mobile app on your smartphone, or calling the Member Service. Once you have located a LIBERTY contracted provider, you can call the office to schedule an appointment. The PCD will contact LIBERTY to verify your eligibility.

IMPORTANT: Unless otherwise noted in the Exception below, if you do not select a PCD, one will be chosen for you by LIBERTY upon your enrollment and you will be notified of this assignment.

2. Changing PCDs: You can request to change your PCD at any time. You can use our mobile dental app to find a dentist and request an office transfer, call our member services toll-free at (888) 703-6999/TTY: 877-855-8039, during regular business hours, or submit a change request in writing to: LIBERTY Dental Plan, P.O. Box 26110, Santa Ana, CA, 92799-6110.

Your requested change to a PCD will be in effect on the 1st day of the following month if the change is received by LIBERTY prior to the 20th of the current month.

3. Care from a Dental Specialist: You may only obtain care from a dental specialist only after your referral to a specialist has been submitted by your contracted 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.”**

4. Non-LIBERTY Dental Providers: If you see a general dentist or dental specialist that is not in LIBERTY’s network, and your dental plan does not allow out-of-network benefits, you will be fully financially responsible for payment for all completed services.

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 24 hours per day, 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.

Your 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.

Contact your PCD if you are experiencing dental pain or a potential dental emergency. If your PCD is not available, contact 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 \$75.00, 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 determines that your treatment was not due to a dental emergency, the services of any 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 24 hours per day, 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 mental 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 \$75.00, 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 \$75.00 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, 92799-6111.

Please include a copy of the claim from the provider's office or a legible statement of services/invoice. Please forward to LIBERTY 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 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 888-703-6999/TTY: 8977-855-8039 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 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 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."
- 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

A prior authorization is not 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 dentist, that you were referred to, must be pre-authorized before completing 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 888-703-6999/TTY: 877-855-8039 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 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 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 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 888-703-6999/TTY: 877-855-8039 to see if you may be eligible for this benefit. You have the right to ask for 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 888-703-6999/TTY: 877-855-8039 to see if you may be eligible for this benefit. You have the right to ask for 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.

V. FEES AND CHARGES – WHAT YOU PAY

A. PREMIUMS AND PREPAYMENT FEES

- Your initial binder payment is due to LIBERTY by the 15th of the effective month. Once your initial binder payment has been received, your annual payment 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 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 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. RESPONSIBILITY 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 specialty dentist.
- 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 888-703-6999/TTY: 877-855-8039.

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 888-703-6999/TTY: 877-855-8039 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

E. PROVIDER REIMBURSEMENT

Review this section for an explanation of LIBERTY payment procedures to understand the methods of payments applicable to your provider choice and how it may impact your out-of-pocket costs.

Providers will deliver services at a charge that has been contractually agreed upon with LIBERTY. Payment for covered services performed by a LIBERTY contracted providers is based on the maximum contract allowance. Payment for emergency dental service claims are subject to clinical review to ensure the services were medically necessary.

LIBERTY pays for covered services to contracted PCDs and specialists via a variety of arrangements including capitation, fee-for-service and supplemental repayments. Reimbursement varies by geographic area, general dentist, specialty dentist and procedure code. You will not be held financially responsible for any monies owed to a LIBERTY contracted PCD or specialty dentist. In the event that LIBERTY fails to pay a non-contracted provider, you will be responsible for the cost of services you received.

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.

VI. **Notice of Privacy Practices**

A statement describing LIBERTY's policies and procedures for preserving the confidentiality of dental records is available online and will be furnished to you upon request.

As required by law, this notice is about your rights, our legal duties and privacy practices with respect to the privacy of Personal Health Information (PHI). This notice also talks about the way we may collect, use, and disclose your PHI. We must follow the orders of the notice currently in effect. We keep the right to make changes to this notice from time to time and to make the changed notice effective for all PHI we keep. You can find our most current privacy notice on our website at:

<https://www.libertydentalplan.com/About-LIBERTY/Compliance/HIPAA-Privacy-Notice.aspx>

Call our Member Services at 888-703-6999/TTY: 877-855-8039 to request a written copy of this notice.

VII. **ELIGIBILITY AND ENROLLMENT**

A. **ELIGIBILITY REQUIREMENTS**

You will become eligible to receive benefits on the date stated in the contract. If your dependents are covered, they will be eligible when you are or as soon as they become dependents.

Start of member coverage: A LIBERTY member becomes eligible for benefits at 12:01 a.m. on the first day of the month following the month in which the member is listed as eligible.

End of member coverage: A LIBERTY member's coverage will end based on one of the following, which event takes place first:

- Expiration or termination of this agreement
- The member submits a request to end coverage.
- The end of the period for which the last premium payment was submitted by the member.
- The date the member enters into full-time military service.
- The member's dependent child reaches the age of 26 years old, unless the requirements are met for continuation of eligibility.
- LIBERTY determined that the member has committed fraud, or allowed another person to commit fraud, with respects to benefits.

- The member is unable to establish and keep a satisfactory relationship with a LIBERTY network provider.

B. 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 to be enrolled on your dental plan:

- Your spouse or your domestic partner
 - A domestic partner is any person whose domestic partnership is currently registered with a governmental body pursuant to state or local law. This includes both same-sex and opposite-sex couples.
- 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 26; Please note: An enrolled dependent child who reaches age 26 shall have their coverage end on the last day of the benefit year 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.

C. WHO IS ENTITLED TO BENEFITS

If LIBERTY receives your completed dental application 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 LIBERTY. 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 Appendix 1 with applicable Limitations and Exclusions 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.

VIII. 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.

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.

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.

D. ENDODONTIC SERVICES

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

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.

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.

G. ORAL SURGERY SERVICES

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

H. ADJUNCTIVE DENTAL SERVICES

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

I. ORTHODONTIC SERVICES

Orthodontic dental services include braces for straightening teeth and treating discrepancies in the bite relationship of the teeth and jaws.

IX. LIMITATIONS, EXCLUSIONS, EXCEPTIONS, REDUCTIONS

See your Schedule of Benefits 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.
- Any dental procedure or services that is not medically necessary, as determined by LIBERTY, in accordance with professionally recognized standards of dental practice.
- Any dental procedure or services that is not specifically listed as a covered benefit under your dental plan. See your Schedule of Benefits (Appendix 1) for a full list of exclusions.
- Any dental procedure or services for cosmetic purposes or for conditions that are a results of a hereditary development defect.
- Any dental procedure, service, or applicable provided by a dentist who specializes in prosthodontic services.
- 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 your PCD, specialty dentist, or to get dental 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 to 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 888-703-6999/TTY: 877-855-8039 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.

X. TERMINATION, RESCISSION AND CANCELLATION OF COVERAGE

A. TERMINATION OF BENEFITS

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.

1. 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 will 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.

2. 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.

3. 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.

4. Termination Due to Health Status

LIBERTY does not terminate based on any health status. If you believe that your coverage has been terminated based on your health status or requirements for health care services, you may request a review to be performed by the director of the Department of Managed Health Care. If the director determines that a proper complaint exists under the provisions of this section, the director shall notify the plan. Within 15 days after receipt of such notice, 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 Department of Managed Health Care at 1-888-466-2219 or on a TDD line at 1-877-688-989 for the hearing and speech impaired. The Department of Managed Health Care’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

A member can cancel the agreement and receive a partial refund in accordance with the refund policy under the following conditions:

1. There are no contracted/in-network dentists available to the member.
2. The member has changed primary residency and has moved out of LIBERTY's California service areas for the remainder of the plan year. This does not include travel.
3. The member changes coverage to a group dental program

Members must send a request for cancellation to LIBERTY in writing through mail, email, or fax at least 30 days in advance. All requests for cancellation must include:

- Member full name and ID number
- Member mailing address
- Member phone number
- Member email address
- Reason for cancellation
- Cancellation with proof of the following:
 - Forwarding address is moving out of LIBERTY's California service areas.
 - Letter that includes the effective date if joining a new group plan

All cancellation requests, including the information outlined about, must be sent to one of the following:

Email: eligibility@libertydentalplan.com

Fax: 1-949-223-0011, Attn: Eligibility Department

Mail: LIBERTY Dental Plan

Attn: Eligibility Department

P.O. Box 26110

Santa Ana, CA 92799-6110

Cancellation of member eligibility will automatically cancel the enrollment of any of any dependent members. Any cancellation is subject to the written notification requirement as outlined above.

If a member believes that eligibility has been cancelled or not renewed because of health status or requirements for health care services, including dependent(s) eligibility, the member can request a review by the Director of the California Department of Managed Health Care.

D. REFUND POLICY

If a member is eligible for a refund after the cancellation of the contract, LIBERTY will issue a pro-rated amount of the monies paid for the premium. The refund will only apply to the months that payment was received but not utilized, not to exceed 9 months of premium payment. An enrollment or activation fee is applicable and will not be refunded. LIBERTY will issue all refunds within 30 days of receipt of the written notice of cancellation.

E. 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.

XI. RENEWAL AND REINSTATEMENT OF COVERAGE

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

LIBERTY has contracted to provide dental benefits to the member for a period of 1 year. A member can renew the contract at a discounted renewal rate within 30 days of the original contract expiration, unless the original benefit plan has been terminated. If more than 1 calendar month has passed since the original contract has expired, a new benefit plan can be purchased at the standard premium rate. In the event that the member's benefit plan is no longer available from a their PCD or LIBERTY, the member can select another benefit plan.

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

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 Department of Managed Health Care.

Option 1 - You may submit a grievance to LIBERTY.

You may submit a grievance to LIBERTY by calling 888-703-6999 or use TDD/TTY 877-855-8039, 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 Department, 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 3 calendar days of receipt. If you do not receive a response from LIBERTY 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 Department of Managed Health Care.

You may submit a grievance directly to the Department of Managed Health Care (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

XIII. 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 888-703-6999/TTY: 877-855-8039. 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:

- Online: LIBERTY's website by visiting www.libertydentalplan.com
- By fax to: LIBERTY's Grievances and Appeals at 833-250-1814
- By telephone to: LIBERTY's Member Services Department at 888-703-6999/TTY: 877-855-8039
- In writing to: LIBERTY Dental Plan, P.O. Box 26110, Santa Ana, CA, 92799-6110

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 5 calendar days of receipt. Grievances will be resolved within 30 calendar days.

A. GRIEVANCES EXEMPT FROM WRITTEN ACKNOWLEDGEMENT AND RESPONSE

In some cases, LIBERTY's member services can help resolve grievances received over the telephone within 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 be 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.

B. URGENT (EXPEDITED) GRIEVANCES AND APPEALS

You can request an urgent or expedited review of your grievance or appeal when you feel there could be 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 qualify for expedited review, LIBERTY will resolve your grievance or appeal within 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 or fax number listed below.

Online: www.libertydentalplan.com

Fax: 833-250-1814

Mail: LIBERTY Dental Plan of California, Inc., Attn: 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.

C. 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 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.

The paragraph below provides you with information on how to request an Independent Medical Review with the DMHC. Not that the term grievance is talking about both complaints and appeals:

California Required Statement: “The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **888-703-6999**, or **TTY 877-855-8039** 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 has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an 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 website www.dmhc.ca.gov complaint forms, IMR application forms and instructions online.”

D. 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:

Online: www.libertydentalplan.com

Fax: 833-250-1814

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

Or you may contact LIBERTY's Member Services Department by telephone at 888-703-6999/TTY: 877-855-8039. 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 888-703-6999/TTY: 877-855-8039.

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 888-703-6999/TTY: 877-855-8039 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.

E. 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.

F. 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 888-703-6999/TTY:877-855-8039, 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.

G. 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 binding arbitration for resolution. You or one of your eligible dependents can submit a grievance to the Department of Managed Health Care for review and resolution prior to any arbitration.

As a condition of your membership in LIBERTY, disputes arising from or relating to your participation as a LIBERTY member, including contract or medical liability or malpractice (for example, whether any covered services rendered were unnecessary or unauthorized, or were improperly, negligently, or incompetently rendered) will be settled by binding arbitration.

Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

The arbitration will be conducted according to the commercial rules of the American Arbitration Association (AAA) in force at the time of the occurrence of the grievance (dispute or controversy) and subject to California laws and related codes.

Arbitration will be conducted by a mutually acceptable arbitrator selected by the parties, or if the parties are unable to agree, by the arbitrator selection process established by AAA.

You can initiate arbitration by submitting a written request for arbitration to LIBERTY.

- Mail to:
LIBERTY Dental Plan
Attn: Arbitration Request
P.O. Box 26110
Santa Ana, CA 92799-6110

The written request must include a clear statement describing the nature of the dispute, attempts to resolve the dispute with LIBERTY, the relief or remedy sought, and the dollar amount involved. The arbitration will take place in California, unless some other location is mutually agreed upon by the parties.

The arbitrator is required to follow applicable state or federal law. The arbitrator can interpret the terms of this EOC but will not have the power to change, modify, or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law. The arbitrator will have the power to grant all legal and equitable remedies and award compensatory damages provided by California law, except that punitive damages will not be awarded. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award, setting forth findings of fact and conclusions of law. The award will be final and binding on all parties except to the extent that state or federal law provides for judicial review of arbitration proceedings.

You must pay your own attorney's fees, should you choose to have an attorney. LIBERTY will have to pay its own attorney's fees. If you cannot pay your part of the arbitrator's fees and expenses due to extreme hardship, you can ask LIBERTY in writing to assume all or a portion of your share of the fees. Upon such written notice, LIBERTY can send your request to an independent professional dispute resolution organization to make a determination as to whether LIBERTY should pay for some or all of your share of the arbitrator's fees and expenses. Such requests should be submitted to the address provided above.

Arbitration must be initiated within 1 year of the earlier of the date the dispute arose, was discovered, or should have been discovered with reasonable diligence; otherwise, it will be deemed waived and forever barred.

XIV. 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 PUBLIC POLICY COMMITTEE

LIBERTY has a group called the Public Policy Committee. This group is made up of members, support staff and our dental director. The group talks about LIBERTY policies and is responsible for:

- Recommending ways to better serve our members.
- Reviewing quality metrics to ensure member satisfaction.
- Suggesting improvements to LIBERTY's programs
- Reviewing LIBERTY's financial reports

Joining this group is voluntary and you will be paid for each meeting you attend. If you would like to take part in LIBERTY's Public Policy Committee, please call or email us or you can complete the Public Policy Committee Application included in Appendix 4 "FORMS" and return it to LIBERTY, information listed below.

- Mail to:
LIBERTY Dental Plan of California
Public Policy Committee (QM Department)
P.O. Box 26110
Santa Ana, CA 92799-6110
- Call: 888-703-6999 or TTY 888-855-8039
- Fax to 888-334-6027
- Email: QM@libertydentalplan.com

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 888-703-6999. Or, if you cannot hear or speak well, please call 877-855-8039.

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 888-703-6999. Or if you cannot hear or speak well, please call 877-855-8039.
- 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**.
- In writing: Fill out a complaint form or send a letter to:
(Telecommunications Relay Service).
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 number 711 to contact the department. Our toll-free number is 888-703-6999/TTY: 877-855-8039.

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 in your primary spoken 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.
- 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 member.
- Treat the PCD, office staff and LIBERTY staff with respect and courtesy.

- Keep scheduled appointments or contact the dental office 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.

XV. 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.

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/TTY: 877-855-8039
- LIBERTY's Compliance Unit email: compliance@libertydentalplan.com
- LIBERTY's Special Investigations Unit Hotline: 888-704-9833/TTY: 877-855-8039
- 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) 703-6999/TTY: 833-855-8039



**Appendix 1:
SCHEDULE OF BENEFITS
COVERED SERVICES**



LIBERTY Dental Plan of California, Inc.

CA50 Plan Schedule of Benefits

Covered Benefits, Member Co-payments, Limitations Exclusions

No Annual Deductible

No Annual Dollar Amount Maximum

- ✓ Members must select, and be assigned to, a LIBERTY Dental Plan contracted dental office to utilize covered benefits. Your assigned office will initiate a treatment plan or will initiate the specialty referral process with LIBERTY Dental Plan if the services are dentally necessary and outside the scope of general dentistry.
- ✓ Member Co-payments are payable to the dental office at the time services are rendered.
- ✓ This Schedule does not guarantee benefits. All services are subject to eligibility and dental necessity at the time of service.
- ✓ Dental procedures not listed as covered benefits are available at the dental office's usual and customary fee.
- ✓ Dental procedures not listed as covered benefits are available at the dental office's usual and customary fee.

CDT Code	Description	Member Co-payment		Frequency
		General	Specialist	
Diagnostic Services				
D0120	Periodic oral evaluation	\$0.00	NPB	
D0140	Limited oral evaluation	\$0.00	\$50.00	
D0145	Oral evaluation under age 3	\$0.00	\$50.00	
D0150	Comprehensive oral evaluation	\$0.00	\$50.00	
D0160	Oral evaluation, problem focused	\$0.00	\$50.00	
D0170	Re-evaluation, limited, problem focused	\$0.00	\$50.00	
D0171	Re-evaluation, post operative office visit	\$0.00	\$50.00	
D0180	Comprehensive periodontal evaluation	\$0.00	\$50.00	
D0210	Intraoral, comprehensive series of radiographic images	\$0.00	\$85.00	1 of (D0210, D0372, D0387, D0709) every 36 months
D0220	Intraoral, periapical, first radiographic image	\$0.00	\$21.00	
D0230	Intraoral, periapical, each add 'l radiographic image	\$0.00	\$12.00	
D0240	Intraoral, occlusal radiographic image	\$0.00	\$21.00	
D0250	Extra-oral 2D projection radiographic image, stationary radiation source	\$0.00	\$31.00	
D0251	Extra-oral posterior dental radiographic image	\$0.00	\$20.00	
D0270	Bitewing, single radiographic image	\$0.00	\$20.00	
D0272	Bitewings, two radiographic images	\$0.00	\$31.00	
D0273	Bitewings, three radiographic images	\$0.00	\$35.00	
D0274	Bitewings, four radiographic images	\$0.00	\$45.00	
D0277	Vertical bitewings, 7 to 8 radiographic images	\$0.00	\$45.00	
D0330	Panoramic radiographic image	\$0.00	NPB	
D0372	Intraoral tomosynthesis, comprehensive series of radiographic images	\$0.00	\$85.00	1 of (D0210, D0372, D0387, D0709) every 36 months
D0373	Intraoral tomosynthesis, bitewing radiographic image	\$0.00	\$20.00	
D0374	Intraoral tomosynthesis, periapical radiographic image	\$0.00	\$21.00	
D0387	Intraoral tomosynthesis, comprehensive series, radiographic images, image capture only	\$0.00	\$85.00	1 of (D0210, D0372, D0387, D0709) every 36 months
D0388	Intraoral tomosynthesis, bitewing radiographic image, image capture only	\$0.00	\$20.00	
D0389	Intraoral tomosynthesis, periapical radiographic image, image capture only	\$0.00	\$21.00	
D0414	Laboratory process of microbial specimen, culture, sensitivity, prep, report	\$25.00	NPB	
D0415	Collection of microorganisms for culture	\$25.00	NPB	
D0425	Caries susceptibility tests	\$15.00	NPB	
D0460	Pulp vitality tests	\$0.00	NPB	
D0470	Diagnostic casts	\$0.00	NPB	
D0472	Accession of tissue, gross exam, prep & report	\$40.00	NPB	
D0473	Accession of tissue, gross/micro. exam, prep, report	\$40.00	NPB	
D0474	Accession of tissue, gross/micro. exam, report	\$40.00	NPB	
D0701	Panoramic radiographic image, image capture only	\$0.00	NPB	
D0705	Extra-oral posterior dental radiographic image, image capture only	\$0.00	\$20.00	
D0706	Intraoral, occlusal radiographic image, image capture only	\$0.00	\$21.00	
D0707	Intraoral, periapical radiographic image, image capture only	\$0.00	\$12.00	
D0708	Intraoral, bitewing radiographic image, image capture only	\$0.00	\$20.00	
D0709	Intraoral, comprehensive series of radiographic images, image capture only	\$0.00	\$85.00	1 of (D0210, D0372, D0387, D0709) every 36 months
Preventive Services				
D1110	Prophylaxis, adult	\$9.00	\$55.00	1 of (D1110, D1120, D4346) every 6 months
	Prophylaxis, adult (additional prophylaxis)	\$54.00	\$65.00	
D1120	Prophylaxis, child	\$9.00	\$55.00	
	Prophylaxis, child (additional prophylaxis)	\$44.00	\$60.00	
D1206	Topical application of fluoride varnish	\$9.00	\$38.00	1 of (D1206, D1208) every 6 months, additional D1208 covered up to the 18th birthday (copay applies)
D1208	Topical application of fluoride, excluding varnish up to the 18th birthday (additional fluoride)	\$9.00 \$18.00	\$25.00 \$25.00	
D1310	Nutritional counseling for control of dental disease	\$0.00	\$0.00	
D1320	Tobacco counseling, control/prevention oral disease	\$0.00	\$0.00	
D1321	Counseling for the control and prevention of adverse oral, behavioral, health effects associated with high-risk substance use	\$0.00	\$0.00	
D1330	Oral hygiene instruction	\$0.00	\$0.00	
D1351	Sealant, per tooth	\$10.00	\$37.00	Limited to first and second permanent molars up to the 14th birthday
D1352	Preventive resin restoration, permanent tooth	\$10.00	\$37.00	
D1353	Sealant repair, per tooth	\$0.00	\$0.00	
D1510	Space maintainer, fixed, unilateral, per quadrant	\$50.00	\$215.00	
D1516	Space maintainer, fixed, bilateral, maxillary	\$50.00	\$258.00	
D1517	Space maintainer, fixed, bilateral, mandibular	\$50.00	\$258.00	
D1520	Space maintainer, removable, unilateral, per quadrant	\$50.00	\$210.00	
D1526	Space maintainer, removable, bilateral, maxillary	\$50.00	\$210.00	
D1527	Space maintainer, removable, bilateral, mandibular	\$50.00	\$210.00	
D1551	Re-cement or re-bond bilateral space maintainer, maxillary	\$0.00	\$22.00	
D1552	Re-cement or re-bond bilateral space maintainer, mandibular	\$0.00	\$22.00	
D1553	Re-cement or re-bond unilateral space maintainer, per quadrant	\$0.00	\$22.00	
D1556	Removal of fixed unilateral space maintainer, per quadrant	\$15.00	\$60.00	
D1557	Removal of fixed bilateral space maintainer, maxillary	\$15.00	\$60.00	
D1558	Removal of fixed bilateral space maintainer, mandibular	\$15.00	\$60.00	
D1575	Distal shoe space maintainer, fixed, per quadrant	\$50.00	\$215.00	
Restorative Services				
D2140	Amalgam, one surface, primary or permanent	\$11.00	\$71.00	
D2150	Amalgam, two surfaces, primary or permanent	\$13.00	\$105.00	
D2160	Amalgam, three surfaces, primary or permanent	\$15.00	\$126.00	
D2161	Amalgam, four or more surfaces, primary or permanent	\$17.00	\$141.00	
D2330	Resin-based composite, one surface, anterior	\$15.00	\$84.00	



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CA50 Plan Schedule of Benefits

Covered Benefits, Member Co-payments, Limitations Exclusions

CDT Code	Description	Member Co-payment		Frequency
		General	Specialist	
Restorative Services (continued)				
D2331	Resin-based composite, two surfaces, anterior	\$18.00	\$94.00	
D2332	Resin-based composite, three surfaces, anterior	\$23.00	\$105.00	
D2335	Resin-based composite, four or more surfaces, involving incisal angle	\$25.00	\$115.00	
D2390	Resin-based composite crown, anterior	\$30.00	\$152.00	
D2391	Resin-based composite, one surface, posterior	\$50.00	\$71.00	
D2392	Resin-based composite, two surfaces, posterior	\$70.00	\$105.00	
D2393	Resin-based composite, three surfaces, posterior	\$120.00	\$126.00	
D2394	Resin-based composite, four or more surfaces, posterior	\$135.00	\$135.00	
*GUIDELINES for Inlays, Onlays, and Single Crowns:				
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.				
D2510	Inlay, metallic, one surface	\$170.00	NPB	1 of (D2510-D2794, D6205-D6794) per tooth every 5 year period
D2520	Inlay, metallic, two surfaces	\$170.00	NPB	
D2530	Inlay, metallic, three or more surfaces	\$170.00	NPB	
D2542	Onlay, metallic, two surfaces	\$175.00	NPB	
D2543	Onlay, metallic, three surfaces	\$195.00	NPB	
D2544	Onlay, metallic, four or more surfaces	\$195.00	NPB	
D2610	Inlay, porcelain/ceramic, one surface	\$170.00*	NPB	
D2620	Inlay, porcelain/ceramic, two surfaces	\$170.00*	NPB	
D2630	Inlay, porcelain/ceramic, three or more surfaces	\$170.00*	NPB	
D2642	Onlay, porcelain/ceramic, two surfaces	\$195.00*	NPB	
D2643	Onlay, porcelain/ceramic, three surfaces	\$195.00*	NPB	
D2644	Onlay, porcelain/ceramic, four or more surfaces	\$195.00*	NPB	
D2650	Inlay, resin-based composite, one surface	\$170.00*	NPB	
D2651	Inlay, resin-based composite, two surfaces	\$170.00*	NPB	
D2652	Inlay, resin-based composite, three or more surfaces	\$195.00*	NPB	
D2662	Onlay, resin-based composite, two surfaces	\$195.00*	NPB	
D2663	Onlay, resin-based composite, three surfaces	\$195.00*	NPB	
D2664	Onlay, resin-based composite, four or more surfaces	\$195.00*	NPB	
D2710	Crown, resin-based composite (indirect)	\$195.00*	NPB	
D2712	Crown, ¾ resin-based composite (indirect)	\$195.00*	NPB	
D2720	Crown, resin with high noble metal	\$195.00*	NPB	
D2721	Crown, resin with predominantly base metal	\$195.00*	NPB	
D2722	Crown, resin with noble metal	\$195.00*	NPB	
D2740	Crown, porcelain/ceramic	\$225.00*	NPB	
D2750	Crown, porcelain fused to high noble metal	\$195.00*	NPB	
D2751	Crown, porcelain fused to predominantly base metal	\$195.00*	NPB	
D2752	Crown, porcelain fused to noble metal	\$195.00*	NPB	
D2753	Crown, porcelain fused to titanium and titanium alloys	\$195.00*	NPB	
D2780	Crown, ¾ cast high noble metal	\$195.00*	NPB	
D2781	Crown, ¾ cast predominantly base metal	\$195.00	NPB	
D2782	Crown, ¾ cast noble metal	\$195.00*	NPB	
D2783	Crown, ¾ porcelain/ceramic	\$195.00*	NPB	
D2790	Crown, full cast high noble metal	\$195.00*	NPB	
D2791	Crown, full cast predominantly base metal	\$195.00	NPB	
D2792	Crown, full cast noble metal	\$195.00*	NPB	
D2794	Crown, titanium and titanium alloys	\$195.00*	NPB	
D2799	Interim crown	\$140.00	NPB	
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	\$0.00	NPB	
D2915	Re-cement or re-bond indirectly fabricated/prefabricated post & core	\$10.00	NPB	
D2920	Re-cement or re-bond crown	\$0.00	\$45.00	
D2928	Prefabricated porcelain/ceramic crown, permanent tooth	\$50.00	\$126.00	
D2930	Prefabricated stainless steel crown, primary tooth	\$50.00	\$126.00	
D2931	Prefabricated stainless steel crown, permanent tooth	\$50.00	\$178.00	
D2932	Prefabricated resin crown	\$25.00	\$136.00	
D2933	Prefabricated stainless steel crown with resin window	\$25.00	NPB	
D2934	Prefabricated esthetic coated stainless steel crown, primary tooth	\$25.00	NPB	
D2940	Protective restoration	\$0.00	\$99.00	
D2950	Core buildup, including any pins when required	\$50.00	NPB	
D2951	Pin retention, per tooth, in addition to restoration	\$15.00	NPB	
D2952	Post and core in addition to crown, indirectly fabricated	\$50.00	NPB	
D2953	Each additional indirectly fabricated post, same tooth	\$40.00	NPB	
D2954	Prefabricated post and core in addition to crown	\$45.00	NPB	
D2955	Post removal	\$10.00	NPB	
D2957	Each additional prefabricated post, same tooth	\$20.00	NPB	
D2960	Labial veneer (resin laminate), direct	\$200.00	NPB	
D2961	Labial veneer (resin laminate), indirect	\$325.00	NPB	
D2962	Labial veneer (porcelain laminate), indirect	\$500.00	NPB	
D2971	Additional procedure to customize new crown, existing partial denture frame	\$45.00	NPB	
D2980	Crown repair necessitated by restorative material failure	\$45.00	NPB	
Endodontic Services				
D3110	Pulp cap, direct (excluding final restoration)	\$5.00	\$50.00	
D3120	Pulp cap, indirect (excluding final restoration)	\$5.00	\$45.00	
D3220	Therapeutic pulpotomy (excluding final restoration)	\$20.00	\$80.00	
D3221	Pulpal debridement, primary and permanent teeth	\$10.00	NPB	
D3230	Pulpal therapy, anterior, primary tooth (excluding final restoration)	\$40.00	\$95.00	
D3240	Pulpal therapy, posterior, primary tooth (excluding final restoration)	\$40.00	\$95.00	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	\$110.00	\$385.00	



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Covered Benefits, Member Co-payments, Limitations Exclusions

CDT Code	Description	Member Co-payment		Frequency	
		General	Specialist		
Endodontic Services (continued)					
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	\$120.00	\$470.00		
D3330	Endodontic therapy, molar tooth (excluding final restoration)	\$265.00	\$580.00		
D3331	Treatment of root canal obstruction; non-surgical access	\$225.00	NPB		
D3332	Incomplete endodontic therapy; inoperable, unrestorable, fractured tooth	\$130.00	NPB		
D3333	Internal root repair of perforation defects	\$225.00	NPB		
D3346	Retreatment of previous root canal therapy, anterior	\$110.00	\$385.00		
D3347	Retreatment of previous root canal therapy, premolar	\$130.00	\$470.00		
D3348	Retreatment of previous root canal therapy, molar	\$275.00	\$580.00		
D3351	Apexification/recalcification, initial visit	\$65.00	\$125.00		
D3352	Apexification/recalcification, interim medication replacement	\$65.00	\$125.00		
D3353	Apexification/recalcification, final visit	\$65.00	\$310.00		
D3410	Apicoectomy, anterior	\$150.00	\$545.00		
D3421	Apicoectomy, premolar (first root)	\$150.00	\$565.00		
D3425	Apicoectomy, molar (first root)	\$150.00	\$485.00		
D3426	Apicoectomy, (each additional root)	\$100.00	\$485.00		
D3430	Retrograde filling, per root	\$30.00	\$170.00		
D3450	Root amputation, per root	\$95.00	\$350.00		
D3910	Surgical procedure for isolation of tooth with rubber dam	\$20.00	NPB		
D3920	Hemisection, not including root canal therapy	\$90.00	\$395.00		
D3950	Canal preparation and fitting of preformed dowel or post	\$0.00	NPB		
Periodontal Services					
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	\$125.00	\$685.00		
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant	\$16.00	\$320.00		
D4212	Gingivectomy or gingivoplasty, restorative procedure, per tooth	\$0.00	\$0.00		
D4240	Gingival flap procedure, four or more teeth per quadrant	\$250.00	\$475.00		
D4241	Gingival flap procedure, one to three teeth per quadrant	\$250.00	\$315.00		
D4245	Apically positioned flap	\$260.00	NPB		
D4249	Clinical crown lengthening, hard tissue	\$352.00	NPB		
D4260	Osseous surgery, four or more teeth per quadrant	\$250.00	\$675.00		
D4261	Osseous surgery, one to three teeth per quadrant	\$250.00	\$675.00		
D4263	Bone replacement graft, retained natural tooth, first site, quadrant	\$242.00	NPB		
D4264	Bone replacement graft, retained natural tooth, each additional site	\$132.00	NPB		
D4270	Pedicle soft tissue graft procedure	\$425.00	NPB		
D4273	Autogenous connective tissue graft procedure, first tooth	\$425.00	NPB		
D4274	Mesial/distal wedge procedure, single tooth	\$240.00	NPB		
D4275	Non-autogenous connective tissue graft, first tooth	\$425.00	NPB		
D4277	Free soft tissue graft, first tooth	\$425.00	NPB		
D4278	Free soft tissue graft, each additional tooth	\$425.00	NPB		
D4283	Autogenous connective tissue graft procedure, each additional tooth, per site	\$425.00	NPB		
D4285	Non-autogenous connective tissue graft procedure, each additional tooth, per site	\$425.00	NPB		
D4322	Splint, intra-coronal; natural teeth or prosthetic crowns	\$148.00	NPB		
D4323	Splint, extra-coronal; natural teeth or prosthetic crowns	\$148.00	NPB		
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	\$50.00	\$210.00		
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	\$50.00	\$140.00		
D4346	Scaling in presence of moderate or severe inflammation, full mouth after evaluation	\$9.00	\$55.00	1 of (D1110, D1120, D4346) every 6 months	
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis, subsequent visit	\$40.00	NPB		
D4381	Localized delivery of antimicrobial agent/per tooth	\$40.00	NPB		
D4910	Periodontal maintenance	\$40.00	\$85.00		
D4920	Unscheduled dressing change (other than treating dentist or staff)	\$20.00	\$35.00		
Removable Prosthodontic Services					
D5110	Complete denture, maxillary	\$250.00	NPB	1 of (D5110-D5283) per arch every 5 year period, if the appliance cannot be made functional through reline or repair	
D5120	Complete denture, mandibular	\$250.00	NPB		
D5130	Immediate denture, maxillary	\$250.00	NPB		
D5140	Immediate denture, mandibular	\$250.00	NPB		
D5211	Maxillary partial denture, resin base	\$375.00	NPB		
D5212	Mandibular partial denture, resin base	\$375.00	NPB		
D5213	Maxillary partial denture, cast metal, resin base	\$400.00	NPB		
D5214	Mandibular partial denture, cast metal, resin base	\$400.00	NPB		
D5221	Immediate maxillary partial denture, resin base	\$375.00	NPB		
D5222	Immediate mandibular partial denture, resin base	\$375.00	NPB		
D5223	Immediate maxillary partial denture, cast metal framework, resin denture base	\$400.00	NPB		
D5224	Immediate mandibular partial denture, cast metal framework, resin denture base	\$400.00	NPB		
D5225	Maxillary partial denture, flexible base	\$400.00	NPB		
D5226	Mandibular partial denture, flexible base	\$400.00	NPB		
D5227	Immediate maxillary partial denture, flexible base	\$400.00	NPB		
D5228	Immediate mandibular partial denture, flexible base	\$400.00	NPB		
D5282	Removable unilateral partial denture, one piece cast metal, maxillary	\$250.00	NPB		
D5283	Removable unilateral partial denture, one piece cast metal, mandibular	\$250.00	NPB		
D5284	Removable unilateral partial denture, one piece flexible base, per quadrant	\$250.00	NPB		1 of (D5284, D5286) per site every 5 year period, if the appliance cannot be made function through reline or repair
D5286	Removable unilateral partial denture, one piece resin, per quadrant	\$250.00	NPB		
D5410	Adjust complete denture, maxillary	\$10.00	NPB		
D5411	Adjust complete denture, mandibular	\$10.00	NPB		
D5421	Adjust partial denture, maxillary	\$10.00	NPB		
D5422	Adjust partial denture, mandibular	\$10.00	NPB		
D5511	Repair broken complete denture base, mandibular	\$45.00	NPB		
D5512	Repair broken complete denture base, maxillary	\$45.00	NPB		
D5520	Replace missing or broken teeth, complete denture	\$20.00	NPB		
D5611	Repair resin partial denture base, mandibular	\$45.00	NPB		
D5612	Repair resin partial denture base, maxillary	\$45.00	NPB		
D5621	Repair cast partial framework, mandibular	\$45.00	NPB		
D5622	Repair cast partial framework, maxillary	\$45.00	NPB		
D5630	Repair or replace broken retentive clasping materials, per tooth	\$45.00	NPB		
D5640	Replace broken teeth, per tooth	\$45.00	NPB		



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Covered Benefits, Member Co-payments, Limitations Exclusions

CDT Code	Description	Member Co-payment		Frequency
		General	Specialist	
Removable Prosthodontic Services (continued)				
D5650	Add tooth to existing partial denture	\$30.00	NPB	
D5660	Add clasp to existing partial denture, per tooth	\$45.00	NPB	
D5670	Replace all teeth & acrylic on cast metal frame, maxillary	\$88.00	NPB	
D5671	Replace all teeth & acrylic on cast metal frame, mandibular	\$88.00	NPB	
D5710	Rebase complete maxillary denture	\$70.00	NPB	
D5711	Rebase complete mandibular denture	\$70.00	NPB	
D5720	Rebase maxillary partial denture	\$70.00	NPB	
D5721	Rebase mandibular partial denture	\$70.00	NPB	
D5725	Rebase hybrid prosthesis	\$70.00	NPB	
D5730	Reline complete maxillary denture, direct	\$60.00	NPB	2 of (D5730-D5761) per arch every 12 months
D5731	Reline complete mandibular denture, direct	\$60.00	NPB	
D5740	Reline maxillary partial denture, direct	\$60.00	NPB	
D5741	Reline mandibular partial denture, direct	\$60.00	NPB	
D5750	Reline complete maxillary denture, indirect	\$75.00	NPB	
D5751	Reline complete mandibular denture, indirect	\$75.00	NPB	
D5760	Reline maxillary partial denture, indirect	\$75.00	NPB	
D5761	Reline mandibular partial denture, indirect	\$75.00	NPB	
D5765	Soft liner for complete or partial removable denture, indirect	\$60.00	NPB	
D5810	Interim complete denture, maxillary	\$178.00	NPB	
D5811	Interim complete denture, mandibular	\$178.00	NPB	
D5820	Interim partial denture, maxillary	\$90.00	NPB	
D5821	Interim partial denture, mandibular	\$90.00	NPB	
D5850	Tissue conditioning, maxillary	\$30.00	NPB	
D5851	Tissue conditioning, mandibular	\$30.00	NPB	
Implant Services				

GUIDELINE:
 Implants and all services associated with implants are listed at the actual member co-payment amount. No additional fee is allowable for porcelain, noble metal, high noble metal, or titanium for implants and procedures associated with implants.

D6010	Surgical placement of implant body, endosteal	\$2,000.00	\$2,300.00	
D6056	Prefabricated abutment, includes modification and placement	\$210.00	\$241.00	
D6058	Abutment supported porcelain/ceramic crown	\$1,110.00	\$1,276.00	
D6059	Abutment supported porcelain fused to high noble crown	\$1,096.00	\$1,259.00	
D6060	Abutment supported porcelain fused to base metal crown	\$1,035.00	\$1,190.00	
D6061	Abutment supported porcelain fused to noble metal crown	\$1,056.00	\$1,214.00	
D6062	Abutment supported cast metal crown, high noble	\$1,003.00	\$1,153.00	
D6063	Abutment supported cast metal crown, base metal	\$861.00	\$990.00	
D6064	Abutment supported cast metal crown, noble metal	\$912.00	\$1,048.00	
D6065	Implant supported porcelain/ceramic crown	\$1,040.00	\$1,196.00	
D6066	Implant supported crown, porcelain fused to high noble alloys	\$1,013.00	\$1,165.00	
D6067	Implant supported crown, high noble alloys	\$984.00	\$1,131.00	
D6068	Abutment supported retainer, porcelain/ceramic FPD	\$1,110.00	\$1,276.00	
D6069	Abutment supported retainer, metal FPD, high noble	\$1,096.00	\$1,260.00	
D6070	Abutment supported retainer, porcelain fused to metal FPD, base metal	\$1,035.00	\$1,190.00	
D6071	Abutment supported retainer, porcelain fused to metal FPD, noble	\$1,056.00	\$1,214.00	
D6072	Abutment supported retainer, cast metal FPD, high noble	\$1,028.00	\$1,182.00	
D6073	Abutment supported retainer, cast metal FPD, base metal	\$930.00	\$1,069.00	
D6074	Abutment supported retainer, cast metal FPD, noble	\$1,005.00	\$1,155.00	
D6075	Implant supported retainer for ceramic FPD	\$1,092.00	\$1,255.00	
D6076	Implant supported retainer for FPD, porcelain fused to high noble alloys	\$1,064.00	\$1,223.00	
D6077	Implant supported retainer for metal FPD, high noble alloys	\$984.00	\$1,131.00	
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant	\$9.00	\$55.00	1 (D6081) per implant every 12 months
D6082	Implant supported crown, porcelain fused to predominantly base alloys	\$984.00	\$1,131.00	
D6083	Implant supported crown, porcelain fused to noble alloys	\$984.00	\$1,131.00	
D6084	Implant supported crown, porcelain fused to titanium and titanium alloys	\$984.00	\$1,131.00	
D6085	Interim implant crown	\$140.00	NPB	
D6086	Implant supported crown, predominantly base alloys	\$984.00	\$1,131.00	
D6087	Implant supported crown, noble alloys	\$984.00	\$1,131.00	
D6088	Implant supported crown, titanium and titanium alloys	\$984.00	\$1,131.00	
D6092	Re-cement or re-bond implant/abutment supported crown	\$45.00	\$52.00	
D6093	Re-cement or re-bond implant/abutment supported FPD	\$65.00	\$75.00	
D6094	Abutment supported crown, titanium, and titanium alloys	\$670.00	\$770.00	
D6096	Remove broken implant retaining screw	\$75.00	\$75.00	
D6097	Abutment supported crown, porcelain fused to titanium and titanium alloys	\$984.00	\$1,131.00	
D6098	Implant supported retainer, porcelain fused to predominantly base alloys	\$984.00	\$1,131.00	
D6099	Implant supported retainer for FPD, porcelain fused to noble alloys	\$984.00	\$1,131.00	
D6105	Removal of implant body not requiring bone removal or flap elevation	\$15.00	\$95.00	
D6120	Implant supported retainer, porcelain fused to titanium and titanium alloys	\$984.00	\$1,131.00	
D6121	Implant supported retainer for metal FPD, predominantly base alloys	\$984.00	\$1,131.00	
D6122	Implant supported retainer for metal FPD, noble alloys	\$984.00	\$1,131.00	
D6123	Implant supported retainer for metal FPD, titanium and titanium alloys	\$984.00	\$1,131.00	
D6194	Abutment supported retainer crown for FPD titanium, titanium and titanium alloys	\$670.00	\$770.00	
D6195	Abutment supported retainer, porcelain fused to titanium and titanium alloys	\$984.00	\$1,131.00	
D6197	Replacement of restorative material, close access opening of screw-retained implant supported prosthesis, per implant	\$50.00	\$71.00	1 (D6197) per implant every 6 months
Fixed Prosthodontic Services				

***GUIDELINES for Pontics, Retainer Crowns, Retainer Inlays, Retainer Onlays:**
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.

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



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Covered Benefits, Member Co-payments, Limitations Exclusions

CDT Code	Description	Member Co-payment		Frequency
		General	Specialist	
Fixed Prosthodontic Services (continued)				
D6205	Pontic, indirect resin based composite	\$195.00*	NPB	1 of (D2510-D2794, D6205-D6252, D6545-D6792, D6794) per tooth every 5 year period
D6210	Pontic, cast high noble metal	\$195.00*	NPB	
D6211	Pontic, cast predominantly base metal	\$195.00	NPB	
D6212	Pontic, cast noble metal	\$195.00*	NPB	1 of (D2510-D2794, D6205-D6252, D6545-D6792, D6794) per tooth every 5 year period
D6214	Pontic, titanium, and titanium alloys	\$195.00*	NPB	
D6240	Pontic, porcelain fused to high noble metal	\$195.00*	NPB	
D6241	Pontic, porcelain fused to predominantly base metal	\$195.00*	NPB	
D6242	Pontic, porcelain fused to noble metal	\$195.00*	NPB	
D6243	Pontic, porcelain fused to titanium and titanium alloys	\$195.00*	NPB	
D6245	Pontic, porcelain/ceramic	\$195.00*	NPB	
D6250	Pontic, resin with high noble metal	\$195.00*	NPB	
D6251	Pontic, resin with predominantly base metal	\$195.00*	NPB	
D6252	Pontic, resin with noble metal	\$195.00*	NPB	
D6253	Interim pontic	\$150.00	NPB	
D6545	Retainer, cast metal for resin bonded fixed prosthesis	\$160.00*	NPB	1 of (D2510-D2794, D6205-D6252, D6545-D6792, D6794) per tooth every 5 year period
D6548	Retainer, porcelain/ceramic, resin bonded fixed prosthesis	\$160.00*	NPB	
D6549	Resin retainer, for resin bonded fixed prosthesis	\$160.00	NPB	
D6600	Retainer inlay, porcelain/ceramic, two surfaces	\$275.00*	NPB	
D6601	Retainer inlay, porcelain/ceramic, three or more surfaces	\$280.00*	NPB	
D6602	Retainer inlay, cast high noble metal, two surfaces	\$275.00*	NPB	
D6603	Retainer inlay, cast high noble metal, three or more surfaces	\$280.00*	NPB	
D6604	Retainer inlay, cast base metal, two surfaces	\$275.00	NPB	
D6605	Retainer inlay, cast base metal, three or more surfaces	\$280.00	NPB	
D6606	Retainer inlay, cast noble metal, two surfaces	\$275.00*	NPB	
D6607	Retainer inlay, cast noble metal, three or more surfaces	\$280.00*	NPB	
D6624	Retainer inlay, titanium	\$280.00*	NPB	
D6608	Retainer onlay, porcelain/ceramic, two surfaces	\$285.00*	NPB	
D6609	Retainer onlay, porcelain/ceramic, three or more surfaces	\$290.00*	NPB	
D6610	Retainer onlay, cast high noble metal, two surfaces	\$285.00*	NPB	
D6611	Retainer onlay, cast high noble metal, three or more surfaces	\$290.00*	NPB	
D6612	Retainer onlay, cast base metal, two surfaces	\$285.00	NPB	
D6613	Retainer onlay, cast base metal, three or more surfaces	\$290.00	NPB	
D6614	Retainer onlay, cast noble metal, two surfaces	\$285.00*	NPB	
D6615	Retainer onlay, cast noble metal three or more surfaces	\$290.00*	NPB	
D6634	Retainer onlay, titanium	\$290.00*	NPB	
D6710	Retainer crown, indirect resin based composite	\$195.00*	NPB	
D6720	Retainer crown, resin with high noble metal	\$195.00*	NPB	
D6721	Retainer crown, resin with predominantly base metal	\$195.00*	NPB	
D6722	Retainer crown, resin with noble metal	\$195.00*	NPB	
D6740	Retainer crown, porcelain/ceramic	\$195.00*	NPB	
D6750	Retainer crown, porcelain fused to high noble metal	\$195.00*	NPB	
D6751	Retainer crown, porcelain fused to predominantly base metal	\$195.00*	NPB	
D6752	Retainer crown, porcelain fused to noble metal	\$195.00*	NPB	
D6753	Retainer crown, porcelain fused to titanium and titanium alloys	\$195.00*	NPB	
D6780	Retainer crown, ¾ cast high noble metal	\$195.00*	NPB	
D6781	Retainer crown, ¾ cast predominantly base metal	\$195.00	NPB	
D6782	Retainer crown, ¾ cast noble metal	\$195.00*	NPB	
D6783	Retainer crown, ¾ porcelain/ceramic	\$195.00*	NPB	
D6784	Retainer crown ¾, titanium and titanium alloys	\$195.00*	NPB	
D6790	Retainer crown, full cast high noble metal	\$195.00*	NPB	
D6791	Retainer crown, full cast predominantly base metal	\$195.00	NPB	
D6792	Retainer crown, full cast noble metal	\$195.00*	NPB	
D6793	Interim retainer crown	\$125.00	NPB	
D6794	Retainer crown, titanium and titanium alloys	\$195.00*	NPB	1 of (D2510-D2794, D6205-D6252, D6545-D6792, D6794) per tooth every 5 year period
D6930	Re-cement or re-bond fixed partial denture	\$25.00	NPB	
D6940	Stress breaker	\$165.00	NPB	
D6980	Fixed partial denture repair, restorative material failure	\$45.00	NPB	
Oral & Maxillofacial Services				
D7111	Extraction, coronal remnants, primary tooth	\$10.00	\$75.00	
D7140	Extraction, erupted tooth or exposed root	\$15.00	\$95.00	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth	\$25.00	\$145.00	
D7220	Removal of impacted tooth, soft tissue	\$45.00	\$165.00	
D7230	Removal of impacted tooth, partially bony	\$55.00	\$220.00	
D7240	Removal of impacted tooth, completely bony	\$80.00	\$260.00	
D7241	Removal impacted tooth, complete bony, complication	\$130.00	\$290.00	
D7250	Removal of residual tooth roots (cutting procedure)	\$35.00	\$95.00	
D7261	Primary closure of a sinus perforation	\$310.00	NPB	
D7270	Tooth reimplantation and/or stabilization, accident	\$285.00	NPB	
D7280	Exposure of an unerupted tooth	\$140.00	NPB	
D7282	Mobilization of erupted/malpositioned tooth	\$80.00	NPB	
D7283	Placement, device to facilitate eruption, impaction	\$80.00	NPB	
D7285	Incisional biopsy of oral tissue, hard (bone, tooth)	\$60.00	\$195.00	
D7286	Incisional biopsy of oral tissue, soft	\$45.00	\$195.00	
D7287	Exfoliative cytological sample collection	\$8.00	NPB	
D7288	Brush biopsy, transepithelial sample collection	\$8.00	NPB	
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	\$30.00	\$130.00	
D7311	Alveoloplasty with extractions, one to three teeth per quadrant	\$30.00	\$130.00	
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant	\$40.00	\$160.00	
D7321	Alveoloplasty, w/o extractions, one to three teeth per quadrant	\$40.00	\$160.00	
D7340	Vestibuloplasty, ridge extension (2nd epithelialization)	\$135.00	\$1,260.00	
D7350	Vestibuloplasty, ridge extension	\$195.00	\$2,625.00	
D7450	Removal, benign odontogenic cyst/tumor, up to 1.25 cm	\$140.00	NPB	
D7451	Removal, benign odontogenic cyst/tumor, greater than 1.25 cm	\$290.00	NPB	
D7460	Removal, benign nonodontogenic cyst/tumor, up to 1.25 cm	\$165.00	NPB	
D7461	Removal, benign nonodontogenic cyst/tumor, greater than 1.25 cm	\$220.00	NPB	



LIBERTY Dental Plan of California, Inc.

CA50 Plan Schedule of Benefits

Covered Benefits, Member Co-payments, Limitations Exclusions

CDT Code	Description	Member Co-payment		Frequency
		General	Specialist	
Oral & Maxillofacial Services (continued)				
D7471	Removal of lateral exostosis, maxilla or mandible	\$175.00	NPB	
D7472	Removal of torus palatinus	\$130.00	NPB	
D7473	Removal of torus mandibularis	\$130.00	NPB	
D7485	Reduction of osseous tuberosity	\$90.00	NPB	
D7509	Marsupialization of odontogenic cyst	\$0.00	\$0.00	
D7510	Incision & drainage of abscess, intraoral soft tissue	\$18.00	\$110.00	
D7511	Incision & drainage of abscess, intraoral soft tissue, complicated	\$28.00	NPB	
D7520	Incision & drainage of abscess, extraoral soft tissue	\$18.00	\$265.00	
D7521	Incision & drainage of abscess, extraoral soft tissue, complicated	\$28.00	NPB	
D7530	Remove foreign body, mucosa, skin, tissue	\$35.00	NPB	
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	\$88.00	NPB	
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot, stabilization, per site	\$0.00	\$0.00	
D7961	Buccal/labial frenectomy (frenulectomy)	\$60.00	\$325.00	
D7962	Lingual frenectomy (frenulectomy)	\$60.00	\$325.00	
D7963	Frenuloplasty	\$60.00	NPB	
D7970	Excision of hyperplastic tissue, per arch	\$40.00	\$350.00	
D7971	Excision of pericoronal gingiva	\$40.00	\$200.00	
D7993	Surgical placement of craniofacial implant, extra oral	\$2,000.00	\$2,300.00	
D7994	Surgical placement: zygomatic implant	\$2,000.00	\$2,300.00	
Adjunctive General Services				
D9110	Palliative treatment of dental pain, per visit	\$10.00	\$80.00	
D9120	Fixed partial denture sectioning	\$12.00	NPB	
D9210	Local anesthesia not in conjunction, operative or surgical procedures	\$0.00	\$0.00	
D9211	Regional block anesthesia	\$0.00	\$0.00	
D9212	Trigeminal division block anesthesia	\$0.00	\$0.00	
D9215	Local anesthesia in conjunction with operative or surgical procedures	\$0.00	\$0.00	
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	\$0.00	\$40.00	
**GUIDELINE:				
Deep sedation/general anesthesia is a covered benefit only when in conjunction with covered oral surgery and pedodontic procedures when dispensed in a dental office by a practitioner acting within the scope of his/her licensure; and when warranted by documented conditions that local anesthetic and contraindicated. General anesthesia, as used for dental pain control, means the elimination of all sensations accompanied by a state of unconsciousness. Patient apprehension and/or nervousness are not of themselves sufficient justification for deep sedation/general anesthesia or intravenous conscious sedation/analgesia.				
D9222	Deep sedation/general anesthesia, first 15 minute increment	\$125.00**	\$125.00**	
D9223	Deep sedation/general anesthesia, each subsequent 15 minute increment	\$125.00**	\$125.00**	
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	\$40.00	\$45.00	
D9239	Intravenous moderate (conscious) sedation/analgesia, first 15 minute increment	\$125.00**	\$125.00**	
D9243	Intravenous moderate (conscious) sedation/analgesia, each subsequent 15 minute increment	\$125.00**	\$125.00**	
D9248	Non-intravenous (conscious) sedation, includes non-IV minimal and moderate sedation	\$100.00	\$100.00	
D9310	Consultation, other than requesting dentist	\$50.00	\$65.00	
D9311	Consultation with a medical health care professional	\$0.00	\$0.00	
D9430	Office visit, observation, regular hours, no other services	\$0.00	\$40.00	
D9440	Office visit, after regularly scheduled hours	\$20.00	\$125.00	
D9450	Case presentation, subsequent, detailed, extensive treatment planning	\$0.00	\$0.00	
D9630	Drugs or medicaments dispensed in the office for home use	\$15.00	\$35.00	
D9910	Application of desensitizing medicament	\$15.00	NPB	
D9911	Application of desensitizing resin for cervical, root surface, per tooth	\$15.00	NPB	
D9912	Pre-visit patient screening	\$0.00	\$0.00	
D9930	Treatment of complications, post surgical, unusual, by report	\$15.00	NPB	
D9942	Repair and/or relines of occlusal guard	\$40.00	NPB	
D9944	Occlusal guard, hard appliance, full arch	\$175.00	NPB	
D9945	Occlusal guard, soft appliance, full arch	\$175.00	NPB	
D9946	Occlusal guard, hard appliance, partial arch	\$175.00	NPB	
D9950	Occlusion analysis, mounted case	\$0.00	NPB	
D9951	Occlusal adjustment, limited	\$0.00	\$75.00	
D9952	Occlusal adjustment, complete	\$20.00	\$210.00	
D9971	Odontoplasty, per tooth	\$10.00	NPB	
D9986	Missed appointment	\$25.00	\$25.00	
D9987	Cancelled appointment	\$0.00	\$0.00	
D9991	Dental case management, addressing appointment compliance barriers	\$0.00	\$0.00	
D9992	Dental case management, care coordination	\$0.00	\$0.00	
D9993	Dental case management, motivational interviewing	\$0.00	\$0.00	
D9994	Dental case management, patient education to improve oral health literacy	\$0.00	\$0.00	
D9997	Dental case management, patients with special health care needs	\$0.00	\$0.00	
	Office visit, per visit	\$6.00	\$10.00	

Limitations:

1. Any routine dental services performed by a Primary Care Dentist or Specialist in an inpatient/outpatient hospital setting, under certain circumstances, will be considered for coverage.

Exclusions:

1. Any procedure not specifically listed as a Covered Benefit.
2. Replacement of lost or stolen prosthetics or appliances including crowns, bridges, partial dentures, full dentures, and orthodontic appliances
3. Any treatment requested, or appliances made, which are either not necessary for maintaining or improving dental health, or are for cosmetic purposes unless otherwise covered as a benefit.
4. Procedures considered experimental, treatment involving implants or pharmacological regimens other than listed as Covered Benefit (See "Independent Medical Review" in the Group Evidence of Coverage and Disclosure Form).
5. Oral surgery requiring the setting of bone fractures or bone dislocations.
6. Hospitalization
7. Out-patient services
8. Ambulance services
9. Durable Medical Equipment
10. Mental Health services
11. Chemical Dependency services
12. Home Health services
13. General anesthesia, analgesia, intravenous/intramuscular sedation or the services of an anesthesiologist other than listed as Covered Benefit.
14. Treatment started before the member was eligible, or after the member was no longer eligible.



LIBERTY Dental Plan of California, Inc.

CA50 ORTHO PLAN SCHEDULE OF BENEFITS

- Primary Dentition: Teeth developed and erupted first in order of time.
- Transitional Dentition: The Final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.
- Adolescent Dentition: The dentition that is present after the normal loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment.
- Adult Dentition: The dentition that is present after the cessation of growth that would affect orthodontic treatment.

**Treatment must be provided by a LIBERTY Dental Plan contracted orthodontic provider.
Any procedure not listed is available at the provider's usual and customary fee**

CDT Code	Description	Member Co-payment
D0340	2D cephalometric radiographic image, measurement and analysis	\$100.00
D0470	Diagnostic casts	\$75.00
D0702	2-D cephalometric radiographic image, image capture only	\$100.00
D9310	Consultation, other than requesting dentist	\$0.00
D8010	Limited orthodontic treatment of the primary dentition	\$1,100.00
D8020	Limited orthodontic treatment of the transitional dentition	\$1,100.00
D8030	Limited orthodontic treatment of the adolescent dentition	\$1,100.00
D8040	Limited orthodontic treatment of the adult dentition	\$1,150.00
D8070	Comprehensive orthodontic treatment of the transitional dentition	\$2,200.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition	\$2,200.00
D8090	Comprehensive orthodontic treatment of the adult dentition	\$2,300.00
D8210	Removable appliance therapy	\$350.00
D8220	Fixed appliance therapy	\$350.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	\$0.00
D8670	Periodic orthodontic treatment visit	\$0.00
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	\$300.00
D9986	Missed appointment	\$20.00
D9987	Cancelled appointment	\$0.00

Orthodontic Exclusions:

1. Lost, stolen or broken appliances
2. Extractions for orthodontic purposes, (will not be applied if extraction is consistent with professionally recognized standards of dental practice or arises in the context of an emergency dental condition).
3. Temporomandibular joint syndrome (TMJ) surgical orthodontics
4. Myofunctional therapy
5. Treatment of cleft palate
6. Treatment of micrognathia
7. Treatment of macroglossia



LIBERTY Dental Plan of California, Inc.

CA80 Plan Schedule of Benefits

Covered Benefits, Member Co-payments, Limitations Exclusions

No Annual Deductible

No Annual Dollar Amount Maximum

- ✓ Provider office pre-assignment is not required. However, 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 dentally necessary and outside the scope of general dentistry.
- ✓ Member Co-payments are payable to the dental office at the time services are rendered.
- ✓ This Schedule does not guarantee benefits. All services are subject to eligibility and dental necessity at the time of service.
- ✓ Dental procedures not listed as covered benefits are available at the dental office's usual and customary fee.
- ✓ For a complete description of your Plan, please refer to the Evidence of Coverage in addition to this Schedule.

CDT Code	Description	Member Co-payment		Frequency
		General	Specialist	
Diagnostic Services				
D0120	Periodic oral evaluation	\$8.00	NPB	
D0140	Limited oral evaluation	\$0.00	\$50.00	
D0145	Oral evaluation under age 3	\$8.00	\$50.00	
D0150	Comprehensive oral evaluation	\$8.00	\$50.00	
D0160	Oral evaluation, problem focused	\$8.00	\$50.00	
D0170	Re-evaluation, limited, problem focused	\$8.00	\$50.00	
D0171	Re-evaluation, post operative office visit	\$0.00	\$50.00	
D0180	Comprehensive periodontal evaluation	\$8.00	\$50.00	
D0210	Intraoral, comprehensive series of radiographic images	\$0.00	\$85.00	1 of (D0210, D0372, D0387, D0709) every 36 months
D0220	Intraoral, periapical, first radiographic image	\$0.00	\$21.00	
D0230	Intraoral, periapical, each add 'l' radiographic image	\$0.00	\$12.00	
D0240	Intraoral, occlusal radiographic image	\$0.00	\$21.00	
D0250	Extra-oral 2D projection radiographic image, stationary radiation source	\$0.00	\$31.00	
D0251	Extra-oral posterior dental radiographic image	\$0.00	\$20.00	
D0270	Bitewing, single radiographic image	\$0.00	\$20.00	
D0272	Bitewings, two radiographic images	\$0.00	\$31.00	
D0273	Bitewings, three radiographic images	\$0.00	\$35.00	
D0274	Bitewings, four radiographic images	\$0.00	\$45.00	
D0277	Vertical bitewings, 7 to 8 radiographic images	\$5.00	\$45.00	
D0330	Panoramic radiographic image	\$0.00	NPB	
D0372	Intraoral tomosynthesis, comprehensive series of radiographic images	\$0.00	\$85.00	1 of (D0210, D0372, D0387, D0709) every 36 months
D0373	Intraoral tomosynthesis, bitewing radiographic image	\$0.00	\$20.00	
D0374	Intraoral tomosynthesis, periapical radiographic image	\$0.00	\$21.00	
D0387	Intraoral tomosynthesis, comprehensive series, radiographic images, image capture only	\$0.00	\$85.00	1 of (D0210, D0372, D0387, D0709) every 36 months
D0388	Intraoral tomosynthesis, bitewing radiographic image, image capture only	\$0.00	\$20.00	
D0389	Intraoral tomosynthesis, periapical radiographic image, image capture only	\$0.00	\$21.00	
D0460	Pulp vitality tests	\$8.00	NPB	
D0470	Diagnostic casts	\$8.00	NPB	
D0701	Panoramic radiographic image, image capture only	\$0.00	NPB	
D0705	Extra-oral posterior dental radiographic image, image capture only	\$0.00	\$20.00	
D0706	Intraoral, occlusal radiographic image, image capture only	\$0.00	\$21.00	
D0707	Intraoral, periapical radiographic image, image capture only	\$0.00	\$12.00	
D0708	Intraoral, bitewing radiographic image, image capture only	\$0.00	\$20.00	
D0709	Intraoral, comprehensive series of radiographic images, image capture only	\$0.00	\$85.00	1 of (D0210, D0372, D0387, D0709) every 36 months
Preventive Services				
D1110	Prophylaxis, adult	\$0.00	\$55.00	1 of (D1110, D1120, D4346) every 6 months
	Prophylaxis, adult (additional prophylaxis)	\$54.00	\$65.00	
D1120	Prophylaxis, child	\$0.00	\$55.00	
	Prophylaxis, child (additional prophylaxis)	\$44.00	\$60.00	
D1206	Topical application of fluoride varnish	\$20.00	\$38.00	1 of (D1206, D1208) every 6 months, additional D1208 covered up to the 18th birthday (copay applies)
D1208	Topical application of fluoride, excluding varnish up to the 18th birthday (additional fluoride)	\$0.00	\$25.00	
			\$18.00	\$25.00
D1310	Nutritional counseling for control of dental disease	\$0.00	\$0.00	
D1320	Tobacco counseling, control/prevention oral disease	\$0.00	\$0.00	
D1321	Counseling for the control and prevention of adverse oral, behavioral, health effects associated with high-risk substance use	\$0.00	\$0.00	
D1330	Oral hygiene instruction	\$0.00	\$0.00	
D1351	Sealant, per tooth	\$15.00	\$37.00	Limited to first and second permanent molars up to the 14th birthday
D1352	Preventive resin restoration, permanent tooth	\$15.00	\$37.00	
D1353	Sealant repair, per tooth	\$0.00	\$0.00	
D1510	Space maintainer, fixed, unilateral, per quadrant	\$100.00	\$215.00	
D1516	Space maintainer, fixed, bilateral, maxillary	\$100.00	\$258.00	
D1517	Space maintainer, fixed, bilateral, mandibular	\$100.00	\$258.00	
D1520	Space maintainer, removable, unilateral, per quadrant	\$100.00	\$210.00	
D1526	Space maintainer, removable, bilateral, maxillary	\$100.00	\$210.00	
D1527	Space maintainer, removable, bilateral, mandibular	\$100.00	\$210.00	
D1551	Re-cement or re-bond bilateral space maintainer, maxillary	\$10.00	\$20.00	
D1552	Re-cement or re-bond bilateral space maintainer, mandibular	\$10.00	\$20.00	
D1553	Re-cement or re-bond unilateral space maintainer, per quadrant	\$10.00	\$20.00	
D1556	Removal of fixed unilateral space maintainer, per quadrant	\$20.00	\$60.00	
D1557	Removal of fixed bilateral space maintainer, maxillary	\$20.00	\$60.00	
D1558	Removal of fixed bilateral space maintainer, mandibular	\$20.00	\$60.00	
D1575	Distal shoe space maintainer, fixed, per quadrant	\$100.00	\$215.00	
Restorative Services				
D2140	Amalgam, one surface, primary or permanent	\$25.00	\$71.00	
D2150	Amalgam, two surfaces, primary or permanent	\$32.00	\$105.00	
D2160	Amalgam, three surfaces, primary or permanent	\$42.00	\$126.00	
D2161	Amalgam, four or more surfaces, primary or permanent	\$53.00	\$141.00	



LIBERTY Dental Plan of California, Inc.

CA80 Plan Schedule of Benefits

Covered Benefits, Member Co-payments, Limitations Exclusions

CDT Code	Description	Member Co-payment		Frequency
Restorative Services (continued)				
D2330	Resin-based composite, one surface, anterior	\$38.00	\$84.00	
D2331	Resin-based composite, two surfaces, anterior	\$48.00	\$94.00	
D2332	Resin-based composite, three surfaces, anterior	\$58.00	\$105.00	
D2335	Resin-based composite, four or more surfaces, involving incisal angle	\$68.00	\$115.00	
D2390	Resin-based composite crown, anterior	\$75.00	\$152.00	
D2391	Resin-based composite, one surface, posterior	\$45.00	\$71.00	
D2392	Resin-based composite, two surfaces, posterior	\$50.00	\$105.00	
D2393	Resin-based composite, three surfaces, posterior	\$55.00	\$126.00	
D2394	Resin-based composite, four or more surfaces, posterior	\$65.00	\$135.00	
<p>*GUIDELINES for Inlays, Onlays, and Single Crowns: 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>4. Base metal is the benefit: If elected, a) noble, b) high noble metal, or c) titanium may be considered an elective upgraded procedure.</p>				
D2510	Inlay, metallic, one surface	\$180.00	NPB	1 of (D2510-D2794, D6210-D6794) per tooth every 5 year period
D2520	Inlay, metallic, two surfaces	\$180.00	NPB	
D2530	Inlay, metallic, three or more surfaces	\$180.00	NPB	
D2542	Onlay, metallic, two surfaces	\$185.00	NPB	
D2543	Onlay, metallic, three surfaces	\$205.00	NPB	
D2544	Onlay, metallic, four or more surfaces	\$205.00	NPB	
D2720	Crown, resin with high noble metal	\$280.00*	NPB	
D2721	Crown, resin with predominantly base metal	\$280.00*	NPB	
D2722	Crown, resin with noble metal	\$280.00*	NPB	
D2740	Crown, porcelain/ceramic	\$280.00*	NPB	
D2750	Crown, porcelain fused to high noble metal	\$280.00*	NPB	
D2751	Crown, porcelain fused to predominantly base metal	\$280.00*	NPB	
D2752	Crown, porcelain fused to noble metal	\$280.00*	NPB	
D2753	Crown, porcelain fused to titanium and titanium alloys	\$280.00*	NPB	
D2780	Crown, ¾ cast high noble metal	\$240.00*	NPB	
D2781	Crown, ¾ cast predominantly base metal	\$240.00	NPB	
D2782	Crown, ¾ cast noble metal	\$240.00*	NPB	
D2790	Crown, full cast high noble metal	\$235.00*	NPB	
D2791	Crown, full cast predominantly base metal	\$235.00	NPB	
D2792	Crown, full cast noble metal	\$235.00*	NPB	
D2794	Crown, titanium and titanium alloys	\$235.00*	NPB	
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	\$18.00	NPB	
D2915	Re-cement or re-bond indirectly fabricated/prefabricated post & core	\$15.00	NPB	
D2920	Re-cement or re-bond crown	\$18.00	\$45.00	
D2928	Prefabricated porcelain/ceramic crown, permanent tooth	\$50.00	\$126.00	
D2930	Prefabricated stainless steel crown, primary tooth	\$50.00	\$126.00	
D2931	Prefabricated stainless steel crown, permanent tooth	\$50.00	\$178.00	
D2932	Prefabricated resin crown	\$42.00	\$136.00	
D2940	Protective restoration	\$99.00	\$99.00	
D2950	Core buildup, including any pins when required	\$99.00	NPB	
D2951	Pin retention, per tooth, in addition to restoration	\$30.00	NPB	
D2952	Post and core in addition to crown, indirectly fabricated	\$90.00	NPB	
D2953	Each additional indirectly fabricated post, same tooth	\$45.00	NPB	
D2954	Prefabricated post and core in addition to crown	\$90.00	NPB	
D2955	Post removal	\$25.00	NPB	
D2957	Each additional prefabricated post, same tooth	\$45.00	NPB	
Endodontic Services				
D3110	Pulp cap, direct (excluding final restoration)	\$20.00	\$50.00	
D3120	Pulp cap, indirect (excluding final restoration)	\$20.00	\$45.00	
D3220	Therapeutic pulpotomy (excluding final restoration)	\$40.00	\$80.00	
D3230	Pulpal therapy, anterior, primary tooth (excluding final restoration)	\$35.00	\$95.00	
D3240	Pulpal therapy, posterior, primary tooth (excluding final restoration)	\$40.00	\$95.00	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	\$150.00	\$385.00	
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	\$190.00	\$470.00	
D3330	Endodontic therapy, molar tooth (excluding final restoration)	\$245.00	\$580.00	
D3346	Retreatment of previous root canal therapy, anterior	\$170.00	\$385.00	
D3347	Retreatment of previous root canal therapy, premolar	\$220.00	\$470.00	
D3348	Retreatment of previous root canal therapy, molar	\$255.00	\$580.00	
D3351	Apexification/recalcification, initial visit	\$85.00	\$125.00	
D3352	Apexification/recalcification, interim medication replacement	\$85.00	\$125.00	
D3353	Apexification/recalcification, final visit	\$85.00	\$310.00	
D3410	Apicoectomy, anterior	\$475.00	\$545.00	
D3421	Apicoectomy, premolar (first root)	\$475.00	\$565.00	
D3425	Apicoectomy, molar (first root)	\$475.00	\$485.00	
D3426	Apicoectomy, (each additional root)	\$475.00	\$485.00	
D3430	Retrograde filling, per root	\$100.00	\$170.00	
D3450	Root amputation, per root	\$100.00	\$350.00	
D3920	Hemisection, not including root canal therapy	\$150.00	\$395.00	



LIBERTY Dental Plan of California, Inc.

CA80 Plan Schedule of Benefits

Covered Benefits, Member Co-payments, Limitations Exclusions

CDT Code	Description	Member Co-payment		Frequency	
Periodontal Services					
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	\$220.00	\$685.00		
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant	\$20.00	\$320.00		
D4212	Gingivectomy or gingivoplasty, restorative procedure, per tooth	\$0.00	\$0.00		
D4240	Gingival flap procedure, four or more teeth per quadrant	\$300.00	\$475.00		
D4241	Gingival flap procedure, one to three teeth per quadrant	\$300.00	\$315.00		
D4260	Osseous surgery, four or more teeth per quadrant	\$650.00	\$675.00		
D4261	Osseous surgery, one to three teeth per quadrant	\$650.00	\$675.00		
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	\$60.00	\$210.00		
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	\$60.00	\$140.00		
D4346	Scaling in presence of moderate or severe inflammation, full mouth after evaluation	\$0.00	\$55.00	1 of (D1110, D1120, D4346) every 6 months	
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis, subsequent visit	\$50.00	NPB		
D4910	Periodontal maintenance	\$50.00	\$85.00		
D4920	Unscheduled dressing change (other than treating dentist or staff)	NPB	\$35.00		
Removable Prosthodontic Services					
D5110	Complete denture, maxillary	\$385.00	NPB	1 of (D5110-D5283) per arch every 5 year period, if the appliance cannot be made functional through reline or repair	
D5120	Complete denture, mandibular	\$385.00	NPB		
D5130	Immediate denture, maxillary	\$385.00	NPB		
D5140	Immediate denture, mandibular	\$385.00	NPB		
D5211	Maxillary partial denture, resin base	\$385.00	NPB		
D5212	Mandibular partial denture, resin base	\$385.00	NPB		
D5213	Maxillary partial denture, cast metal, resin base	\$385.00	NPB		
D5214	Mandibular partial denture, cast metal, resin base	\$385.00	NPB		
D5221	Immediate maxillary partial denture, resin base	\$385.00	NPB		
D5222	Immediate mandibular partial denture, resin base	\$385.00	NPB		
D5223	Immediate maxillary partial denture, cast metal framework, resin denture base	\$385.00	NPB		
D5224	Immediate mandibular partial denture, cast metal framework, resin denture base	\$385.00	NPB		
D5225	Maxillary partial denture, flexible base	\$425.00	NPB		
D5226	Mandibular partial denture, flexible base	\$425.00	NPB		
D5227	Immediate maxillary partial denture, flexible base	\$425.00	NPB		
D5228	Immediate mandibular partial denture, flexible base	\$425.00	NPB		
D5282	Removable unilateral partial denture, one piece cast metal, maxillary	\$395.00	NPB		
D5283	Removable unilateral partial denture, one piece cast metal, mandibular	\$395.00	NPB		
D5284	Removable unilateral partial denture, one piece flexible base, per quadrant	\$395.00	NPB		1 of (D5284, D5286) per site every 5 year period, if the appliance cannot be made function through reline or repair
D5286	Removable unilateral partial denture, one piece resin, per quadrant	\$395.00	NPB		
D5410	Adjust complete denture, maxillary	\$22.00	NPB		
D5411	Adjust complete denture, mandibular	\$22.00	NPB		
D5421	Adjust partial denture, maxillary	\$22.00	NPB		
D5422	Adjust partial denture, mandibular	\$22.00	NPB		
D5511	Repair broken complete denture base, mandibular	\$30.00	NPB		
D5512	Repair broken complete denture base, maxillary	\$30.00	NPB		
D5520	Replace missing or broken teeth, complete denture	\$35.00	NPB		
D5611	Repair resin partial denture base, mandibular	\$35.00	NPB		
D5612	Repair resin partial denture base, maxillary	\$35.00	NPB		
D5621	Repair cast partial framework, mandibular	\$35.00	NPB		
D5622	Repair cast partial framework, maxillary	\$35.00	NPB		
D5630	Repair or replace broken retentive clasping materials, per tooth	\$25.00	NPB		
D5640	Replace broken teeth, per tooth	\$25.00	NPB		
D5650	Add tooth to existing partial denture	\$30.00	NPB		
D5660	Add clasp to existing partial denture, per tooth	\$30.00	NPB		
D5710	Rebase complete maxillary denture	\$75.00	NPB		
D5711	Rebase complete mandibular denture	\$75.00	NPB		
D5720	Rebase maxillary partial denture	\$75.00	NPB		
D5721	Rebase mandibular partial denture	\$75.00	NPB		
D5725	Rebase hybrid prosthesis	\$75.00	NPB		
D5730	Reline complete maxillary denture, direct	\$60.00	NPB	2 of (D5730-D5761) per arch every 12 months	
D5731	Reline complete mandibular denture, direct	\$60.00	NPB		
D5740	Reline maxillary partial denture, direct	\$60.00	NPB		
D5741	Reline mandibular partial denture, direct	\$60.00	NPB		
D5750	Reline complete maxillary denture, indirect	\$90.00	NPB		
D5751	Reline complete mandibular denture, indirect	\$90.00	NPB		
D5760	Reline maxillary partial denture, indirect	\$90.00	NPB		
D5761	Reline mandibular partial denture, indirect	\$90.00	NPB		
D5765	Soft liner for complete or partial removable denture, indirect	\$60.00	NPB		
D5820	Interim partial denture, maxillary	\$90.00	NPB		
D5821	Interim partial denture, mandibular	\$90.00	NPB		
D5851	Tissue conditioning, mandibular	\$55.00	NPB		
D5850	Tissue conditioning, maxillary	\$55.00	NPB		
D5863	Overdenture, complete, maxillary	\$850.00	NPB		
D5865	Overdenture, complete, mandibular	\$850.00	NPB		
Implant Services					
GUIDELINE:					
Implants and all services associated with implants are listed at the actual member co-payment amount. No additional fee is allowable for porcelain, noble metal, high noble metal, or titanium for implants and procedures associated with implants.					
D6010	Surgical placement of implant body, endosteal	\$2,000.00	\$2,300.00		
D6056	Prefabricated abutment, includes modification and placement	\$210.00	\$241.00		



LIBERTY Dental Plan of California, Inc.

CA80 Plan Schedule of Benefits

Covered Benefits, Member Co-payments, Limitations Exclusions

CDT Code	Description	Member Co-payment	Frequency	
Implant Services (continued)				
D6058	Abutment supported porcelain/ceramic crown	\$1,110.00	\$1,276.00	
D6059	Abutment supported porcelain fused to high noble crown	\$1,096.00	\$1,259.00	
D6060	Abutment supported porcelain fused to base metal crown	\$1,035.00	\$1,190.00	
D6061	Abutment supported porcelain fused to noble metal crown	\$1,056.00	\$1,214.00	
D6062	Abutment supported cast metal crown, high noble	\$1,003.00	\$1,153.00	
D6063	Abutment supported cast metal crown, base metal	\$861.00	\$990.00	
D6064	Abutment supported cast metal crown, noble metal	\$912.00	\$1,048.00	
D6065	Implant supported porcelain/ceramic crown	\$1,040.00	\$1,196.00	
D6066	Implant supported crown, porcelain fused to high noble alloys	\$1,013.00	\$1,165.00	
D6067	Implant supported crown, high noble alloys	\$984.00	\$1,131.00	
D6068	Abutment supported retainer, porcelain/ceramic FPD	\$1,110.00	\$1,276.00	
D6069	Abutment supported retainer, metal FPD, high noble	\$1,096.00	\$1,260.00	
D6070	Abutment supported retainer, porcelain fused to metal FPD, base metal	\$1,035.00	\$1,190.00	
D6071	Abutment supported retainer, porcelain fused to metal FPD, noble	\$1,056.00	\$1,214.00	
D6072	Abutment supported retainer, cast metal FPD, high noble	\$1,028.00	\$1,182.00	
D6073	Abutment supported retainer, cast metal FPD, base metal	\$930.00	\$1,069.00	
D6074	Abutment supported retainer, cast metal FPD, noble	\$1,005.00	\$1,155.00	
D6075	Implant supported retainer for ceramic FPD	\$1,092.00	\$1,255.00	
D6076	Implant supported retainer for FPD, porcelain fused to high noble alloys	\$1,064.00	\$1,223.00	
D6077	Implant supported retainer for metal FPD, high noble alloys	\$984.00	\$1,131.00	
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant	\$0.00	\$55.00	1 (D6081) per implant every 12 months
D6082	Implant supported crown, porcelain fused to predominantly base alloys	\$984.00	\$1,131.00	
D6083	Implant supported crown, porcelain fused to noble alloys	\$984.00	\$1,131.00	
D6084	Implant supported crown, porcelain fused to titanium and titanium alloys	\$984.00	\$1,131.00	
D6086	Implant supported crown, predominantly base alloys	\$984.00	\$1,131.00	
D6087	Implant supported crown, noble alloys	\$984.00	\$1,131.00	
D6088	Implant supported crown, titanium and titanium alloys	\$984.00	\$1,131.00	
D6092	Re-cement or re-bond implant/abutment supported crown	\$45.00	\$52.00	
D6093	Re-cement or re-bond implant/abutment supported FPD	\$65.00	\$75.00	
D6094	Abutment supported crown, titanium, and titanium alloys	\$670.00	\$770.00	
D6096	Remove broken implant retaining screw	\$0.00	\$0.00	
D6097	Abutment supported crown, porcelain fused to titanium and titanium alloys	\$984.00	\$1,131.00	
D6098	Implant supported retainer, porcelain fused to predominantly base alloys	\$984.00	\$1,131.00	
D6099	Implant supported retainer for FPD, porcelain fused to noble alloys	\$984.00	\$1,131.00	
D6105	Removal of implant body not requiring bone removal or flap elevation	\$28.00	\$95.00	
D6120	Implant supported retainer, porcelain fused to titanium and titanium alloys	\$984.00	\$1,131.00	
D6121	Implant supported retainer for metal FPD, predominantly base alloys	\$984.00	\$1,131.00	
D6122	Implant supported retainer for metal FPD, noble alloys	\$984.00	\$1,131.00	
D6123	Implant supported retainer for metal FPD, titanium and titanium alloys	\$984.00	\$1,131.00	
D6194	Abutment supported retainer crown for FPD titanium, titanium and titanium alloys	\$670.00	\$770.00	
D6195	Abutment supported retainer, porcelain fused to titanium and titanium alloys	\$984.00	\$1,131.00	
D6197	Replacement of restorative material, close access opening of screw-retained implant supported prosthesis, per implant	\$45.00	\$71.00	1 (D6197) per implant every 6 months
Fixed Prosthodontic Services				

***GUIDELINES for Pontics, Retainer Crowns, Retainer Inlays, Retainer Onlays:**

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.

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

D6210	Pontic, cast high noble metal	\$220.00*	NPB	1 of (D2510-D2794, D6210-D6794) per tooth every 5 year period
D6211	Pontic, cast predominantly base metal	\$220.00	NPB	
D6212	Pontic, cast noble metal	\$220.00*	NPB	
D6214	Pontic, titanium, and titanium alloys	\$220.00*	NPB	
D6240	Pontic, porcelain fused to high noble metal	\$220.00*	NPB	
D6241	Pontic, porcelain fused to predominantly base metal	\$280.00*	NPB	
D6242	Pontic, porcelain fused to noble metal	\$280.00*	NPB	
D6243	Pontic, porcelain fused to titanium and titanium alloys	\$220.00*	NPB	
D6250	Pontic, resin with high noble metal	\$280.00*	NPB	
D6251	Pontic, resin with predominantly base metal	\$280.00*	NPB	
D6252	Pontic, resin with noble metal	\$280.00*	NPB	
D6545	Retainer, cast metal for resin bonded fixed prosthesis	\$180.00*	NPB	
D6720	Retainer crown, resin with high noble metal	\$280.00*	NPB	
D6721	Retainer crown, resin with predominantly base metal	\$280.00*	NPB	
D6722	Retainer crown, resin with noble metal	\$280.00*	NPB	
D6750	Retainer crown, porcelain fused to high noble metal	\$280.00*	NPB	
D6751	Retainer crown, porcelain fused to predominantly base metal	\$280.00*	NPB	
D6752	Retainer crown, porcelain fused to noble metal	\$280.00*	NPB	
D6753	Retainer crown, porcelain fused to titanium and titanium alloys	\$280.00*	NPB	
D6780	Retainer crown, ¾ cast high noble metal	\$235.00*	NPB	
D6781	Retainer crown, ¾ cast predominantly base metal	\$235.00	NPB	
D6782	Retainer crown, ¾ cast noble metal	\$235.00*	NPB	



LIBERTY Dental Plan of California, Inc.

CA80 Plan Schedule of Benefits

Covered Benefits, Member Co-payments, Limitations Exclusions

CDT Code	Description	Member Co-payment		Frequency
Fixed Prosthodontic Services (continued)				
D6784	Retainer crown ¾, titanium and titanium alloys	\$235.00*	NPB	1 of (D2510-D2794, D6210-D6794) per tooth every 5 year period
D6790	Retainer crown, full cast high noble metal	\$280.00*	NPB	
D6791	Retainer crown, full cast predominantly base metal	\$280.00	NPB	
D6792	Retainer crown, full cast noble metal	\$280.00*	NPB	
D6794	Retainer crown, titanium and titanium alloys	\$280.00*	NPB	
D6930	Re-cement or re-bond fixed partial denture	\$35.00	NPB	
Oral & Maxillofacial Services				
D7111	Extraction, coronal remnants, primary tooth	\$25.00	\$75.00	
D7140	Extraction, erupted tooth or exposed root	\$28.00	\$95.00	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth	\$48.00	\$145.00	
D7220	Removal of impacted tooth, soft tissue	\$68.00	\$165.00	
D7230	Removal of impacted tooth, partially bony	\$100.00	\$220.00	
D7240	Removal of impacted tooth, completely bony	\$130.00	\$260.00	
D7241	Removal impacted tooth, complete bony, complication	\$140.00	\$290.00	
D7250	Removal of residual tooth roots (cutting procedure)	\$70.00	\$95.00	
D7285	Incisional biopsy of oral tissue, hard (bone, tooth)	\$20.00	\$195.00	
D7286	Incisional biopsy of oral tissue, soft	\$20.00	\$195.00	
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	\$35.00	\$130.00	
D7311	Alveoloplasty with extractions, one to three teeth per quadrant	\$35.00	\$130.00	
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant	\$40.00	\$160.00	
D7321	Alveoloplasty, w/o extractions, one to three teeth per quadrant	\$40.00	\$160.00	
D7340	Vestibuloplasty, ridge extension (2nd epithelialization)	\$230.00	\$1,260.00	
D7350	Vestibuloplasty, ridge extension	\$330.00	\$2,625.00	
D7509	Marsupialization of odontogenic cyst	\$0.00	\$0.00	
D7510	Incision & drainage of abscess, intraoral soft tissue	\$30.00	\$110.00	
D7520	Incision & drainage of abscess, extraoral soft tissue	\$30.00	\$265.00	
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot, stabilization, per site	\$0.00	\$0.00	
D7961	Buccal/labial frenectomy (frenulectomy)	\$20.00	\$325.00	
D7962	Lingual frenectomy (frenulectomy)	\$20.00	\$325.00	
D7970	Excision of hyperplastic tissue, per arch	\$70.00	\$350.00	
D7971	Excision of pericoronal gingiva	\$40.00	\$200.00	
D7993	Surgical placement of craniofacial implant, extra oral	\$2,000.00	\$2,300.00	
D7994	Surgical placement: zygomatic implant	\$2,000.00	\$2,300.00	
Adjunctive General Services				
D9110	Palliative treatment of dental pain, per visit	\$15.00	\$80.00	
D9210	Local anesthesia not in conjunction, operative or surgical procedures	\$0.00	\$0.00	
D9211	Regional block anesthesia	\$0.00	\$0.00	
D9212	Trigeminal division block anesthesia	\$0.00	\$0.00	
D9215	Local anesthesia in conjunction with operative or surgical procedures	\$0.00	\$0.00	
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	\$45.00	\$45.00	
D9310	Consultation, other than requesting dentist	\$50.00	\$65.00	
D9311	Consultation with a medical health care professional	\$50.00	\$65.00	
D9430	Office visit, observation, regular hours, no other services	\$0.00	\$40.00	
D9440	Office visit, after regularly scheduled hours	\$20.00	\$125.00	
D9450	Case presentation, subsequent, detailed, extensive treatment planning	\$0.00	\$0.00	
D9630	Drugs or medicaments dispensed in the office for home use	\$20.00	\$35.00	
D9912	Pre-visit patient screening	\$0.00	\$0.00	
D9951	Occlusal adjustment, limited	\$20.00	\$75.00	
D9952	Occlusal adjustment, complete	\$20.00	\$210.00	
D9986	Missed appointment	\$10.00	\$25.00	
D9987	Cancelled appointment	\$0.00	\$0.00	
D9991	Dental case management, addressing appointment compliance barriers	\$0.00	\$0.00	
D9992	Dental case management, care coordination	\$0.00	\$0.00	
D9993	Dental case management, motivational interviewing	\$0.00	\$0.00	
D9994	Dental case management, patient education to improve oral health literacy	\$0.00	\$0.00	
D9997	Dental case management, patients with special health care needs	\$0.00	\$0.00	
	Office visit, per visit	\$8.00	\$10.00	



LIBERTY Dental Plan of California, Inc.

Schedule of Benefits

Covered Benefits, Member Co-payments, Limitations Exclusions

Limitations:

1. Any routine dental services performed by a Primary Care Dentist or Specialist in an inpatient/outpatient hospital setting, under certain circumstances, will be considered for coverage.

Exclusions:

1. Any procedure not specifically listed as a Covered Benefit.
2. Replacement of lost or stolen prosthetics or appliances including crowns, bridges, partial dentures, full dentures, and orthodontic appliances.
3. Any treatment requested, or appliances made, which are either not necessary for maintaining or improving dental health, or are for cosmetic purposes unless otherwise covered as a benefit.
4. Procedures considered experimental, treatment involving implants or pharmacological regimens other than listed as Covered Benefit (See "Independent Medical Review" in the Group Evidence of Coverage and Disclosure Form).
5. Oral surgery requiring the setting of bone fractures or bone dislocations.
6. Hospitalization
7. Out-patient services
8. Ambulance services
9. Durable Medical Equipment
10. Mental Health services
11. Chemical Dependency services
12. Home Health services
13. General anesthesia, analgesia, intravenous/intramuscular sedation or the services of an anesthesiologist other than listed as Covered Benefit.
14. Treatment started before the member was eligible, or after the member was no longer eligible.



LIBERTY Dental Plan of California, Inc.

CA80 ORTHO PLAN SCHEDULE OF BENEFITS

- Primary Dentition: Teeth developed and erupted first in order of time.
- Transitional Dentition: The Final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.
- Adolescent Dentition: The dentition that is present after the normal loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment.
- Adult Dentition: The dentition that is present after the cessation of growth that would affect orthodontic treatment.

**Treatment must be provided by a LIBERTY Dental Plan contracted orthodontic provider.
Any procedure not listed is available at the provider's usual and customary fee**

CDT Code	Description	Member Co-payment
D0340	2D cephalometric radiographic image, measurement and analysis	\$100.00
D0470	Diagnostic casts	\$75.00
D0702	2-D cephalometric radiographic image, image capture only	\$100.00
D9310	Consultation, other than requesting dentist	\$0.00
D8010	Limited orthodontic treatment of the primary dentition	\$1,100.00
D8020	Limited orthodontic treatment of the transitional dentition	\$1,100.00
D8030	Limited orthodontic treatment of the adolescent dentition	\$1,100.00
D8040	Limited orthodontic treatment of the adult dentition	\$1,150.00
D8070	Comprehensive orthodontic treatment of the transitional dentition	\$2,200.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition	\$2,200.00
D8090	Comprehensive orthodontic treatment of the adult dentition	\$2,300.00
D8210	Removable appliance therapy	\$350.00
D8220	Fixed appliance therapy	\$350.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	\$0.00
D8670	Periodic orthodontic treatment visit	\$0.00
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	\$300.00
D9986	Missed appointment	\$20.00
D9987	Cancelled appointment	\$0.00

Orthodontic Exclusions:

1. Lost, stolen or broken appliances
2. Extractions for orthodontic purposes, (will not be applied if extraction is consistent with professionally recognized standards of dental practice or arises in the context of an emergency dental condition).
3. Temporomandibular joint syndrome (TMJ) surgical orthodontics
4. Myofunctional therapy
5. Treatment of cleft palate
6. Treatment of micrognathia
7. Treatment of macroglossia



LIBERTY Dental Plan of California, Inc.

CA90 Plan Schedule of Benefits

Covered Benefits, Member Co-payments, Limitations Exclusions

No Annual Deductible

No Annual Dollar Amount Maximum

- ✓ Provider office pre-assignment is not required. However, 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 dentally necessary and outside the scope of general dentistry.
- ✓ Member Co-payments are payable to the dental office at the time services are rendered.
- ✓ This Schedule does not guarantee benefits. All services are subject to eligibility and dental necessity at the time of service.
- ✓ Dental procedures not listed as covered benefits are available at the dental office's usual and customary fee.
- ✓ For a complete description of your Plan, please refer to the Evidence of Coverage in addition to this Schedule.

CDT Code	Description	Member Co-payment		Frequency
		General	Specialist	
Diagnostic Services				
D0120	Periodic oral evaluation	\$10.00	NPB	
D0140	Limited oral evaluation	\$10.00	\$50.00	
D0145	Oral evaluation under age 3	\$10.00	\$50.00	
D0150	Comprehensive oral evaluation	\$10.00	\$50.00	
D0160	Oral evaluation, problem focused	\$10.00	\$50.00	
D0170	Re-evaluation, limited, problem focused	\$10.00	\$50.00	
D0171	Re-evaluation, post operative office visit	\$10.00	\$50.00	
D0180	Comprehensive periodontal evaluation	\$10.00	\$50.00	
D0210	Intraoral, comprehensive series of radiographic images	\$24.00	\$85.00	1 of (D0210, D0372, D0387, D0709) every 36 months
D0220	Intraoral, periapical, first radiographic image	\$5.00	\$21.00	
D0230	Intraoral, periapical, each add 'l' radiographic image	\$5.00	\$12.00	
D0240	Intraoral, occlusal radiographic image	\$24.00	\$21.00	
D0250	Extra-oral 2D projection radiographic image, stationary radiation source	\$5.00	\$31.00	
D0251	Extra-oral posterior dental radiographic image	\$0.00	\$20.00	
D0270	Bitewing, single radiographic image	\$5.00	\$20.00	
D0272	Bitewings, two radiographic images	\$0.00	\$31.00	
D0273	Bitewings, three radiographic images	\$0.00	\$35.00	
D0274	Bitewings, four radiographic images	\$0.00	\$45.00	
D0277	Vertical bitewings, 7 to 8 radiographic images	\$10.00	\$45.00	
D0330	Panoramic radiographic image	\$24.00	NPB	
D0372	Intraoral tomosynthesis, comprehensive series of radiographic images	\$24.00	\$85.00	1 of (D0210, D0372, D0387, D0709) every 36 months
D0373	Intraoral tomosynthesis, bitewing radiographic image	\$5.00	\$20.00	
D0374	Intraoral tomosynthesis, periapical radiographic image	\$5.00	\$21.00	
D0387	Intraoral tomosynthesis, comprehensive series, radiographic images, image capture only	\$24.00	\$85.00	1 of (D0210, D0372, D0387, D0709) every 36 months
D0388	Intraoral tomosynthesis, bitewing radiographic image, image capture only	\$5.00	\$20.00	
D0389	Intraoral tomosynthesis, periapical radiographic image, image capture only	\$5.00	\$21.00	
D0460	Pulp vitality tests	\$0.00	NPB	
D0470	Diagnostic casts	\$0.00	NPB	
D0701	Panoramic radiographic image, image capture only	\$24.00	NPB	
D0705	Extra-oral posterior dental radiographic image, image capture only	\$0.00	\$20.00	
D0706	Intraoral, occlusal radiographic image, image capture only	\$24.00	\$21.00	
D0707	Intraoral, periapical radiographic image, image capture only	\$5.00	\$12.00	
D0708	Intraoral, bitewing radiographic image, image capture only	\$5.00	\$20.00	
D0709	Intraoral, comprehensive series of radiographic images, image capture only	\$24.00	\$85.00	1 of (D0210, D0372, D0387, D0709) every 36 months
Preventive Services				
D1110	Prophylaxis, adult	\$17.00	\$55.00	1 of (D1110, D1120, D4346) every 6 months
	Prophylaxis, adult (additional prophylaxis)	\$56.00	\$65.00	
D1120	Prophylaxis, child	\$15.00	\$55.00	
	Prophylaxis, child (additional prophylaxis)	\$45.00	\$60.00	
D1206	Topical application of fluoride varnish	\$25.00	\$38.00	1 of (D1206, D1208) every 6 months, additional D1208 covered up to the 18th birthday (copay applies)
D1208	Topical application of fluoride, excluding varnish up to the 18th birthday (additional fluoride)	\$8.00	\$25.00	
			\$20.00	\$25.00
D1310	Nutritional counseling for control of dental disease	\$0.00	\$0.00	
D1320	Tobacco counseling, control/prevention oral disease	\$0.00	\$0.00	
D1321	Counseling for the control and prevention of adverse oral, behavioral, health effects associated with high-risk substance use	\$0.00	\$0.00	
D1330	Oral hygiene instruction	\$0.00	\$0.00	
D1351	Sealant, per tooth	\$16.00	\$37.00	Limited to first and second permanent molars up to the 14th birthday
D1352	Preventive resin restoration, permanent tooth	\$16.00	\$37.00	
D1353	Sealant repair, per tooth	\$0.00	\$0.00	
D1510	Space maintainer, fixed, unilateral, per quadrant	\$104.00	\$215.00	
D1516	Space maintainer, fixed, bilateral, maxillary	\$121.00	\$258.00	
D1517	Space maintainer, fixed, bilateral, mandibular	\$121.00	\$258.00	
D1520	Space maintainer, removable, unilateral, per quadrant	\$104.00	\$210.00	
D1526	Space maintainer, removable, bilateral, maxillary	\$121.00	\$210.00	
D1527	Space maintainer, removable, bilateral, mandibular	\$121.00	\$210.00	
D1551	Re-cement or re-bond bilateral space maintainer, maxillary	\$35.00	\$22.00	
D1552	Re-cement or re-bond bilateral space maintainer, mandibular	\$35.00	\$22.00	
D1553	Re-cement or re-bond unilateral space maintainer, per quadrant	\$35.00	\$22.00	
D1556	Removal of fixed unilateral space maintainer, per quadrant	\$30.00	\$60.00	
D1557	Removal of fixed bilateral space maintainer, maxillary	\$30.00	\$60.00	
D1558	Removal of fixed bilateral space maintainer, mandibular	\$30.00	\$60.00	
D1575	Distal shoe space maintainer, fixed, per quadrant	\$104.00	\$215.00	
Restorative Services				
D2140	Amalgam, one surface, primary or permanent	\$45.00	\$71.00	
D2150	Amalgam, two surfaces, primary or permanent	\$55.00	\$105.00	
D2160	Amalgam, three surfaces, primary or permanent	\$65.00	\$126.00	
D2161	Amalgam, four or more surfaces, primary or permanent	\$70.00	\$141.00	



LIBERTY Dental Plan of California, Inc.

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Covered Benefits, Member Co-payments, Limitations Exclusions

CDT Code	Description	Member Co-payment	Frequency
Restorative Services (continued)			
D2330	Resin-based composite, one surface, anterior	\$55.00	\$84.00
D2331	Resin-based composite, two surfaces, anterior	\$60.00	\$94.00
D2332	Resin-based composite, three surfaces, anterior	\$65.00	\$105.00
D2335	Resin-based composite, four or more surfaces, involving incisal angle	\$70.00	\$115.00
D2390	Resin-based composite crown, anterior	\$80.00	\$152.00
D2391	Resin-based composite, one surface, posterior	\$65.00	\$71.00
D2392	Resin-based composite, two surfaces, posterior	\$70.00	\$105.00
D2393	Resin-based composite, three surfaces, posterior	\$75.00	\$126.00
D2394	Resin-based composite, four or more surfaces, posterior	\$85.00	\$135.00
<p>*GUIDELINES for Inlays, Onlays, and Single Crowns: 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>4. Base metal is the benefit: If elected, a) noble, b) high noble metal, or c) titanium may be considered an elective upgraded procedure.</p>			
D2510	Inlay, metallic, one surface	\$250.00	NPB
D2520	Inlay, metallic, two surfaces	\$340.00	NPB
D2530	Inlay, metallic, three or more surfaces	\$400.00	NPB
D2542	Onlay, metallic, two surfaces	\$370.00	NPB
D2543	Onlay, metallic, three surfaces	\$480.00	NPB
D2544	Onlay, metallic, four or more surfaces	\$560.00	NPB
D2720	Crown, resin with high noble metal	\$440.00*	NPB
D2721	Crown, resin with predominantly base metal	\$440.00*	NPB
D2722	Crown, resin with noble metal	\$440.00*	NPB
D2740	Crown, porcelain/ceramic	\$440.00*	NPB
D2750	Crown, porcelain fused to high noble metal	\$440.00*	NPB
D2751	Crown, porcelain fused to predominantly base metal	\$440.00*	NPB
D2752	Crown, porcelain fused to noble metal	\$440.00*	NPB
D2753	Crown, porcelain fused to titanium and titanium alloys	\$440.00*	NPB
D2780	Crown, ¾ cast high noble metal	\$440.00*	NPB
D2781	Crown, ¾ cast predominantly base metal	\$440.00*	NPB
D2782	Crown, ¾ cast noble metal	\$440.00*	NPB
D2790	Crown, full cast high noble metal	\$440.00*	NPB
D2791	Crown, full cast predominantly base metal	\$440.00*	NPB
D2792	Crown, full cast noble metal	\$440.00*	NPB
D2794	Crown, titanium and titanium alloys	\$440.00*	NPB
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	\$38.00	NPB
D2915	Re-cement or re-bond indirectly fabricated/prefabricated post & core	\$30.00	NPB
D2920	Re-cement or re-bond crown	\$38.00	\$45.00
D2928	Prefabricated porcelain/ceramic crown, permanent tooth	\$88.00	\$126.00
D2930	Prefabricated stainless steel crown, primary tooth	\$88.00	\$126.00
D2931	Prefabricated stainless steel crown, permanent tooth	\$104.00	\$178.00
D2932	Prefabricated resin crown	\$85.00	\$136.00
D2940	Protective restoration	\$110.00	\$99.00
D2950	Core buildup, including any pins when required	\$120.00	NPB
D2951	Pin retention, per tooth, in addition to restoration	\$60.00	NPB
D2952	Post and core in addition to crown, indirectly fabricated	\$132.00	NPB
D2953	Each additional indirectly fabricated post, same tooth	\$55.00	NPB
D2954	Prefabricated post and core in addition to crown	\$132.00	NPB
D2955	Post removal	\$35.00	NPB
D2957	Each additional prefabricated post, same tooth	\$55.00	NPB
Endodontic Services			
D3110	Pulp cap, direct (excluding final restoration)	\$30.00	\$50.00
D3120	Pulp cap, indirect (excluding final restoration)	\$30.00	\$45.00
D3220	Therapeutic pulpotomy (excluding final restoration)	\$50.00	\$80.00
D3230	Pulpal therapy, anterior, primary tooth (excluding final restoration)	\$45.00	\$95.00
D3240	Pulpal therapy, posterior, primary tooth (excluding final restoration)	\$45.00	\$95.00
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	\$245.00	\$385.00
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	\$295.00	\$470.00
D3330	Endodontic therapy, molar tooth (excluding final restoration)	\$395.00	\$580.00
D3346	Retreatment of previous root canal therapy, anterior	\$255.00	\$385.00
D3347	Retreatment of previous root canal therapy, premolar	\$310.00	\$470.00
D3348	Retreatment of previous root canal therapy, molar	\$410.00	\$580.00
D3351	Apexification/recalcification, initial visit	\$125.00	\$125.00
D3352	Apexification/recalcification, interim medication replacement	\$125.00	\$125.00
D3353	Apexification/recalcification, final visit	\$125.00	\$310.00
D3410	Apicoectomy, anterior	\$350.00	\$545.00
D3421	Apicoectomy, premolar (first root)	\$350.00	\$565.00
D3425	Apicoectomy, molar (first root)	\$350.00	\$485.00
D3426	Apicoectomy, (each additional root)	\$350.00	\$485.00
D3430	Retrograde filling, per root	\$120.00	\$170.00
D3450	Root amputation, per root	\$110.00	\$350.00
D3920	Hemisection, not including root canal therapy	\$220.00	\$395.00

1 of (D2510-D2794, D6210-D6794) per tooth every 5 year period



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Covered Benefits, Member Co-payments, Limitations Exclusions

CDT Code	Description	Member Co-payment		Frequency	
Periodontal Services					
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	\$200.00	\$685.00		
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant	\$75.00	\$320.00		
D4212	Gingivectomy or gingivoplasty, restorative procedure, per tooth	\$0.00	\$0.00		
D4240	Gingival flap procedure, four or more teeth per quadrant	\$300.00	\$475.00		
D4241	Gingival flap procedure, one to three teeth per quadrant	\$300.00	\$315.00		
D4260	Osseous surgery, four or more teeth per quadrant	\$650.00	\$675.00		
D4261	Osseous surgery, one to three teeth per quadrant	\$650.00	\$675.00		
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	\$75.00	\$210.00		
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	\$75.00	\$140.00		
D4346	Scaling in presence of moderate or severe inflammation, full mouth after evaluation	\$17.00	\$55.00	1 of (D1110, D1120, D4346) every 6 months	
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis, subsequent visit	\$75.00	NPB		
D4910	Periodontal maintenance	\$55.00	\$85.00		
D4920	Unscheduled dressing change (other than treating dentist or staff)	NPB	\$35.00		
Removable Prosthodontic Services					
D5110	Complete denture, maxillary	\$500.00	NPB	1 of (D5110-D5283) per arch every 5 year period, if the appliance cannot be made functional through reline or repair	
D5120	Complete denture, mandibular	\$500.00	NPB		
D5130	Immediate denture, maxillary	\$500.00	NPB		
D5140	Immediate denture, mandibular	\$500.00	NPB		
D5211	Maxillary partial denture, resin base	\$599.00	NPB		
D5212	Mandibular partial denture, resin base	\$599.00	NPB		
D5213	Maxillary partial denture, cast metal, resin base	\$599.00	NPB		
D5214	Mandibular partial denture, cast metal, resin base	\$599.00	NPB		
D5221	Immediate maxillary partial denture, resin base	\$599.00	NPB		
D5222	Immediate mandibular partial denture, resin base	\$599.00	NPB		
D5223	Immediate maxillary partial denture, cast metal framework, resin denture base	\$599.00	NPB		
D5224	Immediate mandibular partial denture, cast metal framework, resin denture base	\$599.00	NPB		
D5225	Maxillary partial denture, flexible base	\$435.00	NPB		
D5226	Mandibular partial denture, flexible base	\$435.00	NPB		
D5227	Immediate maxillary partial denture, flexible base	\$435.00	NPB		
D5228	Immediate mandibular partial denture, flexible base	\$435.00	NPB		
D5282	Removable unilateral partial denture, one piece cast metal, maxillary	\$415.00	NPB		
D5283	Removable unilateral partial denture, one piece cast metal, mandibular	\$415.00	NPB		
D5284	Removable unilateral partial denture, one piece flexible base, per quadrant	\$415.00	NPB		1 of (D5284, D5286) per site every 5 year period, if the appliance cannot be made function through reline or repair
D5286	Removable unilateral partial denture, one piece resin, per quadrant	\$415.00	NPB		
D5410	Adjust complete denture, maxillary	\$30.00	NPB		
D5411	Adjust complete denture, mandibular	\$30.00	NPB		
D5421	Adjust partial denture, maxillary	\$30.00	NPB		
D5422	Adjust partial denture, mandibular	\$30.00	NPB		
D5511	Repair broken complete denture base, mandibular	\$59.00	NPB		
D5512	Repair broken complete denture base, maxillary	\$59.00	NPB		
D5520	Replace missing or broken teeth, complete denture	\$66.00	NPB		
D5611	Repair resin partial denture base, mandibular	\$59.00	NPB		
D5612	Repair resin partial denture base, maxillary	\$59.00	NPB		
D5621	Repair cast partial framework, mandibular	\$104.00	NPB		
D5622	Repair cast partial framework, maxillary	\$104.00	NPB		
D5630	Repair or replace broken retentive clasping materials, per tooth	\$66.00	NPB		
D5640	Replace broken teeth, per tooth	\$66.00	NPB		
D5650	Add tooth to existing partial denture	\$66.00	NPB		
D5660	Add clasp to existing partial denture, per tooth	\$66.00	NPB		
D5710	Rebase complete maxillary denture	\$200.00	NPB		
D5711	Rebase complete mandibular denture	\$200.00	NPB		
D5720	Rebase maxillary partial denture	\$200.00	NPB		
D5721	Rebase mandibular partial denture	\$200.00	NPB		
D5725	Rebase hybrid prosthesis	\$200.00	NPB		
D5730	Reline complete maxillary denture, direct	\$165.00	NPB	2 of (D5730-D5761) per arch every 12 months	
D5731	Reline complete mandibular denture, direct	\$165.00	NPB		
D5740	Reline maxillary partial denture, direct	\$165.00	NPB		
D5741	Reline mandibular partial denture, direct	\$165.00	NPB		
D5750	Reline complete maxillary denture, indirect	\$195.00	NPB		
D5751	Reline complete mandibular denture, indirect	\$195.00	NPB		
D5760	Reline maxillary partial denture, indirect	\$195.00	NPB		
D5761	Reline mandibular partial denture, indirect	\$195.00	NPB		
D5765	Soft liner for complete or partial removable denture, indirect	\$165.00	NPB		
D5820	Interim partial denture, maxillary	\$220.00	NPB		
D5821	Interim partial denture, mandibular	\$220.00	NPB		
D5851	Tissue conditioning, mandibular	\$49.00	NPB		
D5850	Tissue conditioning, maxillary	\$49.00	NPB		
D5863	Overdenture, complete, maxillary	\$850.00	NPB		
D5865	Overdenture, complete, mandibular	\$850.00	NPB		
Implant Services					
GUIDELINE:					
Implants and all services associated with implants are listed at the actual member co-payment amount. No additional fee is allowable for porcelain, noble metal, high noble metal, or titanium for implants and procedures associated with implants.					
D6010	Surgical placement of implant body, endosteal	\$2,000.00	\$2,300.00		
D6056	Prefabricated abutment, includes modification and placement	\$210.00	\$241.00		



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Covered Benefits, Member Co-payments, Limitations Exclusions

CDT Code	Description	Member Co-payment	Frequency	
Implant Services (continued)				
D6058	Abutment supported porcelain/ceramic crown	\$1,110.00	\$1,276.00	
D6059	Abutment supported porcelain fused to high noble crown	\$1,096.00	\$1,259.00	
D6060	Abutment supported porcelain fused to base metal crown	\$1,035.00	\$1,190.00	
D6061	Abutment supported porcelain fused to noble metal crown	\$1,056.00	\$1,214.00	
D6062	Abutment supported cast metal crown, high noble	\$1,003.00	\$1,153.00	
D6063	Abutment supported cast metal crown, base metal	\$861.00	\$990.00	
D6064	Abutment supported cast metal crown, noble metal	\$912.00	\$1,048.00	
D6065	Implant supported porcelain/ceramic crown	\$1,040.00	\$1,196.00	
D6066	Implant supported crown, porcelain fused to high noble alloys	\$1,013.00	\$1,165.00	
D6067	Implant supported crown, high noble alloys	\$984.00	\$1,131.00	
D6068	Abutment supported retainer, porcelain/ceramic FPD	\$1,110.00	\$1,276.00	
D6069	Abutment supported retainer, metal FPD, high noble	\$1,096.00	\$1,260.00	
D6070	Abutment supported retainer, porcelain fused to metal FPD, base metal	\$1,035.00	\$1,190.00	
D6071	Abutment supported retainer, porcelain fused to metal FPD, noble	\$1,056.00	\$1,214.00	
D6072	Abutment supported retainer, cast metal FPD, high noble	\$1,028.00	\$1,182.00	
D6073	Abutment supported retainer, cast metal FPD, base metal	\$930.00	\$1,069.00	
D6074	Abutment supported retainer, cast metal FPD, noble	\$1,005.00	\$1,155.00	
D6075	Implant supported retainer for ceramic FPD	\$1,092.00	\$1,255.00	
D6076	Implant supported retainer for FPD, porcelain fused to high noble alloys	\$1,064.00	\$1,223.00	
D6077	Implant supported retainer for metal FPD, high noble alloys	\$984.00	\$1,131.00	
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant	\$17.00	\$55.00	1 (D6081) per implant every 12 months
D6082	Implant supported crown, porcelain fused to predominantly base alloys	\$984.00	\$1,131.00	
D6083	Implant supported crown, porcelain fused to noble alloys	\$984.00	\$1,131.00	
D6084	Implant supported crown, porcelain fused to titanium and titanium alloys	\$984.00	\$1,131.00	
D6086	Implant supported crown, predominantly base alloys	\$984.00	\$1,131.00	
D6087	Implant supported crown, noble alloys	\$984.00	\$1,131.00	
D6088	Implant supported crown, titanium and titanium alloys	\$984.00	\$1,131.00	
D6092	Re-cement or re-bond implant/abutment supported crown	\$45.00	\$52.00	
D6093	Re-cement or re-bond implant/abutment supported FPD	\$65.00	\$75.00	
D6094	Abutment supported crown, titanium, and titanium alloys	\$670.00	\$770.00	
D6096	Remove broken implant retaining screw	\$0.00	\$0.00	
D6097	Abutment supported crown, porcelain fused to titanium and titanium alloys	\$984.00	\$1,131.00	
D6098	Implant supported retainer, porcelain fused to predominantly base alloys	\$984.00	\$1,131.00	
D6099	Implant supported retainer for FPD, porcelain fused to noble alloys	\$984.00	\$1,131.00	
D6105	Removal of implant body not requiring bone removal or flap elevation	\$50.00	\$95.00	
D6120	Implant supported retainer, porcelain fused to titanium and titanium alloys	\$984.00	\$1,131.00	
D6121	Implant supported retainer for metal FPD, predominantly base alloys	\$984.00	\$1,131.00	
D6122	Implant supported retainer for metal FPD, noble alloys	\$984.00	\$1,131.00	
D6123	Implant supported retainer for metal FPD, titanium and titanium alloys	\$984.00	\$1,131.00	
D6194	Abutment supported retainer crown for FPD titanium, titanium and titanium alloys	\$670.00	\$770.00	
D6195	Abutment supported retainer, porcelain fused to titanium and titanium alloys	\$984.00	\$1,131.00	
D6197	Replacement of restorative material, close access opening of screw-retained implant supported prosthesis, per implant	\$65.00	\$71.00	1 (D6197) per implant every 6 months
Fixed Prosthodontic Services				

***GUIDELINES for Pontics, Retainer Crowns, Retainer Inlays, Retainer Onlays:**

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.

D6210	Pontic, cast high noble metal	\$440.00*	NPB	1 of (D2510-D2794, D6210-D6794) per tooth every 5 year period
D6211	Pontic, cast predominantly base metal	\$440.00*	NPB	
D6212	Pontic, cast noble metal	\$440.00*	NPB	
D6214	Pontic, titanium, and titanium alloys	\$440.00*	NPB	
D6240	Pontic, porcelain fused to high noble metal	\$440.00*	NPB	
D6241	Pontic, porcelain fused to predominantly base metal	\$440.00*	NPB	
D6242	Pontic, porcelain fused to noble metal	\$440.00*	NPB	
D6243	Pontic, porcelain fused to titanium and titanium alloys	\$440.00*	NPB	
D6250	Pontic, resin with high noble metal	\$440.00*	NPB	
D6251	Pontic, resin with predominantly base metal	\$440.00*	NPB	
D6252	Pontic, resin with noble metal	\$190.00*	NPB	
D6545	Retainer, cast metal for resin bonded fixed prosthesis	\$440.00*	NPB	
D6720	Retainer crown, resin with high noble metal	\$440.00*	NPB	
D6721	Retainer crown, resin with predominantly base metal	\$440.00*	NPB	
D6722	Retainer crown, resin with noble metal	\$440.00*	NPB	
D6750	Retainer crown, porcelain fused to high noble metal	\$440.00*	NPB	
D6751	Retainer crown, porcelain fused to predominantly base metal	\$440.00*	NPB	
D6752	Retainer crown, porcelain fused to noble metal	\$440.00*	NPB	
D6753	Retainer crown, porcelain fused to titanium and titanium alloys	\$440.00*	NPB	
D6780	Retainer crown, ¾ cast high noble metal	\$440.00*	NPB	
D6781	Retainer crown, ¾ cast predominantly base metal	\$440.00*	NPB	
D6782	Retainer crown, ¾ cast noble metal	\$440.00*	NPB	



LIBERTY Dental Plan of California, Inc.

CA90 Plan Schedule of Benefits

Covered Benefits, Member Co-payments, Limitations Exclusions

CDT Code	Description	Member Co-payment		Frequency
Fixed Prosthodontic Services (continued)				
D6784	Retainer crown ¾, titanium and titanium alloys	\$440.00*	NPB	1 of (D2510-D2794, D6210-D6794) per tooth every 5 year period
D6790	Retainer crown, full cast high noble metal	\$440.00*	NPB	
D6791	Retainer crown, full cast predominantly base metal	\$440.00	NPB	
D6792	Retainer crown, full cast noble metal	\$440.00*	NPB	
D6794	Retainer crown, titanium and titanium alloys	\$440.00*	NPB	
D6930	Re-cement or re-bond fixed partial denture	\$45.00	NPB	
Oral & Maxillofacial Services				
D7111	Extraction, coronal remnants, primary tooth	\$40.00	\$75.00	
D7140	Extraction, erupted tooth or exposed root	\$50.00	\$95.00	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth	\$89.00	\$145.00	
D7220	Removal of impacted tooth, soft tissue	\$115.00	\$165.00	
D7230	Removal of impacted tooth, partially bony	\$145.00	\$220.00	
D7240	Removal of impacted tooth, completely bony	\$175.00	\$260.00	
D7241	Removal impacted tooth, complete bony, complication	\$195.00	\$290.00	
D7250	Removal of residual tooth roots (cutting procedure)	\$110.00	\$95.00	
D7285	Incisional biopsy of oral tissue, hard (bone, tooth)	\$137.00	\$195.00	
D7286	Incisional biopsy of oral tissue, soft	\$82.00	\$195.00	
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	\$45.00	\$130.00	
D7311	Alveoloplasty with extractions, one to three teeth per quadrant	\$45.00	\$130.00	
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant	\$60.00	\$160.00	
D7321	Alveoloplasty, w/o extractions, one to three teeth per quadrant	\$60.00	\$160.00	
D7340	Vestibuloplasty, ridge extension (2nd epithelialization)	\$500.00	\$1,260.00	
D7350	Vestibuloplasty, ridge extension	\$750.00	\$2,625.00	
D7509	Marsupialization of odontogenic cyst	\$0.00	\$0.00	
D7510	Incision & drainage of abscess, intraoral soft tissue	\$50.00	\$110.00	
D7520	Incision & drainage of abscess, extraoral soft tissue	\$60.00	\$265.00	
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot, stabilization, per site	\$0.00	\$0.00	
D7961	Buccal/labial frenectomy (frenulectomy)	\$40.00	\$325.00	
D7962	Lingual frenectomy (frenulectomy)	\$40.00	\$325.00	
D7970	Excision of hyperplastic tissue, per arch	\$95.00	\$350.00	
D7971	Excision of pericoronal gingiva	\$60.00	\$200.00	
D7993	Surgical placement of craniofacial implant, extra oral	\$2,000.00	\$2,300.00	
D7994	Surgical placement: zygomatic implant	\$2,000.00	\$2,300.00	
Adjunctive General Services				
D9110	Palliative treatment of dental pain, per visit	\$27.00	\$80.00	
D9210	Local anesthesia not in conjunction, operative or surgical procedures	\$0.00	\$0.00	
D9211	Regional block anesthesia	\$0.00	\$0.00	
D9212	Trigeminal division block anesthesia	\$0.00	\$0.00	
D9215	Local anesthesia in conjunction with operative or surgical procedures	\$0.00	\$0.00	
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	\$45.00	\$45.00	
D9310	Consultation, other than requesting dentist	\$50.00	\$65.00	
D9311	Consultation with a medical health care professional	\$50.00	\$65.00	
D9430	Office visit, observation, regular hours, no other services	\$10.00	\$40.00	
D9440	Office visit, after regularly scheduled hours	\$40.00	\$125.00	
D9450	Case presentation, subsequent, detailed, extensive treatment planning	\$0.00	\$0.00	
D9630	Drugs or medicaments dispensed in the office for home use	\$25.00	\$35.00	
D9912	Pre-visit patient screening	\$0.00	\$0.00	
D9951	Occlusal adjustment, limited	\$35.00	\$75.00	
D9952	Occlusal adjustment, complete	\$90.00	\$210.00	
D9986	Missed appointment	\$25.00	\$25.00	
D9987	Cancelled appointment	\$0.00	\$0.00	
D9991	Dental case management, addressing appointment compliance barriers	\$0.00	\$0.00	
D9992	Dental case management, care coordination	\$0.00	\$0.00	
D9993	Dental case management, motivational interviewing	\$0.00	\$0.00	
D9994	Dental case management, patient education to improve oral health literacy	\$0.00	\$0.00	
D9997	Dental case management, patients with special health care needs	\$0.00	\$0.00	
	Office visit, per visit	\$10.00	\$10.00	



LIBERTY Dental Plan of California, Inc.
Schedule of Benefits
Covered Benefits, Member Co-payments, Limitations Exclusions

Limitations:

1. Any routine dental services performed by a Primary Care Dentist or Specialist in an inpatient/outpatient hospital setting, under certain circumstances, will be considered for coverage.

Exclusions:

1. Any procedure not specifically listed as a Covered Benefit.
2. Replacement of lost or stolen prosthetics or appliances including crowns, bridges, partial dentures, full dentures, and orthodontic appliances.
3. Any treatment requested, or appliances made, which are either not necessary for maintaining or improving dental health, or are for cosmetic purposes unless otherwise covered as a benefit.
4. Procedures considered experimental, treatment involving implants or pharmacological regimens other than listed as Covered Benefit (See "Independent Medical Review" in the Group Evidence of Coverage and Disclosure Form).
5. Oral surgery requiring the setting of bone fractures or bone dislocations.
6. Hospitalization
7. Out-patient services
8. Ambulance services
9. Durable Medical Equipment
10. Mental Health services
11. Chemical Dependency services
12. Home Health services
13. General anesthesia, analgesia, intravenous/intramuscular sedation or the services of an anesthesiologist other than listed as Covered Benefit.
14. Treatment started before the member was eligible, or after the member was no longer eligible.



LIBERTY Dental Plan of California, Inc.

CA90 ORTHO PLAN SCHEDULE OF BENEFITS

- Primary Dentition: Teeth developed and erupted first in order of time.
- Transitional Dentition: The Final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.
- Adolescent Dentition: The dentition that is present after the normal loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment.
- Adult Dentition: The dentition that is present after the cessation of growth that would affect orthodontic treatment.

**Treatment must be provided by a LIBERTY Dental Plan contracted orthodontic provider.
Any procedure not listed is available at the provider's usual and customary fee**

CDT Code	Description	Member Co-payment
D0340	2D cephalometric radiographic image, measurement and analysis	\$100.00
D0470	Diagnostic casts	\$75.00
D0702	2-D cephalometric radiographic image, image capture only	\$100.00
D9310	Consultation, other than requesting dentist	\$0.00
D8010	Limited orthodontic treatment of the primary dentition	\$1,100.00
D8020	Limited orthodontic treatment of the transitional dentition	\$1,100.00
D8030	Limited orthodontic treatment of the adolescent dentition	\$1,100.00
D8040	Limited orthodontic treatment of the adult dentition	\$1,150.00
D8070	Comprehensive orthodontic treatment of the transitional dentition	\$2,200.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition	\$2,200.00
D8090	Comprehensive orthodontic treatment of the adult dentition	\$2,300.00
D8210	Removable appliance therapy	\$350.00
D8220	Fixed appliance therapy	\$350.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	\$0.00
D8670	Periodic orthodontic treatment visit	\$0.00
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	\$300.00
D9986	Missed appointment	\$20.00
D9987	Cancelled appointment	\$0.00

Orthodontic Exclusions:

1. Lost, stolen or broken appliances
2. Extractions for orthodontic purposes, (will not be applied if extraction is consistent with professionally recognized standards of dental practice or arises in the context of an emergency dental condition).
3. Temporomandibular joint syndrome (TMJ) surgical orthodontics
4. Myofunctional therapy
5. Treatment of cleft palate
6. Treatment of micrognathia
7. Treatment of macroglossia

Appendix 2:
**PREMIUM, PRE-PAYMENT FEES
AND CHARGES**

LIBERTY Dental Plan			
Individual Plan Annual Premiums			
Plan Options	CA50 Plan	CA80 Plan	CA90 Plan
Member	\$279.51	\$160.02	\$120.47
Member + 1	\$455.73	\$199.54	\$154.30
Member + 2 or more	\$666.44	\$267.05	\$176.52
Senior Member (65+)	\$253.56	\$146.02	N/A
Senior Member (65+) +1	\$412.16	\$181.59	N/A
Senior Member (65+) + 2 or more (65+)	\$601.79	\$242.34	N/A

Appendix 3:



Notice of Language Assistance (TAGLINES)

English Tagline

ATTENTION: If you need help in your language call 1-888-703-6999 TTY: 1-877-855-8039. Aids and services for people with disabilities, like documents in braille and large print, are also available. These services are free of charge.

الشعار بالعربية (Arabic)

تنبيه: إذا كنت بحاجة إلى مساعدة بلغتك، فاتصل على الرقم 1-888-703-6999 الهاتف النصي: 1-877-855-8039. المساعدات والخدمات للأشخاص ذوي الإحتياجات الخاصة متوفرة أيضًا، مثل المستندات المكتوبة بطريقة برايل والأحرف بالطباعة الكبيرة. هذه الخدمات مجانية.

Հայերեն պիտակ (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե Ձեր լեզվով օգնության կարիք ունեք, զանգահարեք 1-888-703-6999 TTY՝ 1-877-855-8039: Մատչելի են նաև աջակցություններ և ծառայություններ հաշմանդամների համար, օրինակ՝ փաստաթղթերը բրայլով կամ մեծ տառատեսակով: Այս ծառայությունները մատուցվում են անվճար:

ឃ្លាសម្គាល់ជាភាសាខ្មែរ (Cambodian)

ចំណាំ: ប្រសិនបើអ្នកត្រូវការជំនួយជាភាសារបស់អ្នក សូមទូរសព្ទទៅលេខ 1-888-703-6999 TTY: 1-877-855-8039 ។ ជំនួយនិងសេវាកម្មសម្រាប់ជនពិការ ដូចជាឯកសារអក្សរសម្រាប់ជនពិការភ្នែក និងអក្សរពុម្ពធំ ក៏មានផងដែរ។ សេវាកម្មទាំងនេះមានដោយមិនគិតថ្លៃ។

简体中文标语 (Simplified Chinese)

请注意：如果您需要以您的母语提供帮助，请致电 1-888-703-6999 TTY: 1-877-855-8039。我们另外还提供针对残疾人士的帮助和服务，例如盲文和大字体阅读，提供您方便取用。这些服务都是免费的

فارسی زبان به مطلب (Farsi)

توجه: اگر به کمک در زبان خود نیاز دارید با شماره 1-800-703-6999 ، TTY: 1-877-855-8039. کمکها و خدمات برای افراد دارای معلولیت، مانند اسناد به خط بریل یا چاپ بزرگنمایی شده نیز وجود دارد. این خدمات مجانی هستند.

हिंदी टैगलाइन (Hindi)

ध्यान दें: यदि आपको अपनी भाषा में सहायता चाहिए तो 1-888-703-6999 TTY: 1-877-855-8039. विकलांग लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में दस्तावेज़ भी उपलब्ध हैं। ये सेवाएं नि:शुल्क हैं।

Nqe Lus Hmoob Cob (Hmong)

CEEB TOOM: Yog nej xav tau kev pab txhais koj yam lus cia li hu 1-888-703-6999 TTY: 1-877-855-8039. Tej khoom pab thiab tej kev pab rau cov neeg uas xiam oob qhab, xws li cov ntaub ntawv uas muaj braille thiab muaj tsiaj ntawv loj, los kuj muaj thiab. Tej kev pab no los pub dawb tsis them nqi li.

日本語表記 (Japanese)

注意：日本語によるヘルプが必要な場合は、1-888-703-6999、または1-877-855-8039（TTY）にお電話ください。障害をお持ちの方のために、点字や大きい活字の文書などによる支援およびサービスもご用意しています。これらのサービスは無料でご利用いただけます。

한국어 태그라인 (Korean)

주의: 본인이 사용하는 언어로 도움을 받고자 할 경우 1-888-703-6999, TTY: 1-877-855-8039번으로 연락하시기 바랍니다. 장애인을 위한 점자 또는 큰 활자 문서와 같은 지원 및 서비스도 이용할 수 있습니다. 이러한 서비스는 무료입니다.

ຄຳບັນຍາຍເປັນພາສາລາວ (LAOTIAN)

ຂໍ້ຄວນໃສໃຈ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານ ໃຫ້ໂທຫາ 1-888-703-6999, TTY: 1-877-855-8039. ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການຕ່າງໆ ສຳລັບຄົນພິການ ເຊັ່ນວ່າ: ເອກະສານທີ່ເປັນຕົວອັກສອນສຳລັບຄົນພິການຕາ ແລະ ພິມເປັນຕົວໃຫຍ່ ກໍມີໃຫ້ພ້ອມໃຊ້ງານໄດ້. ການບໍລິການເຫຼົ່ານີ້ ແມ່ນບໍ່ໄດ້ເສຍຄ່າ.

Mien Tagline (Mien)

COR-FIM JANGX LONGX: Beiv taux gorngv meih qiex longc mienh tengx faan benx meih nyei fingz waac bun muangx nor douc waac lorx taux 1-888-703-6999 TTY: 1-877-855-8039. Maaih jaa sic tengx goux aengx caux nzie weih gong se duqv mbenc liouh bun ninh mbuo wuaaic fangx mienh longc beiv taux benx sou-nzangc pokc bun hluo doqc aengx caux domh sou-daan bun longc. Naaiv deix nzie weih gong se bun wang-henh longc maiv zuqc feix zinh nyaanh oc.

ਪੰਜਾਬੀ ਟੈਗਲਾਈਨ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ 1-888-703-6999 'ਤੇ ਕਾਲ ਕਰੋ, TTY: 1-877-855-8039. ਅਪੰਗਤਾਵਾਂ ਵਾਲੇ ਲੋਕਾਂ ਲਈ ਸਹਾਇਕ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ।

Русский слоган (Russian)

ОБРАТИТЕ ВНИМАНИЕ! Если вам нужна помощь на родном языке, позвоните по телефону 1-888-703-6999, линия TTY: 1-877-855-8039. Также предоставляются услуги и материалы в специальных форматах для людей с особыми потребностями, например документы, набранные шрифтом Брайля и крупным шрифтом. Такие услуги предоставляются бесплатно.

Mensaje en español (Spanish)

ATENCIÓN: Si necesita ayuda en su idioma, llame al 1-888-703-6999, TTY: 1-877-855-8039. También se encuentran disponibles ayudas y servicios para personas con discapacidades, como documentos en braille y en letra grande. Estos servicios son gratuitos.

Tagalog Tagline (Tagalog)

ATENSIYON: Kung kailangan mo ng tulong sa iyong wika tumawag sa 1-888-703-6999, TTY: 1-877-855-8039. Ang mga tulong at serbisyo para sa mga taong may kapansanan, tulad ng mga dokumento sa braille at malalaking letra, ay makukuha rin. Ang mga serbisyong ito ay libre.

แท็กไลน์ภาษาไทย (Thai)

หมายเหตุ: หากท่านต้องการความช่วยเหลือในภาษาของท่าน ให้โทรไปที่ 1-888-703-6999, TTY: 1-877-855-8039. มีทั้งอุปกรณ์ช่วยและบริการต่าง ๆ สำหรับคนพิการ เช่นเอกสารที่เป็นอักษรเบรลล์หรือตัวพิมพ์ใหญ่ ไม่ต้องเสียค่าใช้จ่ายสำหรับบริการเหล่านี้

Примітка українською (Ukrainian)

ЗВЕРНІТЬ УВАГУ! Якщо вам потрібна допомога рідною мовою, зателефонуйте на номер 1-888-703-6999, лінія TTY: 1-877-855-8039. Також надаються послуги та матеріали в спеціальних форматах для людей з особливими потребами, наприклад документи, набрані шрифтом Брайля та крупним шрифтом. Такі послуги надаються безкоштовно.

Khẩu hiệu tiếng Việt (Vietnamese)

LƯU Ý: Nếu quý vị cần hỗ trợ với ngôn ngữ của quý vị, hãy gọi theo số 1-888-703-6999, TTY: 1-877-855-8039. Cũng có sẵn các hỗ trợ và dịch vụ dành cho người khuyết tật, như tài liệu chữ nổi braille và bản in chữ lớn. Các dịch vụ này là miễn phí.

NONDISCRIMINATION NOTICE

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, contact LIBERTY between Monday through Friday, 8 a.m. to 5 p.m. (PST). If you cannot hear or speak well, please call (877) 855-8039. Upon request, this document can be made available to you in braille, largeprint, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, please call or write to:

LIBERTY Dental Plan
P.O. Box 26110
Santa Ana, CA 92799-6110
(888) 703-6999 TTY: (877) 855-8039
California Relay: 711

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 between 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 877-855-8039.
- In writing: Fill out a complaint form or write a letter and send it to:

LIBERTY's Civil Rights Coordinator
P.O. Box 26110
Santa Ana, CA 92799-6110
- In person: Visit your doctor's office or LIBERTY and say you want to file a grievance.
- Electronically: Visit LIBERTY Dental Plan's website at <https://www.libertydentalplan.com/Members/File-a-Grievance-or-Appeal.aspx>

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:

**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>.

**Appendix 4:
FORMS**



WRITTEN MEMBER GRIEVANCE AND APPEAL FORM – CALIFORNIA

Please use this form to help file a grievance or appeal with LIBERTY Dental Plan (LIBERTY). You can also use this form to give LIBERTY more information to help us review your case. If you have filed an **appeal over the telephone**, you can complete this form and mail it back to LIBERTY. This is optional. We will review your case without a written appeal.

MEMBER INFORMATION (PLEASE PRINT)			
Member last name	Member first name	Today's date	
Member street address	City	State	ZIP code
Member phone number	Member identification number (see identification card)		
Employer or Group	Patient name	Relationship	

AUTHORIZED REPRESENTATIVE INFORMATION, IF APPLICABLE (PLEASE PRINT)		
I am authorizing LIBERTY Dental Plan to allow the following person to act on my behalf during the grievance/appeals		
Representative last name	Representative first name	Representative phone number
Representative Signature	Member Signature	

DENTAL OFFICE/PROVIDER INFORMATION (PLEASE PRINT)			
I am authorizing LIBERTY Dental Plan to request my information, including chart records and x-rays, if applicable, from			
Office number	Dental office name	Date of last visit	
Dental office street address	City	State	ZIP Code
Dental office phone number	Name(s) of dental office staff involved (if known)		

Medicaid Appeals must be filed within 60 days from the date on your Denial Letter.

Medicaid Grievances can be filed at any time.

Medicare Appeals and Grievances must be filed within 90 days from the date on your Denial Letter or from the event that causes your dissatisfaction

Commercial/Individual Appeals and Grievances must be filed within 180 days from the date on your Denial Letter or from the event that causes your dissatisfaction

If you need help completing this form, call our Member Services Department at 888-703-6999 or TTY 877-855-8039, Monday through Friday 8:00 a.m. to 5:00 p.m. We can give you an interpreter at no cost, if you need one. You or someone you authorize have the right to review your case file at any time. We'll give you copies free of charge.

SUMMARY OF GRIEVANCE OR APPEAL

Please share any information you have about your grievance or appeal. Please give us as many details as you can, if possible please provide the dates, names and any treatment. If needed you can attach an additional page.

[Empty box for grievance details]

Please share with us how you would like to see your grievance or appeal resolved.

[Empty box for resolution preferences]

Member Signature

Date

PLEASE SEND COMPLETED SIGNED FORM TO:

Mail To:
LIBERTY Dental Plan of California
Grievances and Appeals Department
P.O. Box 26110
Santa Ana, CA 92602-26110

- Fax to LIBERTY's Grievances and Appeals Department fax at 949-270-0109
- Telephone LIBERTY Dental Plan's Member Services Department at 866-703-6999, or TTY (877) 855-8039
- Electronically using the website online grievance filing process by visiting www.libertydentalplan.com.
- Emailing us at: GandA@libertydentalplan.com

You will receive a letter acknowledging receipt of your grievance or appeal within 5 calendar days of receipt by LIBERTY. You will receive a written resolution to your grievance or appeal within 30 calendar days of receipt by LIBERTY.

“The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-888-703-6999/TTY 877-550-3875** and use your health plan’s grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-446-2219**) 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.”



CALIFORNIA PUBLIC POLICY COMMITTEE APPLICATION FORM

Thank you for your interest in joining LIBERTY Dental Plan's California Public Policy Committee. Please fill out this form and return by mail, e-mail or fax. Information is found at the bottom of the page.

If you are **ACCEPTED** to join this Committee, you will receive a check for \$100.00 for each meeting that you attend.

What is your first and last name?
What is your date of birth?
What is your address?
What is your daytime phone number?
What is your LIBERTY ID Number?
Where do you work?:
What is your job title?
Please select your education level: <input type="checkbox"/> 8 th Grade <input type="checkbox"/> High School <input type="checkbox"/> College <input type="checkbox"/> Other

You contact us at 1-888-703-6999 or TTY/TTD 1-877-855-8039, Monday through Friday from 8:00 a.m. to 8:00 p.m. (EST) if you need help completing this form or if you have any questions.

Please e-mail this form to QM@libertydentalplan.com. You may also mail/fax it to:

LIBERTY Dental Plan of California
Public Policy Committee (QM Dept.)
P.O. Box 26110
Santa Ana, CA 92799
Fax number: 888-334-6027

INDEPENDENT MEDICAL REVIEW (IMR) APPLICATION/COMPLAINT FORM

IMPORTANT INFORMATION

You can submit your IMR Application/Complaint Form online at: www.HealthHelp.ca.gov

- ❖ **FREE:** The IMR/Complaint process is free.
- ❖ **FAST:** IMRs are usually decided within 45 days, or within 7 days if the health issue is urgent.
- ❖ **SUCCESSFUL:** Approximately **68** percent of patients receive the requested service through IMR.
- ❖ **FINAL:** Health plans must follow the IMR decision and promptly provide the service.

PATIENT INFORMATION

First Name _____ Middle Initial ____ Last Name _____

Patient's Date of Birth (mm/dd/yyyy) _____

Gender: Male Female Something Else _____

Name of Parent or Guardian if Filing for Minor Child _____

Street Address _____

City _____ State _____ Zip _____

Phone # _____ Email Address _____

Would you like communication/correspondence sent to this email? Yes No

Health Plan Name _____ Patient's Membership # _____

Medical Group Name (if enrolled in a medical group) _____

Employer _____

Do you want someone to help you with your complaint? Yes No

If yes, please complete the attached 'Authorized Assistant Form.'

Do you have Medi-Cal? Yes No

If yes, have you filed a Request for a State Fair Hearing? Yes No

Do you have Medicare or Medicare Advantage? Yes No

Have you filed a complaint or grievance with your health plan? Yes No

Do you want payment for a health care service that you already received? Yes No

If yes, list the date(s) of service, and the provider's name:

YOUR HEALTH PROBLEM

(Use a separate sheet and attach other documents, if needed.)

Do you want your health plan to pay for future services? Yes No

What is your medical condition or doctor's diagnosis (Please be specific) _____

What medical treatment(s)/service(s) and/or medication(s) are you asking for? (Please be specific)

Did your health plan deny, delay or modify your treatment? Yes No

If yes, please check the reason given: (Check one)

- Not Medically Necessary Experimental or Investigational Not an Emergency/Urgent
 Not a Covered Benefit Other (Please explain below)

List the name and phone number of your primary care doctor and other providers who have seen, treated, or advised you for this condition.

Have you seen any out-of-network providers for your condition? Yes No

If yes, please include the medical records with this form.

Briefly describe the problem you are having with your plan. For example, explain if the problem is a denied treatment, an unpaid bill, trouble getting an appointment or medication, or if your coverage has been cancelled by the health plan.

MEDICAL RELEASE

I request the Department of Managed Health Care (Department) to make a decision about my problem with my health plan. I request the Department to review my Independent Medical Review (IMR) Application/Complaint Form to determine if my complaint qualifies for an IMR or the Department's Complaint process. I allow my providers, past and present, and my plan to release my medical records and information to review this issue. These records may include medical, mental health, substance abuse, HIV, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the Department to review these records and information and send them to my plan. My permission will end one year from the date below, except as allowed by law. For example, the law allows the Department to continue to use my information internally. I can end my permission sooner if I wish. All the information that I have provided on this sheet is true.

Patient or Parent Name (Print) _____

Patient or Parent Signature _____ Date _____

Please see the instruction sheet for mailing or faxing information.

STATISTICAL INFORMATION ONLY

You are asked to voluntarily provide the following information. Giving this information will help the Department identify any patterns of problems. Health and Safety Code section 1374.30 authorizes the Department to obtain this information for research and statistical purposes. Giving this information is optional and will not affect the IMR or complaint decision in any way.

Primary Language Spoken: _____

Would you like us to communicate/correspond with you in your primary language? Yes

Race/Ethnicity: _____

AUTHORIZED ASSISTANT FORM

- If you want to give another person permission to assist you with your Independent Medical Review (IMR) or complaint, complete Parts A and B below.
- If you are a parent or legal guardian filing this IMR or complaint for a child under the age of 18, you do not need to complete this form.
- If you are filing this IMR or complaint for a patient who cannot complete this form because the patient is either incompetent or incapacitated, and you have legal authority to act for this patient, please complete Part B only. Also attach a copy of the power of attorney for health care decisions or other documents that say you can make decisions for the patient.

PART A: COMPLETED BY PATIENT

I allow the person named below in Part B to assist me in my IMR or complaint filed with the Department of Managed Health Care (Department). I allow the Department and IMR staff to share information about my medical condition(s) and care with the person named below. This information may include mental health treatment, HIV treatment or testing, alcohol or drug treatment, or other health care information.

I understand that only information related to my IMR or complaint will be shared.

My approval of this assistance is voluntary and I have the right to end it. If I want to end it, I must do so in writing.

Patient Name (Print) _____

Patient Signature _____ Date _____

PART B: COMPLETED BY PERSON ASSISTING PATIENT

Name of Person Assisting (Print) _____

Address _____

City _____ State _____ Zip _____

Relationship to Patient _____

Primary Phone # _____ Secondary Phone # _____

Email Address _____

My power of attorney for health care decisions or other legal document is attached.

IMR Application/Complaint Form Instruction Sheet

If you have questions, call the Help Center at 1-888-466-2219 or TDD at 1-877-688-9891. This call is free.

Before You File:

In most cases, you must complete your plan's complaint or grievance process before you file a complaint or IMR request to the Department. Your plan must give you a decision within 30 days or within 3 days if your problem is an immediate and serious threat to your health.

If your plan denied your treatment because it was experimental/investigational, you do not have to take part in your plan's complaint or grievance process before you file an IMR application.

You must apply for an IMR within six months after your health plan sends you a written response to your appeal. The Department may accept your application after six months if it is determined that circumstances prevented timely submission. Please be aware that if you decide not to file a complaint with the DEPARTMENT for an issue that would qualify for an IMR, you may be giving up your rights to pursue legal action against your plan regarding the service or treatment you are requesting.

How to File:

1. File online at www.HealthHelp.ca.gov. This is the fastest way.

OR

Fill out and sign the IMR Application/Complaint Form.

2. If you want someone to help you with your IMR or complaint, complete the 'Authorized Assistant Form.'
3. If you have medical records from **out of network providers**, please include them with your IMR Application/Complaint Form. Your plan will provide medical records from network providers.
4. You may include other documents that support your request. However, there is no need to provide any documents or correspondence between you and your plan relating to this complaint. The Department will obtain this information directly from your plan as part of the investigation.
5. If you are not submitting online, please mail or fax your form and any supporting documents to:

Department of Managed Health Care Help Center
980 9th Street, Suite 500
Sacramento, CA 95814-2725
FAX: 916-255-5241

What Happens Next?

The Help Center will send you a letter within seven days telling you if you qualify for an IMR. If it is determined that your complaint qualifies for an IMR, your case is assigned to a state contractor who will perform the review. The state contractor is also known as the Independent Medical Review Organization (IMRO). All of the information in the Help Center's possession related to your complaint, including your medical records, will be sent to the IMRO. The IMRO will make a decision usually within 30 days or within seven days if your case is urgent. You will be notified in writing of the decision.

If it is determined that your complaint should be reviewed through the Consumer Complaint process, a decision about your issue will be made within 30 days. You will be notified in writing of the decision.

IMR Application/Complaint Form Instruction Sheet

The Information Practices Act of 1977 (California Civil Code Section 1798.17) requires the following notice.

- California's Knox-Keene Act gives the Department the authority to regulate health plans and investigate the complaints of health plan members.
- The Department's Help Center uses your personal information to investigate your problem with your plan and to provide an IMR if you qualify for one.
- You provide the Department this information voluntarily. You do not have to provide this information. However, if you do not, the Department may not be able to investigate your complaint or provide an IMR.
- The Department may share your personal information, as needed, with the plan and providers who conduct the IMR.
- The Department may also share your information with other government agencies as required or allowed by law.
- You have a right to see your personal information. To do this, contact the Department Records Request Coordinator, Department of Managed Health Care, Office of Legal Services, 980 9th Street Suite 500, Sacramento CA 95814-2725, or call 916-322-6727.