LIBERTY Dental Plan

Evidence of Coverage

This Evidence of Coverage (EOC) describes the dental care plan made available to Eligible Employees of the Employer (referred to as "Group") and their Eligible Family Members.

LIBERTY Dental Plan of Missouri, Inc. (LIBERTY), and the Group have agreed to all of the terms of this EOC. It is part of the contract (Group Enrollment Agreement or "GEA") between LIBERTY and Group. This EOC may be terminated by LIBERTY or the Group upon appropriate written notice in accordance with the GEA. The Group is responsible for giving Members notice of termination.

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

You may contact LIBERTY's Member Services Department at:

Address: LIBERTY Dental Plan

P.O. Box 26110

Santa Ana, CA 92799-6110]

Phone: (Monday – Friday from 7:00 a.m. until 7:00 p.m., CST.

I.888.902.0407

We encourage you to contact us with your questions or concerns.

Also, you may directly contact the Missouri Department of Insurance, Financial Institutions and Professional Registration ("MDI"). MDI has established a process to receive inquiries and complaints from consumers of healthcare in Missouri concerning healthcare plans.

For More Information Contact MDI's Consumer Hotline:: 1- 800-726-7390

Inquiries and complaints may be filed online at:

http://insurance.mo.gov/consumer/complaints/index.htm

or by mailing or faxing your inquiry or complaint to:

Missouri DIFP
Attn: Consumer Affairs
P.O. Box 690
Jefferson City, MO 65102-0690

Fax Number: 573-526-4898

Evidence of Coverage

SECTION 1. Eligibility, Enrollment and Effective Date

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

1.1 Who Is Eligible

You and your eligible dependents are eligible to enroll in LIBERTY Dental Plan so long as you meet the eligibility requirements imposed by your employer.

A. Be a bona fide employee of the Group; and

B. Meet the following criteria:

- Be employed full-time;
- Be actively at work;
- Work at least the minimum number of hours per week indicated by the Group in its Application;
- Meet the applicable waiting period indicated by the Group in its Application;
- Enroll during an enrollment period;
- Live or work in the service area; and
- Work for an employer that meets the Minimum Employer Contribution Percentage for the applicable coverage.

The actively at work requirement will not apply to Individuals covered under Group's prior welfare benefit plan on the date of that plan's discontinuance, provided that this EOC is initially effective no more than sixty (60) days after the prior plan's discontinuance. All other requirements will apply to such Individuals.

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

- A Subscriber's legal spouse or a legal spouse for whom a court has ordered coverage.
- Registered domestic partner
- A child by birth. Adopted child. Stepchild. Minor child for whom a court has ordered coverage. Child being placed for Adoption with the Subscriber. A child for whom a court has appointed the Subscriber or the Subscriber's spouse the legal guardian.
- The DEPENDENT CHILD of a SUBSCRIBER up to the child's twenty-sixth (26th) birthday unless such child is eligible for employer-sponsored coverage (other than coverage through the SUBSCRIBER). The children and spouse of a DEPENDENT CHILD are excluded from coverage.
- Any unmarried child who is incapable of self-sustaining employment due to mental or physical handicap, chiefly dependent upon the Subscriber for economic support and maintenance, and who has satisfied all of the requirements of (a) or (b) below.

  (a) The child must be a Dependent enrolled under this EOC before reaching the limiting age, and proof of incapacity and dependency must be given to LIBERTY by the Subscriber within thirty-one (31) days of the child reaching the limiting age; or

  (b) The handicap started before the child reached the limiting age, but the Group was enrolled with another health insurance carrier that covered the child as a handicapped Dependent prior to the Group enrolling with LIBERTY.

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

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

If a policy provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in the policy, such policy, so long as it remains in force, until the dependent child attains the limiting age, shall remain in force at the option of the certificate holder. Eligibility for continued coverage shall be established where the dependent child is:

(a) Unmarried and no more than that twenty-five years of age; and

(b) A resident of this state; and

(c) Not provided coverage as a named subscriber, insured, enrollee, or covered person under any group or individual health benefit plan, or entitled to benefits under Title XVIII of the Social Security Act, P.L. 89-97, 42 U.S.C. Section 1395, et seq.;

1.2 Who Is Not Eligible

Eligible Dependents may not include:

- A foster child.
- A child placed in the Subscriber's home other than for adoption.
- A grandchild.
- Any other person not defined in Section 1.1.

1.3 Changes In Eligibility Status

It is the Subscriber's responsibility to give his/her employer notice within thirty-one (31) days of changes, which affect his Dependents' eligibility. Changes include:

- Reaching the limiting age.
- Death.
- Divorce.
- Marriage.
- Or transfer of residence or work outside LIBERTY's Service Area.

1.4 Enrollment

Eligible Employees and Eligible Family Members must enroll during one of the Enrollment Periods described below or within thirty-one (31) days of first becoming eligible in order to have coverage under this Plan.

1. **Initial Enrollment Period.** An Initial Enrollment Period is the period of time during which an Eligible Employee may enroll under this Plan, as shown in the GEA signed by the Group.
2. **Group Open Enrollment Period.** An Open Enrollment Period of at least thirty-one (31) days may be held at least once a year allowing Eligible Employees and Eligible Family Members to enroll under this Plan without giving evidence of good health.
3. **Special Enrollment Period.** A Special Enrollment Period allows a Special Enrollee to enroll for coverage under this Plan upon a Special Enrollment Event as defined herein during a period of at least thirty-one (31) days following the Special Enrollment Event.
4. **Right to Deny Application.** LIBERTY can deny membership to any person who:

   Violates or has violated any provision of a LIBERTY EOC.

   Misrepresents or fails to disclose a material fact which would affect coverage under this Plan.

   Fails to follow LIBERTY rules.
5. **Right to Deny Application for Renewal.** As a condition of Group's renewal under this Plan, LIBERTY may require Group to exclude a

Subscriber or Dependent who committed fraud upon LIBERTY or misrepresented and/or failed to disclose a material fact, which affected his coverage under this Plan.

SECTION 2. Termination

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

2.1 Termination by LIBERTY

- Failure to maintain eligibility requirements as set forth in Section 1.
- On the first day of the month that a contribution was due and not received by LIBERTY.
- With thirty (30) days written notice, if the Member allows his or any other Member's LIBERTY ID card to be used by any other person, or uses another person's card. The Member will be liable to LIBERTY for all costs incurred as a result of the misuse of the LIBERTY Member card.
- If information given to LIBERTY by the Member in his Enrollment Form is untrue, inaccurate, or incomplete, LIBERTY has the right to declare the coverage under the Plan null and void as of the original Effective Date of coverage.
- When a Subscriber moves his primary residence outside the Service Area and/or no longer has his place of work within the Service Area or when a Dependent moves his primary residence outside LIBERTY's Service Area, Subscriber must notify his/her employer within thirty-one (31) days of the change.
- On the date the GEA terminates for any reason, including but not limited to:

1. Nonpayment of premiums.
2. Failure to meet minimum enrollment requirements.
3. LIBERTY amends this EOC and the Group does not accept the amendment.

2.2 Termination by the Subscriber

Subscriber has the right to terminate his coverage under the Plan by notice to his/her employer. . Such termination is effective on the last day of the month when the notice is received by LIBERTY, unless stated otherwise in the GEA.

2.3 Reinstatement

Any member, who has been terminated in any manner, may be reinstated by LIBERTY at its sole discretion.

2.4 Retroactive Termination

A request for retroactive termination by Group may be granted as shown in the GEA.

2.5 Effect of Termination

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

SECTION 3. Using this Plan

This Plan offers you a choice of Plan Providers where you receive your dental care. You must receive services from a Plan Provider to utilize benefits covered by this Plan. Your out-of-pocket costs are identified in the Schedule of Benefits. You will also not need to submit any claim forms when you receive your care from a Plan Provider. To receive benefits for care provided by a

Specialist you must be referred to the Specialist by a Plan Provider **and** have your care pre-authorized by the Plan.

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

SECTION 4. Covered Services

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

4.1 Benefits Available

Subject to the Exclusions listed herein, dental services related to a Member's dental health as identified in the Benefits Schedule are available to Members.

Benefits must be obtained from Plan Providers. The Benefit Schedule Identifies the copayments that are to be paid to Plan Providers.

4.2 Claim Payments

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

Written notice of claim must be given to LIBERTY within twenty days after the occurrence or commencement of any loss covered by the policy.

Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible;

LIBERTY shall furnish to the person making claim, or to the policyholder for delivery to such person, such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of fifteen days after the insurer receives notice of any claim under the policy, the person making such claim shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made

4.3 Emergency Services

In the event of a dental emergency outside the service area of the Plan, the Member should contact LIBERTY at 888.902.0407. The Plan will direct you to an available dentist or Specialist. Should no Plan Provider be available in a fifty (50) mile radius you can seek treatment from an out-of-network provider. In such an event, the Plan will reimburse you for the cost of Emergency Services received from an out-of-network provider as if you had visited a Plan Provider, up to a maximum of seventy-five dollars ($75) less applicable co-payments.

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

SECTION 5. Exclusions and Limitations

5.1 Exclusions

This section tells you what services or supplies are excluded from coverage under this Plan.

- Dental services for aesthetics only and/or cosmetic dental care.
- General anesthesia, intravenous and inhalation sedation, prescription drugs for anesthesia, and the services of a special anesthesiologist.
- Dental conditions arising out of and due to a Member's employment or for which the Member is entitled to Workers' Compensation benefits.
- Hospital and medical facility charges of any kind.
- Charges from a medical doctor, doctor of osteopathic medicine and/or other medical professional except for dental services otherwise covered herein.
- Treatment of fractures or dislocations.
- Loss or theft or dentures, partials or other appliances (e.g. crowns, bridges, full or partial dentures).
- Services which are normally reimbursed by a third part or liability insurance and/or under the medical portion of a group health plan.
- Dental procedures for which treatment started prior to the time Member became eligible for benefits.
- Procedures, appliances, restorations or other treatment to correct congenital or developmental malformations.
- Treatment and/or removal of: (a) malignancies; (b) cysts or benign tumors not within the scope of usual dental care; (c) odontogenic cysts exceeding 1.25 cm in diameter.
- Drugs/ medications not normally supplied or prescribed by a dental office.
- Any treatment which, on the opinion of LIBERTY's Dental Director, is not necessary for the Member's dental health.
- Replacement of an existing bridge, partial or denture which, in the opinion of LIBERTY's Dental Director, is satisfactory or that can be made satisfactory.
- Orthognathic surgery.
- Implants or any prosthesis attached to or dependent upon an implant.
- Any experimental, investigational or exotic procedure not approved by the ADA Council on Dental Therapeutics.

- Treatment to alter vertical dimension or to restore occlusion, unless dentures are involved.
- Major therapy for Temporomandibular Joint (TMJ) problems including, but not limited to, assessment beyond that customarily provided in a general dental practice.
- Expense or charge incurred by a Member confined to an institution of any kind.
- Cases in which, in the reasonable professional judgment LIBERTY's Dental Director, a satisfactory result cannot be obtained.
- Replacement of long-standing missing tooth/teeth in an otherwise stable dentition.
- Orthodontic services unless otherwise noted as a covered benefit in the member's Benefit Schedule.
- Care related to the bite, alignment of teeth, or bite correction.
- Charges for specialized techniques involving precision attachments, personalization or characterization of a temporary or permanent prosthesis.
- Charges related to the Member's failure to appear at a scheduled appointment.

5.2 Limitations

This section tells you when LIBERTY's duty to provide or arrange for services is limited.

- LIBERTY will not be liable for any delay or failure to provide or arrange for Covered Services if the delay or failure is caused by the following:
  - Natural disaster.
  - War.
  - Riot.
  - Civil insurrection.
  - Epidemic.
  - Or any other emergency beyond LIBERTY's control.
- Prophylaxis is limited to one treatment each (6) month period (includes periodontal maintenance following active therapy).
- Oral evaluation is limited to one each (6) month period.
- Oral hygiene instruction is limited to one per twenty-four (24) month period.
- Fluoride treatment is limited to one per twelve (12) month period.
- Crowns, bridges and dentures may not be replaced within five (5) years from the initial placement.
- Partial dentures are not to be replaced within five (5) years of the initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
- Denture relines are limited to one per denture during any twelve (12) consecutive months.
- Covered charge for both a temporary and a permanent prosthesis will be limited to the charge for a permanent prosthesis only.
- Charges for adjustment of a prosthesis will be limited to one in a six (6) month period.

- Periodontal treatments, including root planing and scaling, are limited to four quadrants during any twenty-four (24) consecutive months.
- Full mouth debridement (gross scale) is limited to one treatment in any thirty-six (36) consecutive month period.
- Osseous surgery is limited to one treatment in any five (5) year period.
- Crowns will be covered only if, in the opinion of LIBERTY's Dental Director, there is not enough retentive quality left in the tooth to hold a filing.
- Bitewing x-rays are limited to not more than one series in any six (6) month period.
- Full mouth x-rays and/or panographic type films are limited to one set every twenty-four (24) consecutive months.
- Sealant benefits include the application of sealants only to permanent first and second molars with no decay up to the age of fifteen (15). Sealants are limited to once per thirty-six (36) month period per tooth.

SECTION 6. General Provisions

6.1 Relationship of Parties

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

6.2 Entire Agreement

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

6.3 Contestability

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

6.4 Authority to Change the Form or Content of EOC

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

6.5 Identification Card

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

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

6.6 Notice

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

LIBERTY Dental Plan

P.O. Box 26110

Santa Ana, CA 92799-6110

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

6.7 Assignment

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

6.8 Modifications

The Group makes LIBERTY coverage available to individuals who are eligible under Section 1. However, this EOC is subject to amendment, modification and termination with sixty (60) days written notice to the Group without the consent of Members.

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

6.9 Clerical Error

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

6.10 Policies and Procedures

LIBERTY may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this EOC with which Members shall comply. These policies and procedures are maintained by LIBERTY at its offices. Such policies and procedures may have bearing on whether a dental service and/or supply is covered.

6.11 Overpayments

LIBERTY has the right to collect payments for services made in error. Dentists, Specialists and other providers have the responsibility to return any overpayments or incorrect payments to LIBERTY. LIBERTY has the right to offset any overpayment against any future payments.

6.12 Release of Records

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

6.13 Gender References

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

6.14 Availability of Providers

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

6.15 Legal Action

No action at law or in equity shall be brought to recover on the policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy and that no such action shall be brought at all unless brought within three years from the expiration of the time within which proof of loss is required by the policy.

6.16 Incontestability

The validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue, and that no statement made by any person covered under the policy relating to insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime nor unless it is contained in a written instrument signed by the person making such statement; except that, no such provision shall preclude the assertion at any time of defenses based upon the person's ineligibility for coverage under the policy or upon other provisions in the policy.

SECTION 7. Appeals and Grievances

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

If a Member's Plan is governed by ERISA, a Member must exhaust all mandatory levels of mandatory appeal before bringing a claim in court for a Claim of Benefits.

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

A Member may contact MDI for assistance at any time using the contact information provided on the cover page of this EOC. A Member that receives an Adverse Benefit Determination may file a grievance with MDI without exhausting the Appeals Procedures.

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

The following Appeals Procedures will be followed for all Grievances.

- **Informal Review:** Available for all Grievances, including a complaint regarding an Adverse Benefit Determination, which are directed to the LIBERTY Member Services Department via phone or in person. If the Informal Review resolves the Grievance to the satisfaction of the Member, the matter ends. The Informal Review is **voluntary**.

- **1st Level Formal Appeal:** Available for all Grievances, including a complaint regarding an Adverse Benefit Determination, which LIBERTY's Customer Response and Resolution Department investigates. If a 1st Level Formal Appeal resolves the Grievance to the satisfaction of the Member, the appeal is closed. The 1st Level Formal Appeal is **mandatory** if the Member is not satisfied with the initial determination and the Member wishes to appeal such determination.

- **2nd Level Formal Appeal:** If a 1st Level Formal Appeal is not resolved to the Member's satisfaction, a Member may then file a 2nd Level Formal Appeal. A 2nd Level Formal Appeal is submitted in writing and reviewed by the Grievance Advisory Panel. The 2nd Level Formal Appeal is **voluntary** for all Adverse Benefit Determinations.

- **Grievance Advisory Panel:** A committee consisting of other Members, representatives of LIBERTY that were not involved in the circumstances giving rise to the Grievance or any subsequent investigation or determination, and, where the Grievance involves an Adverse Benefit Determination, a majority of persons that are appropriate clinical peers in the same or similar specialty as would typically manage the case being reviewed who were not involved in the circumstances giving rise to the Grievance or any subsequent investigation or determination.

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

7.1 Informal Review

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

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

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

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

7.2 1st Level Formal Appeal

When an Informal Review does not resolve the Grievance in a manner that is satisfactory to the Member or when the Member chooses not to file an Informal Review and the Member wishes to pursue the matter further, the Member must file a Grievance requesting a 1st Level Formal Appeal. A Grievance requesting a 1st Level Formal Appeal regarding an Adverse Benefit Determination must be submitted in writing to LIBERTY's Customer Response and Resolution Department within 180 days of the Adverse Benefit Determination. A Grievance requesting a 1st Level Formal Appeal regarding any other type of Grievance must be submitted in writing to LIBERTY's Customer Response and Resolution Department within 180 days of the event giving rise to the Grievance. Grievances requesting 1st Level Formal Appeals not filed in a timely manner will be deemed waived with respect to the Grievance, including the Adverse Benefit Determination, to which they relate.

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

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

Additionally, the Member may submit any supporting medical records, Dentist's letters, or other information that explains why LIBERTY should approve the Claim for Benefits. The Member can request the assistance of a Member Services Representative at any time during this process. The Member has the right to have any other person help them with the Grievance requesting a 1st Level Formal Appeal of the Grievance.

The Grievance requesting a 1st Level Formal Appeal should be sent or faxed to the following:

Address: LIBERTY Dental

Attn: Customer Response and Resolution Dept.

LIBERTY Dental Plan

P.O. Box 26110

Santa Ana, CA 92799-6110

Fax: (888) 223-0011

LIBERTY will acknowledge receipt of the Grievance requesting a 1st Level Formal Appeal from a Member within ten (10) working days of its receipt by LIBERTY. LIBERTY will conduct a complete investigation within twenty (20) working days after receipt of the Grievance requesting a 1st Level Formal Appeal, unless the investigation cannot be completed within this time. If the investigation cannot be completed within twenty (20) working days after receipt of the Grievance requesting a 1st Level Formal Appeal, LIBERTY shall notify the Member in

writing on or before the twentieth (20th) working day and the investigation shall be completed within thirty (30) working days thereafter. The notice will set forth with specificity the reasons for which additional time is needed for the investigation. 1st Level Formal Appeals will be decided by a grievance review committee established by LIBERTY.

Within five (5) working days of the completion of the investigation, the Member will be informed in writing of the resolution. If the 1st Level Formal Appeal results in an Adverse Benefit Determination, the Member will be informed in writing of the following:

- The specific reason or reasons for upholding the Adverse Benefit Determination;
- Reference to the specific Plan provisions on which the determination is based;
- A statement that the Member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's Claim for Benefits;
- A statement describing any voluntary appeal procedures offered by LIBERTY and the Member's right to receive additional information describing such procedures;
- For Member's whose coverage is subject to ERISA, a statement of the Member's right to bring a civil action under ERISA Section 502(a) following an Adverse Benefit Determination, if applicable;
- A statement that any internal rule, guideline, protocol or other similar criteria that was relied on in making the determination is available free of charge upon the Member's request; and
- If the Adverse Benefit Determination is based on Medical Necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment or a statement that such explanation will be provided free of charge.

If the resolution to the Grievance requesting a 1st Level Formal Appeal is not acceptable to the Member and the Member wishes to pursue the matter further, the Member is entitled to file a 2nd Level Formal Appeal. The Member will be informed of this right at the time the Member is informed of the resolution of his 1st Level Formal Appeal.

If the person who submitted the Grievance requesting a 1st level Formal Appeal was not the Member, LIBERTY will notify the person submitting the request of the resolution within fifteen (15) working days after the investigation is completed.

7.3 Expedited Appeal

The Member can ask (either orally or in writing) for an Expedited Appeal of an Adverse Benefit Determination for a Pre-Service Claim for which the Member or his Dentist believe that the health of the Member could be seriously harmed by waiting for a routine appeal decision. Expedited Appeals are not available for appeals regarding denied claims for benefit payment (Post-Service Claim). Expedited Appeals must be decided no later than seventy-two (72) hours after receipt of

the appeal, provided all necessary information has been submitted to LIBERTY. If the initial notification was oral, LIBERTY shall provide a written or electronic explanation to the Member within three (3) days of the oral notification.

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

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

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

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

7.4 2nd Level Formal Appeal

When a 1st Level Formal Appeal is not resolved in a manner that is satisfactory to the Member, the Member may initiate a 2nd Level Formal Appeal. This appeal must be submitted in writing within one hundred eighty (180) days after the Member has been informed of the resolution of the 1st Level Formal Appeal.

Exhaustion of the 1st Level Formal Appeal procedure is a precondition to filling a 2nd Level Formal Appeal. A 2nd Level Formal Appeal not filed in a timely manner will be deemed waived with respect to the Grievance, including the Adverse Benefit Determination, to which it relates. The 2nd Level Formal Appeal is **voluntary** for all Pre-Service and Post-Service Claims for Benefits**.**

The Member shall be entitled to the same reasonable access to copies of documents referenced above under the 1st Level Formal Appeal.

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

Upon request a Member is entitled to attend and provide a formal presentation on a 2nd Level Formal Appeal. If such a hearing is requested LIBERTY shall make every reasonable effort to schedule one at a time mutually convenient to the parties involved. Repeated refusal on the part of the Member to cooperate in the scheduling of the formal presentation shall relieve the Grievance Advisory Panel of the responsibility of hearing a formal presentation, but not of reviewing the 2nd Level Formal Appeal. If a formal presentation is held, the Member will be permitted to provide documents to the Grievance Advisory Panel and to have assistance in presenting the matter to the Grievance Advisory Panel, including representation by counsel. However, LIBERTY must be notified at least five (5) business days before the date of the scheduled formal presentation of the Member's intent to be represented by counsel and/or to have others present during the formal presentation. Additionally, the Member must provide LIBERTY with copies of all documents the Member may use at the formal presentation (5) business days before the date of the scheduled formal presentation.

Upon LIBERTY's receipt of the written request for a 2nd Level Formal Appeal, the request will be forwarded to the Grievance Advisory Panel along with all available documentation relating to the appeal.

The Grievance Advisory Panel shall:

- acknowledge receipt of the request for a 2nd Level Formal Appeal within ten (10) working days of its receipt by LIBERTY;
- consider the 2nd Level of Appeal;
- schedule and conduct a formal presentation if applicable;
- obtain additional information from the Member and/or staff as it deems appropriate;
- conduct a complete investigation within twenty (20) working days after receipt of the request for a 2nd Level Formal Appeal, unless the investigation cannot be completed within this time. If the investigation cannot be completed within twenty (20) working days after receipt of the request for a 2nd Level Formal Appeal, LIBERTY shall notify the Member in writing on or before the twentieth (20th) working day and the investigation shall be completed within thirty (30) working days thereafter. The notice will set forth with specificity the reasons for which additional time is needed for the investigation; and
- make a decision and communicate its decision to the Member within five (5) working days of the completion of the investigation. This notice of the Grievance Advisory Panel's decision will also include notice of the Member's right to file an appeal with MDI of the Grievance Advisory Panel's decision and the toll-free telephone number and address of MDI.

If the resolution of the 2nd Level Formal Appeal results in an Adverse Benefit Determination, the Member will be informed in writing of the following:

- The specific reason or reasons for upholding the Adverse Benefit Determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement describing any additional voluntary levels of appeal; and
- For Member's whose coverage is subject to ERISA, a statement of the Member's right to bring a civil action under ERISA Section 502(a) following an Adverse Benefit Determination, if applicable.

SECTION 8. Glossary

"Adverse Benefit Determination" means a decision by the Plan to deny, in whole or in part, a Member's Claim for Benefits. Receipt of an Adverse Benefit Determination entitles the Member or his Authorized Representative to appeal the decision, utilizing LIBERTY's Appeals Procedures set forth in section 8.

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

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

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

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

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

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

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

"Copayment" means the amount the Member pays when a Covered Service is received.

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

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

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

"Dependent" means an Eligible Family Member of the Subscriber's family who:

- meets the eligibility requirements of the Plan as set forth in Section 1 of this EOC;
- is enrolled under this Plan; and
- for whom premiums have been received and accepted by LIBERTY.

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

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

"Eligible Employee" means a natural person that:

A. Is a bona fide employees of the Group; and

B. Meet the following criteria:

- Is employed full-time;
- Is actively at work;
- Work at least the minimum number of hours per week indicated by the Group in this Application;
- Meet the applicable waiting period
- Enroll during an enrollment period
- Live or work in the service area; and
- Works for an employer that meets the Minimum Employer Contribution Percentage for the applicable coverage

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

"Eligible Dental Expenses" or "EDE" means charges up to the LIBERTY Reimbursement Schedule amount, incurred by a Member while he/she is covered under this EOC for Covered Services.

"Emergency Services" means Covered Services (a dental screening, examination, evaluation by dentist or dental specialist to determine if an emergency dental condition exists, and to provide care that would be acknowledged as within professionally recognized standards of care and in order to alleviate any emergency symptoms in a dental office) provided after the sudden onset of a dental condition with symptoms severe enough to cause a prudent person to believe that lack of

immediate medical attention could result in serious:

- jeopardy to his health;
- jeopardy to the health of an unborn child;
- if an enrollee reasonably believes that the condition, if not diagnosed or treated, may lead to disability, dysfunction or death.

"Enrollment Date" means the first day of coverage under this Plan or, if there is a Waiting Period, the first day of the Waiting Period.

"ERISA" means Employee Retirement Income Security Act of 1974, as amended, including regulations implementing the Act.

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

"Grievance" means a written complaint submitted by or on behalf of a Member regarding the:

- availability, delivery or quality of Covered Services, including a complaint regarding an Adverse Benefit Determination;
- claims payment, handling or reimbursement for Covered Services; or
- matters pertaining to the contractual relationship between LIBERTY and a Member.

"Group" means an employer or legal entity that has completed a Group Application and signed a Group Enrollment Agreement with LIBERTY for LIBERTY to provide Covered Services.

"Group Enrollment Agreement" or "GEA" means the agreement signed by LIBERTY and Group that states the conditions for coverage, eligibility and enrollment requirements and premiums.

"Initial Enrollment Period" means the period of time during which an eligible person may enroll under this Plan, as shown in the GEA signed by the Group.

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

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

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

- the likelihood of a certain service or supply producing a significant positive outcome;
- reports in peer-review literature;
- evidence based reports and guidelines published by nationally recognized professional organizations that include supporting scientific data;
- professional standards of safety and effectiveness that are generally

recognized in the United States for diagnosis, care or treatment;

- the opinions of independent expert Dentists in the health specialty involved when such opinions are based on broad professional consensus; or
- other relevant information obtained by LIBERTY.

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

"Member" means a person who meets the eligibility requirements of Section 1, who has enrolled under this Plan and for whom premiums have been received by LIBERTY.

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

"Open Enrollment Period" means an annual thirty-one (31) day period of time during which Eligible Employees and their Eligible Family Members may enroll under this Plan.

"Plan" means LIBERTY Dental Plan.

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

"Post-Service Claim" means any Claim for Benefits under a Group Health Plan regarding payment of benefits that is not considered a Pre-Service Claim.

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

"Pre-Service Claim" means any Claim for Benefits under a Group Health Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

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

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

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

"Rider" means a provision added to the agreement or the EOC to expand benefits or coverage.

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

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

"Subscriber" means an employee of the Group who meets the eligibility requirements, who has enrolled under the Plan, and for whom premiums have been received.

"Waiting Period" means the period of time as established by the Group that must pass before coverage for an Eligible Employee or Eligible Family Member can become effective. If an Eligible Employee or Eligible Family Member enrolls as a Special Enrollee, any period before such Special Enrollment is not a Waiting Period.