



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

Valley Health Plan Children’s Dental HMO Benefit (EPDB) Plan

**Valley Health Plan is your Qualified Health Plan (QHP)
Valley Health Plan arranges for your Essential Pediatric Dental Benefit
coverage provided by LIBERTY Dental Plan of California.**

ANNOUNCEMENTS

Availability of Language Assistance: Interpretation and translation services may be available for Members with limited English proficiency, including translation of documents into certain threshold languages at no cost to You. To ask for language services call 1-888-902-0403. Make sure to notify Your provider (Dentist) of Your personal language needs upon Your initial dental visit.

Spanish (Español)

IMPORTANTE: ¿Puede leer esta noticia? Si no, alguien le puede ayudar a leerla. Además, es posible que reciba esta noticia escrita en su propio idioma sin ningún costo a usted. Para obtener ayuda gratuita, llame ahora mismo al 1-888-902-0403.

Hereinafter in this document, LIBERTY Dental Plan of California, Inc. may be referred to as “LIBERTY” or “the Plan.” Valley Health Plan may be referred to as “VHP”.

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

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

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

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

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

I. GENERAL INFORMATION – OVERVIEW OF YOUR DENTAL BENEFIT PLAN

BENEFITS MATRIX

THE FOLLOWING MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE COMBINED EVIDENCE OF COVERAGE AND

DISCLOSURE FORM AND THE PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

(A) Deductibles	None. Minimum Coverage Plan Only: Your Children’s Dental HMO plan’s deductible will be integrated with Your medical plan’s deductible. Once Your out-of-pocket expenditures for all covered Medical and Dental services reach the integrated deductible, You may be required to pay a Copayment amount for each procedure as shown in the Description of Benefits and Copayments. The integrated deductible does not apply to preventive and diagnostic services.
(B) Lifetime Maximums	None
(C) Out-of-Pocket Maximums	Your Children's Dental HMO plan’s out-of-pocket maximum will be integrated with Your medical plan’s out-of-pocket maximum. Once Your out-of-pocket expenditures for all covered Medical and Dental services reach the integrated out-of-pocket maximum, all further covered dental procedures will be paid for by LIBERTY. Charges for optional, non-covered or upgraded material services are not included in the calculation for the integrated out-of-pocket maximum. Any payments for dental services accrue toward Your Health Plan medical out of pocket maximum for the applicable metal level plan selected. Minimum coverage plan benefits are covered at 100% by the plan after the member meets the medical plan deductible and Annual Out-of-Pocket Maximum. Please refer to page 6 for information on Annual Out-of-Pocket Maximum.
(D) Professional services	<p>An Enrollee may be required to pay a Copayment amount for each procedure as shown in the Description of Benefits and Copayments, subject to the Limitations and Exclusions.</p> <p>Copayments range by category of service. Examples are as follows:</p> <ul style="list-style-type: none"> • Diagnostic Services No Cost • Preventive Services No Cost • Restorative Services No Cost - \$350.00 • Periodontic Services \$40.00 - \$350.00 • Prosthodontic Services No Cost - \$350.00 • Oral and Maxillofacial Surgery No Cost - \$350.00 • Orthodontic Services No Cost - \$1,000.00
(E) Outpatient Services	Not Covered
(F) Hospitalization Services	Not Covered
(G) Emergency Dental Coverage	The Enrollee may receive a maximum Benefit of up to \$75 per emergency for out-of-area Emergency Services.
(H) Ambulance Services	Not Covered
(I) Prescription Drug Services	Not Covered
(J) Durable Medical Equipment	Not Covered
(K) Mental Health Services	Not Covered
(L) Chemical Dependency Services	Not Covered
(M) Home Health Services	Not Covered
(N) Other	Not Covered

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

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 comprehensive Schedule of Benefits (on page 20), which lists co-pays and other fees. This EOC represents the Children's Dental HMO benefits covered as part of your Health Plan as arranged by Valley Health Plan. To be eligible for this coverage, You must meet the eligibility requirements as stated in this document.

B. How to Contact LIBERTY

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

LIBERTY Dental Plan of California, Inc.
P.O. Box 26110
Santa Ana, CA 92799-6110
Member Services (Toll-Free): (888) 902-0403
Website: www.LIBERTYdentalplan.com

C. LIBERTY's Service Area

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. **Valley Health Plan's Dental Benefit Plan's Service Area is Covered California Region 7 and 9, Santa Clara, Monterey, San Benito, and Santa Cruz Counties.**

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 Primary Care Dentist and other Participating Providers. Call 1-888-902-0403 to ask for a LIBERTY Provider Directory or use the website.

If You go a Non-Participating Provider, You will have to pay all the cost, unless You received pre-approval from LIBERTY, or You require Emergency/Urgent Care or Out-of-Area Urgent Care. If You are new to LIBERTY, or LIBERTY ends Your Provider's contract, You can continue to see Your current dentist in some cases. This is called *continuity of care* (see page 11).

E. Your Primary Care Dentist (see ACCESS TO SERVICES ON page 7)

A Primary Care Provider is usually a General Dentist who provides Your basic care and coordinates the care You need from other dental specialty Providers. You do not choose a Primary Care Dentist. You may access services from any contracted General Dentist in the network.

F. Language and Communication Assistance (see page 3)

Interpretation and translation services are available for members with limited English proficiency, including translation of documents into certain threshold languages. If English is not Your first language, LIBERTY provides interpretation services and translation of certain written materials in Your preferred language. If You have a preferred language, please call us at 1-888-902-0403 and let us know. You can also go online and take our survey at <https://www.libertydentalplan.com/Members/Member-Language-Survey.aspx>.

G. How to Get Dental Care When You Need It

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

- You usually need a referral and pre-approval to get care from a Provider other than Your Primary Care Dentist. See the next section titled Referrals and Pre-Authorizations.
- The care must be Medically Necessary for Your health. Your dentist and LIBERTY follow guidelines and policies to decide if the care is Medically Necessary. If You disagree with LIBERTY about whether a service You want is Medically Necessary, You can file a Grievance, or, in some cases, You may request an Independent Medical Review (see page 19).

- The care must be a service that LIBERTY covers. Covered Services are also called Benefits. To see what services LIBERTY covers, see the Schedule of Benefits. Your comprehensive Schedule of Benefits is provided with this document at the inception of the contract and is also available separately upon request from Member Services or via the LIBERTY website.

H. TIMELY ACCESS TO CARE

You are entitled to schedule an appointment with Your Primary Care Dentist within a reasonable time that is appropriate to Your condition:

- Emergency appointments should be available 24 hours a day, 7 days a week. Contact your PCD for an immediate appointment or in the event of a life-threatening situation, call “911”.
- Urgent appointments should be scheduled within 72 hours. Discuss Your individual needs with Your Primary Care Dentist to determine how soon You can be seen (See pages 7 and 8)
- Non-Urgent Appointments should be offered within 36 business days.
- Preventive dental care appointments should be offered within 40 business days.

If for any reason You are unable to schedule an appointment within these timeframes, please call the Member Services Department at 1-888-902-0403 for assistance.

LIBERTY provides language assistance services at all points of contact, including at Your dental appointment. If your Primary Care Dentist or Specialist, or their office staff, cannot communicate with You in Your language, LIBERTY can arrange for interpretation services at Your appointment at no cost to You. LIBERTY makes these services available to You even if You are accompanied at Your appointment by a family member or friend that can assist with interpretation. Please contact LIBERTY’s Member Services Department at 1-888-902-0403 to arrange these services as far in advance of Your appointment time as possible.

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

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

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

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

J. EMERGENCY CARE (see page 9)

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

K. URGENT CARE (see page 9)

Urgent Care is care that You need soon to prevent a serious health problem. Urgent Care is a Covered Service, regardless of whether care is rendered within the Service Area.

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

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

M. COSTS (see the “SCHEDULE OF BENEFITS” IN APPENDIX I and “What You Pay” on page 11)

- The Premium is what You pay to Your Qualified Health Plan (QHP) to keep coverage. Premiums are paid to Valley Health Plan.
- A Co-pay (Co-payment) is the amount that You must pay for a particular covered procedure. After You pay your Co-payment for that service, LIBERTY pays for the rest of that covered service.
- Your plan has a yearly Out-of-Pocket Maximum. The yearly Out-of-Pocket maximum is the most money You have to pay for Your Covered Services in a year. Out-of-Pocket costs include co-pays, coinsurance, or deductibles for all covered medical and dental services. Any payment for dental services accrue toward Your Health Plan’s medical Out-of-Pocket maximum for the applicable metal level plan selected. There may be other costs incurred for optional, non-covered and upgraded material services that do not apply toward Out-of-Pocket Maximums. To verify Your Out-of-Pocket Maximum, You can visit Valley Health Plan’s website at www.valleyhealthplan.org or call Valley Health Plan’s Member Services **1-888-421-8444 (toll-free)**. After You have reached the yearly Out-of-Pocket maximum, LIBERTY will pay the rest of the cost of dental services for that year, as long as the service You receive is a covered benefit performed by Your assigned contracted dental Provider or authorized dental Provider.
- **IMPORTANT:** If you opt to receive dental services that are not covered services under this plan, a participating dental provider may charge You his or her usual and customary rate for those services. Prior to providing a patient with dental services that are

not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If You would like more information about dental coverage options, You may call member services at 1-888-902-0403 or Your insurance broker. To fully understand Your coverage, You may wish to carefully review this evidence of coverage document.

N. IF YOU HAVE A GRIEVANCE ABOUT YOUR LIBERTY DENTAL PLAN (see page 16)

LIBERTY provides a Grievance resolution process You can file a Grievance (also called a complaint or appeal) with LIBERTY for any dissatisfaction You have with LIBERTY, Your Benefits, a claim determination, a benefit or coverage determination, Your Provider or any aspect of Your dental Benefit Plan.

If You disagree with LIBERTY's decision about Your grievance, You can get help from the State of California's HMO Help Center. In some cases, the HMO Help Center can help You apply for an Independent Medical Review (IMR) or file a complaint. IMR is a review of Your case by doctors who are not part of Your health plan.

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 a member, or other authorized designee to review an action by the Plan to delay, modify or deny services.

Advanced Premium Tax Credit (APTC): A feature of the Affordable Care Act that provides a subsidy to pay for a part of Your dental Premium.

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

Benefits: Services covered by Your LIBERTY Dental Plan.

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

Benefit Year: The year of coverage of Your LIBERTY Dental Plan.

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

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

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

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

Contracting Dentist: A dentist who has signed a contract to provide services to LIBERTY Members in accordance with LIBERTY's rules and regulations.

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.

Deductible: Refers to the medical deductible amount a Member must meet before any Co-payments can be charged. The Member will cover total cost of dental services received until the medical deductible amount has been met.

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 charting, treatment plans, consultation reports, or other written material relating to an individual's medical and dental history, diagnosis, condition, treatment, or evaluation.

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

Medical Necessity or Medically Necessary: A Covered Service that meets LIBERTY's clinical guidelines for appropriateness and reasonableness based on 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.

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

Disputed Dental Service: Any service that is the subject of a dispute filed by either Member, Authorized Representative on behalf of the Member, General Dentist or Dental Specialist.

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

Enrollee: see Member.

Emergency Care / Emergency Dental Service: Emergency Dental Service and care include (and are covered by LIBERTY Dental Plan) dental screening, examination, evaluation by a General Dentist or dental Specialist to determine if an emergency dental condition exists. A condition may be considered an emergency if, without treatment, Your health may be in serious jeopardy, You may experience serious impairment to bodily functions or serious dysfunction of any bodily organ or part. Medical emergencies are not covered by LIBERTY Dental Plan if the services are rendered in a hospital setting which are covered by a Medical Plan, or if LIBERTY Dental Plan determines the services were not dental in nature.

Enrollee: see Member.

EPDB or Essential Pediatric Dental Benefit: Refers to plans mandated by the Affordable Care Act to provide essential pediatric dental benefits to children.

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

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

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

Independent Medical Review (IMR): A California program where certain denied services may be subject to an external review. IMR is only available for medical services or services that are available due to enrollment in a related full-service medical plan.

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

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

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

Non-Participating Provider: A dentist or specialist that is not contracted with LIBERTY to provide services to members

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

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

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

Out-of-Pocket Maximum: Refers to the maximum amount You will spend for Covered Services each year. After meeting this amount of expense, all additional Covered Services during the year are covered by Your Plan. Out-of-Pocket costs include co-pays, coinsurance, or deductibles for all covered medical and dental services. Any payment for dental services accrue toward Your Health Plan's medical Out-of-Pocket Maximum for the applicable metal level plan selected. There may be other costs incurred for optional, non-covered and upgraded material services that do not apply toward Out-of-Pocket Maximums.

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

Plan: LIBERTY Dental Plan of California, Inc.

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

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

Primary Care Dentist: Normally, a General Dentist affiliated with LIBERTY to provide services to covered Members of the Plan. The Primary Care Dentist 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 the Plan.

Qualified Health Plan (QHP): A health plan that meets the qualifications to be offered under the Affordable Care Act as qualified by Covered California.

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

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

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

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

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

Urgent Care: Care that You need soon to prevent a serious health problem.

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

You: pertains to Members who are the beneficiary of this dental Benefit Plan.

IV. ACCESS TO SERVICES – SEEING A DENTIST

LIBERTY Dental Plan contracts with General Dentists and Specialists to provide services covered by Your Plan. Your Primary Care Dentist will provide for all of Your dental care needs, including referring You to a Specialist, should it be necessary. All services and Benefits described in this publication are covered only if provided by a contracted Primary Care Dentist or Specialist. The only time You may receive care outside the network is for Emergency Dental Services as described herein under “Emergency Dental Care” or “Urgent Care.”

LIBERTY makes available Primary Care Dentists (General Dentists) and Specialists throughout the state of California within a reasonable distance from Your home or workplace. Most Enrollees should have a residence or workplace within thirty (30) minutes or fifteen (15) miles of a Primary Care Dental office. Contact LIBERTY toll-free at 1-888-902-0403 or via website at www.LIBERTYdentalplan.com to find a dentist in Your area.

A. FACILITIES

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. We conduct a quality assessment program, which includes ongoing contract management to assure compliance with continuing education, accessibility for Members, appropriate diagnosis and treatment planning.

B. DENTAL HEALTH EDUCATION

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

- i. **General Dentistry/Primary Care Dentistry:** To access care, simply contact a General Dentist who is contracted to provide services under Your selected plan for an appointment. The contracting General Dentist will then contact LIBERTY Dental Plan to verify Your eligibility. You may obtain information on Providers in your area by phone or website. On this plan, You are not assigned to this Provider and may change to a different contracting General Dentist at any time.

All family Members in the Essential Pediatric Benefit Plan on the same Individual Plan must be assigned to and receive treatment from the same Primary Care Dentist.

- ii. **Care from a Dental Specialist:** You may only obtain care from a dental Specialist only after Your referral to a Specialist has been submitted by Your assigned Primary Care Dentist 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 Dental Plan participating Primary Care Dentist 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. URGENT CARE

Urgent Care is care You need within 72 hours, and are services needed to prevent the serious deterioration of Your dental health resulting from an unforeseen illness or injury for which treatment cannot be delayed. The Plan provides coverage for urgent dental services only if the services are required to alleviate severe pain or bleeding or if an Enrollee reasonably believes that the condition, if not diagnosed or treated, may lead to disability, dysfunction or death. Contact Your Primary Care Dentist for Your urgent needs during business hours or after hours. If You are out of the area, You may contact LIBERTY for referral to another contracted dentist that can treat Your urgent condition. For after-hours Urgent Care outside the Service Area, You may proceed to find a dentist who can assist You. LIBERTY will reimburse You for covered dental expenses up to a maximum of seventy-five dollars (\$75), less applicable Co-payments per calendar year. You should notify LIBERTY as soon as possible after receipt of Urgent Care services preferably within 48 hours. If We determine that Your treatment was not due to a dental emergency, the services rendered by a Non-Participating Provider will not be covered.

E. EMERGENCY DENTAL CARE

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

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

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

Emergency Dental Service (covered by your LIBERTY Dental Plan) is defined in the California Health & Safety Code, to include a dental screening, examination, evaluation by dentist or Specialist to determine if an emergency dental condition exists, and to provide

care that would be acknowledged as within professionally recognized standards of dental care and in order to alleviate any emergency symptoms in a dental office/clinic setting and emergency department in a hospital. Emergency medical services may be an allowable benefit, in accordance with the schedule of benefits. LIBERTY shall provide benefits for such emergency dental services and shall ensure the availability of a provider in the event that an on-call network provider is unavailable in a dental setting or hospital. LIBERTY does not cover services that LIBERTY determines were not dental in nature.

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

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

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

- The reason for the denial.
- Reference to the pertinent Evidence of Coverage provisions on which the denial is based.
- Notice of your right to request reconsideration of the denial, and an explanation of the Grievance procedures. You may also refer to the EOC section, GRIEVANCE PROCEDURES below.

F. SECOND OPINION

At no cost to You, You may request a second dental opinion, by directly contacting the Plan’s Member Services either by calling the toll-free number 1-888-902-0403 or by writing to: LIBERTY Dental Plan, P.O. Box 26110, Santa Ana, CA, 92799-6110. Your Primary Care Dentist may also request a second dental opinion on Your behalf by submitting a Standard Specialty or Orthodontic Referral form with appropriate x-rays. All requests for a second dental opinion are processed by LIBERTY Dental Plan within five (5) business days of receipt of the request, or 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 Dental Plan will make the appropriate second dental opinion arrangements and advise the attending dentist of Your concerns. You will then be advised of the arrangement so an appointment can be scheduled. Upon request, You may obtain a copy of LIBERTY Dental Plan’s policy description for a second dental opinion.

G. REFERRAL TO A SPECIALIST

In the event that You need to be seen by a Specialist, LIBERTY Dental Plan requires Pre-Authorization. Your Primary Care Dentist is responsible for obtaining authorization for You to receive specialty care. The Pre-Authorization submission will be responded to within five (5) business days of receipt, unless urgent. In the case of an urgent request, your General Dentist can call LIBERTY’s Referral Unit at 800-268-9012 to submit a request for prior authorization to a specialist.

If Your specialty referral Pre-Authorization is denied or You are dissatisfied with the Pre-Authorization, you have the right to file a Grievance. See GRIEVANCE PROCEDURES below.

If Your Primary Care Dentist has difficulty locating a Specialist in Your area, contact LIBERTY Member Services for assistance in locating a Specialist.

Specialty services and treatment plans that are pre-authorized, and found to be medically 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 specialists 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.

V. AUTHORIZATION, MODIFICATION OR DENIAL OF SERVICES

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

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

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

You or Your Providers may call Member Services toll-free at 1-888-902-0403 for information on Pre-Authorization of services policies, procedures or the status of a particular referral or Pre-Authorization.

Specialty referral and Pre-Authorization of specialty services proposed by the Specialist is processed within 5 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 Provider and You of the information needed to complete the review and the anticipated date when the determination will be made.

Any denial, delay or modification of services will be provided in writing and contain a clear and concise description of the 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.

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

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

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

For urgent appeal requests, LIBERTY may request an extension of fourteen (14) additional calendar days, if the need for additional information is in your best interest. You may also request an extension.

A. CONTINUITY OF CARE

Current Members: Current Members may have the right to the benefit of completion of care with their Terminated Provider for certain specified acute or serious chronic dental conditions. Please call the Plan at 1-888-902-0403 to see if You may be eligible for this benefit. You may request a copy of the Plan's Continuity of Care Policy. You must make a specific request to continue under the care of Your Terminated Provider. We are not required to continue Your care with that Provider if You are not eligible under our policy or if we cannot reach agreement with Your Terminated Provider on the terms regarding Your care in accordance with California law.

New Members: A new member may have the right to the qualified benefit of completion of care with their Non-Participating Provider for certain specified acute or serious chronic dental conditions. Please call the Plan at 1-888-902-0403 to see if You may be eligible for this benefit. You may request a copy of the Plan's Continuity of Care Policy. You must make a specific request to continue under the care of Your current Provider. We are not required to continue Your care with that Provider if You are not eligible under our policy or if we cannot reach agreement with Your Provider on the terms regarding Your care in accordance with California law. This policy does not apply to new Members of an individual Subscriber contract.

VI. FEES AND CHARGES – WHAT YOU PAY

A. PREMIUMS AND PREPAYMENT FEES

Premiums are due to Your QHP prior to the month of coverage. In turn, Valley Health Plan must provide Premiums to LIBERTY to establish and continue Your coverage.

Your Premium and payment terms, including mailing address for payments, are defined by Your Qualified Health Plan.

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

B. CHANGES TO BENEFITS AND PREMIUMS

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

C. OTHER CHARGES

You are responsible only for Premiums and listed Co-payments for Covered Services. You may be responsible for other Charges for non-covered or optional services as described in this Evidence of Coverage document. You should discuss any Charges for non-covered or optional services directly with Your Provider. 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 Provider's usual fee to the Provider for any such services.

You may be responsible for additional fees for returned or dishonored checks, cancelled credit card payments, broken or missed appointments. Charges, such as finance charges from any third party payment organization, as agreed upon mutually by You and Your Provider as per business arrangements and disclosures made by the treating Provider.

Your plan has a yearly Out-of-Pocket Maximum. The yearly Out-of-Pocket Maximum is the most money You have to pay for Your Covered Services in a year. Out-of-Pocket costs include co-pays, coinsurance, or deductibles for all covered medical and dental services. Any payments for dental services accrue toward Your Health Plan's medical Out-of-Pocket maximum for the applicable metal level plan selected. There may be other costs incurred for optional, non-covered and upgraded material services that do not apply toward Out-of-Pocket maximums. To verify Your Out-of-Pocket Maximum, You can visit Valley Health Plan's website at www.valleyhealthplan.org or call Valley Health Plan's Member Services **1-888-421-8444 (toll-free)**. After You have reached the yearly Out-of-Pocket Maximum, LIBERTY will pay the rest of the cost of dental services for that year, as long as the service You receive is a covered benefit performed by Your assigned contracted dental Provider or authorized dental Provider.

D. LIABILITY FOR PAYMENT

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

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

- Non-covered services under your dental plan
- Services completed with a non-contracted office, General Dentist or Specialist
- Services completed prior to or without a Pre-Authorization from LIBERTY
- Services received out of area, that are later deemed to not qualify as Emergency or Urgent Care services by LIBERTY, including but not limited to, routine treatment beyond the stabilization of the emergency situation

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

IMPORTANT: Prior to providing You with non-covered services, Your Contracted Dentist should provide You a treatment plan that includes each anticipated service and the estimated cost. If You would like more information about dental coverage options, You may contact our Member Services Department at 1-888-902-0403.

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 1-888-902-0403 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

E. PROVIDER REIMBURSEMENT

LIBERTY pays for Covered Services to Contracted Dentists via a variety of arrangements including Capitation, fee-for-service and supplemental surpayments in addition to Capitation. Reimbursement varies by geographic area, general dentist, specialty dentist and procedure code. For more information on reimbursement, you may address a request in writing to LIBERTY at LIBERTY Dental Plan, P.O. Box 26110, Santa Ana, CA, 92799-6110.

VII. ELIGIBILITY AND ENROLLMENT

A. WHO IS ENTITLED TO BENEFITS?

Your LIBERTY Dental Plan is provided by Your QHP and coordinated through LIBERTY. If LIBERTY receives Your completed enrollment form payment by the 20th day of the month, You are eligible to receive care on the first day of the following month. You may call Your selected dentist at any time after the effective date of Your coverage. Be sure to identify Yourself as a Member of LIBERTY Dental Plan when You call the dentist for an appointment. We also suggest that You keep this Evidence of Coverage or the Schedule of Benefits with applicable Limitations and Exclusions with You when You go to your appointment. You can then reference Benefits and applicable Co-payments which are the out-of-pocket costs associated with Your plan, as well as any non-covered treatment.

B. WHO IS ELIGIBLE TO ENROLL?

For Essential Pediatric Dental Benefit plans: You must live in the plan Service Area. Enrollment is available for:

- Dependent children (including adopted) up to the nineteenth (19) birthday
- New Dependent children placed for adoption and stepchildren up to the nineteenth (19) birthday, and newborns.

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. Your Schedule of Benefits is provided to You at the inception of this agreement, or may be included herein as Appendix 1, when required. You may also receive a copy of Your Schedule of Benefits from LIBERTY or Your QHP.

A. DIAGNOSTIC DENTAL SERVICES

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

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

B. PREVENTIVE DENTAL SERVICES

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

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

C. RESTORATIVE DENTAL SERVICES

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

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

D. ENDODONTIC SERVICES

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

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

E. PERIODONTIC SERVICES

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

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

F. PROSTHODONTIC SERVICES

Removable prosthodontics is the replacement of lost teeth by a removable prosthesis (removable denture) and the maintenance of those appliances.

Fixed prosthodontics is the replacement of lost teeth by a fixed prosthesis (fixed bridge).

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

G. ORAL SURGERY SERVICES

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

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

H. ADJUNCTIVE DENTAL SERVICES

Adjunctive Dental Services are ancillary services such as anesthesia (deep sedation) during dental services, mouthguards and other procedures are listed in the Schedule of Benefits.

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

I. ORTHODONTIC SERVICES

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

IX. LIMITATIONS, EXCLUSIONS, EXCEPTIONS, REDUCTIONS

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

A. GENERAL EXCLUSIONS

LIBERTY will not cover:

- Care You get from a doctor who is not in the LIBERTY network, unless You have pre-approval from LIBERTY, or You need Emergency or Urgent Care and are outside the LIBERTY Service Area.
- Care that is not medically necessary
- Procedures that are not listed or included in the Schedule of Benefits.
- Exams that You need only to get work, go to school, play a sport, or get a license or professional certification.
- Services that are ordered for You by a court unless they are medically necessary and covered by LIBERTY.
- The cost of copying Your medical records. (This cost is usually a small fee per page)
- Expenses for travel, such as taxis and bus fare, to see a General Dentist, Specialist 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 opt to receive dental services that are not covered services under this plan, a Contracting Dentist may charge You his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, call member services at 1-888-902-0403 or speak with Your insurance broker. To fully understand Your coverage, carefully review this Evidence of Coverage.

B. MISSED APPOINTMENTS

LIBERTY strongly recommends that if You need to cancel or reschedule an appointment with Your Provider that You notify the Dental Office as far in advance as possible but no later than 72 hours prior to your appointment. This will allow LIBERTY and the Provider time 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

1. Termination Due to Loss of Eligibility

Your LIBERTY Plan may be terminated by Your Qualified Health Plan (QHP) coverage. If this happens, You will receive notice through Your QHP at least 30 days before the change takes effect.

Your LIBERTY Plan coverage may also end if You no longer live or work in the LIBERTY Service Area or if LIBERTY no longer offers Your dental plan.

IMPORTANT: This is an EPDB plan, and therefore You will be terminated upon reaching the age limit for coverage stated in this EOC document.

2. Termination Due to Non-Payment of Premium

If Your Qualified Health Plan (QHP) does not pay the Premium, LIBERTY will send a notice to Your QHP saying that the Premium is overdue. Please refer to your Qualified Health Plan's EOC for details on how your QHP would term based on non-payment of Premium.

iii. Completion of Treatment In Progress After Termination

If You terminate from the Plan while the contract between You and LIBERTY Dental Plan is in effect, Your Primary Care Dentist 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.

iv. Termination Due to Fraud

Existing in-force coverage may be terminated, if LIBERTY can demonstrate that a Member has performed an act of practice constituting fraud or made an intentional misrepresentation of material fact. Fraudulent practices or acts include, but are not limited to, permitting any other person to use their Member ID card to obtain services under this dental plan, or otherwise engages in fraud or deception in the provision of incomplete or incorrect "material" information to LIBERTY or to the Provider that would affect enrollment information, for use of the services or facilities of the plan or knowingly permits such fraud or deception by another. In such cases, Subscriber will receive a letter via certified mail at least 30 days prior to the effective date of the termination explaining the reason for the intended termination, and the notice of appeal rights. A Subscriber who alleges that an enrollment has been or will be improperly canceled, rescinded, or not renewed may request a review by the Director of the DMHC. Upon notice of completion of the appeal process, termination will be effective immediately upon such notice from LIBERTY Dental Plan.

v. Termination Due to Health Status

LIBERTY does not terminate based on any health status. If You believe that Your coverage has been terminated based on Your health status or requirements for health care services, You may request a review to be performed by the Director of the Department of Managed Health Care. If the Director determines that a proper complaint exists under the provisions of this section, the Director shall notify the plan. Within 15 days after receipt of such notice, the plan shall either request a hearing or reinstate the Enrollee or Subscriber. A reinstatement shall be retroactive to time of cancellation or failure to renew and the plan shall be liable for the expenses incurred by the Subscriber or Enrollee for covered health care services from the date of cancellation or non-renewal to and including the date of reinstatement. You can contact the Department of Managed Health Care at (1-888-466-2219) or on a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's Internet web site is <http://www.dmhc.ca.gov>.

B. EFFECTIVE DATE OF TERMINATION

Coverage may be terminated, cancelled or non-renewed following 30 days since the date of notification of termination, except for fraud and intentional misrepresentation of material fact, which is effective immediately upon notification.

C. DISENROLLMENT

You may disenroll at any time from the plan with reasonable notice of at least fourteen (14) days by contacting Covered California or Your Qualified Health Plan by phone or in writing. Disenrollment is effective on the date specified or fourteen (14) days after termination is requested, if reasonable notice is not provided.

D. RESCISSION

Rescission means that LIBERTY may cancel Your coverage as if no coverage ever existed. Rescission may be elected by LIBERTY only in the event of fraud or intentional misrepresentation of material fact such as, but not limited to, if You intentionally submitted incomplete or incorrect material information in Your enrollment application. You have the right to appeal any decision to rescind Your membership. Appeal procedures will be provided to You in the notice of rescission. A Subscriber who alleges that an enrollment has been or will be improperly canceled, rescinded, or not renewed may request a review by the Director of the DMHC. Upon notice of completion of the appeal process, termination will be effective immediately upon such notice from LIBERTY Dental Plan. Except as provided by law, LIBERTY may not rescind Your coverage after 24 months from the issuance of the coverage contract.

XI. RENEWAL AND REINSTATEMENT OF COVERAGE

Please refer to Your Valley Health Plan EOC for information regarding Renewal and Reinstatement of Coverage.

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

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

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

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

You may submit a grievance to LIBERTY by calling 888-902-0403 or use TDD/TTY 800-735-2929, go online to www.libertydentalplan.com, fax your written grievance to 833-250-1814 or mail your written grievance to LIBERTY Dental Plan, Grievances and Appeals, P.O. Box 26610, Santa Ana, CA 92799-6110.

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

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

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

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

- You may submit a grievance to the DMHC online at: www.dmhc.gca.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 PROCEDURES

If You are dissatisfied with Your selected Primary Care Dentist, personnel, facilities, specialty referral, Pre-Authorization, claim, or the dental care You receive, You have the right to file a Grievance with LIBERTY. A Grievance is the same as a complaint. Grievance Forms may be requested from your dental office or by contacting LIBERTY Dental Plan's Member Services Department at 888-902-0403. 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 LIBERTY in any of the following ways:

- In writing to: LIBERTY Dental Plan, Grievances and Appeals, P.O. Box 26110, Santa Ana, CA, 92799-6110, or
- By fax to: LIBERTY’s Grievances and Appeals Department at (833) 250-1814, or
- By telephone to: LIBERTY’s Member Services Department at 1-888-902-0403, or
- Online: LIBERTY’s website by visiting www.libertydentalplan.com.

You may use a “patient advocate” to help you file a Grievance. For Grievances involving minors, dependents or member’s with a disability that 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” 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 primary care dentist for filing a Grievance.

You have the right to file a Grievance for at least 180 calendar days following any incident or action that is the subject of Your dissatisfaction. LIBERTY’s representatives will review the problem with you and take appropriate steps for a quick resolution. You will receive acknowledgement of your Grievance within five (5) calendar days of receipt. Grievances will be resolved within thirty (30) calendar days.

Grievances Exempt from Written Acknowledgement and Response: In some cases, LIBERTY’s Member Services can help resolve Grievances that are received over the telephone within twenty-four (24) hours of receipt but no later than the close of the next business day. Grievances resolved by Member Services within the time frame mentioned above do not require a written acknowledgment 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.

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

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 a health care service plan, or requests for review of cancellations, rescissions and non-renewals under Health and Safety Code section 1365(b) and related guidance and rules. Except in cases of emergency dental situation as described above, you must file your grievance with LIBERTY first; if you are not satisfied with the outcome of your grievance or if you do not receive a written response within thirty (30) calendar days, you can contract the DMHC to file a complaint against LIBERTY. Please note: DMHC complaints can only be filed once you have exhausted your grievance rights with LIBERTY.

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

California Required Statement: The California Department of Managed Health Care 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 **1-888-902-0403** 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 (**1-888-466-2219**) and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The Department's Internet web site www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.

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

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

Urgent 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, limb, or major bodily function. A LIBERTY licensed dentist will review your request to determine if Your case meets the expedite criteria for processing. Upon review and determination that your case does qualify for expedited review, LIBERTY will resolve to the urgent condition within three (3) calendar days of receipt of the Grievance, or sooner, based on the condition.

LIBERTY may extend the review of your expedited appeal for up to fourteen (14) calendar days, if there is a need for additional documentation and the delay is in your best interest.

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 above. You may also submit additional materials for reconsideration to LIBERTY's Grievances and Appeals Department, at the address listed below.

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

Any additional information will be processed as a new Grievance.

Your Right to File an Appeal:

Appeal Resolution and Responses: An appeal is a request, by a member, providers acting on behalf of a member or other authorized individual, to review an action by LIBERTY to delay, modify or deny services, in whole or in part. You can also file and appeal if You are not satisfied with LIBERTY's initial grievance determination. 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.

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 appeal to:

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

Or You may contact LIBERTY's Member Services Department by telephone at 1-888-902-0403 to initiate the appeal process.

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 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 Department by telephone at 1-888-902-0403.

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 Department by telephone at 1-888-902-0403 in order to initiate the arbitration process. You also have the right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act in response to an unsuccessful grievance.

A. 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.

B. INDEPENDENT MEDICAL REVIEW (IMR)

Cases denied by LIBERTY, for covered services that are found not medically necessary, may be eligible for the DMHC Independent Medical Review (IMR) program. Subscribers may request a form for IMR of their case by contacting LIBERTY Dental Plan at 1-888-902-0403 or writing to: LIBERTY Dental Plan, Grievances and Appeals, P.O. Box 26110, Santa Ana, CA, 92799-6110. You may also request the forms from the Department of Managed Health Care. The Department of Managed Health Care may be reached at 1-888-466-

2219 or TDD line 877-688-9891 or by visiting their website at: www.dmh.ca.gov. Independent Medical Review is only available for certain medical services.

C. ARBITRATION

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

XIV. MISCELLANEOUS PROVISIONS

A. COORDINATION OF BENEFITS

As a covered Member, You will always receive Your LIBERTY Benefits. LIBERTY does not consider Your Individual Plan secondary to any other coverage You might have. You are entitled to receive benefits as listed in this EOC document despite any other coverage You might have in addition. However, any Covered California coverage that You have that is embedded into a full service health plan will act as the primary payor when You have a supplemental pediatric dental benefit through a family benefit plan.

B. THIRD PARTY LIABILITY

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

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

LIBERTY's Public Policy Committee is a group of members, support staff and our Dental Director. The Public Policy Committee discusses ways LIBERTY can better serve our members and how to improve our policies and programs. Joining this group is voluntary and you will be financially compensated for attending. If You wish to participate in LIBERTY's Public Policy Committee, please contact our Quality Management Department at qm@libertydentalplan.com or call 1-888-902-0403.

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 (800) 735-2929

HOW TO FILE A GRIEVANCE

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

- **By phone:** Call LIBERTY's Civil Rights Coordinator, Monday through Friday, 8 a.m. to 5 p.m. (PST) by calling 888-704-9833. Or if you cannot hear or speak well, please call (800) 735-2929.
- **In writing:** Fill out a complaint form or write a letter and send it to:
LIBERTY Dental Plan
Civil Rights Coordinator
P.O. Box 26110
Santa Ana, CA 92799-6110
- **In person:** Visit your doctor's office or LIBERTY Dental Plan and say you want to file a grievance.
- **Electronically:** Visit LIBERTY Dental Plan website at <https://www.libertydentalplan.com>.

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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

- **By phone:** Call **916-440-7370**. If you cannot speak or hear well, please call **711 (Telecommunications Relay Service)**.
- **In writing:** Fill out a complaint form or send a letter to:
Complaint forms are available at http://www.dhcs.ca.gov/Pages/Language_Access.aspx.

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

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

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

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

A. FILING CLAIMS

As stated throughout this document, You are not required to file claims directly with LIBERTY. Your general dental services are arranged with the participating Primary Care Dentist 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).

B. 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/>

C. LIBERTY DENTAL PLAN MEMBER SERVICES DEPARTMENT

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

D. MEMBER RIGHTS

As a Member, You have the right to:

- To be treated with respect, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information.
- To be provided with information about the plan and its services, including Covered Services.
- To be able to choose a PCD within LIBERTY's network.
- To participate in decision making regarding your own health care, including the right to refuse treatment.
- To voice grievances, either verbally or in writing, about the organization or the care received.
- To receive care coordination.
- To request an appeal of decisions to deny, defer or limit services or benefits.
- To receive oral interpretation services for their language.
- To formulate advance directives.
- To disenroll upon request.
- To access Minor Consent Services.
- To receive written member-informing materials in alternative formats (such as braille, large-size print and audio format) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare & Institutions Code Section 14182 (b)(12).
- 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, as specified in 45 Code of Federal Regulations §164.524 and 164.526.
- 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.

E. MEMBER RESPONSIBILITIES

As a Member, You have the responsibility to:

- 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
- Keeping your planned appointments with your PCD or specialist
- Paying any fees or monies to your dental when agreeing to complete services not covered under your plan
- Telling your PCD or specialist ahead of time if you are unable to make your planned appointments
- Your own actions if you refuse treatment or do not follow your PCD's or specialist's treatment plan, instructions and advise Understanding your dental benefits, including what is and is not covered

F. 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 medical necessity by an appropriately licensed and qualified dentist working within LIBERTY's written clinical criteria guidelines and with due consideration of the individual member needs as well as the characteristics of the local delivery system. LIBERTY does not reward or incentivize reviewers for issuing denials for coverage or care, nor provide incentives that would encourage barriers to care/services or decisions that result in underutilization. LIBERTY's Utilization Management staff annually signs an attestation that review decisions were made based solely on appropriateness of care and services and existence of coverage.

XII. COMPLIANCE PLAN

A. COMPLIANCE PLAN OBJECTIVE:

LIBERTY Dental Plan 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 Dental Plan Board Members, officers, employees, contractors, providers and members are expected to meet these various legal requirements. For these reasons, LIBERTY Dental Plan 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.

B. 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 subscriber or enrollee 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.

C. 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.

D. 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 Dental Plan's Quality Management team for full investigation.

- LIBERTY'S Corporate Compliance Hotline: (888) 704-9833
- LIBERTY'S Compliance Unit email: compliance@libertydentalplan.com
- LIBERTY'S Special Investigations Unit Hotline: (888) 704-9833
- LIBERTY'S Special Investigations Unit email: SIU@libertydentalplan.com

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

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

LIBERTY Dental Plan of California, Inc.

P.O. Box 26110

Santa Ana, CA 92799-6110

1-888-902-0403



Appendix 1:
SCHEDULE OF BENEFITS

Schedule of Benefits are provided as a separate document with your dental ID Card.

Appendix 2:

**PREMIUM, PRE-PAYMENT FEES
AND CHARGES**

Premiums and Fees are established by Valley Health Plan.

Appendix 3: NOTICE OF LANGUAGE ASSISTANCE SERVICES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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