LIBERTY Dental Plan of Nevada, Inc.

Evidence of Coverage
POS Plans

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

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

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

LIBERTY Dental Plan Member Services Department

(888) 401-1128

LIBERTY provides toll-free customer services support Monday through Friday from 6:00 a.m. through 8:00 p.m. to assist members.

Members may also log onto our internet site, www.Libertydentalplan.com, to view plan information, view claim status, print ID cards, search for Plan Providers, and send an e-mail notice to our Member Services Department.

The Department of Business and Industry

State of Nevada

Division of Insurance

Telephone Numbers
for
Consumers of Healthcare

The Division of Insurance ("Division") has established a telephone service to receive inquiries and complaints from consumers of healthcare in Nevada concerning healthcare plans.

The hours of operation of the Division are:

Monday through Friday from 8:00 a.m. until 5:00 p.m., Pacific Standard Time (PST)

The Division local telephone numbers are:

Carson City (775) 687-4270

Las Vegas (702) 486-4009

The Division also provides a toll-free number for consumers residing outside of the above areas:

1-(888) 872-3234

All questions about Preexisting Condition Limitation should be directed to LIBERTY's Member Services Department:

Address: LIBERTY Dental Plan of Nevada, Inc.
6385 S. Rainbow Blvd., Suite 200
Las Vegas, NV 89118

Phone (Monday – Friday from 8:00 a.m. until 5:00 p.m., Pacific Standard Time):
(888) 401-1128

Evidence of Coverage

SECTION 1. ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

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

1.1 WHO IS ELIGIBLE

Subscriber. To be eligible to enroll as a Subscriber, an employee must:

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

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

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

- A Subscriber's legal spouse or a legal spouse for whom a court has ordered coverage.
- Subscriber's Domestic Partner meeting all of the criteria for a Qualified Domestic Partnership set forth in LIBERTY's Affidavit of Domestic Partnership.
- A child by birth. Adopted child. Stepchild. Child for whom a court has ordered coverage. Child being placed for Adoption with the Subscriber. A child for whom a court has appointed the Subscriber or the Subscriber's spouse the legal guardian. The child of a Subscriber meeting one of these conditions is eligible for coverage under this Plan up to the child's twenty-sixth (26^{th}) birthday unless such child is eligible for employer-sponsored coverage (other than coverage through the Subscriber). The children and spouse of a dependent child are excluded from coverage.
- Any unmarried child who is incapable of self-sustaining employment due to mental or physical handicap, chiefly dependent upon the Subscriber for economic support and maintenance, and who has satisfied all of the requirements of (a) or (b) below.

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

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

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

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

- Group's eligibility rules may supersede the Dependent guidelines noted above. Please contact the sponsor of this program to determine eligibility requirements.

1.2 WHO IS NOT ELIGIBLE

Eligible Dependents do not include:

- A foster child.
- A child placed in the Subscriber's home other than for the purpose of adoption.
- A grandchild other than:
    1. A grandchild that has been adopted by the grandparents and/or has been placed in the home of the grandparents for the purposes of adoption; or
    2. For the first thirty-one (31) days after birth only, a grandchild that is also the child of a Dependant as that term is defined in Section 1.1 of this EOC.
- Any other person not defined in Section 1.1.

1.3 CHANGES IN ELIGIBILITY STATUS

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

- Reaching the limiting age.
- Death.
- Divorce.
- Marriage.
- Termination of a Domestic Partnership that qualifies for coverage under LIBERTY's Affidavit of Domestic Partnership.
- Or transfer of residence or work outside LIBERTY's Service Area.

If Subscriber fails to give notice, which would have resulted in termination of coverage, LIBERTY shall have the right to terminate coverage retroactively.

1.4 ENROLLMENT

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

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

    Violates or has violated any provision of a LIBERTY EOC.

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

    Fails to follow LIBERTY rules.

    Fails to make a premium payment.

5. **Right to Deny Application for Renewal.** As a condition of Group's renewal under this Plan, LIBERTY may require Group to exclude a Subscriber or Dependent who committed fraud upon LIBERTY or misrepresented and/or failed to disclose a material fact, which affected his coverage under this Plan.

1.5 EFFECTIVE DATE OF COVERAGE

Before coverage can become effective, LIBERTY must receive and accept premium payments and an Enrollment Form for the person applying to be a Member.

When a person applies to be a Member on or before the date he is eligible, coverage starts as shown in the GEA signed by Group.

1. If a person applies to be a Member within thirty-one (31) days of the date he is first eligible to apply, coverage starts on the first day of the calendar month following the month when the Enrollment Form is received by LIBERTY.
2. Subscriber's newborn natural child is covered for the first thirty-one (31) days from birth. Coverage continues after thirty-one (31) days only if the Subscriber enrolls the child as a Dependent the premium is paid within thirty-one (31) days of the date of birth.
3. An adopted child is covered for the first thirty-one (31) days from birth only if the adoption has been legally completed before the child's birth. A child Placed for Adoption at any other age is covered for the first thirty-one (31) days after the placement for adoption.

   Coverage continues after thirty-one (31) days only if the Subscriber enrolls the child as a Dependent and the premium is paid within thirty-one (31) days following the placement of the child in the Subscriber's home. In the event adoption proceedings are terminated, coverage of a child Placed for Adoption ends on the date the adoption proceedings are terminated.
4. If a court has ordered Subscriber to cover his or her legal spouse or unmarried minor child, that person will be covered for the first thirty-one (31) days following the date of the court order. Coverage continues after thirty-one (31) days if the Subscriber enrolls the Dependent and the Dependent's premium is paid. A copy of the court order must be given to LIBERTY.
5. For a Special Enrollee, the Effective Date of coverage is as follows:
   - In the case of marriage, on the first day of the calendar month after the marriage date; or
   - In the case of birth, adoption or Placement for Adoption, upon the Dependent's date of birth, or upon the Dependent's date of adoption or Placement for Adoption; or
   - In the case of all other Special Enrollment Events, on the first day of the calendar month after an Enrollment Form is received, unless otherwise specified in the GEA.
6. When a person applies to be a Member during the Open Enrollment Period, coverage starts on the first day of the calendar month following the Open Enrollment Period.

   Subscriber must give LIBERTY a copy of the certified birth certificate, decree of adoption, or certificate of placement for adoption for coverage to continue after thirty-one (31) days for newborn and adopted children.

   Subscriber must give LIBERTY a copy of the certified marriage certificate, complete affidavit of domestic partnership (LIBERTY's form only), proof of student status or any other required documents before coverage can be effective for other Eligible Family Members.

SECTION 2. TERMINATION

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

2.1 TERMINATION BY LIBERTY

- Failure to maintain eligibility requirements as set forth in Section 1.

- Payment is due on the day of each month that you are insured by LIBERTY. There is a 30 day grace period for payment to be received by LIBERTY. The member will be terminated on the 31st day if payment has not been received by LIBERTY.
- On the first day of the month that a contribution was due and not received by LIBERTY.
- With thirty (30) days written notice, if the Member allows his or any other Member's LIBERTY ID card to be used by any other person, or uses another person's card. The Member will be liable to LIBERTY for all costs incurred as a result of the misuse of the LIBERTY Member card.
- If information given to LIBERTY by the Member in his Enrollment Form is untrue, inaccurate, or incomplete, LIBERTY has the right to declare the coverage under the Plan null and void as of the original Effective Date of coverage if the discovery is made within two years of the document being received by LIBERTY.
- When a Subscriber moves his primary residence outside the Service Area and/or no longer has his place of work within the Service Area or when a Dependent moves his primary residence outside LIBERTY's Service Area, Subscriber must notify LIBERTY within thirty-one (31) days of the change. LIBERTY will request proof of the change of residence and/or place of work.
- On the date the GEA terminates for any reason, including but not limited to:
    1. Nonpayment of premiums.
    2. Failure to meet minimum enrollment requirements.
    3. LIBERTY amends this EOC and the Group does not accept the amendment.

2.2 TERMINATION BY THE SUBSCRIBER

Subscriber has the right to terminate his coverage under the Plan. Termination notice must be reported to LIBERTY by the sponsor of this program. Such termination is effective on the last day of the month when the notice is received by LIBERTY, unless stated otherwise in the GEA.

2.3 REINSTATEMENT

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

2.4 Retroactive Termination

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

2.5 EFFECT OF TERMINATION

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

SECTION 3. USING THIS PLAN

This Plan offers you a choice of where you receive your dental care by offering three tiers of coverage – EPO, PPO, and Out-of-Network. You will find the most affordable care is available through Tier I EPO Plan Providers. When you choose to receive your care from any dentist that is an EPO Plan Provider, your costs will be limited by the costs identified in the Schedule of Benefits. You will also not need to submit any claim forms when you receive your care from an EPO Plan Provider. To receive in-network benefits for care provided by a Specialist your EPO Plan Provider must initiate the referral process with LIBERTY. LIBERTY will then refer you to a Specialist who is an EPO Plan Specialty Provider for approved Specialty services.

If you choose to receive care from a dentist that is not a Tier I EPO Plan Provider your benefit will be more limited and you will have an annual deductible and an annual maximum.

When you choose to receive your care from any dentist that is a Tier II PPO Plan Provider, your costs will be limited by the PPO Plan Provider's contracted fees. You will only be responsible for your deductible, your co-insurance percentage (based on your Plan coverage) of the PPO Plan Provider's contracted rate, non-covered services, and amounts over your annual maximum payable by the Plan. You will also not need to submit any claim forms when you receive your care from a Plan Provider.

If you receive care from a Tier III Out-of-Network Provider, the Plan will pay the applicable percentage (based on your Plan coverage) of the regional usual and customary fees and you will be responsible for any amount charged by the Out-of-Network Provider over and above that payable by the Plan. Out-of-Network Providers may ask you to pay the full amount of the charges and have you submit the claim to LIBERTY for reimbursement. **You will be responsible for the difference in what the Out-of-Network Provider charges and the total amount that LIBERTY pays.**

In addition, care by a Specialist that was not approved by LIBERTY following the Specialty Referral process noted above will be paid under Tier II if the specialist is in the PPO Plan network or Tier III if the specialist is not in the PPO Plan network.

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

SECTION 4. COVERED SERVICES

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

4.1 BENEFITS AVAILABLE

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

Tier I In-network benefits must be obtained from EPO Plan Providers. The Benefit Schedule identifies the member copayments that are to be paid to Tier I EPO Plan Providers at the time of service.

Tier II In-network benefits must be obtained from PPO Plan Providers. Plan payment is based on the applicable percentages of the PPO Plan Providers contracted fees. Deductibles and maximums apply for care received from PPO Plan Providers.

Tier III Out-of-network benefits can be obtained from any dentist licensed in the United States. Plan payment is based on the applicable percentages of the regional usual and customary fees Deductibles and maximums apply for care received from dentists and Specialists that are not Plan Providers. You will be responsible for any charges over the Plan Pays amount.

4.2 CLAIM PAYMENTS

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

Tier II PPO Plan Providers are paid based on the applicable percentages of the PPO Plan Providers contracted fees.

Tier III out-of-network providers are paid an amount based on the applicable percentages of the regional usual and customary fees. The Plan's payment to an out-of-network provider may not fully compensate the provider for the services provided to the Member. The Member is responsible for the difference between the amount paid by the Plan to an out-of-network provider and the out-of-network provider's charge.

When you receive services from an Out-of-Network provider, you may be asked to pay 100% of the charges at the time of service. You must submit a claim form with the supporting documentation to LIBERTY when requesting reimbursement. When obtaining care from a Tier I EPO Plan Provider or a Tier II PPO Provider, the Plan Provider will submit the claim form on your behalf. LIBERTY accepts standard American Dental Association claim forms which most providers have in their office. Claims forms are also available from LIBERTY.

All claims shall be approved or denied within thirty (30) days after receipt by the Plan, unless additional information is requested. If the claim is approved, the claim will be paid within thirty (30) days after it is approved. If the Plan requires additional information, the Member shall be notified within twenty (20) days after the Plan actually receives the claim. The claim will be paid or denied within thirty (30) days of the Plan's receipt of all of the additional information it requested.

All claims must be submitted to LIBERTY within sixty (60) days from the date expenses were incurred, unless it shall be shown not to have been reasonably possible to give notice within the time limit, and that notice was furnished as soon as was reasonably possible. If Member authorizes payment directly to the Provider, a check will be mailed to that Provider. A check will be mailed to the Member directly if payment directly to the Provider is not authorized. Member will receive an explanation of how the payment was determined.

No payments shall be made under this EOC with respect to any claim, including additions or corrections to a claim which has already been submitted, that is not received by LIBERTY within twelve (12) months after the date Covered Services were provided.

Denials of claims can be submitted to the Plan's Grievance procedures described in this EOC.

4.3 EMERGENCY SERVICES

In the event of an emergency outside the service area of the Plan, the Member should contact LIBERTY at (888) 401-1128. The Plan will direct you to an available Tier I EPO Plan Provider if possible. Should no Tier I EPO Plan Provider be available in a fifty (50) mile radius you can seek treatment from any licensed dentist. In such an event, the Plan will reimburse you for the cost of qualified emergency services received from a non-EPO Plan Provider up to a maximum of seventy-five dollars ($75), less any applicable member co-payments based on the Tier I EPO In-Network Benefits. Any non-qualified emergency services will be considered under either the Tier II PPO Benefits if a PPO Plan Provider is used or the Tier III Out-of-Network Benefits if the Provider is not a PPO Plan Provider.

The Plan provides coverage for emergency dental services only if the services are required to alleviate severe pain or bleeding or if an enrollee reasonably believes that the condition, if not diagnosed or treated, may lead to disability, dysfunction or death.

Qualified emergency dental service and care include a dental screening, examination, evaluation by a dentist or dental specialist to determine if an emergency dental condition exists, and to provide care that would be acknowledged as within professionally recognized standards of care an in order to alleviate any emergency symptoms in a dental office.

SECTION 5. EXCLUSIONS AND LIMITATIONS

5.1 EXCLUSIONS

In addition to items identified as NOT COVERED in the Benefits Schedule, this section tells you what services or supplies are excluded from coverage under this Plan.

- Dental services for aesthetics only and/or cosmetic dental care unless otherwise listed as a covered benefit.
- General anesthesia, intravenous and inhalation sedation, prescription drugs for anesthesia, and the services of a special anesthesiologist unless otherwise listed as a covered benefit.
- Dental conditions arising out of and due to a Member's employment or for which the Member is entitled to Workers' Compensation benefits.
- Hospital and medical facility charges of any kind.
- Services of any kind provided in the home.
- Ambulance services.
- Durable Medical Equipment.
- Mental Health services.
- Chemical Dependency services
- General anesthesia, analgesia, intravenous/intramuscular sedation or the services of an anesthesiologist unless otherwise listed as a Covered Benefit.
- Treatment started before the member was eligible, or after the member was no longer eligible.
- Any services performed outside of your assigned dental office, unless expressly authorized by Liberty Dental Plan, or unless as outlined and covered as emergency dental care.
- Charges from a medical doctor, doctor of osteopathic medicine and/or other medical professional except for dental services otherwise covered herein.
- Treatment of fractures or dislocations.
- Replacement of lost or stolen dentures, partials or other appliances (e.g. crowns, bridges, full or partial dentures).
- Services which are normally reimbursed by a third party or liability insurance and/or under the medical portion of a group health plan.
- Dental procedures for which treatment was started prior to the time Member became eligible for benefits.
- Procedures, appliances, restorations or other treatment to correct congenital or developmental malformations.
- Treatment and/or removal of: (a) malignancies; (b) cysts or benign tumors not within the scope of usual dental care; (c) odontongenic cysts exceeding 1.25 cm in diameter.
- Drugs/medications not normally supplied or prescribed by a dental office.
- Any treatment which, on the opinion of LIBERTY's Dental Director, is not necessary for the Member's dental health.

- Replacement of an existing bridge, partial or denture which, in the opinion of LIBERTY's Dental Director, is satisfactory or that can be made satisfactory.
- Orthognathic surgery.
- Implants or any prosthesis attached to or dependent upon an implant unless otherwise listed as a covered benefit on the Benefits Schedule.
- Any experimental, investigational or exotic procedure not approved by the ADA Council on Dental Therapeutics.
- Treatment to alter vertical dimension or to restore occlusion, unless dentures are involved.
- Treatment or therapy for Temporo Mandibular Joint (TMJ) problems including, but not limited to, assessment beyond that customarily provided in a general dental practice.
- Procedures, appliances, or restorations to correct congenital, developmental or medically induced dental disorder, including but not limited to: myofunctional (e.g. speech therapy), myoskeletal, or temporomandibular joint dysfunctions (e.g. adjustments/corrections to the facial bones) unless otherwise covered as an orthodontic benefit.
- Appliances needed to increase vertical dimension or restore occlusion.
- Crowns for the primary purpose of splinting, altering, or maintaining vertical dimension or restoring occlusion.
- Treatment or service which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years.
- Treatment or service replacing tooth structure lost from abrasion, attrition, erosion, or abfraction.
- Expense or charge incurred by a Member confined to an institution of any kind.
- Cases in which, in the reasonable professional judgment LIBERTY's Dental Director, a satisfactory result cannot be obtained.
- Replacement of long-standing missing tooth/teeth in an otherwise stable dentition.
- Orthodontic services unless otherwise listed as a covered benefit.
- Care related to the bite, alignment of teeth, or bite correction.
- Charges for specialized techniques involving precision attachments, personalization or characterization of a temporary or permanent prosthesis.
- Any service not specifically listed as a Covered Benefit on the Benefits Schedule.

5.2 LIMITATIONS

In addition to the limitations of coverage identified in the Benefits Schedule, this section tells you when LIBERTY's duty to provide or arrange for services is limited.

- LIBERTY will not be liable for any delay or failure to provide or arrange for Covered Services if the delay or failure is caused by the following:
  - Natural disaster.
  - War.
  - Riot.
  - Civil insurrection.
  - Epidemic.

- Or any other emergency beyond LIBERTY's control.

- Benefits in excess of the yearly or lifetime maximum benefits. Please see the Benefit Schedule for Calendar Year maximum benefits and lifetime maximum benefit limitations on certain services.
- Prophylaxis is limited to one treatment each (6) month period (includes periodontal maintenance following active therapy). Unless optional one treatment per four (4) month rider is purchased.
- Oral evaluation is limited to two in each (12) month period.
- Oral hygiene instruction is limited to one per twenty-four (24) month period.
- Fluoride treatment is limited to one treatment every six (6) month period.
- Crowns, bridges and dentures may not be replaced within five (5) years from the initial placement.
- Partial dentures are not to be replaced within five (5) years of the initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
- Denture relines are limited to one per denture during any twelve (12) consecutive months.
- Covered charge for both a temporary and a permanent prosthesis will be limited to the charge for a permanent prosthesis only.
- Charges for adjustment of a prosthesis will be limited to one in a six (6) month period.
- Periodontal treatments are limited to one time per quadrant during any twenty-four (24) consecutive months.
- Fill mouth debridement (gross scale) is limited to one treatment in any thirty-six (36) consecutive month period.
- Osseous surgery is limited to one treatment in any five (5) year period.
- Crowns will be covered only if, in the opinion of LIBERTY's Dental Director, there is not enough retentive quality left in the tooth to hold a filing.
- Bitewing x-rays are limited to not more than one series of four films in any six (6) month period.
- Full mouth x-rays and/or panographic type films are limited to one set every thirty-six (36) consecutive months. Sealant benefits include the application of sealants only to permanent first and second molars with no decay for dependent children only up to the age of 14. Sealant benefits Limited to once per tooth in any 36 consecutive month period.
- Periodontal scaling and root planning limited to once each quadrant in any 24 consecutive month period.
- Periodontal surgical procedures are limited to once per quadrant in any 36 consecutive month period.
- Crowns are covered only if the tooth cannot be restored by a filling.
- If LIBERTY determines that more than one procedure could be performed to correct a dental condition, the covered benefit will be the least expensive of the procedures that would provide professionally acceptable results.

SECTION 6. GENERAL PROVISIONS

6.1 RELATIONSHIP OF PARTIES

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

6.2 ENTIRE AGREEMENT

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

6.3 CONTESTABILITY

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

6.4 AUTHORITY TO CHANGE THE FORM OR CONTENT OF EOC

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

6.5 IDENTIFICATION CARD

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

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

6.6 NOTICE

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

LIBERTY Dental Plan of Nevada, Inc.

6385 S. Rainbow Blvd., Suite 200

Las Vegas, NV 89118

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

6.7 ASSIGNMENT

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

6.8 MODIFICATIONS

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

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

6.9 CLERICAL ERROR

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

6.10 POLICIES AND PROCEDURES

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

6.11 OVERPAYMENTS

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

6.12 RELEASE OF RECORDS

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

6.13 GENDER REFERENCES

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

6.14 AVAILABILITY OF PROVIDERS

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

SECTION 7. APPEALS AND GRIEVANCES

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

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

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

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

The following Appeals Procedures will be followed if the dental service site matter cannot be resolved at the site or if the concern involves the Adverse Benefit Determination of a Claim for Benefits.

- **Informal Review:** An Adverse Benefit Determination or other complaint/concern which is directed to the LIBERTY Member Services Department via phone or in person. If an Informal Review is resolved to the satisfaction of the Member, the matter ends. The Informal Review is **voluntary**.

- **1st Level Formal Appeal:** An appeal of an Adverse Benefit Determination filed either orally or in writing which LIBERTY's Customer Response and Resolution Department investigates. If a 1st Level Formal Appeal is resolved to the satisfaction of the Member, the appeal is closed. The 1st Level Formal Appeal is **mandatory** if the Member is not satisfied with the initial determination and the Member wishes to appeal such determination.

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

- **Grievance Review Committee:** A committee of three (3) or more individuals, the majority of which must be Members of LIBERTY.

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

7.1 INFORMAL REVIEW

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

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

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

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

7.2 FIRST LEVEL FORMAL APPEAL

When an Informal Review is not resolved in a manner that is satisfactory to the Member or when the Member chooses not to file an Informal Review and the Member wishes to pursue the matter further, the Member must file a 1st Level Formal Appeal. The 1st Level Formal Appeal must be submitted in writing to LIBERTY's Customer Response and Resolution Department within 180 days of an Adverse Benefit Determination. 1st Level Formal Appeals not filed in a timely manner will be deemed waived with respect to the Adverse Benefit Determination to which they relate.

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

- The Member's name (or name of Member and Member's Authorized Representative), address, and telephone number;
- The Member's LIBERTY membership number and Group name; and

- A brief statement of the nature of the matter, the reason(s) for the appeal, and why the Member feels that the Adverse Benefit Determination was wrong.

Additionally, the Member may submit any supporting medical/dental records, Dentist's letters, or other information that explains why LIBERTY should approve the Claim for Benefits. The Member can request the assistance of a Member Services Representative at any time during this process.

The 1st Level Formal Appeals should be sent or faxed to the following:

Address: LIBERTY Dental Plan of Nevada, Inc.
Attn: Customer Response and Resolution Dept.
6385 S. Rainbow Blvd., Suite 200
Las Vegas, NV 89118
Fax: (888) 401-1129

LIBERTY will investigate the appeal. When the investigation is complete, the Member will be informed in writing of the resolution within thirty (30) days of receipt of the request for the 1st Level Formal Appeal. This period may be extended one (1) time by LIBERTY for up to fifteen (15) days, provided that the extension is necessary due to matters beyond the control of LIBERTY and LIBERTY notifies the Member prior to the expiration of the initial thirty (30) day period of the circumstances requiring the extension and the date by which LIBERTY expects to render a decision. If the extension is necessary due to a failure of the Member to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information and the Member shall be afforded at least forty-five (45) days from receipt of the notice to provide the information.

1st Level Formal Appeals will be decided by a Grievance Review Committee.

If the 1st Level Formal Appeal results in an Adverse Benefit Determination, the Member will be informed in writing of the following:

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

Limited extensions may be required if additional information is required in order for LIBERTY to reach a resolution.

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

7.3 EXPEDITED APPEAL

The Member can ask (either orally or in writing) for an Expedited Appeal of an Adverse Benefit Determination for a Pre-Service Claim that the Member or his Dentist believe that the health of the Member could be seriously harmed by waiting for a routine appeal decision. Expedited Appeals are not available for appeals regarding denied claims for benefit payment (Post-Service Claim). Expedited Appeals must be decided no later than seventy-two (72) hours after receipt of the appeal, provided all necessary information has been submitted to LIBERTY. If the initial notification was oral, LIBERTY shall provide a written or electronic explanation to the Member within three (3) days of the oral notification.

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

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

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

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

7.4 SECOND LEVEL FORMAL APPEAL

When a 1st Level Formal Appeal is not resolved in a manner that is satisfactory to the Member, the Member may initiate a 2nd Level Formal Appeal. This appeal must be submitted in writing within thirty (30) days after the Member has been informed of the resolution of the 1st Level Formal Appeal.

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

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

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

Upon request a Member is entitled to attend and provide a formal presentation on a 2nd Level Formal Appeal. If such a hearing is requested LIBERTY shall make every reasonable effort to schedule one at a time mutually convenient to the parties involved. Repeated refusal on the part of the Member to cooperate in the scheduling of the formal presentation shall relieve the Grievance Review Committee of the responsibility of hearing a formal presentation, but not of

reviewing the 2nd Level Formal Appeal. If a formal presentation is held, the Member will be permitted to provide documents to the Grievance Review Committee and to have assistance in presenting the matter to the Grievance Review Committee, including representation by counsel. However, LIBERTY must be notified at least five (5) business days before the date of the scheduled formal presentation of the Member's intent to be represented by counsel and/or to have others present during the formal presentation. Additionally, the Member must provide LIBERTY with copies of all documents the Member may use at the formal presentation (5) business days before the date of the scheduled formal presentation.

Upon LIBERTY's receipt of the written request, the request will be forwarded to the Grievance Review Committee along with all available documentation relating to the appeal.

The Grievance Review Committee shall:

- consider the 2nd Level of Appeal;
- schedule and conduct a formal presentation if applicable;
- obtain additional information from the Member and/or staff as it deems appropriate; and
- make a decision and communicate its decision to the Member within thirty (30) days following LIBERTY's receipt of the request for a 2nd Level Formal Appeal.

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

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

Limited extensions may be required if additional information is required or a formal presentation is requested and the Member agrees to the extension of time.

7.5 EXTERNAL REVIEW

LIBERTY offers Members the right to an External Review of a final Adverse Benefit Determination when a Member or the Member's Dentist receives notice of a final Adverse Benefit Determination from LIBERTY, and when the Member is required to pay $500 or more for healthcare services that are the subject of the final Adverse Benefit Determination. A Member is entitled to an External Review only after the Member has exhausted all procedures provided in this plan for reviewing the Adverse Benefit Determination or if LIBERTY agrees in writing to submit the matter to External Review before the Member has exhausted all procedures provided in this plan for reviewing the Adverse Benefit Determination. The Member, Member's Dentist, or an Authorized Representative may within sixty (60) days after receiving notice of such final Adverse Benefit Determination, submit a request to LIBERTY's Managed Care Program for an External Review.

Within five (5) days after LIBERTY receives such a request, LIBERTY shall notify the Member, his Authorized Representative or Dentist, and the Nevada Office for Consumer Health Assistance that the request has been received and filed.

The Nevada Office for Consumer Health Assistance shall assign an External Review Organization to review the case.

Within five (5) days after receiving notification specifying the assigned External Review Organization from the Nevada Office for Consumer Health, LIBERTY shall provide to the selected External Review Organization all documents and materials relating to the final Adverse Benefit Determination, including, without limitation:

- Any medical records of the Member relating to the final Adverse Benefit Determination;
- A copy of the provisions of the Plan upon which the final Adverse Benefit Determination was based;
- Any documents used and the reason(s) given by LIBERTY for the final Adverse Benefit Determination; and
- If applicable, a list that specifies each Provider who provided healthcare to the Member and the corresponding medical records from the Provider relating to the final Adverse Benefit Determination.

Within five (5) days after the External Review Organization receives the required documentation from LIBERTY, they shall notify the Member, his Dentist, and LIBERTY if any additional information is required to conduct the review.

The External Review Organization shall approve, modify, or reverse the final Adverse Benefit Determination within fifteen (15) days after it receives the information required to make such a determination.

The External Review Organization shall submit a copy of its determination, including the basis thereof, to the:

- Member;
- Member's Dentist;
- Authorized Representative of the Member, if any; and
- LIBERTY.

If the determination of an External Review Organization concerning an External Review of a final Adverse Benefit Determination is in favor of the Member, the determination is final, conclusive and binding.

The cost of conducting an External Review of a final Adverse Benefit Determination will be paid by LIBERTY.

7.6 EXPEDITED EXTERNAL REVIEW

If the Member's healthcare Provider submits proof to LIBERTY that failure to proceed in an expedited manner may jeopardize the life or health of the Member, then LIBERTY shall approve or deny a request for an expedited External Review of an Adverse Benefit Determination no later than seventy-two (72) hours after the request for an expedited External Review is received.

If LIBERTY approves the expedited External Review, LIBERTY shall assign the request to an External Review Organization no later than one (1) business day after approving the request. All relevant medical documents previously listed herein that were used to establish the final Adverse Benefit Determination will be forwarded to the External Review Organization concurrently.

The External Review Organization shall complete its External Review no later than two (2) business days after initially being assigned the case unless the Member and LIBERTY agree to a longer time period.

The External Review Organization shall notify the following parties by telephone no later than one (1) business day after completing its External Review:

- Member;
- Member's Dentist;
- Authorized Representative of the Member, if any; and
- LIBERTY.

The External Review Organization shall then submit a written copy of its determination no later than five (5) business days to the applicable parties listed above.

If the determination of an External Review Organization concerning an External Review of a final Adverse Benefit Determination is in favor of the Member, the determination is final, conclusive and binding.

The cost of conducting an External Review of a final Adverse Benefit Determination will be paid by LIBERTY.

SECTION 8. GLOSSARY

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

The External Review provision in this EOC only applies if the Adverse Benefit Determination was made based on the Plan's determination that the denied service or supply was not necessary or that the denied service or supply was determined to be experimental or investigational.

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

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

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

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

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

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

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

"Copayment" means the amount the Member pays directly to a Plan Provider when a Covered Service is received.

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

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

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

"Dependent" means an Eligible Family Member or Qualified Domestic Partner of the Subscriber's family who:

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

"Domestic Partner" means a person of at least 18 years of age has registered for a domestic partnership with Subscriber under the laws of the State of Nevada with the Nevada Secretary of State.

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

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

"Eligible Employee" means a natural person that:

A. Is a bona fide employee of the Group; and
B. Meets the criteria in Section 1.1

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

"Emergency Services" means Covered Services provided after the sudden onset of a dental condition with symptoms severe enough to cause a prudent person to believe that lack of immediate medical attention could result in serious:

- jeopardy to his health;
- jeopardy to the health of an unborn child;
- impairment of a bodily function; or
- dysfunction of any bodily organ or part.

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

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

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

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

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

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

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

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

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

- the likelihood of a certain service or supply producing a significant positive outcome;
- reports in peer-review literature;
- evidence based reports and guidelines published by nationally recognized professional organizations that include supporting scientific data;
- professional standards of safety and effectiveness that are generally recognized in the United States for diagnosis, care or treatment;
- the opinions of independent expert Dentists in the health specialty involved when such opinions are based on broad professional consensus; or
- other relevant information obtained by LIBERTY.

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

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

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

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

"Plan" means LIBERTY Dental Plan of Nevada, Inc.

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

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

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

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

"Prior Authorization" or "Prior Authorized" means a system that requires a Provider to get approval from LIBERTY before providing non-emergency health care services to a Member for

those services to be considered Covered Services. Prior authorization is not an agreement to pay for a service.

"Qualified Domestic Partner" means a Domestic Partner that is in a Qualified Domestic Partnership with Subscriber.

"Qualified Domestic Partnership" means a relationship between Subscriber and a Domestic Partner in which:

- Both the Subscriber and the Domestic Partner are at least 18 years of age;
- The Subscriber and the Domestic Partner have chosen to share one another's lives in an intimate and committed relationship;
- Have entered into a domestic partnership out of their own free will;
- Have filed the required affidavits for the formation of a Domestic Partnership under the laws of the State of Nevada with the Secretary of State for the State of Nevada;
- The Subscriber and the Domestic Partner are unmarried to each other or any other person;
- The Subscriber and the Domestic Partner are not in any other domestic partnership; and
- The Subscriber and the Domestic Partner are not related by blood to a degree that would prohibit a spousal relationship.

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

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

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

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

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

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

"**Waiting Period"** means the period of time as established by the Group that must pass before coverage for an Eligible Employee or Dependent can become effective.