GROUP AGREEMENT

kp.org

Willamette University

KAISER PERMANENTE®

All Plans offered and underwritten by
Kaiser Foundation Health Plan of the Northwest

April 2, 2020

Danita Phr Chapin
Willamette University
900 State Street

Salem, OR 97301

Group number: 2014-006, 007

Dear Danita Phr,

Choosing a health plan for your group is an important decision. Thank you for selecting Kaiser Permanente for your employees' health care needs.

Enclosed is the Dental Plan Group Agreement effective 4/1/2020 through 3/31/2021 for Willamette University. The Group Agreement includes group contract provisions, such as monthly Premium amounts, and incorporates the Evidence of Coverage (EOC) which is the member portion of the contract. The EOC contains benefit descriptions and cost sharing amounts, limitations, exclusions, and information to assist the member in obtaining care.

Also enclosed is a Summary of Changes and Clarifications. Please review this to learn about changes to the Group Agreement for this year.

We know you have a choice of health plans and we appreciate your business. If you have any questions about this Group Agreement or your health plan, please contact Otoniel Rosales at (503) 813-3391.

Sincerely,

Kaiser Permanente Sales & Account Management Team
Enclosures

/kjm

Kaiser Permanente Building
500 N.E. Multnomah Street, Suite 100
Portland, OR 97232-2099

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KAISER PERMANENTE®

2020 *Group Agreement* and *Evidence of Coverage* Summary of Changes and Clarifications for Oregon Large Employer Groups

This is a summary of changes and clarifications that we have made to your *Group Agreement*. The *Group Agreement* includes the *Evidence of Coverage* (*EOC*), "Benefit Summary," and any applicable rider and endorsement documents. This summary does not include minor changes and clarifications we are making to improve the readability and accuracy of the *Group Agreement*. These changes and clarifications do not include changes that may occur throughout the remainder of the year as a result of federal or state mandates.

Other Group-specific or product-specific plan design changes (including changes to Copayment or Coinsurance amounts) may apply, such as moving to standard benefits. Refer to the Rate Proposal and/or the Summary of Plan Changes document for information about these types of changes.

To the extent that this summary of changes and clarifications conflicts with, modifies, or supplements the information contained in your *Group Agreement*, the information contained in the *Group Agreement* shall supersede what is set forth below. Unless another date is listed, the changes in this document are effective when your Group renews in 2020. The products named below are offered and underwritten by Kaiser Foundation Health Plan of the Northwest.

Changes and clarifications that apply to Traditional, Deductible, High Deductible, Added Choice®, and PPO Plus medical plans

Changes to Senior Advantage plans are explained at the end of this summary.

Benefit changes

- The "Referrals to Participating Providers and Participating Facilities" section of the Traditional, Deductible, and High Deductible Health Plan *EOC* has been modified. Ophthalmology has been removed from the list of departments that do not require a referral for outpatient Services. A referral will now be required to schedule an appointment for ophthalmology Services.

Benefit clarifications

- The "What You Pay" section of the *EOC* has been modified to align with changes made to the "Benefit Summary" describing all Deductible accumulation types in terms of a self-only Deductible, an individual Family Member Deductible, and a Family Deductible. The edits provide clarification to Members by distinguishing the difference between self-only and an individual in a Family. Aggregate and embedded accumulation types are now discerned by the amounts listed on the "Benefit Summary" for each of the categories.
- The "What You Pay" section of the *EOC* has been modified to align with changes made to the "Benefit Summary" describing all Out-of-Pocket accumulation types in terms of a self-only Out-of-Pocket Maximum, an individual Family Member Out-of-Pocket Maximum, and a Family Out-of-Pocket Maximum to provide clarification to Members by distinguishing the difference between self-only and an individual in a Family. Aggregate and embedded accumulation types are now discerned by the amounts listed on the "Benefit Summary" for each of these categories.
- The "Emergency, Post-Stabilization and Urgent Care" in the *EOC* has been modified to reflect a change in terminology on the "Benefit Summary." Emergency Services has been changed to emergency

department visit to more accurately describe when the emergency department visit Copayment or Coinsurance applies.

- The "Emergency Services" section of the *EOC* has been modified to specify that Emergency Services may be received anywhere in the world as long as the Services would have been covered under the "Benefits" section if received by a Participating Provider or at a Participating Facility.
- The "Preventive Care Services" section of the *EOC* has been modified to clarify that Services to diagnose current or ongoing signs or symptoms are not considered preventive and may be subject to applicable cost shares.
- The "Hearing Aid Services for Dependents" section of the *EOC* has been modified to clarify coverage requirements per the amendment of ORS 743A.141 in the 2018 Oregon House Bill (HB) 4104. A new "Hearing Aid Services for Dependents Limitations" section has been added to describe the limited coverage of replacement ear molds and hearing aid batteries as stated in HB 4104. These benefits were covered in 2019, language has been added to the 2020 contract documents for Member clarity. An exclusion has also been removed from the "Hearing Aid Services for Dependents Exclusions."
- The "Limited Outpatient Prescription Drugs and Supplies" section of the *EOC* has been modified for better alignment with the "Outpatient Prescription Drug Rider" and to provide clarity regarding how to get covered drugs and supplies.
- The "Limited Outpatient Prescription Drugs and Supplies" section of the *EOC* has been modified to clarify that lancets and injection aids are covered under the "Outpatient Durable Medical Equipment (DME)" section.
- The "Outpatient Durable Medical Equipment (DME)" section of the *EOC* has been modified to reflect that lancets and injection aids are covered under the DME benefit.
- The "Reconstructive Surgery Services" section of the Traditional, Deductible and High Deductible Health Plan *EOCs* has been modified to specify that Services are covered when prescribed by a Participating Physician and are subject to Utilization Review. The word significant has been removed in this section for consistency across products. Services are covered based upon Utilization Review.
- The "Custodial Services" exclusion in the "Exclusions and Limitations" section of the *EOC* has been changed to "Custodial Care." The exclusion has also been modified to align across lines of business for Member clarity.
- The phrase "not subject to Deductible" has been removed from several rows of the "Benefit Summary" for contract integrity and continuity. Our contract convention is to specify when benefits are subject to the Deductible and to not reference the Deductible when it does not apply. The "What You Pay" section of the *EOC* notes that the "Benefit Summary" indicates which Services are subject to the Deductible.
- The "Deductible" section of the "Benefit Summary" has been modified to describe all accumulation types in terms of a self-only Deductible, an individual Family Member Deductible, and a Family Deductible. Aggregate accumulation is represented when the individual Family Member Deductible amount equals the Family Deductible amount. Embedded accumulation is represented when the self-only Deductible amount equals the individual Family Member Deductible amount.
- The "Out-of-Pocket Maximum" section of the "Benefit Summary" has been modified to describe all accumulation types in terms of a self-only Out-of-Pocket Maximum, an individual Family Member Out-of-Pocket Maximum, and a Family Out-of-Pocket Maximum. Aggregate accumulation is represented when the individual Family Member Out-of-Pocket Maximum amount equals the Family Out-of-Pocket

Maximum amount. Embedded accumulation is represented when the self-only Out-of-Pocket Maximum amount equals the individual Family Member Out-of-Pocket Maximum amount.

- The Emergency Services row of the "Benefit Summary" has been changed to emergency department visit to more accurately reflect when the emergency department visit Copayment or Coinsurance applies.
- The "Hearing Aid Services for Dependents" section of the "Benefit Summary" has been modified to clarify coverage requirements per the amendment of ORS 743A.141 in the 2018 Oregon House Bill (HB) 4104. Language has been added to clarify that hearing aids are limited to one per ear every 36 months.
- A "Maternal diabetes management" row has been added to the "Maternity and Newborn Care" section of all HSA-qualified plan "Benefit Summaries" to reflect that these benefits are covered at $0 after Deductible.
- The "Palliative and comfort care" row in the "Benefit Summary" has been removed to avoid confusion. These Services are included under hospice Services without a separate cost share.
- A row for tobacco use cessation drugs has been added to the "Limited Outpatient Prescription Drugs and Supplies" section of the "Benefit Summary" to align with covered Services listed in the *EOC*.
- The "Lancets and injection aids" row in the "Benefit Summary has been moved from the "Limited Outpatient Prescription Drugs and Supplies" section to the "Outpatient Durable Medical Equipment" section for accuracy as the DME cost share applies to these items.

Administrative changes or clarifications

- The "Definitions" section of the *EOC* has been modified. The definition of Dependent Limiting Age has been modified for consistency of terminology with the "Benefit Summary."
- The defined term "Medical Directory" has been changed throughout the Traditional, Deductible, and High Deductible Health Plan *EOCs* to "Medical Facility Directory" to accurately reflect the directory name as it appears on **kp.org**. The definition has also been modified for accuracy.
- The "Definitions" section of the *EOC* has been modified. Language indicating that a Member may contact Member Services has been removed from definitions where present, as it is not a defining characteristic and to reduce redundancy.
- The definition of "Dependent Limiting Age" has been modified for clarity.
- The "Dependents" section in the "Who is Eligible" section has been updated for clarity regarding the eligibility of a person who is under the student Dependent Limiting Age. This applies to Groups that choose to cover Dependents over the age 26 if they are full-time registered students.
- The Advice Nurses section has been modified for accuracy to reflect that an Advice Nurse may be reached by contacting the Member Services number during normal business hours, as well as, evenings, weekends, and holidays rather than contacting a specific medical office. The list of Member Services numbers has been removed to ensure accuracy and consistency. It is listed on the *EOC* cover, as well as, in the "Getting Assistance" section.
- The "Your Primary Care Participating Provider" section of the Traditional, Deductible, and High Deductible Health Plan *EOC* has been modified for accuracy, to reflect that changes to a primary care Participating Provider take effect immediately.
- Language in the "Appointments for Routine Services" section has been re-ordered for accuracy and alignment across products.

- The Member Services phone number has been removed from the body of the *EOC* (except in the "Grievances, Claims, Appeals, and External Review" section) to ensure accuracy and consistency. It is listed on the *EOC* cover, as well as, in the "Getting Assistance" section.
- The "Limited Outpatient Prescription Drugs and Supplies" section of the *EOC* has been modified. Language has been added to explain that while a Member may obtain a first fill of a prescription drug at any participating pharmacy, all refills must be obtained at a pharmacy owned and operated by Kaiser Permanente (including our mail-order pharmacy), or at another participating pharmacy we designate for covered refills.
- The "Help with Your Claim and/or Appeal" section of the *EOC* has been modified. The name of the Consumer Advocacy Unit has been updated to the Consumer Advocacy Section, a fax number has been added, the email address has been revised, and the URL has been updated for accuracy.
- In the "Grievances, Claims, Appeals, and External Review" section of the *EOC*, the Member Relations fax number has changed to accommodate a new digital fax process.
- Language in the "Termination Due to Loss of Eligibility" section of the *EOC* has been revised for clarity.
- The "Nondiscrimination" section of the *EOC* has been modified to confirm that we do not discriminate based on a Member's marital status.
- The "Limited Outpatient Prescription Drugs and Supplies" section of the Traditional, Deductible, and High Deductible Health Plan "Benefit Summary" has been modified for consistency within the contract. The word "formulary" has been removed from the row for contraceptive drugs, as all prescription drugs received from a Participating Pharmacy are formulary.
- A "Grandfathered Health Plan Coverage" section has been added to the "Miscellaneous Provisions" section of the *Group Agreement*, indicating that a Group must inform Company if coverage identified as a "grandfathered health plan" in the *EOC* does not meet (or no longer meets) the requirements for grandfathered status.

Additional changes and clarifications that apply to Added Choice® medical plans only

Benefit changes

- The "Referrals to Select Providers and Select Facilities" section of *EOC* has been modified. Ophthalmology has been removed from the list of departments that do not require a referral for outpatient Services. A referral will now be required to schedule an appointment for ophthalmology Services.

Benefit clarifications

- The "Reconstructive Surgery Services" section of the *EOC* has been modified to align with other sections within the *EOC*. Language indicating that Services are covered when prescribed by a Select, PPO, or Non-Participating Provider has been moved to the beginning of the section. Additionally, language has been added to specify that Services are subject to Utilization Review. The word significant has been removed in this section for consistency across products. Services are covered based upon Utilization Review.

- The Chiropractic Services Received Without a Referral" exclusion in the "Exclusions and Limitations" section of the *EOC* has been retitled "Chiropractic Services" for alignment with other products and other exclusions within the section.
- The "Custodial Care" exclusion in the "Exclusions and Limitations" section of the *EOC* has been modified to align across lines of business and for Member clarity.
- The "Optometric Vision Therapy and Orthoptics (Eye Exercises)" exclusion in the "Exclusions and Limitations" section of the *EOC* has been modified for clarity and moved so that it appears in alphabetical order. Language has been added explaining that Services related to optometric vision therapy and orthoptics (eye exercises) are excluded.
- A "Hospitalization on Your Effective Date" section has been added to the *EOC* for alignment across products.
- A sentence has been added to the second paragraph of the "Benefit Summary" to clarify that all applicable visit limits are combined across all tiers, unless otherwise indicated in the *EOC*. Language has been removed from the left column of the "Benefit Summary" table indicating "all tiers combined."
- A row for "certain preventive medications" has been added to the "Limited Outpatient Prescription Drugs and Supplies" section of the "Benefit Summary" to align with covered Services listed in the *EOC*.
- The "Limited Outpatient Prescription Drugs and Supplies" section of the "Benefit Summary" has been modified for better alignment with the "Outpatient Prescription Drug Rider" to more accurately reflect that these drugs may be obtained from Select Pharmacies or Medimpact Pharmacies.

Administrative changes or clarifications

- The "Limited Outpatient Prescription Drugs and Supplies" section of the "Benefit Summary" has been modified for accuracy. The word "formulary" has been removed from the row for contraceptive drugs. In addition to Select Pharmacies and Facilities, this section represents limited prescription drugs and supplies received from MedImpact Pharmacies, which are not subject to the formulary.
- The defined term "Added Choice Medical Directory" has been changed throughout the *EOC* to "Medical Facilities Directory" to accurately reflect the directory name as it appears on **kp.org**. The definition has also been modified for accuracy.
- The "Your Primary Care Select Provider" section of the *EOC* has been modified for accuracy to reflect that changes to a primary care Select Provider take effect immediately.

Additional changes and clarifications that apply to PPO Plus medical plans only

Benefit clarifications

- The "Reconstructive Surgery Services" section of the *EOC* has been modified to align with other sections within the *EOC*. Language has been moved and modified to specify that Services are subject to Utilization Review by Company. The word significant has been removed in this section for consistency across products. Services are covered based upon Utilization Review.
- The "Custodial Care" exclusion in the "Exclusions and Limitations" section of the *EOC* has been modified to align across lines of business and for Member clarity.

- A sentence has been added to the "Benefit Summary" to clarify that all applicable visit limits are combined across both tiers, unless otherwise indicated in the *EOC*. Language has been removed from the left column of the "Benefit Summary" table indicating "both tiers combined."
- The "Limited Outpatient Prescription Drugs and Supplies" section of the "Benefit Summary" has been modified for better alignment with the "Outpatient Prescription Drug Rider" to more accurately reflect that these drugs may be obtained from Medimpact or Kaiser Permanente Pharmacies.

Administrative changes or clarifications

- The "Limited Outpatient Prescription Drugs and Supplies" section of the "Benefit Summary" has been modified for accuracy. The word "formulary" has been removed from the row for contraceptive drugs. In addition to Kaiser Permanente Pharmacies, this section represents limited prescription drugs and supplies received from MedImpact Pharmacies, which are not subject to the formulary.

Changes and clarifications that apply to medical benefit riders

Benefit clarifications

- The "Alternative Care Services Rider" has been modified for better clarity around coverage for specific treatment modalities. References to the *EOC* "Exclusions and Limitations" have been moved to the subsections for each modality. Additionally, the modality references in the provider definitions have been removed.
- The "Outpatient Prescription Drug Rider" has been modified. All references to the medical directory have been updated to "Medical Facility Directory" to reflect the revised definition in the *EOC*.
- The "Outpatient Prescription Drug Rider" used for Traditional, Deductible, and High Deductible Health Plans has been modified. A sentence has been added to the "Copayments and Coinsurance for Covered Drugs and Supplies" section to clarify that prescription drugs and supplies received are subject to the Deductible, Copayment, or Coinsurance until the medical Out-of-Pocket Maximum is met.
- The "Outpatient Prescription Drug Rider" used for PPO Plus plans has been modified. A sentence has been added to the "Copayments and Coinsurance for Covered Drugs and Supplies" section to clarify that prescription drugs and supplies received at MedImpact Pharmacies are subject to the Deductible, Copayment, or Coinsurance until the Tier 1 medical Out-of-Pocket Maximum is met.
- The "Outpatient Prescription Drug Rider" has been modified. A "Prior Authorization Exception Process" subsection has been added to the "About Our Drug Formulary" section to align across lines of business and ensure consistency of administration.
- The rows for tobacco use cessation drugs and contraceptives have been removed from the "Outpatient Prescription Drug Rider Benefit Summary" to reduce redundancy. These items are included in the "Limited Outpatient Prescription Drugs and Supplies" section of the *EOC*.
- References to the Deductible and Prescription Drug Deductible have been removed from the "Copayments and Coinsurance for Covered Drugs and Supplies" and "Day Supply Limit" sections of the "Outpatient Prescription Drug Rider" contract integrity and administrative consistency. The "Deductible" section of the *EOC* describes how the Deductible is applied. The "Outpatient Prescription Drug Rider Benefit Summary" indicates which Services are subject to the Deductible.
- The "About Our Drug Formulary" section in the "Outpatient Prescription Drug Rider" has been modified for accuracy and Member clarity.

- The phrase "not subject to Deductible" has been removed from several rows of the "Outpatient Prescription Drug Rider Benefit Summary" for contract integrity and continuity. Our contract convention is to specify when benefits are subject to the Deductible and to not reference the Deductible when it does not apply.
- The "Pediatric Vision Hardware and Optical Services Rider Benefit Summary" (including the rider for the enhanced benefit) has been modified for clarity. The "You Pay" cells for comprehensive eye exams and low vision evaluations have been updated to show the Member cost share rather than pointing to the primary care visit cost share in the *EOC* "Benefit Summary."

Administrative changes or clarifications

- The "Covered Drugs and Supplies" section of the "Outpatient Prescription Drug Rider" has been modified. Language has been added to explain that while a Member may obtain a first fill of a prescription drug at any participating pharmacy, all refills must be obtained at a pharmacy owned and operated by Kaiser Permanente (including our mail-order pharmacy), or at another participating pharmacy we designate for covered refills.

Changes and clarifications that apply to dental plans

Benefit clarifications

- To align with current administration, language regarding diagnosis and evaluation was removed from the Oral Surgery Services, Periodontic Services, and Endodontic Services sections and added to the Oral Exam row in the benefit summary to clarify that all exams, including diagnosis and evaluation, are subject to the Preventive and Diagnostic Services cost share.
- Benefits within the *EOC* and Benefit Summary have been alphabetized when appropriate to do so.
- The "Exclusions and Limitations" section has been modified to align across lines of business, where appropriate, ensure consistency of administration, and aid in Member clarity. This synchronization did not result in any benefit changes.
- To better align with state regulations, several limitations in the "Limitations" section have been modified by changing the language from "covered" to "limited to."

Administrative changes or clarifications

- The definition of *Dental Provider Directory* has been modified for accuracy and a new definition for *Dental Facility Directory* has been added. References throughout the *EOC* have been updated with the corresponding directory name.
- In the "Definitions" section and throughout the *EOC*, the dental PPO Third Party Administrator (TPA) name has changed from Scion Dental, Inc. to SKYGEN USA, LLC, ("SKYGEN").
- The definition of "Dependent Limiting Age" in the "Definitions" section of the *EOC* has been modified for clarity.
- The "Dependents" section under "Who is Eligible" in the *EOC* has been updated to clarify the bullet regarding the eligibility of a person who is under the student Dependent Limiting Age. This section applies to Groups that choose to cover Dependents over the age 26 if they are full-time registered students.

- The "Adding New Dependents to an Existing Account" section of the *EOC* has been modified. Language has been added to clarify that an enrollment application is required to add new dependents if additional premium is required to add the dependent and that the application requirement is waived if additional premium is not required.
- A "Referrals" section has been added to all nonPPO plans for clarity and transparency.
- The "Prior Authorization" section in PPO plans has been modified to reflect that providers can now request Prior Authorization on a Member's behalf electronically. The language about requesting prior authorization by fax has also been removed, since there is no longer a fax number on the back of Members' ID cards.
- The address in the "Post-Service Claims - Services Already Received" section has been updated to reflect that nonPPO dental claim forms should be sent to our local dental claims' office in Portland, Oregon.
- The Member Services phone number has been removed throughout the *EOC* when referring Members to contact Member Services (except in the "Grievances, Claims, and Appeals" section) to ensure accuracy and consistency. It is listed on the *EOC* cover, as well as, in the "Getting Assistance" section.
- The "Help with Your Claim and/or Appeal" section has been modified. The name of the Consumer Advocacy Unit has been updated to the Consumer Advocacy Section, a fax number has been added, the email address has been revised, and the URL has been updated for accuracy.
- In the "Grievances, Claims, and Appeals" section, the Member Relations fax number has changed to accommodate a new digital fax process.
- Language in the "Termination Due to Loss of Eligibility" section has been revised for clarity.
- The language in the "Termination for Cause" section has been revised to reflect that Members may only be terminated for fraud and misrepresentation. It has also been updated for consistency.
- The "Nondiscrimination" section has been modified to confirm that we do not discriminate based on a Member's marital status.

Changes and clarifications that apply to dental benefit riders

Benefit clarifications

- The "Dental Implant Services Rider" has been modified for clarity.
    - The first bullet in the "Dental Implant Benefit" section has been moved out of alphabetical order to the end of the list since it is a secondary alternative to the other benefits listed.
    - The "Repair of a Dental Implant" limitation has been modified to include a clarifying sentence that provides for repairs when postoperative complications or failure of a Dental Implant happens through no fault of the Member.

Changes and clarifications that apply to all Senior Advantage plans

Benefit changes and clarifications

- The following changes have been made to the Medical Benefits Chart:

- Opioid treatment program services have been added to the Chart. Covered services include FDA-approved opioid treatment medications, substance use counseling, individual and group therapy, and toxicology testing.
- Outpatient hospital observation services are now in a separate row of the Chart. Previously, these services were addressed under the "Emergency care" and "Outpatient hospital services" rows. Language has been added to explain to members what observation services are and the conditions for coverage.
- The Member cost-sharing for health and wellness education programs has changed from various amounts per class of session to no charge.
- More detailed information about covered telehealth services has been added to the "Physician/practitioner services, including doctor's office visits" section of the Chart. This section now describes numerous services available through telehealth when clinically appropriate.

- In Chapter 3, Section 2.2 of the *EOC*, the list of services that do not require referral has changed. Members will need a PCP referral for services from obstetrics/gynecology, occupational health and social services.
- Information has been added to Chapter 3, Section 3.2 of the *EOC* to clarify the circumstances under which we cover worldwide urgent care services outside the United States.
- For Medicare Part D plans, Chapter 5, Section 5.2 of the *EOC* has been modified to explain that we will offer a temporary supply of a non-formulary drug if the member experiences a level of care change. We will cover up to a one-month supply of the Part D drug during level of care transitions even if the drug is not on our Drug List (formulary).
- For Medicare Part D plans, Chapter 5, Section 6.2 of the *EOC* has been edited to clarify what happens when there are changes to the Drug List (formulary); if and when coverage changes for a drug the member is taking; and how the member is notified. The Senior Advantage 2020 Annual Notice of Change (*ANOC*) that is sent to Senior Advantage members provides additional detail explaining what happens if a drug the member is taking is changed or removed from the 2020 Drug List, and what a member can do, such as working with their provider to find a different drug that we cover or to ask for a formulary exception.

Administrative changes and clarifications

- The eligibility requirements list in Chapter 1, Section 2.1 of the *EOC*, has been modified to remove a restriction. We allow enrollment in our group Senior Advantage plan when a person's Medicare coverage is either primary or secondary to the group plan.
- Information about coverage decisions, appeals and complaints in Chapter 9 of the *EOC* for plans with Medicare Part D, and Chapter 7 of the *EOC* for plans without Medicare Part D, has been updated to explain when we or the IRO must respond if the request for benefits determination is for a Medicare Part B drug.

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation

Portland, Oregon

Large Group Dental Plan
Group Agreement

Group *Name:* **Willamette University**

Group Number: 2014-006, 007

Term of *Agreement*

4/1/2020 through 3/31/2021

Anniversary date

April 1

Ruth W. Brinkley

Ruth Williams Brinkley, FACHE
President, Northwest Region
Kaiser Foundation Health Plan & Hospitals

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KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST

A Nonprofit Corporation

Group Agreement

INTRODUCTION

This *Group Agreement* (*Agreement*), including the attached Evidence of Coverage (*EOC)* incorporated herein by reference, and any amendments, constitutes the contract between Kaiser Foundation Health Plan of the Northwest (Company) and Willamette University (Group). In this *Agreement,* some capitalized terms have special meaning; please see the "Definitions" section in the *EOC* document for terms you should know.

To be eligible under this *Agreement*, the Group must meet the underwriting requirements set forth in Company's Rate Assumptions and Requirements document.

PREMIUM

Group will pay to Company, for each Subscriber and his or her Dependents, the Premium amount(s) specified for each month on or before the date on the monthly invoice or, if Group is self-pay, then the date to which Company and Group agree in writing, but in no event later than the last day of the month preceding the month of coverage (the "Premium Due Date"). If Group fails to make payments on or before the Premium Due Date, then upon renewal and at Company's option (and in lieu of any other remedy), the new Premium may include an additional charge.

When this *Agreement* terminates, if Group does not have another agreement with Company, then the due date for all Premium amounts will be the earlier of: (1) the last Premium Due Date, or (2) the termination date of this *Agreement*.

Monthly Premium Amounts

Group will pay Company the following Premium amount(s) each month for each Subscriber and his or her Dependents. Only Members for whom Company has received the appropriate Premium payment listed below are entitled to coverage under this *Agreement*, and then only for the period for which Company has received appropriate payment.

Subscriber only: $63.69

Subscriber with one Family Dependent: $127.37

Subscriber with two or more Family Dependents: $177.04

TERM OF *AGREEMENT*, ACCEPTANCE OF *AGREEMENT*, AND RENEWAL

Term of *Agreement*

Unless terminated as set forth in the "Termination of *Agreement*" section, this *Agreement* is effective for the term shown on the cover page.

Acceptance of *Agreement*

Group will be deemed as having accepted this *Agreement* and any amendments issued during the term of this *Agreement*, if Group pays Company any amount toward Premium.

Group may **not** change this *Agreement* by adding or deleting words, and any such addition or deletion is void. If Group wishes to change anything in this *Agreement*, Group must contact its Company account manager.

Company might not respond to any changes or comments that Group may submit. Group may not construe Company's lack of response to any submitted changes or comments to imply acceptance. Company will issue a new *agreement* or amendment if Company and Group agree on any changes.

Renewal

This *Agreement* is guaranteed renewable but does not automatically renew. If Group complies with all of the terms of this *Agreement,* Company will offer to renew this *Agreement,* upon not less than 30 days prior written notice to Group, either by sending Group a new group *agreement* to become effective immediately after termination of this *Agreement,* or by extending the term of this *Agreement* pursuant to "Amendments Effective on Anniversary Date" in the "Amendment of *Agreement*" section. The new or extended group *agreement* will include a new term of *agreement* and other changes. If Group does not renew this *Agreement*, Group must give Company written notice as described under "Termination on Notice" in the "Termination of *Agreement*" section.

AMENDMENT OF *AGREEMENT*

Amendments Effective on Anniversary Date

Upon not less than 30 days prior written notice to Group, Company may extend the term of this *Agreement* and make other changes by amending this *Agreement* effective on the anniversary date of any year (see cover page for anniversary date).

Amendment due to Tax or Other Charges

If during the term of this *Agreement* a government agency or other taxing authority imposes or increases a tax or other charge (other than a tax on or measured by net income) upon Company, Permanente Dental Associates, PC, or Kaiser Foundation Hospitals or upon any activity of any of them, then upon 31 days prior written notice, Company may increase Group's Premium to include Group's share of the new or increased tax or charge.

Other Amendments

Company may amend this *Agreement* at any time by giving written notice to Group, in order to: (a) address any law or regulatory requirement; (b) reduce or expand the Company Service Area; or (c) increase any benefits of any Medicare product approved by the Centers for Medicare and Medicaid Services (CMS), if applicable to this *Agreement*.

TERMINATION OF *AGREEMENT*

This *Agreement* will terminate under any of the conditions listed in this "Termination of *Agreement*" section. All rights to benefits under this *Agreement* end at 11:59 p.m. on the termination date, except as expressly provided in the "Termination of Membership" or "Continuation of Membership" sections of *the EOC*.

If Company fails to give notice as required, this *Agreement* shall continue in effect from the date notice should have been given until the date the Group receives the notice. Company will waive the Premium for the period for which coverage is continued.

Termination on Notice

Group may terminate this *Agreement* by giving prior written notice to Company not less than 30 days prior to the termination date and remitting all amounts payable relating to this *Agreement*, including Premium, for the period through the termination date.

Termination due to Nonacceptance of Amendments

All amendments are deemed accepted by Group unless Group gives Company written notice of nonacceptance at least 15 days before the effective date of the amendment in which case this *Agreement* will terminate the day before the effective date of the amendment.

Termination for Nonpayment

When Group fails to pay Premium on or before the Premium Due Date, Group shall have a period of at least 31 days to pay all Premiums owed ("Grace Period"). The Grace Period shall begin the day after the Premium Due Date. If Group fails to pay all Premiums owed (including those owed for the Grace Period) on or before the last day of the Grace Period, then Company may, at its option and in lieu of any other remedy, terminate this Agreement without further extension or consideration.

Company will notify Group of the past-due amount and the effective date of termination. Such notice shall be sent at least 10 days prior to the effective date of termination. Group shall continue to be liable for all Premiums due through the date of termination.

This *Agreement* will remain in full force and effect throughout the Grace Period and Group will remain responsible for payment of Premiums. If Company receives full payment of Premiums on or before the last day of the Grace Period, this *Agreement* will remain in effect according to its terms and conditions.

If Premiums are paid after the Grace Period ends, Company may charge interest on the overdue Premiums. Interest shall not accrue during the Grace Period, and the (simple) interest rate shall be 6 percent per year or the maximum amount permitted by applicable law, whichever is less.

Termination for Fraud

Company may terminate this *Agreement* by giving at least 30 days prior written notice to Group, if Group commits fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan. For example, an intentional misrepresentation of material fact occurs if Group intentionally furnishes incorrect or incomplete material information to Company or is aware that incorrect or incomplete material information has been provided to Company on enrollment or other Company forms.

Termination for Violation of Contribution or Participation Requirements

Company may terminate this *Agreement* upon 31 days prior written notice to Group, if Group fails to comply with Company's contribution or participation requirements (including those listed in the "Contribution and Participation Requirements" section).

Termination for Discontinuance of a Product or all Products within a Market

Company may terminate a particular product or all products offered in the group market as permitted by law.

Company may terminate this *Agreement* if it ceases to write new business in the group market in Oregon or in a specific service area within Oregon, or elects not to renew all of its group Plans in Oregon or in a specific service area within Oregon, or both cease offering and cease renewing all products in Oregon or a specific service area in Oregon, if Company fails to reach an agreement with health care providers. To discontinue all products, Company must: (a) notify the Director of the Department of Consumer and Business Services and all Groups; and (b) not cancel coverage for 180 days after the date of notice to the Director and Groups.

Company may terminate this *Agreement* if it elects not to offer or renew, or offer and renew, this type of Plan in Oregon or within a specific service area within Oregon. Except as provided below regarding failure to reach agreement with providers, in order to discontinue a product, Company must: (a) cease to offer and/or cease to renew this Plan for all groups; (b) offer (in writing) to each group covered by this Plan, enrollment in any other Plan offered by Company in the group market, not less than 90 days prior to discontinuance; and

(c) act uniformly without regard to claims experience of affected groups or the health status of any current or prospective Member.

Company may terminate this *Agreement* if the Director of the Department of Consumer and Business Services orders Company to discontinue coverage upon finding that continuation of coverage (a) would not be in the best interests of the Members; or (b) would impair Company's ability to meet its contractual obligations.

Company may terminate this *Agreement* by providing not less than 90 days prior written notice if there are no Members covered under this *Agreement* who reside or work in the Service Area.

Company may terminate this *Agreement* if it is unable to reach an agreement with the health care providers to provide Services within a specific service area. Company must: (a) cease to offer and cease to renew this Plan for all groups within the service area; and (b) not less than 90 days prior to discontinuance, notify the Director of the Department of Consumer and Business Services and each group in that service area of the decision to discontinue offering the Plan(s) and offer all other group Plans available in that service area.

CONTRIBUTION AND PARTICIPATION REQUIREMENTS

No change in Group's contribution or participation requirements is effective for purposes of this *Agreement* unless Company consents in writing.

Group must:

- Meet all underwriting requirements set forth in Company's Rate Assumptions and Requirements document.
- With respect to all persons entitled to coverage under Group's Plan(s), offer enrollment in Company's Plan to all such persons on conditions no less favorable than those for any other Plan available through Group.
- Permit Company to examine Group's records with respect to contribution and participation requirements, eligibility, and payments under this *Agreement*.

MISCELLANEOUS PROVISIONS

Administration of *Agreement*

Company may adopt policies, procedures, rules, and interpretations to promote efficient administration of this *Agreement*.

Assignment

Company may assign this *Agreement*. Group may not assign this *Agreement* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without Company's prior written consent. This *Agreement* shall be binding on the successors and permitted assignees of Company and Group.

Attorney Fees and Costs

If Company or Group institutes legal action against the other to collect any sums owed under this *Agreement*, the party that substantially prevails will be reimbursed for its reasonable costs of collection, including attorneys' fees, by the other party.

Governing Law

Except as preempted by federal law, this *Agreement* will be governed in accord with Oregon law and any provision that is required to be in this *Agreement* by state or federal law shall bind Group and Company regardless of whether that provision is set forth in this *Agreement*.

No Waiver

Company's failure to enforce any provision of this *Agreement* will not constitute a waiver of that or any other provision or impair Company's right thereafter to require Group's strict performance of any provision.

Notices

Notices must be sent to the addresses listed below, except that Company or Group may change its address for notices by giving written notice to the other. Notices are deemed given when delivered in person, sent via email, or deposited in a U.S. Postal Service receptacle for the collection of U.S. mail.

Notices from Company to Group will be sent to:

Group Contact	Danita PHR Chapin
Group Name	Willamette University
Group Address	900 State Street
Group Address	
Group Address	Salem, OR 97301
Producer Contact	Frederick Fischer
Producer Name	Montgomery & Graham, Inc.
Producer Address	625 Hawthorne Ave. SE #100
Producer Address	
Producer Address	Salem, OR 97301

Note: When Company sends Group a new (or renewed) group *agreement*, Company will enclose a summary that discusses the changes Company has made to this *Agreement*. Groups that want information about changes before receiving the new group *agreement* may request advance information from Group's Company account manager. Also, if Group designates in writing a third party such as a "Producer of Record," Company may send the advance information to the third party rather than to Group (unless Group requests a copy also).

Notices from Group to Company regarding billing and enrollment must be sent to:

Kaiser Foundation Health Plan of the Northwest
P.O. Box 203012
Denver, CO 80220-9012
Or emailed to: **csc-den-roc-group@kp.org**

Notices from Group to Company regarding Premium payments must be sent to:

Kaiser Foundation Health Plan of the Northwest
PO Box 34178
Seattle, WA 98124

Notices from Group to Company regarding termination of this *Agreement* must be sent to the Group's account manager at:

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah Street, Suite 100
Portland, OR 97232

Reporting Membership Changes and Retroactivity

Company's billing statement to Group explains how to report membership changes. Group's Kaiser Permanente account manager can also provide Group with this information. Group must report membership changes (including sending Company-approved membership forms) within the time limit for retroactive

changes and in accord with any applicable "rescission" provisions of the Patient Protection and Affordable Care Act and regulations. The time limit for retroactive membership changes is the calendar month when Company's Denver Service Center receives Group's notification of the change plus the previous two months unless Company agrees otherwise in writing.

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation
Portland, Oregon

Large Group Dental Plan
Evidence of Coverage

Group Name: Willamette University
Group Number: 2014 - 006, 007

This *EOC* is effective 4/1/2020 through 3/31/2021.

Printed: April 2, 2020

Member Services

Monday through Friday (except holidays)
8 a.m. to 6 p.m.
Portland area..... 503-813-2000
All other areas..... 1-800-813-2000

Dental Appointment Center

All areas 1-800-813-2000

TTY

All areas 711

Language interpretation services

All areas 1-800-324-8010

kp.org/dental/nw

DENTAL PLAN BENEFIT SUMMARY

This "Benefit Summary," which is part of this *Evidence of Coverage* (*EOC*), is a summary of answers to the most frequently asked questions about benefits. This summary does not fully describe benefits, limitations, or exclusions. To see complete explanations of what is covered for each benefit (including exclusions and limitations), and for additional benefits that are not included in this summary, please refer to the "Benefits," "Exclusions and Limitations," and "Reductions" sections of this *EOC*. All Services are subject to the Copayment or Coinsurance, unless otherwise noted.

Benefit Maximum	
Per Member per Year	$1,500
Dental Office Visit	**You Pay**
Per visit	$15
Preventive and Diagnostic Services	**You Pay**
Oral exam, including evaluations and diagnostic exams	$0
Fluoride treatments	$0
Teeth cleaning	$0
Sealants	$0
Space maintainers	$0
X-rays	$0
Minor Restorative Services	**You Pay**
Routine fillings	$0
Simple extractions	$0
Restorations (composite/acrylic and steel)	$0
Oral Surgery Services	**You Pay**
Major oral surgery	20% Coinsurance
Surgical tooth extractions	20% Coinsurance
Periodontic Services	**You Pay**
Scaling and root planing	20% Coinsurance
Periodontal surgery	20% Coinsurance
Treatment of gum disease	20% Coinsurance
Endodontic Services	**You Pay**
Root canal and related therapy	
Anterior tooth	20% Coinsurance
Bicuspid tooth	20% Coinsurance
Molar tooth	20% Coinsurance
Major Restorative Services	**You Pay**
Bridge abutments	20% Coinsurance
Noble metal gold or porcelain crowns	20% Coinsurance
Inlays	20% Coinsurance
Pontics	20% Coinsurance
Removable Prosthetic Services	**You Pay**
Full upper and lower dentures	20% Coinsurance
Partial dentures	20% Coinsurance
Rebases	20% Coinsurance
Relines	20% Coinsurance

Emergency Dental Care	**You Pay**
From Participating Providers	$25 plus Copayment or Coinsurance that normally apply for non-emergency dental care Services
From Non-Participating Providers outside the Service Area (coverage is limited to $100 per incident)	All Charges over $100
Other Dental Services (Not counted toward the Benefit Maximum)	**You Pay**
Nightguards	10% Coinsurance
Nitrous oxide	
Members age 13 years and older	$25
Members age 12 years and younger	$0
Dependent Limiting Age	**Limiting Age**
General	26
Student	26

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INTRODUCTION

This *Evidence of Coverage* (*EOC*), including the "Benefit Summary" and any benefit riders attached to this *EOC,* describes the dental care coverage of the Large Group Dental Plan provided under the *Group Agreement (Agreement)* between Kaiser Foundation Health Plan of the Northwest and your Group. For benefits provided under any other plan, refer to that plan's evidence of coverage.

In this *EOC*, Kaiser Foundation Health Plan of the Northwest is sometimes referred to as "Company," "we," "our," or "us." Members are sometimes referred to as "you." Some capitalized terms have special meaning in this *EOC*; please see the "Definitions" section for terms you should know. The benefits under this plan are not subject to a pre-existing condition waiting period.

It is important to familiarize yourself with your coverage by reading this *EOC* and the "Benefit Summary" completely, so that you can take full advantage of your plan benefits. Also, if you have special dental care needs, carefully read the sections applicable to you.

Term of this *EOC*

This *EOC* is effective for the period stated on the cover page, unless amended. Your Group's benefits administrator can tell you whether this *EOC* is still in effect.

About Kaiser Permanente

Kaiser Permanente provides or arranges for Services to be provided directly to you and your Dependents through an integrated dental care system. Company, Participating Providers, and Participating Dental Offices work together to provide you with quality dental care Services. Our dental care program gives you access to the covered Services you may need, such as routine care with your own personal Participating Dentist and other benefits described in the "Benefits" section.

We provide covered Services using Participating Providers and Participating Dental Offices located in our Service Area except as described under "In a Dental Emergency" in the "Emergency and Urgent Dental Care" section and under "Emergency Dental Care and Urgent Dental Care" in the "Benefits" section.

For more information about your benefits, our Services, or other products, please call Member Services or e-mail us by registering at **kp.org/dental/nw**.

DEFINITIONS

Benefit Maximum. The maximum amount of benefits that will be paid in a Year as more fully explained in the "Benefit Maximum" section of this *EOC*. The amount of your Benefit Maximum is shown in the "Benefit Summary."

If you are covered for orthodontic or implant Services, please note that these Services may not count toward your Benefit Maximum. Your orthodontic coverage and your implant coverage may each have a separate benefit maximum.

Benefit Summary. A section of this *EOC* which provides a brief description of your dental plan benefits and what you pay for covered Services.

Charges. The term "Charges" is used to describe the following:

- For Services provided by Permanente Dental Associates, PC, the charges in Company's schedule of charges for Services provided to Members.
- For Services for which a provider (other than Permanente Dental Associates, PC) is compensated on a capitation basis, the charges in the schedule of charges that Company negotiates with the capitated provider.

- For items obtained at a pharmacy owned and operated by Company, the amount the pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item. (This amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Company.)
- For all other Services, the payment that Company makes for the Services (or, if Company subtracts a Copayment or Coinsurance from its payment, the amount Company would have paid if it did not subtract the Copayment or Coinsurance).

Coinsurance. A percentage of Charges that you must pay when you receive a covered Service as described in the "What You Pay" section.

Company. Kaiser Foundation Health Plan of the Northwest, an Oregon nonprofit corporation. This *EOC* sometimes refers to Company as "we," "our," or "us."

Copayment. The defined dollar amount that you must pay when you receive a covered Service as described in the "What You Pay" section.

***Dental Facility Directory*.** The *Dental Facility Directory* includes addresses, maps, and telephone numbers for Participating Dental Offices and provides general information about getting dental care at Kaiser Permanente.

***Dental Provider Directory*.** The *Dental Provider Directory* lists Participating Providers, includes addresses for Participating Dental Offices, and provides general information about each Participating Provider such as gender, specialty, and language spoken.

Dental Specialist. A Participating Provider who is an endodontist, oral pathologist, oral radiologist, oral surgeon, orthodontist, pediatric dentist, periodontist or prosthodontist. A referral by a Participating Dentist is required in order to receive covered Services from a Dental Specialist.

Dentally Necessary. A Service that, in the judgment of a Participating Dentist, is required to prevent, diagnose, or treat a dental condition. A Service is Dentally Necessary only if a Participating Dentist determines that its omission would adversely affect your dental health and its provision constitutes a dentally appropriate course of treatment for you in accord with generally accepted professional standards of practice that are consistent with a standard of care in the dental community and in accordance with applicable law. Unless otherwise required by law, we decide if a service is Dentally Necessary. You may appeal our decision as set forth in the "Grievances, Claims, and Appeals" section. The fact that a Participating Dentist has prescribed, recommended, or approved an item or service does not, in itself, make such item or service Dentally Necessary and, therefore, a covered Service.

Dentist. Any licensed doctor of dental science (DDS) or doctor of medical dentistry (DMD).

Dependent. A Member who meets the eligibility requirements for a dependent as described in the "Who Is Eligible" section.

Dependent Limiting Age. The "Premium, Eligibility, and Enrollment" section requires that most types of Dependents (other than Spouses) be under the Dependent Limiting Age in order to be eligible for membership. The "Benefit Summary" shows the Dependent Limiting Age (the student Dependent Limiting Age is for students, and the general Dependent Limiting Age is for non-students).

Emergency Dental Care. Dentally Necessary Services to treat Emergency Dental Conditions.

Emergency Dental Condition. A dental condition, or exacerbation of an existing dental condition, occurring suddenly and unexpectedly, involving injury, swelling, bleeding, or extreme pain in or around the teeth and gums that would lead a prudent layperson possessing an average knowledge of health and medicine to reasonably expect that immediate dental attention is needed.

Evidence of Coverage (EOC). This *Evidence of Coverage* document provided to the Member that specifies and describes benefits and conditions of coverage. This document, on its own, is not designed to meet the requirements of a summary plan description (SPD) under ERISA.

Family. A Subscriber and his or her Spouse and/or Dependents.

Group. The employer, union trust, or association with which we have an *Agreement* that includes this *EOC*.

Hospital Services. Medical services or dental Services provided in a hospital or ambulatory surgical center.

Kaiser Permanente. Kaiser Foundation Hospitals (a California nonprofit corporation), Company, and Permanente Dental Associates, PC.

Medically Necessary. Our determination that the Service is all of the following: (i) medically required to prevent, diagnose or treat your condition or clinical symptoms; (ii) in accordance with generally accepted standards of medical practice; (iii) not solely for the convenience of you, your family and/or your provider; and, (iv) the most appropriate level of Service which can safely be provided to you. For purposes of this definition, "generally accepted standards of medical practice" means (a) standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; (b) physician specialty society recommendations; (c) the view of physicians practicing in the relevant clinical area or areas within Kaiser Permanente locally or nationally; and/or (d) any other relevant factors reasonably determined by us. Unless otherwise required by law, we decide if a service is Medically Necessary. You may appeal our decision as set forth in the "Grievances, Claims, and Appeals" section. The fact that a Participating Provider has prescribed, recommended, or approved an item or service does not, in itself, make such item or service Medically Necessary and, therefore, a covered Service.

Member. A person who is eligible and enrolled under this *EOC*, and for whom we have received applicable Premiums. This *EOC* sometimes refers to a Member as "you." The term Member may include the Subscriber, his or her Dependent, or other individual who is eligible for and has enrolled under this *EOC*.

Non-Participating Dental Office(s). Any dental office or other dental facility that provides Services, but which is not a Participating Dental Office.

Non-Participating Dentist. Any Dentist who is not a Participating Dentist.

Non-Participating Provider. A person who is either:

- A Non-Participating Dentist, or
- A person who is not a Participating Provider and who is regulated under state law to practice dental or dental-related services or otherwise practicing dental care services consistent with state law.

Participating Dental Office(s). Any facility listed in the *Dental Facility Directory* for our Service Area. Participating Dental Offices are subject to change.

Participating Dentist. Any Dentist who, under a contract directly or indirectly with Company, has agreed to provide covered Services to Members with an expectation of receiving payment, other than Copayment or Coinsurance, from Company rather than from the Member, and who is listed in the *Dental Provider Directory*.

Participating Provider. A person who, under a contract directly or indirectly with Company, has agreed to provide covered Services to Members with an expectation of receiving payment, other than Copayment or Coinsurance, from Company rather than from the Member, and is either:

- A Participating Dentist, or
- A person who is regulated under state law to practice dental or dental-related Services or otherwise practicing dental care Services consistent with state law, including an expanded practice dental hygienist, denturist, or pediatric dental assistant, and who is an employee or agent of a Participating Dentist.

Premium. Monthly membership charges paid by Group.

Service Area. Our Service Area consists of certain geographic areas in the Northwest which we designate by ZIP code. Our Service Area may change. Contact Member Services for a complete listing of our Service Area ZIP codes.

Services. Dental care services, supplies, or items.

Spouse. The person to whom you are legally married under applicable law. For the purposes of this *EOC*, the term "Spouse" includes a person legally recognized as your domestic partner in a valid Certificate of Registered Domestic Partnership issued by the state of Oregon or who is otherwise recognized as your domestic partner under criteria agreed upon, in writing, by Kaiser Foundation Health Plan of the Northwest and your Group.

Subscriber. A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber (Subscriber eligibility requirements are described under, "Who Is Eligible" in the "Premium, Eligibility, and Enrollment" section).

Urgent Dental Care. Treatment for an Urgent Dental Condition.

Urgent Dental Condition. An unforeseen dental condition that requires prompt dental attention to keep it from becoming more serious, but that is not an Emergency Dental Condition.

Usual and Customary Charge (UCC). The lower of (1) the actual fee the provider, facility, or vendor charged for the Service, or (2) the 90th percentile of fees for the same or similar Service in the geographic area where the Service was received according to the most current survey data published by FAIR Health Inc. or another national service designated by Company.

Year. A period of time that is a calendar year beginning on January 1 of any year and ending at midnight December 31 of the same year.

PREMIUM, ELIGIBILITY, AND ENROLLMENT

Premium

Your Group will tell you the Premium amount that you pay and how to pay your Premium.

Who Is Eligible

General

To be eligible to enroll and to remain enrolled in this plan, you must meet all of the following requirements:

- You must meet your Group's eligibility requirements that we have approved. (Your Group is required to inform Subscribers of its eligibility requirements.)
- You must meet the Subscriber or Dependent eligibility requirements described below unless your Group has different eligibility requirements that we have approved.

Subscriber

To be eligible to enroll and to remain enrolled as a Subscriber, you must meet the following requirements:

- You are an employee of your Group; or
- You are otherwise entitled to coverage through your Group under a trust agreement, retirement benefit program, employment contract, or the rules of a professional, trade, or bona fide association.
- You live or physically work inside our Service Area at least 50 percent of the time. For assistance about the Service Area or eligibility, please contact Member Services. The Subscriber's or the Subscriber's Spouse's otherwise eligible children are not ineligible solely because they live outside our Service Area or in another Kaiser Foundation Health Plan service area.

Dependents

If you are a Subscriber, the following persons are eligible to enroll as your Dependents:

- Your Spouse.
- A person who is under the general Dependent Limiting Age shown in the "Benefit Summary" and who is any of the following:
  - Your or your Spouse's child.
  - A child adopted by you or your Spouse, or for whom you or your Spouse have assumed a legal obligation in anticipation of adoption.
  - Any other person for whom you or your Spouse is a court-appointed guardian.
- A person who is over the general Dependent Limiting Age but under the student Dependent Limiting Age shown in the "Benefit Summary," who is a full-time registered student at an accredited college or accredited vocational school, and is any of the following:
  - Your or your Spouse's child.
  - A child adopted by you or your Spouse, or for whom you or your Spouse have assumed a legal obligation in anticipation of adoption.
  - Any other person for whom you or your Spouse is a court-appointed guardian.

  Students who suffer a severe illness or injury that causes them to lose full-time student status will continue to be considered full-time students for eligibility purposes, provided that within 31 days after the loss of full-time student status, we receive written certification from the child's treating physician that the child is suffering from a serious illness or injury and that the leave of absence or other change of enrollment is Medically Necessary. Eligibility as a full-time student under this provision may then continue for up to 12 months from the date that your child's medical leave of absence began, or until your child reaches the student Dependent Limiting Age shown in the "Benefit Summary," whichever comes first.
- A person of any age who is primarily dependent upon you or your Spouse for support and maintenance if the person is incapable of self-sustaining employment by reason of developmental disability or physical handicap which occurred prior to his or her reaching the general Dependent Limiting Age shown in the "Benefit Summary," if the person is any of the following:
  - Your or your Spouse's child.
  - A child adopted by you or your Spouse, or for whom you or your Spouse have assumed legal obligation in anticipation of adoption.
  - Any other person for whom you or your Spouse is a court-appointed guardian and was a court-appointed guardian prior to the person reaching the Dependent Limiting Age shown in the "Benefit Summary" established by the Group.

  We may request proof of incapacity and dependency annually.

Children born to a Dependent other than your Spouse (for example, your grandchildren) are not eligible for coverage beyond the first 31 days of life, including the date of birth, unless: (a) you or your Spouse adopts them or assumes a legal obligation in anticipation of adoption; (b) they are primarily supported by you or your Spouse and you or your Spouse is their court-appointed guardian; or, (c) your Group has different eligibility requirements that we have approved.

Company will not deny enrollment of a newborn child, newly adopted child, or child for whom legal obligation is assumed in anticipation of adoption, or newly placed for adoption solely on the basis that: (a) the child was born out of wedlock; (b) the child is not claimed as a dependent on the parent's federal tax return;

(c) the child does not reside with the child's parent or in our Service Area; or (d) the mother of the child used drugs containing diethylstilbestrol prior to the child's birth. Also, Company does not discriminate between married and unmarried persons, or between children of married or unmarried persons.

When You Can Enroll and When Coverage Begins

A Group is required to inform employees about when they are eligible to enroll and their effective date of coverage. The effective date of coverage for employees and their eligible Dependents is determined by the Group in accord with waiting period requirements in state and federal law. The Group is required to inform the Subscriber of the date membership becomes effective.

New Employees and Their Dependents

When a Group informs an employee that they are eligible to enroll as a Subscriber, they may enroll themselves and any eligible Dependents by submitting a Company-approved enrollment application to the Group within 30 days of eligibility for enrollment.

Open Enrollment

The Group will inform an employee of their open enrollment period and effective date of coverage. An eligible employee may enroll as a Subscriber along with any eligible Dependents if they or their Dependents were not previously enrolled. If you are an existing Subscriber, you may add eligible Dependents not previously enrolled following your Group's enrollment process during the open enrollment period.

Special Enrollment

If an eligible employee or their eligible Dependents do not enroll when they are first eligible and later want to enroll, they can enroll only during open enrollment unless they experience a qualifying event, as defined in applicable state and federal law. Your Group will administer special enrollment rights consistent with applicable state and federal law.

Examples of qualifying events include, but are not limited to:

- Loss of minimum essential coverage for any reason other than nonpayment of Premium, rescission of coverage, misrepresentation, fraud or voluntary termination of coverage.
- Gaining a Dependent through marriage or entering into a domestic partnership, birth, adoption, or placement for adoption or through a child support order or other court order.
- Loss of a Dependent through divorce or legal separation, or if the enrollee, or his or her Dependent dies.

Note: If the individual is enrolling as a Subscriber along with at least one eligible Dependent, only one enrollee must meet one of the requirements for a qualifying event.

The individual must notify the Group within 30 days of a qualifying event, 60 days if they are requesting enrollment due to a change in eligibility for Medicaid or Child Health Insurance Program (CHIP) coverage. The Group will determine if the individual is eligible to select or change coverage. Contact the Group for further instructions on how to enroll.

A Group may require an employee declining coverage to provide a written statement indicating whether the coverage is being declined due to other dental coverage. If this statement is not provided, or if coverage is not declined due to other dental coverage, the employee may not be eligible for special enrollment due to loss of other dental coverage. Contact the Group for further information.

Adding New Dependents to an Existing Account

To enroll a Dependent who becomes eligible to enroll after you became a Subscriber, you must submit a Company-approved enrollment application to your Group as described in this "Adding New Dependents to an Existing Account" section.

Newborns, newly adopted children, or children newly placed for adoption are covered for the first 31 days after birth, adoption, or placement for adoption. In order for coverage to continue beyond this 31-day period, you must submit an enrollment application to your Group within 30 days after the date of birth, adoption, or placement for adoption if additional Premium is required to add the Dependent. If additional Premium is not required, the application requirement is waived; however, please notify your Group and Member Services to add the child to your Plan.

To add all other newly eligible Dependents (such as a new Spouse), you must submit an enrollment application to your Group within 30 days after the qualifying event.

Contact your Group for further instructions on how to enroll your newly eligible Dependent.

When Coverage Begins

Your Group will notify you of the date coverage will begin. Membership begins at 12 a.m. (PT) of the effective date specified.

If an individual enrolls in, adds a Dependent, or changes dental plan coverage during a special enrollment period, the membership effective date will be determined by your Group in compliance with applicable state and federal law.

HOW TO OBTAIN SERVICES

Important Information for Members Whose Benefit Plans are Subject to ERISA.

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that regulated employee benefits, including the claim and appeal procedures for benefit Plans offered by certain employers. If an employer's benefit Plan is subject to ERISA, each time you request Services that must be approved before the Service is provided, you are filing a "pre-service claim" for benefits. You are filing a "post-service claim" when you ask us to pay for or cover Services that have already been received. You must follow our procedure for filing claims, and we must follow certain rules established by ERISA for responding to claims.

As a Member, you must receive all covered Services from Participating Providers and Participating Dental Offices inside our Service Area, except as otherwise specifically permitted in this *EOC*.

We will not directly or indirectly prohibit you from freely contracting at any time to obtain dental Services outside the plan. However, if you choose to receive Services from Non-Participating Providers and Non-Participating Dental Offices, except as otherwise specifically provided in this EOC, those Services will not be covered under this EOC and you will be responsible for the full price of the Services.

Using Your Identification Card

We provide each Member with a Company identification (ID) card that contains the Member health record number. Have your health record number available when you call for advice, make an appointment, or seek Services. We use your health record number to identify your dental records, for billing purposes and for membership information. You should always have the same health record number. If we ever inadvertently issue you more than one health record number, let us know by calling Member Services. If you need to replace your ID card, call Member Services.

Your ID card is for identification only and it does not entitle you to Services. To receive covered Services, you must be a current Member. Anyone who is not a Member will be billed as a non-member for any Services he or she receives. If you let someone else use your ID card, we may keep your card and terminate your

membership (see the "Termination for Cause" section). We may request photo identification in conjunction with your ID card to verify your identity.

Choosing a Personal Care Dentist

Your personal care Participating Dentist plays an important role in coordinating your dental care needs, including routine dental visits and referrals to Dental Specialists. We encourage you and your Dependents to choose a personal care Participating Dentist. To learn how to choose or change your personal care Participating Dentist, please call Member Services.

The online *Dental Provider Directory* provides the names and locations of Participating Dentists. Before receiving Services, you should confirm your Dentist has continued as a Participating Dentist. The information in the *Dental Provider Directory* is updated monthly, however, for the most up-to-date information, contact Member Services or go to **kp.org/dental/nw/directory**. Participating Dentists include both general Dentists and Dental Specialists.

Referrals

Referrals to Participating Providers

When you need Services, you should talk with your personal care Participating Dentist about your dental needs or your request for Services. Your Participating Dentist and other Participating Providers provide covered Services that are Dentally Necessary. Participating Dentists will use their judgment to determine if Services are Dentally Necessary. If you seek a specific Service, you should talk with your personal care Participating Dentist, who will discuss your needs and recommend an appropriate course of treatment. When appropriate, your Participating Dentist will refer you to a Participating Provider who is a Dental Specialist.

Referrals to Non-Participating Providers

If your Participating Dentist decides that you require Dentally Necessary Services that are not available from Participating Providers, and we determine that the Services are covered Services, your Participating Dentist will refer you to a Non-Participating Provider. The Deductible, Copayment, or Coinsurance for these authorized referral Services are the same as those required for Services provided by a Participating Provider and are subject to any benefit limitations and exclusions applicable to the Services.

Appointments for Routine Services

If you need to make a routine dental care appointment, please contact Member Services. Routine appointments are for dental needs that are not urgent such as checkups, teeth cleanings, and follow-up visits that can wait more than a day or two. Try to make your routine care appointments as far in advance as possible. For information about getting other types of care, refer to "Emergency and Urgent Dental Care" in this "How to Obtain Services" section.

Getting Assistance

We want you to be satisfied with the dental care you receive. If you have any questions or concerns, please discuss them with your personal care Participating Dentist or with other Participating Providers who are treating you.

Most Participating Dental Offices have an administrative office staffed with representatives who can provide assistance if you need help obtaining Services. Member Services representatives are also available to assist you Monday through Friday (except holidays), from 8 a.m. to 6 p.m.

Portland area 503-813-2000

All other areas 1-800-813-2000

TTY for the hearing and speech impaired 711

Language interpretation services.....1-800-324-8010

You may also e-mail us by registering on our website at **kp.org/dental/nw.**

Member Services representatives can answer any questions you have about your benefits, available Services, and the facilities where you can receive Services. For example, they can explain your dental benefits, how to make your first dental appointment, what to do if you move, what to do if you need Emergency Dental Care while you are traveling, and how to replace your ID card. These representatives can also help you if you need to file a claim, or a complaint, grievance or appeal as described in the "Grievances, Claims, and Appeals" section. Upon request, Member Services can also provide you with written materials about your coverage.

Emergency and Urgent Dental Care

In a Dental Emergency

If you have an Emergency Dental Condition that is not a medical emergency, Emergency Dental Care is available 24 hours a day, every day of the week. Call the Dental Appointment Center and a representative will assist you or arrange for you to be seen for an Emergency Dental Condition. We cover limited Emergency Dental Care received outside of our Service Area from Non-Participating Providers and Non-Participating Dental Offices. You will need to contact these providers and offices directly to obtain Emergency Dental Care from them. See "Emergency Dental Care" under "Emergency Dental Care and Urgent Dental Care" in the "Benefits" section for details about your Emergency Dental Care coverage.

Obtaining Urgent Dental Care

If you need Urgent Dental Care, call the Dental Appointment Center and a representative will assist you. We do not cover Urgent Dental Care (or other Services that are not Emergency Dental Care) received outside of our Service Area or from Non-Participating Providers and Non-Participating Dental Offices. See "Urgent Dental Care" under "Emergency Dental Care and Urgent Dental Care" in the "Benefits" section for details about your Urgent Dental Care coverage.

Dental Appointment Center

All areas 1-800-813-2000

TTY.....711

POST-SERVICE CLAIMS – SERVICES ALREADY RECEIVED

In general, if you have a dental bill from a Non-Participating Provider or Non-Participating Dental Office, our Dental Claims department will handle the claim. Member Services can assist you with questions about specific claims or about the claim procedures in general.

If you receive Services from a Non-Participating Provider following an authorized referral from a Participating Provider, the Non-Participating Provider will send the bill to Dental Claims directly. You are not required to file a claim.

However, if you receive Services from a Non-Participating Provider or Non-Participating Dental Office without an authorized referral and you believe Company should cover the Services, you need to send a completed dental claim form and the itemized bill to:

Kaiser Permanente
Dental Claims 16th Floor
500 NE Multnomah Street
Portland, OR 97232
Fax: 971-285-9031

You can request a claim form from Member Services. When you submit the claim, please include a copy of your dental records from the Non-Participating Provider or Non-Participating Dental Office if you have them.

Company accepts American Dental Association (ADA) Dental claim forms, CMS 1500 claim forms for professional services and UB-04 forms for hospital claims. Even if the provider bills Company directly, you still need to submit the claim form.

You must submit a claim for a Service within 12 months after receiving that Service. If it is not reasonably possible to submit a claim within 12 months, then you must submit a claim as soon as reasonably possible, but in no case more than 15 months after receiving the Service, except in the absence of legal capacity.

We will reach a decision on the claim and pay those covered Charges within 30 calendar days from receipt unless additional information, not related to coordination of benefits, is required to make a decision. If the 30-day period must be extended, you will be notified in writing with an explanation about why. This written notice will explain how long the time period may be extended depending on the requirements of applicable state and federal laws, including ERISA.

You will receive written notification about the claim determination. This notification will provide an explanation for any unpaid amounts. It will also tell you how to appeal the determination if you are not satisfied with the outcome, along with other important disclosures required by state and federal laws.

If you have questions or concerns about a bill from Company, you may contact Member Services for an explanation. If you believe the Charges are not appropriate, Member Services will advise you on how to proceed.

WHAT YOU PAY

Benefit Maximum

Your dental plan may be subject to a Benefit Maximum selected by your Group. If your plan includes a Benefit Maximum, your benefit is limited during each Year to the amount shown in the "Benefit Summary." The "Benefit Summary" also shows what Services do not count toward your Benefit Maximum. Otherwise, Charges for Services we cover, less Copayment or Coinsurance you pay, count toward the Benefit Maximum. After you reach the Benefit Maximum, you pay 100 percent of Charges for Services incurred during the balance of the Year.

If you are covered for orthodontic or implant Services, please note that these Services may not count toward the Benefit Maximum. Your orthodontic coverage and your implant coverage may each have a separate benefit maximum.

Copayments and Coinsurance

The Copayment or Coinsurance you must pay for each covered Service is shown in the "Benefit Summary." Copayments or Coinsurance are due when you receive the Service. If we must bill you, an accounting fee may be added to offset handling costs.

Dental Office Visits

You are covered for a wide range of dental Services. Most Members pay a Copayment for each Participating Dental Office visit. You may be required to pay additional Copayments or Coinsurance for specific Services shown in the "Benefit Summary."

BENEFITS

The Services described in this *EOC* "Benefits" section are covered only if all of the following conditions are satisfied:

- You are a current Member at the time Services are rendered.
- A Participating Dentist determines that the Services are Dentally Necessary.
- The Services are provided, prescribed, authorized, and/or directed by a Participating Dentist or Participating Provider, except where specifically noted to the contrary in this *EOC*.
- You receive the Services inside our Service Area from a Participating Provider, except where specifically noted to the contrary in this *EOC*.
- The Services are provided in a Participating Dental Office, except where specifically noted to the contrary in this *EOC*.
- Coverage is based on the least costly treatment alternative. If you request a Service that is a more costly treatment alternative from that recommended by your Participating Dentist, but that accomplishes the same goal, we will provide that Service if all of the following requirements are met:
  - The Service would have been covered if it was recommended by your Participating Dentist.
  - A Participating Dentist determines that the Service is Dentally Necessary.
  - You receive the Service from a Participating Provider in a Participating Dental Office inside our Service Area.
- We will cover the Services up to the benefit level of the least costly treatment alternative. You will be responsible for any additional Charges.

Your "Benefit Summary" lists the Copayment or Coinsurance for each covered Service. The Services covered by this plan are described below. All benefits are subject to the "Exclusions and Limitations" and "Reductions" sections of this *EOC*.

Preventive and Diagnostic Services

We cover the following preventive and diagnostic Services:

- Evaluations and diagnostic exams to determine Dentally Necessary treatment.
- Examination of your mouth (oral examination) to determine the condition of your teeth and gums.
- Fluoride treatments.
- Routine preventive teeth cleaning (prophylaxis).
- Sealants.
- Space maintainers (appliances used to maintain spacing after removal of a tooth or teeth).
- X-rays to check for cavities and to determine the condition of your teeth and gums.

Minor Restorative Services

We cover the following minor restorative dental Services:

- Routine fillings.
- Simple extractions.
- Stainless steel and composite/acrylic restorations.
- Synthetic (composite, resin, and glass ionomer) restorations.

Oral Surgery Services

We cover the following oral surgery Services:

- Major oral surgery.
- Surgical tooth extractions.

Periodontic Services

We cover the following periodontic Services:

- Periodontal maintenance.
- Periodontal non-surgical Services (scaling, root planing, and full-mouth debridement).
- Periodontal surgical Services.
- Treatment of gum disease.

Endodontic Services

We cover the following endodontic Services:

- Root canal and related therapy.
- Treatment of the root canal or tooth pulp.

Major Restorative Services

We cover the following major restorative Services:

- Bridge abutments.
- Noble metal gold and porcelain crowns, inlays, and other cast metal restorations.
- Pontics. Artificial tooth on a fixed partial denture (a bridge).

Removable Prosthetic Services

We cover the following removable prosthetic Services:

- Full upper and lower dentures.
- Partial upper and lower dentures.
- Maintenance prosthodontics:
    - Adjustments.
    - Rebase and reline.
    - Repairs.

Emergency Dental Care and Urgent Dental Care

Emergency Dental Care. We cover Emergency Dental Care, including local anesthesia and medication when used prior to dental treatment to avoid any delay in dental treatment, only if the Services would have

been covered under other headings of this "Benefits" section (subject to the "Exclusions and Limitations" section) if they were not Emergency Dental Care.

Inside our Service Area

- We cover Emergency Dental Care you receive inside our Service Area from Participating Providers or Participating Dental Offices.
- We cover Emergency Dental Care you receive inside our Service Area from Non-Participating Providers in a hospital emergency department in conjunction with a medical emergency.

Outside our Service Area

If you are temporarily outside our Service Area, we provide a limited benefit for Emergency Dental Care you receive from Non-Participating Providers or Non-Participating Dental Offices, if we determine that the Services could not be delayed until you returned to our Service Area.

Elective care and reasonably foreseen conditions. Elective care and care for conditions that could have been reasonably foreseen are not covered under your Emergency Dental Care or Urgent Dental Care benefits. Follow-up and continuing care is covered only at Participating Dental Offices. You pay the amount shown in the "Benefit Summary."

Copayments, Coinsurance, and reimbursement. You pay the amount shown in the "Benefit Summary."

An Emergency Dental Care office visit Copayment may apply when you receive Emergency Dental Care or an Urgent Dental Care appointment from a Participating Provider.

If you require Emergency Dental Care from Non-Participating Providers when you are outside the Service Area, you are provided limited coverage for Services, including local anesthesia and medication when used prior to dental treatment to avoid any delay in dental treatment. We will not cover more than the amount shown in the "Benefit Summary" for each incident. Non-Participating Providers may charge additional fees for Emergency Dental Care, based on that Non-Participating Dental Office's policy.

Urgent Dental Care. We cover Urgent Dental Care received in our Service Area from Participating Providers and Participating Dental Offices only if the Services would have been covered under other headings of this "Benefits" section (subject to the "Exclusions and Limitations" section) if they were not urgent. Examples include treatment for toothaches, chipped teeth, broken/lost fillings causing irritation, swelling around a tooth, or a broken prosthetic that may require something other than a routine appointment.

We do not cover Urgent Dental Care (or other Services that are not Emergency Dental Care) received outside of our Service Area or received from Non-Participating Providers and Non-Participating Dental Offices.

Other Dental Services

We cover other dental Services as follows:

- Dental Services in conjunction with Medically Necessary general anesthesia or a medical emergency (subject to the "Exclusions and Limitations" section). We cover the dental Services described in the "Benefits" section when provided in a hospital or ambulatory surgical center, if the Services are performed at that location in order to obtain Medically Necessary general anesthesia for a Member or in a hospital's emergency department in order to provide dental Services in conjunction with a medical emergency. We do not cover general anesthesia Services.
- Nightguards. We cover removable dental appliances designed to minimize the effects of bruxism (teeth grinding) and other occlusal factors.
- Nitrous oxide. We cover use of nitrous oxide during Dentally Necessary treatment as deemed appropriate by the Participating Provider.

EXCLUSIONS AND LIMITATIONS

The Services listed in this "Exclusions and Limitations" section are either completely excluded from coverage or partially limited under this *EOC*. These exclusions and limitations apply to all Services that would otherwise be covered under this *EOC* and are in addition to the exclusions and limitations that apply only to a particular Service as listed in the description of that Service in this *EOC*.

Exclusions

- Additional fees a Non-Participating Provider may charge for an Emergency Dental Care or Urgent Dental Care visit after our payment for covered Services.
- Continuation of Services performed or started prior to your coverage becoming effective.
- Continuation of Services performed or started after your membership terminates.
- Cosmetic Services, supplies, or prescription drugs that are intended primarily to improve appearance, repair, and/or replace cosmetic dental restorations.
- Dental implants, including bone augmentation and fixed or removable prosthetic devices attached to or covering the implants; all related Services, including diagnostic consultations, impressions, oral surgery, placement, removal, and cleaning when provided in conjunction with dental implants; and Services associated with postoperative conditions and complications arising from implants, unless your Group has purchased coverage for dental implants as an additional benefit.
- Dental Services not listed in the "Benefits" section of this *EOC*.
- Drugs obtainable with or without a prescription. These may be covered under your medical benefits.
- Experimental or investigational treatments, procedures, and other Services that are not commonly considered standard dental practice or that require United States Food and Drug Administration (FDA) approval. A Service is experimental or investigational if:
    - the Service is not recognized in accordance with generally accepted dental standards as safe and effective for use in treating the condition in question, whether or not the Service is authorized by law for use in testing, or other studies on human patients: or
    - the Service requires approval by FDA authority prior to use and such approval has not been granted when the Service is to be rendered.
- Fees a provider may charge for a missed appointment.
- Full mouth reconstruction, including, but not limited to, occlusal rehabilitation, appliances, restorations, and procedures needed to alter vertical dimension, occlusion, or correct attrition or abrasion.
- Genetic testing.
- Government agency responsibility, we do not reimburse the government agency for any Services that the law requires be provided only by or received only from a government agency. When we cover any of these Services, we may recover the Charges for the Services from the government agency. However, this exclusion does not apply to Medicaid.
- "Hospital call fees," "call fees" or similar Charges associated with Dentally Necessary Services that are performed at ambulatory surgical centers or hospitals.
- Maxillofacial surgery.
- Medical or Hospital Services, unless otherwise specified in the *EOC*.
- Myofunctional therapy.
- Non-orthodontic recording of jaw movements or positions.

- Orthodontic Services, unless your Group has purchased orthodontic coverage as an additional benefit.
- Orthodontic treatment of primary/transitional dentition.
- Orthognathic surgery.
- Procedures, appliances, or fixed crowns and bridges for periodontal splinting of teeth.
- Prosthetic devices following extraction of a tooth (or of teeth) for nonclinical reasons or when a tooth is restorable.
- Replacement of lost or damaged space maintainers.
- Replacement of prefabricated, noncast crowns, including noncast stainless steel crowns, except when the Member has five or more years of continuous dental coverage with Company.
- Services performed by someone other than a Participating Provider or Non-Participating Provider.
- Speech aid prosthetic devices and follow up modifications.
- Surgery to correct malocclusion or temporomandibular joint (TMJ) disorders; treatment for problems of the jaw joint, including temporomandibular joint (TMJ) syndrome and craniomandibular disorders; and treatment of conditions of the joint linking the jaw bone and skull and of the complex of muscles, nerves, and other tissues related to that joint.
- Treatment of cleft palate.
- Treatment of macroglossia.
- Treatment of micrognathia.
- Treatment to restore tooth structure lost due to attrition, erosion, or abrasion.
- Use of alternative materials for removal and replacement of clinically acceptable material or restorations for any reason, except the pathological condition of the tooth (or teeth).

Limitations

- Examination and prophylaxis (routine preventive teeth cleaning), including scaling and polishing, is limited to two visits per Calendar Year as Dentally Necessary.
- Repair or replacement needed due to normal wear and tear of interim fixed and removable prosthetic devices are limited to once every 12 months.
- Repair or replacement needed due to normal wear and tear of permanent fixed and removable prosthetic devices are limited to once every five years.
- Sedation and general anesthesia (including, but not limited to, intramuscular IV sedation, non-IV sedation, and inhalation sedation) are not covered, except nitrous oxide when pursuant to the "nitrous oxide" provision described in the "Other Dental Services" section.

REDUCTIONS

Coordination of Benefits

The Coordination of Benefits (COB) provision applies when a person has dental care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules governs the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100 percent of the total Allowable Expense.

Definitions

The following terms, when capitalized and used in this "Coordination of Benefits" section, mean:

A. **Plan**. Plan is any of the following that provides benefits or services for dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

(1) Plan includes: group and individual insurance contracts, health maintenance organization (HMO) contracts, group or individual Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured); Medicare or any other federal governmental Plan, as permitted by law; and group and individual insurance contracts and subscriber contracts that pay for or reimburse for the cost of dental care.

(2) Plan does not include: medical care coverage; independent, non-coordinated hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental Plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **This Plan**. This Plan means the part of the contract providing the dental care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. Any other part of the contract providing dental care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. **Primary Plan/Secondary Plan**. The order of benefit determination rules determines whether This Plan is a Primary Plan or Secondary Plan when the person has dental care coverage under more than one Plan.

When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100 percent of the total Allowable Expense.

D. **Allowable Expense**. Allowable Expense is a dental care expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

(1) The difference between the cost of an amalgam filling and a composite filling for certain teeth is not an Allowable Expense, unless one of the Plans provides coverage for composite fillings for those teeth.

(2) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

(3) If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

(4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

(5) The amount of any benefit reduction by the Primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Closed Panel Plan**. A Plan that provides dental care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial Parent**. The parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying Plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

(2) Dependent child covered under more than one Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

- The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's dental care expenses or dental care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Plan years commencing after the Plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's dental care expenses or dental care coverage, the provisions of subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental care expenses or dental care coverage of the dependent child, the provisions of subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's dental care expenses or dental care coverage, the order of benefits for the child are as follows:

- The Plan covering the Custodial Parent;
- The Plan covering the spouse of the Custodial Parent;
- The Plan covering the non-Custodial Parent; and then
- The Plan covering the spouse of the non-Custodial Parent.

(c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid-off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D. (1) can determine the order of benefits.

(5) Longer or shorter length of coverage. The Plan that covered the person as an employee, member, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a Plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other dental care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other dental care coverage.

B. If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about dental care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by This Plan is more than it should have paid under this COB provision, This Plan may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Questions About Coordination of Benefits?
Contact Your State Insurance Department

Injuries or Illnesses Alleged to be Caused by Third Parties

This "Injuries or Illnesses Alleged to be Caused by Third Parties" section applies if you receive covered Services for an injury or illness alleged to be any of the following:

- Caused by a third party's act or omission.
- Received on the premises of a third party.

If you obtain a settlement or judgment from or on behalf of a third party, you must ensure we are reimbursed for covered Services that you receive for the injury or illness, except that we will not collect more than the amount you receive from or on behalf of the third party. This "Injuries or Illnesses Alleged to be Caused by Third Parties" section does not affect your obligation to make any applicable Copayments and Coinsurance payments for these covered Services.

If you do not recover anything from or on behalf of the third party, then you are responsible only for any applicable Copayments and Coinsurance payments.

To the extent permitted by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against a third party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by any third party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney, but we will be subrogated only to the extent of the total Charges for the relevant covered Services.

To secure our rights, we will have a lien on the proceeds of any judgment or settlement you or we (when we subrogate) obtain against a third party, regardless of how those proceeds may be characterized or designated. The proceeds of any judgment or settlement that you or we obtain shall first be applied to satisfy our lien, regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred.

You must make all reasonable efforts to pursue any claim you may have against a third party. Within 30 days after submitting or filing a claim or legal action against a third party, you must send written notice of the claim or legal action to us at:

Kaiser Foundation Health Plan of the Northwest
Patient Financial Services—TPL
7201 N Interstate Avenue
Portland, OR 97217

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, trust agreements, authorizations, assignments, and other documents, including lien forms directing your attorney, the third party, and the third party's liability insurer to pay us directly. You must not take any action prejudicial to our rights.

You must place and hold in trust a portion of the proceeds of your recovery that is sufficient to satisfy our claims under this "Injuries or Illnesses Alleged to be Caused by Third Parties" section pending final resolution of the claims. You must provide us with written notice before you settle a claim or obtain a judgment against any third party based on your injury or illness.

In addition to the rights set forth above, we shall also be entitled to all of the remedies, benefits, and other rights of sections 742.520 – 742.542, Oregon Revised Statutes.

If your estate, parent, guardian, or conservator asserts a claim against a third party based on your injury or illness, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

GRIEVANCES, CLAIMS, AND APPEALS

Company will review claims and appeals, and we may use dental experts to help us review them.

The following terms have the following meanings when used in this "Grievances, Claims, and Appeals" section:

- A claim is a request for us to:
  - Provide or pay for a Service that you have not received (pre-service claim);
  - Continue to provide or pay for a Service that you are currently receiving (concurrent care claim); or
  - Pay for a Service that you have already received (post-service claim).

- An adverse benefit determination is our decision to deny, reduce or terminate a Service, or failure or refusal to provide or to make a payment in whole or in part for a Service that is based on:
  - Denial or termination of enrollment of an individual in a dental benefit plan;
  - Rescission or cancellation of a policy;
  - Imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered Services;
  - Determination that a Service is experimental or investigational or not Dentally Necessary or appropriate; or
  - Determination that a course or plan of treatment that a Member is undergoing is an active course of treatment for purposes of continuity of care.
- A grievance is communication expressing dissatisfaction with an adverse benefit determination, without specifically declining any right to appeal or review, that is:
  - In writing, for an internal appeal;
  - In writing or orally for an expedited response; or
  - A written complaint regarding the:
    - Availability, delivery, or quality of a Service;
    - Claims payment, handling or reimbursement for Services and, unless a request for an internal appeal has not been submitted, the complaint is not disputing an adverse benefit determination; or
    - Matters pertaining to the contractual relationship between the Member and Company.
- An appeal is a request for us to review our initial adverse benefit determination.

If you miss a deadline for making a claim or appeal, we may decline to review it.

Language and Translation Assistance

If we send you an adverse benefit determination, we will include a notice of language assistance (oral translation). You may request language assistance with your claim and/or appeal by calling 1-800-813-2000. The notice of language assistance "Help in Your Language" is also included in this *EOC*.

Appointing a Representative

If you would like someone to act on your behalf regarding your claim, you may appoint an authorized representative, an individual who by law or by your consent may act on your behalf. You must make this appointment in writing. Contact Member Services at 503-813-2000 for information about how to appoint a representative. You must pay the cost of anyone you hire to represent or help you.

Help with Your Claim and/or Appeal

While you are encouraged to use our appeal procedures, you have the right to file a complaint or seek other assistance from the Consumer Advocacy Section of the Division of Financial Regulation. Contact them by mail, e-mail, telephone, fax, or online at:

Department of Consumer and Business Services
Division of Financial Regulation
Consumer Advocacy Section
P.O. Box 14480
Salem, OR 97309-0405
E-mail: DFR.InsuranceHelp@oregon.gov
Phone: 503-947-7984
Toll-Free: 1-888-877-4894
Fax: 503-378-4351
https://dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx

Reviewing Information Regarding Your Claim

If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information (including complete dental necessity criteria, benefit provisions, guidelines, or protocols) used to make a denial determination. You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim. To make a request, you should contact Member Services at 503-813-2000.

Providing Additional Information Regarding Your Claim

When you appeal, you may send us additional information including comments, documents, and additional dental records that you believe support your claim. If we asked for additional information and you did not provide it before we made our initial decision about your claim, then you may still send us the additional information so that we may include it as part of our review of your appeal. Please send or fax all additional information to:

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 N.E. Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: 1-855-347-7239

When you appeal, you may give testimony in writing or by telephone. Please send your written testimony to the Member Relations Department:

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 N.E. Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: 1-855-347-7239

To arrange to give testimony by telephone, you should contact Member Relations at 503-813-4480.

We will add the information that you provide through testimony or other means to your claim file and we will review it without regard to whether this information was submitted and/or considered in our initial decision regarding your claim.

Sharing Additional Information That We Collect

If we believe that your appeal of our initial adverse benefit determination will be denied, then before we issue another adverse benefit determination, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the new or additional information and/or reasons and inform you how you can respond to the information in the letter if you choose to do so. If you do not respond before we must make our final decision, that decision will be based on the information already in your claim file.

Claims and Appeals Procedures

There are several types of claims, and each has a different procedure described below for sending your claim and appeal to us as described in this "Claims and Appeals Procedures" section:

- Pre-service claims (urgent and non-urgent)
- Concurrent care claims (urgent and non-urgent)
- Post-service claims

When you file an appeal, we will review your claim without regard to our previous adverse benefit determination. The individual who reviews your appeal will not have participated in our original decision regarding your claim nor will he/she be the subordinate of someone who did participate in our original decision.

Pre-service Claims and Appeals

Pre-service claims are requests that we provide or pay for a Service that you have not yet received. Failure to receive authorization before receiving a Service that must be authorized in order to be a covered benefit may be the basis for our denial of your pre-service claim or a post-service claim for payment. If you receive any of the Services you are requesting before we make our decision, your pre-service claim or appeal will become a post-service claim or appeal with respect to those Services. If you have any general questions about pre-service claims or appeals, please contact Member Services at 503-813-2000.

Here are the procedures for filing a pre-service claim, a non-urgent pre-service appeal, and an urgent pre-service appeal.

Pre-service Claim

- You may request a pre-service benefit determination on your own behalf. Tell us in writing that you want to make a claim for us to provide or pay for a Service you have not yet received. Your request and any related documents you give us constitute your claim. You must mail or fax your claim to us at:

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 N.E. Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 1-855-347-7239

  - If you want us to consider your pre-service claim on an urgent basis, your request should tell us that. We will decide whether your claim is urgent or non-urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life or health or your ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of your dental condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting, or (c) your attending dental care provider requests that your claim be treated as urgent.

- We will review your claim and, if we have all the information we need, we will make a decision within a reasonable period of time, but not later than 15 days after we receive your claim.

  We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you prior to the expiration of the initial 15-day period.

  If we tell you we need more information, we will ask you for the information before the initial decision period ends, and we will give you 45 days to send the information.

  We will make a decision within 15 days after we receive the first piece of information (including documents) we requested.

  We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision.

  If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

- We will send written notice of our decision to you and, if applicable, to your provider.

  If your pre-service claim was considered on an urgent basis, we will notify you of our decision orally or in writing within a timeframe appropriate to your clinical condition, but not later than 72 hours after we receive your claim. Within 24 hours after we receive your claim, we may ask you for more information. We will notify you of our decision within 48 hours of receiving the first piece of requested information. If we do not receive any of the requested information, then we will notify you of our decision within 48 hours after making our request. If we notify you of our decision orally, we will send you written confirmation within three days after the oral notification.

- If we deny your claim (if we do not agree to provide or pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

Non-Urgent Pre-service Appeal

- Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our denial of your pre-service claim. Please include the following:

  (1) Your name and health record number;

  (2) Your dental condition or relevant symptoms;

  (3) The specific Service that you are requesting;

  (4) All of the reasons why you disagree with our adverse benefit determination; and

  (5) All supporting documents.

  Your request and the supporting documents constitute your appeal. You must mail or fax your appeal to us at:

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 N.E. Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 1-855-347-7239

- We will acknowledge your appeal in writing within seven days after we receive it.
- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.

- We will review your appeal and send you a written decision within 30 days after we receive your appeal.
- If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal.

Urgent Pre-service Appeal

- Tell us that you want to urgently appeal our adverse benefit determination regarding your pre-service claim. Please include the following:

  (1) Your name and health record number;

  (2) Your dental condition or relevant symptoms;

  (3) The specific Service that you are requesting;

  (4) All of the reasons why you disagree with our adverse benefit determination; and

  (5) All supporting documents.

  Your request and the supporting documents constitute your appeal. You must mail, fax, or call your appeal to us at:

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 N.E. Multnomah St., Suite 100
  Portland, OR 97232-2099
  Phone: 503-813-4480
  Fax: 1-855-347-7239

- We will decide whether your appeal is urgent or non-urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life or health, or your ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of your dental condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting, or (c) your attending dental care provider requests that your claim be treated as urgent.
- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- We will review your appeal and give you oral or written notice of our decision as soon as your clinical condition requires, but not later than 72 hours after we receive your appeal. If we notify you of our decision orally, we will send you a written confirmation within three days after the oral notification.
- If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal.

Concurrent Care Claims and Appeals

Concurrent care claims are requests that Company continues to provide, or pay for, an ongoing course of covered treatment to be provided over a period of time or number of treatments, when the course of treatment already being received is scheduled to end. If you have any general questions about concurrent care claims or appeals, please call Member Services at 1-800-813-2000.

Unless you are appealing an urgent care claim, if we either (a) deny your request to extend your current authorized ongoing care (your concurrent care claim) or (b) inform you that authorized care that you are currently receiving is going to end early and you appeal our adverse benefit determination at least 24 hours before your ongoing course of covered treatment will end, then during the time that we are considering your appeal, you may continue to receive the authorized Services. If you continue to receive these Services while

we consider your appeal and your appeal does not result in our approval of your concurrent care claim, then you will have to pay for the Services that we decide are not covered.

Here are the procedures for filing a concurrent care claim, a non-urgent concurrent care appeal, and an urgent concurrent care appeal:

Concurrent Care Claim

- Tell us that you want to make a concurrent care claim for an ongoing course of covered treatment. Inform us in detail of the reasons that your authorized ongoing care should be continued or extended. Your request and any related documents you give us constitute your claim. You must submit your claim by mailing, faxing, or calling us at:

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 N.E. Multnomah St., Suite 100
  Portland, OR 97232-2099
  Phone: 503-813-4480
  Fax: 1-855-347-7239

- If you want us to consider your claim on an urgent basis and you contact us at least 24 hours before your care ends, you may request that we review your concurrent care claim on an urgent basis. We will decide whether your claim is urgent or non-urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life or health or your ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of your dental condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting, or (c) your attending dental care provider requests that your claim be treated as urgent.
- We will review your claim, and if we have all the information we need we will make a decision within a reasonable period of time.

  If you submitted your claim 24 hours or more before your care is ending, we will make our decision before your authorized care actually ends.

  If your authorized care ended before you submitted your claim, we will make our decision no later than 15 days after we receive your claim.

  We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we send you notice before the initial 15-day decision period ends.

  If we tell you we need more information, we will ask you for the information before the initial decision period ends, and we will give you until your care is ending or, if your care has ended, 45 days to send us the information.

  We will make our decision as soon as possible, if your care has not ended, or within 15 days after we first receive any information (including documents) we requested.

  We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision.

  If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.
- We will send written notice of our decision to you and, if applicable, to your provider.
- If we consider your concurrent care claim on an urgent basis, we will notify you of our decision orally or in writing as soon as your clinical condition requires, but not later than 24 hours after we received

your claim. If we notify you of our decision orally, we will send you written confirmation within three days after the oral notification.

- If we deny your claim (if we do not agree to provide or pay for extending the ongoing course of treatment), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

Non-Urgent Concurrent Care Appeal

- Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our adverse benefit determination. Please include the following:

  (1) Your name and health record number;

  (2) Your dental condition or relevant symptoms;

  (3) The ongoing course of covered treatment that you want to continue or extend;

  (4) All of the reasons why you disagree with our adverse benefit determination; and

  (5) All supporting documents.

  Your request and all supporting documents constitute your appeal. You must mail or fax your appeal to us at:

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 N.E. Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 1-855-347-7239

- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- We will review your appeal and send you a written decision as soon as possible if your care has not ended but not later than 30 days after we receive your appeal.
- If we deny your appeal, our adverse benefit determination decision will tell you why we denied your appeal.

Urgent Concurrent Care Appeal

- Tell us that you want to urgently appeal our adverse benefit determination regarding your urgent concurrent care claim. Please include the following:

  (1) Your name and health record number;

  (2) Your dental condition or relevant symptoms;

  (3) The ongoing course of covered treatment that you want to continue or extend;

  (4) All of the reasons why you disagree with our adverse benefit determination; and

  (5) All supporting documents.

Your request and the supporting documents constitute your appeal. You must mail, fax, or call your appeal to us at:

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 N.E. Multnomah St., Suite 100
Portland, OR 97232-2099
Phone: 503-813-4480
Fax: 1-855-347-7239

- We will decide whether your appeal is urgent or non-urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life or health or your ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of your dental condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting; or (c) your attending dental care provider requests that your claim be treated as urgent.
- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- We will review your appeal and notify you of our decision orally or in writing as soon as your clinical condition requires, but no later than 72 hours after we receive your appeal. If we notify you of our decision orally, we will send you a written confirmation within three days after the oral notification.
- If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal.

Post-service Claims and Appeals

Post-service claims are requests that we pay for Services you already received, including claims for out-of-plan Emergency Dental Care. If you have any general questions about post-service claims or appeals, please call Member Services.

Here are the procedures for filing a post-service claim and a post-service appeal:

Post-service Claim

- Within 12 months from the date you received the Services, mail us a letter explaining the Services for which you are requesting payment. Provide us with the following:

  (1) The date you received the Services;

  (2) Where you received them;

  (3) Who provided them;

  (4) Why you think we should pay for the Services; and

  (5) A copy of the bill and any supporting documents.

  Your letter and the related documents constitute your claim. You may contact Member Services to obtain a claim form. You must mail your claim to the Claims Department at:

  Kaiser Permanente
  National Claims Administration - Northwest
  P.O. Box 370050
  Denver, CO 80237-9998

- We will not accept or pay for claims received from you after 12 months from the date of Services, except in the absence of legal capacity.
- We will review your claim, and if we have all the information we need we will send you a written decision within 30 days after we receive your claim.

We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you within 30 days after we receive your claim.

If we tell you we need more information, we will ask you for the information before the end of the initial 30-day decision period, and we will give you 45 days to send us the information.

We will make a decision within 15 days after we receive the first piece of information (including documents) we requested.

We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision.

If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

- If we deny your claim (if we do not pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

Post-service Appeal

- Within 180 days after you receive our adverse benefit determination, tell us in writing that you want to appeal our denial of your post-service claim. Please include the following:

  (1) Your name and health record number;

  (2) Your dental condition or relevant symptoms;

  (3) The specific Services that you want us to pay for;

  (4) All of the reasons why you disagree with our adverse benefit determination; and

  (5) All supporting documents.

  Your request and the supporting documents constitute your appeal. You must mail or fax your appeal to us at:

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 N.E. Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 1-855-347-7239

- We will acknowledge your appeal in writing within seven days after we receive it.
- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- We will review your appeal and send you a written decision within 30 days after we receive your appeal.
- If we deny your appeal, our adverse benefit determination will tell you why we denied your appeal.

Member Satisfaction Procedure

We want you to be satisfied with the Services you receive from Kaiser Permanente. We encourage you to discuss any questions or concerns about your care with your Participating Provider or another member of your dental care team. If you are not satisfied with your Participating Provider, you may request another. Contact Member Services for assistance. You always have the right to a second opinion from a qualified Participating Provider at the applicable Copayment or Coinsurance.

If you are not satisfied with the Services received at a particular Participating Dental Office, or if you have a concern about the personnel or some other matter relating to Services and wish to file a complaint, you may do so by following one of the procedures listed below.

- Contact the administrative office in the Participating Dental Office where you are having the problem.
- Calling Member Services at 503-813-2000; or
- Sending your written complaint to Member Relations at:

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 NE Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 1-855-347-7239

All complaints are handled in a confidential manner.

After you notify us of a complaint, this is what happens:

- A representative reviews the complaint and conducts an investigation, verifying all the relevant facts.
- The representative or a Participating Provider evaluates the facts and makes a recommendation for corrective action, if any.
- When you file a complaint, we will respond within 30 calendar days, unless additional information is required.

We want you to be satisfied with our Participating Dental Offices, Services, and Participating Providers. Using this Member satisfaction procedure gives us the opportunity to correct any problems that keep us from meeting your expectations and your dental care needs. If you are dissatisfied for any reason, please let us know.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedures. If you are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (3272). Alternatively, if your plan is not subject to ERISA (for example, most state or local government plans and church plans or all individual plans), you may have a right to request review in state court.

TERMINATION OF MEMBERSHIP

If your membership terminates, all rights to benefits end at 11:59 p.m. on the termination date. In addition, Dependents' memberships end at the same time the Subscribers' membership ends.

You will be billed as a non-member for any Services you receive after your membership termination date. Company, Participating Providers, and Participating Dental Offices have no further liability or responsibility under this *EOC* after your membership terminates.

Termination due to Loss of Eligibility

You and your Dependents must remain eligible to maintain your Group coverage. You must immediately report to your Group any changes in eligibility status, such as a Spouse's loss of eligibility due to divorce or a Dependent who has reached the Dependent Limiting Age. If you no longer meet the eligibility requirements described in this *EOC,* please confirm with your Group's benefits administrator when your membership will end.

Termination for Cause

If you or any other Member in your Family commits one of the following acts, we may terminate your membership by sending written notice, including the reason for termination and supporting evidence, to the Subscriber at least 31 days before the membership termination date:

- You knowingly commit fraud and intentional misrepresentation in connection with membership, Company, or a Participating Provider. Some examples of fraud include:
  - Misrepresenting eligibility information about yourself or a Dependent.
  - Presenting an invalid prescription or dental order.
  - Intentionally misusing a Company ID card (or letting someone else use your ID card to obtain Services while pretending to be you).
  - Giving us incorrect or incomplete material information.
  - Failing to notify us of changes in Family status or Medicare coverage that may affect your eligibility or benefits.

  We may report fraud and other illegal acts to the authorities for prosecution.

If we terminate your membership for cause, we will:

- Refund any amounts we owe your Group for Premium paid for the period after the termination date.
- Pay you any amounts we have determined that we owe you for claims during your membership.

We may deduct any amounts you owe Company, Participating Providers or Participating Dental Offices from any payment we make to you.

If your coverage is terminated for any of the above reasons, you have the right to file an appeal. For more information, please contact Member Services.

Termination of Your Group's *Agreement* with Us

If your Group's *Agreement* with us terminates for any reason, your membership ends on the same date. The Group is required to notify Subscribers in writing if the *Agreement* with us terminates.

Termination of a Product or All Products

We may terminate a particular product or all products offered in a small or large group market as permitted by law. If we discontinue offering a particular product in a market, we will terminate the particular product upon 90 days prior written notice to you. If we discontinue offering all products to groups in a small or large group market, as applicable, we may terminate the *Agreement* upon 180 days prior written notice to you.

CONTINUATION OF MEMBERSHIP

Continuation of Group Coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA)

You may be able to continue your coverage under this *EOC* for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. COBRA applies to most employees (and most of their covered dependents) of most employers with 20 or more employees (however, it does not apply to church plans as defined by federal law). Please contact your Group for details about COBRA continuation coverage, such as how to elect coverage and how much you must pay your Group for the coverage.

Federal or State-Mandated Continuation of Coverage

Termination of coverage will be postponed if the Member is on a leave of absence and continuation of coverage is required by the federal or state-mandated family or medical leave act or law, as amended.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are called to active duty in the uniformed services, you may be able to continue your coverage under this *EOC* for a limited time after you would otherwise lose eligibility, if required by federal law (USERRA).

You must submit an USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage and how much you must pay your Group for the coverage.

MISCELLANEOUS PROVISIONS

Administration of *Agreement*

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of this *EOC*.

Agreement Binding on Members

By electing coverage or accepting benefits under this *EOC*, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this *EOC*.

Amendment of *Agreement*

Your Group's *Agreement* with us will change periodically. If these changes affect this *EOC*, your Group is required to make revised materials available to you.

Applications and Statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this *EOC*. In the absence of fraud, all statements made by an applicant, Group, or Subscriber shall be deemed representations and not warranties. No statement made for the purpose of effecting coverage shall void coverage or reduce benefits unless contained in a written instrument signed by the Group or Subscriber, a copy of which has been furnished to the Group or Subscriber.

Assignment

You may not assign this *EOC* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without our prior written consent.

Attorney Fees and Expenses

In any dispute between a Member and Company or Participating Providers or Participating Dental Offices, each party will bear its own attorney fees and other expenses, except as otherwise required by law.

Governing Law

Except as preempted by federal law, this *EOC* will be governed in accord with Oregon law and any provision that is required to be in this *EOC* by state or federal law shall bind Members and Company whether or not the provision is set forth in this *EOC*.

Group and Members Not Company Agents

Neither your Group nor any Member is the agent or representative of Company.

No Waiver

Our failure to enforce any provision of this *EOC* will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

Nondiscrimination

We do not discriminate in our employment practices or in the delivery of Services on the basis of race, ethnicity, nationality, actual or perceived gender, age, physical or mental disability, marital status, sexual orientation, genetic information, or religion.

Notices

We will send our notices to you to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change of address. Subscribers who move should call Member Services as soon as possible to give us their new address.

Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives an overpayment, or from any person or organization obligated to pay for the Services.

Privacy Practices

Kaiser Permanente will protect the privacy of your protected health information (PHI). We also require contracting providers to protect your PHI. Your PHI is individually identifiable information about your health, health care Services you receive, or payment for your health care. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

We may use or disclose your PHI for treatment, payment, health research, and health care operations purposes, such as measuring the quality of Services. We are sometimes required by law to give PHI to others, such as government agencies or in judicial actions. In addition, Member-identifiable health information is shared with your Group only with your authorization or as otherwise permitted by law. We will not use or disclose your PHI for any other purpose without your (or your representative's) written authorization, except as described in our Notice of Privacy Practices (see below). Giving us this authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our Notice of Privacy Practices, which provides additional information about our privacy practices and your rights regarding your PHI, is available and will be furnished to you upon request. To request a copy, call Member Services. You can also find the notice at your local Participating Dental Office or on our website at **kp.org/dental/nw**.

Unusual Circumstances

We will do our best to provide or arrange for your dental care needs in the event of unusual circumstances that delay or render impractical the provision of Services under this *EOC*, such as major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Participating Dental Office, complete or partial destruction of facilities, and labor disputes. However, in these circumstances, neither we, nor any Participating Dental Office facilities, or any Participating Provider shall have any liability or obligation because of a delay or failure to provide these Services. In the case of a labor dispute involving Company, we may postpone non-Emergency Dental Care until after resolution of the labor dispute.

NONDISCRIMINATION STATEMENT AND NOTICE OF LANGUAGE ASSISTANCE

Nondiscrimination Notice

Kaiser Foundation Health Plan of the Northwest (Kaiser Health Plan) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call 1-800-813-2000 (TTY: 711)

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail or phone at:

Member Relations Department
Attention: Kaiser Civil Rights Coordinator
500 NE Multnomah St. Ste 100
Portland, OR 97232-2099
Phone: 1-800-813-2000

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
Phone: 1-800-368-1019
TDD: 1-800-537-7697

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

Help in Your Language

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-813-2000** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-813-2000** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-813-2000** (TTY: **711**).

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電**1-800-813-2000**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-813-2000** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-813-2000** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-813-2000** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-813-2000**（TTY: **711**）まで、お電話にてご連絡ください。

ខ្មែរ (Khmer) ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-800-813-2000** (TTY: **711**)។

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-813-2000** (TTY: **711**) 번으로 전화해 주십시오.

ລາວ (Laotian) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-800-813-2000** (TTY: **711**).

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíilnih **1-800-813-2000** (TTY: **711**).

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-813-2000** (TTY: **711**).

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-800-813-2000** (TTY: **711**) 'ਤੇ ਕਾਲ ਕਰੋ।

Română (Romanian) ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la **1-800-813-2000** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-813-2000** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-813-2000** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-813-2000** (TTY: **711**).

ไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-813-2000** (TTY: **711**).

Українська (Ukrainian) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером **1-800-813-2000** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-813-2000** (TTY: **711**).

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST ORTHODONTIC SERVICES RIDER

This rider is part of the Evidence of Coverage (*EOC*) to which it is attached. All provisions of this rider become part of the *EOC* "Benefits" section except for the "Orthodontic Services Rider Benefit Summary," which becomes part of the *EOC* "Benefit Summary." This entire benefit rider is therefore subject to all the terms and provisions of the *EOC*.

This benefit has a Lifetime Benefit Maximum. For purposes of this rider, a Lifetime Benefit Maximum means we will not cover more than the amount shown in the "Orthodontic Services Rider Benefit Summary" for all covered Services during your lifetime. Your Lifetime Benefit Maximum is calculated by adding up the Charges for all Orthodontic Services we covered under this rider or under any other *EOC* with the same group number printed on the *EOC* to which this rider is attached and subtracting any Deductible, Copayments, and Coinsurance you paid for those Services.

Definitions

Orthodontic Services. Orthodontic treatment for abnormally aligned or positioned teeth.

General Benefit Requirements

Treatment under this rider will be covered as long as you meet the following conditions:

- You allow no significant lapse in the continuous orthodontic treatment process.
- You maintain continuous eligibility under this or any other Company dental contract that includes coverage for Orthodontic Services.
- You make timely payment of amounts due.

In all other cases, orthodontic treatment may be completed at the full price of the Service. Orthodontic devices provided at the beginning of treatment are covered. Replacement devices are available at the full price of the Service.

Exclusions and Limitations

Coverage for Services and supplies is not provided for any of the following:

- Maxillofacial surgery.
- Myofunctional therapy.
- Replacement of broken orthodontic appliances.
- Re-treatment of orthodontic cases.
- Treatment of cleft palate.
- Treatment of macroglossia.
- Treatment of micrognathia.
- Treatment of primary/transitional dentition.

Orthodontic Services Rider Benefit Summary

Orthodontics	
Lifetime Benefit Maximum	$1,500
	You Pay
Orthodontic Services	50% of Charges up to the Lifetime Benefit Maximum, and 100% of Charges thereafter.

KAISER PERMANENTE
Kaiser Foundation Health Plan
of the Northwest
500 NE Multnomah St., Ste 100
Portland, OR 97232

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